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

2015 -2020
Version June 10, 2015

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Attachments

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

1. **Memo to California Indian Health Programs and Urban Indian Organizations dated February 11, 2015**

2. **Mental Health Plans (MHP)/Department of Health Care Services (DHCS) Boilerplate Contract**
   http://www.dhcs.ca.gov/services/MH/Documents/Attachment%202%20MHP%20Contract%20Boilerplate.pdf

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

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

5. **DHCS and Behavioral Health Concepts Contract for External Quality Review Organization (EQRO) Activities Work Plan**

6. **EQR schedules for FY 2014-2015**
   www.caleqro.com

7. **MHSD Information Notice 13-09 "Threshold Languages"**
   http://www.dhcs.ca.gov/formsandpubs/Documents/13-09ThreshholdLang.pdf

   7a MHSD Information Notice 13-09 "Threshold Languages" Enclosure 1
   http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf

   7b MHSD Information Notice 13-09 "Threshold Languages" Enclosure 2
   http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf

   7c MHSD Information Notice 13-09 "Threshold Languages" Enclosure 3
   http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf

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

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

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

11. **Mental Health Services Division (MHSD) Information Notice No. 14-027"Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2014-2015" Enclosure 1**
    http://www.dhcs.ca.gov/formsandpubs/Documents/14_027_Encl_1.pdf

12. **MHSD Information Notice No. 14-027 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2014-2015 "**
    http://www.dhcs.ca.gov/formsandpubs/Documents/14-027_Annual_Review_Protocol.pdf

13. **MHSD Information Notice No. 14-027 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2014-2015 " Enclosure 4 Reasons for Recoupment**
    http://www.dhcs.ca.gov/formsandpubs/Documents/14_027_Encl_4.pdf

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

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

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

17. **2015Summary of Department of Mental Health Specialty Mental Health Services by Race/Ethnicity**

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

Facesheet

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

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

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

Type of request. **This is an:**

___ initial request for new waiver. All sections are filled.

__ amendment request for existing waiver, which modifies Section/Part

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

_ Document is replaced in full

_X__ renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

_X_ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is X replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is X__ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in

attached replacement pages

Effective Dates: **This waiver/renewal/is requested for a period of 5 years ; effective July 1, 2015 and ending June 30, 2020. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)**

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

Section A: Program Description

Part I: Program Overview

Tribal consultation

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

The state is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009 (ARRA). DHCS must solicit the advice of designees prior to submission to the Centers for Medicare and Medicaid Services (CMS) of any waiver renewal. On February 11, 2015 a memorandum was provided to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see attachment 1). The State requested that comments be provided within 30 days of the date of the memo. As of the date of this submission, DHCS has received three written comments from federally recognized tribes or other tribal organizations in California. All three comments were received during a webinar hosted by DHCS' Rural and Primary Health Division. Responses were provided to that division.

Program History:

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

Overview of Request for Waiver Renewal

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

Section 1915 (b) waivers relevant to specialty mental health services have been in effect in California since 1995. The current request refers to the ninth renewal of the SMHS waiver and will be effective from July 1, 2015 to June 30, 2020.
Program Design for Medi-Cal Specialty Mental Health Managed Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

services. Nursing facility services (which were provided through the FFS/MC) were not consolidated into the SMHS waiver program; thus, psychiatric nursing facility services is not considered to be a service provided through the SMHS waiver.

Although the SMHS waiver consolidated services provided through the SD/MC and the FFS/MC programs, the term "SD/MC services" remained in general usage to describe the services provided under the SMHS waiver which are now called "specialty mental health services."

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

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

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

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

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

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

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

- **As a component of the Medi-Cal SMHS waiver program, the State continued the laboratory and pharmacy aspect of the San Mateo field test since this had proven effective for the San Mateo MHP and its beneficiaries.**

- **The State did not propose that other MHPs cover these services.**

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

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

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

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

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

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

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

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

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

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

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

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

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

- **SPA #10-016 which updates the State Plan service descriptions for Rehabilitative Mental Health Services and Psychiatric Inpatient Hospital Services was submitted to CMS on December 29, 2010. CMS approved this SPA on March 21, 2011. The effective date for SPA #10-016 was October 1, 2010.**

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

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

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

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

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

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

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

- **SD/MC Phase II (SD/MC II) Electronic Claims Processing System**
  The SD/MC Claims Processing System adjudicates Medi-Cal specialty mental health service claims from California's county MHPs. This new system began operations on February 11, 2010. The old system was phased out on March 31, 2010. The goals of the new SD/MC II system are to adjudicate Health Insurance

Portability and Accountability Act (HIPAA) compliant claims in near "real time" in order to pay MHPs reimbursement funds more quickly and to return denied claims for correction within hours of being received. Another significant statewide system update took place during the 7th waiver period to comply with the federal HIPAA 5010 Transactions and Code Sets regulations.

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

During the eighth waiver renewal which covers the time period July 1, 2013 – June 30, 2015, the SMHS consolidation waiver program will include the following new and/or updated projects/processes.

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

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

- **The EQRO contract was secured by the State for FY 2009/10 - June 30, 2012 with an option to extend the contract for two additional one year extension periods. The State exercised the option of extending the contract through FY 2012-2013. The State is in the process of extending the contract for FY 2013-2014. During waiver period 8, the State will conduct a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E commencing with Section 438.10.**

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

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

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

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

  HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), provides health (including mental health), dental, and vision coverage to over 863,000 children. Children transitioning from the HFP to Medi-Cal will continue to receive health, dental, and vision benefits. MHPs will be responsible for all Specialty Mental Health Services including psychiatric inpatient hospitalization for beneficiaries that meet medical necessity criteria. Historically, MHPs served HFP members that were seriously emotionally disturbed (SED), which accounted for about 1 percent of all HFP members.

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

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

- **Performance and Outcomes System Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Mental Health Services**
  Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012) added Section 14707.5 to the California Welfare and Institutions Code (WIC). It requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission and a stakeholder advisory committee to develop a plan for a performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

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

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

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

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

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

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**
  The department is aware of the upcoming release of DSM-5 and has implemented a workgroup to study the changes to the diagnostic classification system and to make any recommendations which are necessitated by those

changes. Any proposed substantive changes will be submitted to CMS for its approval prior to implementation.

During the ninth waiver renewal which covers the time period July 1, 2015 – June 30, 2020 the SMHS consolidation waiver program will include the following new and/or updated projects/activities.

- **MHP Contract**
  The State has finalized standard contract language and has contracts in place between DHCS and the MHPs. The effective date of the contract was May 1, 2013. This contract will be in place for a period of five years and two months extending until June 30, 2018, to conform to the State fiscal year. (see Attachment 2)

- **EQRO Contracts**
  The State conducted a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E commencing with Section 438.10. The EQRO contract with Behavioral Health Concepts was secured by the State for FY 2014/15 through FY 2016/17 with an option to extend the contract for two additional one year extension periods. The EQROs review has commenced. (see Attachment 5).

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Performance and Outcomes System for Mental Health Services**
  In 2012, in accordance with Senate Bill 1006 (Chapter 32, Statutes of 2012), the California State Legislature enacted a process for DHCS to develop a plan for an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program and system levels and to inform fiscal decision-making related to the purchase of services.

  After two years of research and development, the project will move into its implementation phase during waiver renewal period 9. The Performance Outcomes System implementation will establish a process for bringing together information from multiple sources (e.g., encounter, claims, functional assessment data, pharmacy, child welfare, education status) in order to measure outcomes in the areas of access, engagement, service appropriateness to need, service effectiveness, linkages, cost and satisfaction, at the individual, provider, system, and community levels. The intent of the system is to gather information relevant to particular mental health outcomes from current and enhanced county reporting and state databases to provide useful summary reports for ongoing quality improvement processes and decision-making, to determine if individuals, providers, and service delivery systems are improving, and implement appropriate changes based on the results of data analysis.

DHCS continues to make progress in the areas of working with stakeholders on the development of Performance Outcomes System (POS) domains, indicators and measures; identifying appropriate functional assessment tools and developing quality improvement plans.

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5):**
  DHCS established a workgroup that is reviewing and analyzing the diagnostic codes impacted by DSM-5. During waiver period 9, a determination will be made regarding the impact to the SMHS waiver along with development and distribution of appropriate policy changes.

- **Katie A Lawsuit**
  Katie A v. Bonta is a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of entering the foster care system. In December 2011, a settlement agreement was reached and in December 2012 the court approved an implementation plan to accomplish a systemic change for mental health services to children and youth by promoting, adopting, and endorsing three service approaches provided within the context of a Core Practice Model: Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC). These service approaches fall within the parameter of existing SMHS. The Department is in the process of determining the model for TFC and clarifying with the Centers for Medicare and Medicaid Services prior to implementation. Implementation of ICC, IHBS and TFC on a statewide basis is planned during the 9th waiver period. The federal court's jurisdiction over the lawsuit formally ended on December 1, 2014.

- A. Statutory Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Meet both of the following criteria:

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

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

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

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

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

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

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

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

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

(A) A significant impairment in an important area of life functioning;

(B) A reasonable probability of significant deterioration in an important area of life functioning or;

(C) For children under 21, a reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness or condition of a child. (3) Meet each of the intervention criteria listed below:

(A) the focus of the proposed intervention is to address the impairment/condition identified above;

(B) The expectation is that the proposed intervention will

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Allow the child to progress developmentally as individually appropriate.

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

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

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

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

Treatment for the health care conditions of Medi-Cal beneficiaries who do not meet the medical necessity criteria for specialty mental health services (for example, excluded diagnoses, mental health conditions resulting in mild to moderate impairment of mental, emotional or behavioral functioning as well as all non-mental health medical conditions and services) is not covered under the waiver program. Services for these "excluded" conditions may be provided through other California Medi-Cal programs – primarily the Medi-Cal Managed Care Plans (MCPs) or the Fee-for-Service Medi-Cal (FFS/MC) program.

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

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

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

1. ***DHCS Special projects***
   Enrollees in several small special projects continue to receive most Medi-Cal specialty mental health services through contracts between DHCS and the special projects rather than receiving these services from their respective county MHPs. The special projects involved are the State's projects under the Program for All-Inclusive Care for the

Elderly (PACE) and the Senior Care Action Network (SCAN), a health maintenance organization operating under the authority of 1915(a) of the Social Security Act. Enrollees in these programs may receive rehabilitative mental health services under the Medi-Cal SMHS Consolidation waiver program from their county MHPs

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

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

To assure continuity of care, the Partnership HealthPlan continues to capitate Kaiser Permanente for SMHS provided to its Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership HealthPlan and Kaiser Permanente.

The Solano County MHP reimburses DHCS with funds from its 2011 Realignment allocations associated with the capitated amount provided by DHCS to Partnership HealthPlan.Partnership HealthPlan provides a capitated rate to Kaiser for SMHS provided to Kaiser members.

4. ***Family Mosaic***
The Family Mosaic Project (FMP) is a small special project that provides specialty mental health services, intensive case management, and wraparound services to seriously emotionally disturbed children and youth, and their families, in order to reduce the risk of out-of-home placement. If a child is residing outside of the home, the FMP attempts to provide services that will either maintain or reduce the current level of care in order to avoid institutionalization, juvenile detention, or other restrictive treatment settings.

The FMP operates via contract between the City and County of San Francisco and DHCS under which the City and County of San Francisco receives a per-member, per-month capitated rate for each FMP enrollee. As a condition of the contract, San Francisco County, Department of Public Health, Community Behavioral Health Services

is at risk for all specialty mental health services for FMP enrollees with the exception of psychiatric health facility services, adult residential treatment service, crisis residential treatment services, and TBS. The San Francisco County MHP is also responsible for all non-contracted services for FMP enrollees.

The current FMP contract was extended through June 30, 2015, however DHCS is considering transitioning children and adolescents with Serious Emotional Disturbance (SED) receiving specialty mental health services from the FMP to the San Francisco County MHP during waiver period 9.

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

d. X Section 1902(a)(4) - **To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).**
The State requests that the plan for complying with Title 42, CFR, Section 438.10(f)(3) regarding the distribution of informing materials as specified in a letter from CMS dated April 26, 2005 (see attachment 3) be continued for the duration of the ninth waiver period.

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

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

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

- **Section 438.56 in its entirety along with waivers of related references to disenrollment in other regulations.**

- **Section 438.52 for enrollment of beneficiaries in a single MHP in each county.**

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

To the extent necessary, the continuation of waivers previously granted are requested of all sections of the these federal regulations that mention the obligation to inform all enrollees, instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though an MHP.

B. Delivery Systems

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

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

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

__ The PIHP is paid on a risk basis.

_X_ The PIHP is paid on a non-risk basis. The PIHPs are not at risk for FFP for the cost of services.

In 1994, Medi-Cal mental health managed care statutes were enacted. In accordance with California W&I Code sections14680 et seq and 14712 et seq , specialty mental health services are provided by the MHP. Accordingly, the SMHS Consolidation waiver program is administered locally by each county's MHP and each county's MHP provides, or arranges for, specialty mental health services for Medi-Cal beneficiaries.

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

For FY 2015-2016 through FY 2019-2020, counties will utilize realignment funds, MHSA and/or local county funds to pay for services which counties will then certify as public expenditures.

1. Realignment funds: Realignment funds are continuously appropriated to counties and are not subject to appropriation in the State Budget. Funding is derived from dedicated funding sources. Funding was first realigned to the counties in 1991, through the Bronzan-McCorquodale Act (W&I Code Section 5600-5772) and again as part of the 2011-2012 Governor's budget effective July 1, 2012.

- **1991 Realignment**
  Realignment funds (which originate from a sales tax increase and a vehicle license fee increase) are collected by the State Controller's Office and allocated to various accounts and sub-accounts in a State Local Revenue Fund. Each county has three program accounts: mental health, social services and health. Each month the state distributes funds from the Local Revenue Fund to counties' local health and welfare trust funds for the provision of mental health, social services and health care program(s). State law (W&I Code, Section 14714(j)) specifies that counties must fulfill their Medi-Cal contract obligations before funding other non-Medi-Cal programs with Realignment funds.
- **2011 Realignment**
  Established a Local Revenue Fund 2011 into which a percentage of sales tax and vehicle license fee revenue is deposited. A percentage of sales tax revenue deposited into the Local Revenue Fund 2011 is allocated to a behavioral health subaccount and distributed to counties to provide specialty mental health services, Drug Medi-Cal services, and Substance Use Disorder services (Gov. Code, Section 30025.)

2. MHSA funds: The Mental Health Services Act of 2004 as amended in 2012 imposed a 1 percent income tax on personal income in excess

of $1 million for each taxable year beginning in 2005 (Revenue and Tax (R&T) Code Section 17043). The revenue collected pursuant to R&T Section 17043 is continuously appropriated to the counties into the MHS Fund by the State Controller's Office monthly (Welfare & Institutions Code section 5890 (a).

To the extent that a county mental health system receives MHSA funds (intended for new and innovative programs), counties may provide services to Medi-Cal beneficiaries through these new or transformed programs. Medi-Cal reimbursable services to eligible beneficiaries may be funded with county MHSA funds, at county discretion. However, the funds may not be used to supplant existing state or county funds utilized to provide mental health services.

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

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

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

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

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

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

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

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

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

1. Assurances.

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

_X_ **The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.**

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

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

Beneficiaries are provided with a choice of providers within the MHP and an opportunity to change providers whenever feasible under Title 9, CCR, Section 1830.225. Although the regulation allows MHPs to limit the beneficiary's choice to two (2) providers, the beneficiary may request an additional change if not satisfied. The regulation also states that the opportunity for choice may be limited by feasibility. In

most cases, feasibility is linked to the number of providers in the MHP's network. An MHP in a very small county or in any one geographic area may have a limited number of providers for a particular service. If additional providers are not needed to meet general access requirements, MHPs are not obligated to contract with additional providers to provide more choices for an individual beneficiary. In a very small number of cases, the MHP may deny a request for a change of provider when a change is clinically contraindicated.

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

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

3. Rural Exception.

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f) (1) (ii)):

4. 1915(b)(4) Selective Contracting

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

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

D. Geographic Areas Served by the Waiver

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

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

___ Less than Statewide

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

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

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

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

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

E. Populations Included in Waiver

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

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

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

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

X_ Mandatory enrollment
___ Voluntary enrollment

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

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Foster Care Children **are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.**

X__ Mandatory enrollment
___ Voluntary enrollment

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

__X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Section 1902 (a)(10)(A)(i)(VIII) Adult beneficiaries are nonpregnant adults ages 19 through 64 who are not otherwise mandatorily eligible for Medicaid and with income at or below 133 percent of the federal poverty level

_X_ Mandatory enrollment
___ Voluntary enrollment

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

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

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

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

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

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

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

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

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

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

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

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

___ Other **(Please define):**

F. Services

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

1. Assurances.

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

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

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

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

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

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

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

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

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

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

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

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___ The State will pay for all family planning services, whether provided by network or out-of-network providers.

__ Other (please explain):

_X__ Family planning services are not included under the waiver.

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

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

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

_X_ **The program is** mandatory **and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.**

5. EPSDT Requirements.

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

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

6. 1915(b)(3) Services.

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

7. Self-referrals.

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

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

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

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

Section A: Program Description

Part II: Access

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

A. Timely Access Standards

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

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

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

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval. The MHP contract requires MHPs to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract, and to consider the number and types of providers needed to meet expected utilization. Please refer to the MHP contract scope of work, Exhibit A, Attachment I, pages 3 and 4. The Program Oversight and Compliance Branch system reviews audit to this requirement in their review protocol under the Provider Relations category.

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

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

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

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

9.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

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

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

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

7.___ Other providers (please describe):

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

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

B. Capacity Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*

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

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

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

C. Coordination and Continuity of Care Standards

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

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

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

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

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

The following items are required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

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

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

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

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

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

The EQRO contract with Behavioral Health Concepts, Inc. was secured by the State for FY 2014/15 through FY 2016/17 on August 11, 2014, with an option to extend the contract for two additional one year extension periods. The EQRO has commenced its FY 2014/15 review of MHPs.

Copies of the EQR schedules are available. see attachment 6).

The table below summarizes the State's EQR activities
Note: APS Health Care MidWest conducted EQR activities though FY 2013/2014. Therefore some of the activities noted below were performed by APS.

Program	Name of Organization	Activities To be Conducted FY 2015/2016-2019/2020		
		EQR Study	Mandatory Activities	Optional Activities
	Behavioral Health Concepts	The results of the Performance Measure for 2012/2013 are specified in results of monitoring activities for EQRO section s1 page 110 below. The Performance Measures for FY 2013/2014 includes analyses of claims data including the following data elements: Gender Race/Ethnicity Service Activity Eligibility Category (Aid group) Age Groups by Gender. Performance Improvement Projects (PIPs): Two studies, one	Validation that the MHP meets federal data integrity requirements Validation of performance measures Validation of PIPs Validation that the MHP meets quality requirements by conducting focus groups to obtain client and family member perspective and conducting interviews with providers and other stakeholders Review of the procedures the MHP has in place for collecting and integrating mental health service, financial, eligibility and service provider	Participation in statewide QIC meetings and the annual meeting of QI Coordinators Review of the Cultural Competence Plan (CCP) and/or Update* Focus Groups with beneficiaries Consultation with State and MHP information technology personnel on issues that impact State and MHP Information Systems and EQR activities

Program	Name of Organization	Activities To be Conducted FY 2015/2016-2019/2020		
		EQR Study	Mandatory Activities	Optional Activities
		clinical and one non- clinical, are selected by each MHP and reviewed by the EQR in every MHP.	information covering service related data, from internal and external sources Participation of a diverse group of consumers and family members as part of the on-site review Validation of consumer satisfaction surveys Recommendations based on observed strengths and weaknesses of the MHP's Quality Management Program Technical assistance to each MHP Development of a statewide summary report after FY 2012/2013 and FY 2013/2014 is completed. Participation in statewide meetings as required to provide information on	

Program	Name of Organization	Activities To be Conducted FY 2015/2016-2019/2020		
		EQR Study	Mandatory Activities	Optional Activities
			EQRO activities Recruit and train a diverse group of consumers and family members from around the state who shall participate as part of each on-site review team	

*** The review to confirm MHP compliance with requirement is conducted by DHCS through the Mental Health Service Division's triennial compliance reviews. Additional review of this requirement will take place when MHPs submit Cultural Competence Plan Updates in the new waiver period. The EQRO also uses this information for their annual reviews, to supplement the results of DHCS monitoring of this requirement through the compliance reviews. In addition, DHCS Mental Health Services Division County Support Unit staff obtain evidence of correction from MHPs that were out of compliance with this requirement during their system review, and provide technical assistance and status updates to ensure that MHPs meet this requirement on an ongoing basis**

2. Assurances For PAHP program.

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

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

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

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

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

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

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

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

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

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

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

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

8.___ Change an enrollee's PCCM;

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

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

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

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ Selection and Retention of Providers: **This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the**

State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

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

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

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

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

A. ___ Initial credentialing

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

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

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

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

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

7. __ Other (please describe).

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

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

Section A: Program Description

Part IV: Program Operations

A. Marketing

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

1. Assurances

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

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

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

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

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

2. Details

a. Scope of Marketing

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

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

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

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

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

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

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

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

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

B. Information to Potential Enrollees and Enrollees

1. Assurances.

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

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

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

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

2. Details.

a. Non-English Languages

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

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

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

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

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

beneficiary population, whichever is lower, in an identified geographic area. The most current information notice can be found at: http://www.dhcs.ca.gov/formsandpubs/Documents/13-09ThreshholdLang.pdf (see attachment 7).

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

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

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

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

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

c. Enrollee Information

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

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

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

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

C. Enrollment and Disenrollment

1. Assurances.

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

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

As mentioned previously (see pages 26 & 27), waivers of the following sections of Title 42, CFR, have been requested and granted for the Medi-Cal SMHS Consolidation waiver program in all previous waiver renewals. The State requests that these waivers again be granted as circumstances relevant to enrollment and disenrollment remain unchanged.

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

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

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

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

a. Outreach.

____ The State conducts outreach to inform potential enrollees, providers,

and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

b. Administration of Enrollment Process.

_X_ State staff conducts the enrollment process.

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

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

Broker name: _____

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

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

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

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

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

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

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

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

_X_ The State automatically enrolls **beneficiaries**

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

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

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

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

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

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

d. Disenrollment:

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

i.___ Enrollee submits request to State.

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

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

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

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

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

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

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

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

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

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

D. Enrollee rights.

1. Assurances.

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

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

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

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

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

E. Grievance System

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

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

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

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

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

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

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

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

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

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

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

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

b. Timeframes

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

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

c. Special Needs

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

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

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

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

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

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

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

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

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

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

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

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

___ Other (please explain):

F. Program Integrity

1. Assurances.

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

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

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

The prohibited relationships are:

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

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

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

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

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

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

Employs or contracts directly or indirectly with an individual or entity that is

precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

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

2. Assurances For MCO or PIHP programs

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

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

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

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

Section B: Monitoring Plan

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

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

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

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

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

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

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

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

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

Part I. Summary Chart of Monitoring Activities

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

Please note:

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

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

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

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

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

Part II. Details of Monitoring Activities

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

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

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

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

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

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

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

c. __X__ Consumer Self-Report data

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

Strategy 1: Consumer Perception Survey

Personnel responsible: **State staff**

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

During waiver period 9, a convenience sampling methodology will be used similar to that used in waiver period 8 .

Frequency of Use: **Semi Annual**

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

Strategy 2: Onsite Triennial System Review of MHP Beneficiary Satisfaction Policies/Processes

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

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

During the triennial onsite System Reviews, state staff review the strategies used by the MHP related to beneficiary satisfaction . Strategies may vary from county to county. State staff verify that MHPs have strategies in place and review the strategies with MHP staff during the triennial onsite reviews. MHPs provide documentation of the strategies they use and provide examples of actions they have taken in response to issues which surface during or as a result of beneficiary satisfaction strategies (i.e. reports of focus group discussions or reviews of beneficiary satisfaction survey findings). State staff note deficiencies in in beneficiary satisfaction policies and processes in the Plan of Corrections (POCs) issued to MHPs. Please also see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.

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

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

4c. Monitoring beneficiary satisfaction as evidenced by:
1) A mechanism or activity is in place that regularly gathers and measures beneficiary satisfaction.

***Frequency of Use*: System Reviews of MHPs occur triennially however please see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90**

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

d. _X_ Data Analysis (non-claims)

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

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

***Personnel responsible*: State staff**

***Detailed description of strategy*: DHCS requires MHPs to collect data on an annual fiscal year basis using a standardized reporting format. These grievance and appeals reports summarize the numbers of grievances, appeals and expedited appeals by and also include the subject matter of the grievance or appeal as established by DHCS (e.g., access, denial of services, change of provider, quality of care, confidentiality or other) and its disposition(e.g. referred out, resolved, still pending). By October 1 of each year, counties submit these reports to the County Support Unit in the Mental Health Services Division.**

During waiver period 9, the grievance and appeals data will be used to identify issues that should be addressed with the individual MHPs and/or that indicate statewide trends that require technical assistance or policy clarification The County Support Unit will review the grievances and appeals reports and identify county specific deficiencies or statewide trends in order to address these deficiencies through local Quality Improvement

processes which may include analyzing data to measure against goals, identifying opportunities for improvement, designing and implementing interventions for improving performance, and measuring effectiveness of interventions. The County Support Unit will share its significant findings with Program Oversight and Compliance staff prior to and during the triennial onsite reviews to allow for a more focused review based on deficiencies previously identified.

During waiver period 9 the County Support Unit will again a revise the standardized reporting format for the grievance and appeals report to improve the consistency of reports and quality of data received Specifically, the revised format will contain more clearly-defined terms and reporting categories. The County Support Unit will continue to provide technical assistance and training for the use of the grievance and appeals reporting format. Additionally, the County Support Unit will develop an implementation schedule to ensure that counties submit reports in a timely manner.

***Frequency of use*: Annual**

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

Strategy 2: Onsite Triennial System Review: MHP Grievance and Appeals Policies/Procedures

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

***Detailed description of activity*: All MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. During the triennial onsite System Reviews, state staff review documentation of these strategies and evidence that the annual evaluation has occurred. Staff also ask the MHP to provide 1-2 examples of grievances or appeals from receipt through resolution. Deficiencies in this area are noted in the POCs. Please also see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.**

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

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

4c. Monitoring beneficiary satisfaction as evidenced by:

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

***Frequency of Use*: System Reviews of MHPs occur triennially. Please see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.**

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

Strategy 3: Fair Hearing Data

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

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

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

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

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

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

e.___ Enrollee Hotlines operated by State

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

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

g. __ Geographic mapping of provider network

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

Strategy 1: Review/Analysis of data

Personnel responsible: **State staff**

Detailed description of activity: **Data from a variety of sources is reviewed and analyzed for indicators of potential disparities in beneficiaries' access to SMHS in the context of race/ethnicity analyzed by gender, age, diagnosis and other factors when such information is available. Data from the Short Doyle/Medi-Cal System (SD/MC) and the Client and Service Information (CSI) System are processed through programming code in Statistical Analysis System (SAS) to create counts, sums, and statistics in meaningful categories that can be compared to other data sources. Paid claims and CSI data contain protected health information and personal information of beneficiaries, so the data must be de-identified, primarily by aggregation, before shared with outside parties.**

Sources include:

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

Frequency of use: **As needed.**

How it yields information about the area(s) being monitored**: Review and analysis of this data assists the State to determine potential disparities. The data is archived and updated on a periodic basis and allows the State to choose any number of time periods in the past to analyze potential disparities. One way this data yields information is by comparing the racial or ethnic proportions of the entire population to the proportions of the same racial or ethnic groups that are receiving SMHS in the claims and CSI data.**

Strategy 2: Onsite Triennial System Review: MHP's Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

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

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

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

During the triennial onsite System Reviews, state staff reviews information provided by the MHP to ensure that the above mechanisms are in place. Deficiencies in this area are noted in the POCs. Please also see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.

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

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

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

1a. To the extent resources are available, are services encouraged in every geographic area and are the services to the target populations planned and delivered so as to ensure access by members of the target populations, including all ethnic groups in the state?

1b. To the extent resources are available, is the county organized to provide an array of treatment options in every geographic area to the target population categories as described in W&I section 5600.3, including all ethnic groups?

***Frequency of Use*: System Reviews of MHPs occur triennially. Please see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.**

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

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

Strategy 1: MHP Contract

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

***Detailed description of activity:* The MHP contract (Exhibit A1, Items 2C and D) requires MHPs to offer an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. In addition, in accordance with title 9 CCR Section 1810.310 (c)(2), MHPs are required to report to the Department through an update to the MHP's approved Implementation Plan whenever there is a change in their operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries or a reduction of an average of 25 percent or more in outpatient provider rates. MHPs must also establish its continued capacity requirements by providing details regarding the change and plans to maintain adequate services and providers available to beneficiaries.**

Please refer to page 101 for the waiver monitoring strategy for Implementation Plans.

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

How it yields information about the area(s) being monitored: **Assurance from the MHPs that their networks are adequate to meet the needs of the beneficiaries being served provides the State with more current information on the MHPs' networks.**

Strategy 2: Onsite Triennial System Review: MHP's Policies/Procedures Regarding Numbers and Types of Providers

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

Detailed description of activity: **Each MHP is required to have a Quality Improvement (QI) Work Plan that includes its plan to monitor its service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system. Further, the plan must include goals established for the number, type, and geographic distribution of mental health services. During the triennial onsite System Reviews, state staff review the QI Work Plan and Work Plan Evaluation to verify that goals have been established regarding the number, type and geographic distribution of mental health services within the MHP's delivery system. Staff also review the MHP provider list. Often the MHP will provide a map displaying geographic distribution of services. Deficiencies in this area are noted in the POCs. Please also see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.**

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

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

4a Monitoring the service delivery capacity of the MHP as evidenced by:

1) **A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system.**
2) **Goals are set for the number, type, and geographic distribution of mental health services.**

Frequency of Use: **System Reviews of MHPs occur triennially. Please see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.**

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

j. X Ombudsman

Personnel responsible: **State staff and MHPs**

Detailed description of activity: **The purpose of the Ombudsman Unit is to be a bridge between the mental health system and individuals attempting to access mental health services, by providing information and assistance to help people navigate the system.**
In addition to assistance available through an MHP, it is important for the State to assist beneficiaries. Reasons include but are not limited to:

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

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

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

With most complex cases, the Ombudsman Unit will link the beneficiary with an MHP problem resolution contact to identify a resolution(s) satisfactory to the beneficiary. The office provides information and assistance on other issues of concern; for example, assisting beneficiaries to connect with appropriate local resources and/or agencies for resolution.

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

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

How it yields information about the area(s) being monitored: **The Ombudsman Unit utilizes a database for tracking purposes. This database is used to record and produce reports on the numbers of calls, type of calls, language of the caller, caller's county, and subject area of calls. The Ombudsman Unit works to keep current with changes in governmental policies and procedures that may directly affect beneficiaries served at the local level.**

k. **_X_ On-site review**

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

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

Results for each component are described below

Strategy 1: Triennial System Reviews of the MHP

Detailed description of activity: **The triennial on-site system reviews of the MHPs are conducted to determine the MHP's compliance with state and federal regulations, provisions of the approved 1915(b) waiver and DHCS/MHP contractual requirements. The compliance review protocol for FY 2014-2015 includes the following system review sections: 1) Access; 2) Authorization; 3) Beneficiary Protection; 4) Funding, Reporting and Contracting Requirements; 5) Target Populations; 6) Interface with Physical Health Care; 7)Provider Relations; 8) Program Integrity; and 9) Quality Improvement (see attachments 11 & 12). The compliance protocol includes**

items regarding the MHP's Cultural Competency Plans, Quality Improvement Plans, Compliance Plans, the MHP's policies and procedures and the MHP's application of the policies and procedures in practice.

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

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

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

The protocol is reviewed annually and revised as necessary. The Compliance Advisory Committee (CAC) reviews the compliance protocol and provides consultation and recommendations to the Department. The CAC is comprised of representative stakeholders including consumers, family members advocates, mental health departments, community based providers and mental health boards.

NEW OR ENHANCED MONITORING AND OVERSIGHT ACTIVITIES

During waiver period 9 the goal of the department is to implement new or enhance current monitoring and oversight activities. DHCS is currently considering how best to achieve this goal and the most effective approach for monitoring and oversight. Described below are processes and activities that DHCS is strongly considering for better monitoring and oversight activities to improve compliance issues.

Tiered Review Approach
Currently the department is compiling data regarding each County MHPs overall compliance ratings for the last three (3) review cycles. Once this data is compiled thresholds will be identified whereby MHPs will be placed into Tier 1, 2, or 3.

Utilizing a "phased-in" approach, the department will initially focus on and implement additional oversight and monitoring activities related to Tier 1 which will be the lower performing MHPs. Enhanced monitoring activities for Tier 1 MHPs may include, but are not limited to:

1. **More frequent reviews, e.g., annual or biennial versus triennial**
2. **Plan of Correction (POC) Validation site reviews in order to validate that the POC has been implemented and is effective, while also providing continued and enhanced education and technical assistance.**

3. **Focused training and technical assistance activities which may include but is not limited to MHP site-specific trainings**

The department's goal is to phase in the full tiered system over the next 2-3 years beginning with phasing in Tier 1 during the next fiscal year. This is a work in progress. It is envisioned that this system will include annual reviews for MHPs in Tier 1; biennial reviews for MHPs in Tier 2; and continued triennial reviews for MHPs in Tier 3. This would be a fluid system as a county may move from tier to tier depending on their overall compliance percentage for each review. It is possible that the department may identify the need to improve upon or even change the tiered process in order to be more effective. For example, during implementation, it may be determined that there is the need for more than 3 tiers in the system.

It is of note that beginning this fiscal year (FY 2014/15) the department implemented a "Partial Compliance" rating for items where previously MHPs were either rated all "in" or all "out" of compliance with no allowance made to have a partial compliance rating. For example, one MHP might have 9 of 10 test calls in compliance and another county might have 0 of 10 test calls in compliance, yet they would both be rated as being "out of compliance." This resulted in a less than accurate picture of how each of the MHPs was actually performing in these areas. The partial compliance rating has been now been implemented for questions related to the identified areas of concern by CMS, e.g., 24/7 test calls, TAR adjudication within 14 days, grievance/appeal log containing all required elements, overdue re-certifications. After all MHPs have been reviewed using the new partial compliance ratings for these areas the department will have a much clearer and more accurate picture.

Focused Reviews
In addition to the tiered process, the department will:

1. **Implement focused reviews for counties with specified significant and continuing compliance concerns based on a yet-to-be determined threshold of compliance. This could mean that although an MHP has a higher overall compliance percentage, the MHP continues to have compliance issues related to those review areas identified by CMS, e.g., 24/7 line; TAR adjudication within 14 days; grievance/appeal log having all required elements. The department will be identifying a threshold that would trigger a focused review for this purpose. These reviews will focus on the specific compliance issues that have been identified and will include more in-depth training and technical assistance.**
2. **Establish and implement annual training calendar and provide more regular training for the MHPs to include statewide training for all MHPs as well as site specific training for individual MHPs struggling with compliance issues. This includes two 2-day chart review trainings**

that are planned for August 2015, covering inpatient chart documentation on day one and outpatient chart documentation on day two. This training will be offered in both Northern and Southern California in order to ensure optimum MHP participation.

3. **Offer training utilizing multi-media, including teleconferences, webinars, and site trainings, and post training materials on the DHCS website for MHPs to access and refer to at any time.**
4. **Work on developing a system for the implementation of a continuum of corrective actions that will range from education and training on the low end of the continuum with sanctions and civil money penalties at the high end. It is the department's goal to work closely and collaborate with the MHPs to increase MHP compliance by first implementing corrective actions at the lowest end of the continuum and then moving up the continuum based on set criteria as it becomes necessary.**

***Personnel responsible*: State staff**

Frequency of use: **Each MHP is currently reviewed triennially however, with the new system being developed an MHP may be reviewed more often depending on their level of compliance or non-compliance as well as significant and continuing significant areas of concern .**

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

. Strategy 2: Triennial Outpatient Chart Reviews- Non-Hospital Services (Outpatient) Adult and Children/Youth
Detailed description of activity: **The triennial non-hospital outpatient chart reviews are conducted to monitor and ensure compliance with state and federal regulations and statutes and DHCS/MHP contractual requirements.**

Please also refer to section k. "Onsite Review" under the heading "New or Enhanced Monitoring Activities."

The outpatient chart review team is composed of licensed mental health clinicians and includes both state staff and contractors. The State provides oversight to ensure that the Medi-Cal claims submitted by the MHPs for specialty mental health services (SMHS) met medical necessity criteria for reimbursement and that the documentation in the medical records provided contain the required evidence of medical necessity. The current protocol

being used can be found in the ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES (see attachment 11).

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

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

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

Outpatient chart disallowances are determined in accordance with MHSUDs Information Notice No. 14-27 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2014-2015" Enclosure 4 Reasons for Recoupment (see attachment 13) Currently, there is no extrapolation of the findings, however the state is in the process of developing plans for the application of corrective measures which could include extrapolation.

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

Personnel responsible: **State staff**

Frequency of occurrence of reviews: **The non hospital (outpatient) chart reviews are conducted on a triennial basis. If significantly elevated rates of disallowance or quality of care concerns are detected, reviews may be scheduled more frequently, or may focus on particular areas of concern. Refer to section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities, on Page_90.**

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

Strategy 3: SD/MC Hospital Inpatient Reviews

Personnel responsible: **State staff**

Detailed description of activity: **An inpatient chart review team consisting of state staff and licensed mental health practitioners under contract to the State including, at a minimum, a physician and one or more licensed mental health professionals, conducts triennial reviews of SD/MC acute psychiatric inpatient hospitals.**

The principal focus of the inpatient chart reviews is to determine the following: (1) Whether the hospital's Utilization Review Plan meets requirements outlined in Title 42 of the Code of Federal Regulations Section 456.201-456.245: ; (2) Whether Medical Care Evaluation Studies have been performed as required by Title 42 of the Code of Federal Regulations Section 456.242-243 and whether they have been conducted in a methodologically acceptable fashion; (3) Whether the Plan of Care for each beneficiary meets the standards set forth in Title 42 of the Code of Federal Regulations; (4) Whether documentation for reimbursement of acute hospital days meets the requirements set forth in Section 1820.205 of Title 9 of the California Code of Regulations; (5) Whether documentation for reimbursement of administrative days meets the requirements described in Section 1820.220 of Title 9 of the California Code of Regulations; (6) Whether the hospital's utilization review function is effectively identifying those days for which documentation does not meet medical necessity criteria for admission or continued stay services, or regulatory requirements for administrative day services; and (7) Whether the quality of treatment provided to all beneficiaries meets acceptable community standards of care. The current

protocol for these reviews, Sections K and L of the Compliance Protocol for Consolidated SMHS, is included in MHSD Information Notice No. 12-05, which can be found on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/MHCCY/Enclosure1-FINAL_PROTOCOL_FY2012-13.pdf (see attachment 11)

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

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

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

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

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

- **Plans for discharge**
- **Documentation of the beneficiary's degree of participation in and agreement with the plan**
- **Documentation of the physician's establishment of the plan**

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

For inpatient chart reviews where there has been continued high rates of disallowances, in addition to working on developing a system for the implementation of a continuum of corrective actions, the department is currently considering the following: 1) Adding concurrent review to the current inpatient chart review process instead of only looking at charts retrospectively. This will give the department an opportunity to see the "then" and "now" of the inpatient chart documentation, which is important in cases where the MHPs indicate that they have made changes to their chart review documentation processes since that time and 2) changing the frequency of these reviews from every 3 years (triennially) to every 2 years (biennially) until such time that a hospital maintains a to-be-identified threshold of compliance at which time the reviews for that hospital may revert back to every 3 years. The department is currently working on developing an implementation plan. Please also see section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," Page 90.

***Frequency of occurrence of reviews*: Every third year. If significantly elevated rates of disallowance or quality of care concerns are detected, reviews may be scheduled more frequently, or may focus on particular areas of concern. Refer to section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities," on Page 90.**

***How it yields information about the area(s) being monitored*: The SD/MC hospital inpatient reviews provide information on the degree to which beneficiaries' medical records meet medical necessity criteria for admission and continued stay services and, where appropriate, requirements for administrative day services. This information enables the State to recoup FFP funds for those hospital days which do not meet appropriate regulatory requirements.**

Strategy 4: Provider Certification On-Site Reviews

Personnel responsible: **MHPs and State staff**

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

The Department is responsible for an onsite certification review of County owned and operated sites:

- **For new Medi-Cal certification**
- **When there is a change of address/location**
- **When there is an addition of medication mode of services to existing certifications and medication is stored on site**
- **When recertifying the following services**
    - **Crisis Stabilization Units,**
    - **Juvenile detention facilities,**
    - **Day treatment intensive (full and half day programs),**
    - **Day treatment rehabilitative providers (full and half day programs),**

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

As indicated in DMH Letter 10-04 certain county owned and operated providers have been delegated to the MHP to perform the site re-certifications. In order to increase the department's monitoring and oversight of the MHPs re-certification of these county owned and operated providers, the department will be implementing a process whereby for a yet-to-be-determined number of these providers (expected to be between 10-20 annually) the department will conduct its own site re-certification visit to these providers to ensure the department is maintaining adequate oversight over these sites and the MHPs re-certification of the same. The MHPs will be given advanced notice prior to this new monitoring activity being implemented.

Frequency of occurrence of reviews: **: An initial certification is performed of any new providers with triennial re-certifications thereafter. Certification and recertification of county owned and operated provider sites are conducted as required.**

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

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

X Clinical

X Non-clinical

Personnel responsible: **MHPs**

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

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

During the ninth waiver period the EQRO will be collecting information regarding the two required PIPs and reporting findings in their quarterly and annual reports. Data gathered from the PIPs will be available during the ninth waiver period to assist MHPs to continue to make program enhancements to improve the coordination, quality, effectiveness, and/or efficiency of service delivery to children who are receiving EPSDT services. Currently, there are ongoing discussions between DHCS and the EQRO regarding the possible development of a statewide PIP related to timeliness of and access to services, although timeliness and access may instead be validated through Performance Measures.

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

How it yields information about the area(s) being monitored: **PIPs and other quality improvement activities, depending on the specific issues selected for study, can provide the MHPs with information on access, quality of care,**

continuity/coordination of care, the grievance system, beneficiary informing, and provider selection and capacity. Two of the PIPs, one clinical and one non-clinical are reviewed by the EQRO (for more information regarding the EQRO see section s1 page 107) and a report is completed after each review. These reports provide concrete information on the validity of MHP PIPs.

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

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

Strategy 1: Measurements of indicators of mental health system performance on an ongoing and periodic basis.

Personnel responsible: **State staff**

Detailed description of Activity:

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

- **Consumer Perception Survey**

Information on the consumer perception survey can be found in section c pages 79-80 and section 1 on page 117.

  - **Perception of Access to Services**
  - **Perception of Quality and Appropriateness of Services**
  - **Perception of Outcomes**
  - **Perception of Participation in Treatment Planning/Family Member Participation in Treatment Planning**
  - **General Satisfaction with Services**
  - **Perception of Changes in Functioning**
  - **Perception of Changes in Social Connectedness**
  - **Perception of Cultural Sensitivity of Staff**

- **Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Mental Health**

Welfare and Institutions [W&I] Code, Section 14707.5 (added by Senate Bill [SB] 1009, Statutes of 2012, and amended by Assembly Bill [AB] 82, Statutes of 2013) requires DHCS, in collaboration with the California Health and Human Services Agency and in consultation with the Mental Health Services Oversight and Accountability Commission (MHSOAC), to create a plan for a Performance Outcomes System for Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services. The Performance Outcomes System implementation will establish a process for bringing together information from multiple sources in order to better understand the results of Medi-Cal SMHS provided to children and youth. The statute requires that a performance outcomes system for Medi-Cal specialty mental health services for children and youth be developed to improve outcomes at the individual, program, system, and community levels and to inform fiscal decision-making related to the purchase of services.

The POS approaches evaluation of California's specialty mental health services for children and youth from a broad-based perspective. POS measures the quality and accessibility of services for children and youth and provides information that improves practice at the individual, program, and system levels. POS will ensure the use of evidence-based mental health practices appropriate to client needs that demonstrate effectiveness and positive client outcomes. The outcomes are measured on four levels: Individual (youth/family), Provider, System, and Community (public) levels. POS will measure the outcomes of seven domains:

There are seven domains that will link together the elements of the Performance Outcomes System. These reflect the domains established at the national level by SAMHSA. DHCS, working with stakeholders and partners, has established a framework for outcomes measurement by identifying these domains as key areas to assess:

- **Access;**
- **Engagement;**
- **Service Appropriateness to Need;**
- **Service Effectiveness**
- **Linkages;**
- **Cost;**
- **Satisfaction**

Performance Outcome System Process and Goals

- **Continued Stakeholder Involvement (Stakeholder Advisory Committee, Subject Matter Experts Work Group, Measures Task Force meetings)**
- **Establish Performance Outcomes System Methodology**

- **Initial Performance Outcomes Reporting: Using Existing DHCS Databases**
- **Continuum of Care: Screenings and Referrals**
- **Comprehensive Performance Outcomes Reporting: Expanded Data Collection**
- **Continuous Quality Improvement (QI) Using Performance Outcomes Reports**

DHCS staff will use data captured in legacy systems that were developed and maintained by the former Department of Mental Health (DMH) and the DHCS's data warehouse to generate the Performance Outcomes System reports. Data submitted to existing DHCS legacy systems come from the counties. The following systems are:

- **Client and Services Information System**
- **Data Collection and Reporting System**
- **Management Information System/Decision Support System**
- **Short Doyle/Medi-Cal Claiming System**
- **Web-Based Data Collection Reporting System - Consumer Perception**

While the focus of the Performance Outcomes System is children and youth receiving Medi-Cal specialty mental health services, DHCS is taking a more comprehensive view and developing the system to look at outcomes for all SMHS.

Quality Improvement

As part of a comprehensive system of reporting, analysis, and improvement, DHCS will develop a quality improvement process to strengthen the structure and processes of mental health delivery systems and share successful and cost-effective practices between MHPs. Strategies will specifically focus on partnering, educating, and training MHPs and their providers on removing barriers to access mental health services. Further, training efforts will include providing standards of care using diagnostic assessments and evidence-based treatment, such as trauma-informed care that allows for reducing disparities among children and youth. DHCS acknowledges that many MHPs already utilize performance outcomes information to improve the quality of services to children and youth, and that it would be beneficial to partner with specific MHPs to assist with sharing of successful practices. DHCS will be conducting interviews with other States, MHPs, and Provider Organizations to discuss lessons learned during the development of their performance and outcomes systems.

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

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

Strategy 2: Implementation Plans

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **The State requires MHP applicants to submit Implementation Plans that provide assurance that the entity has the capacity to be a successful MHP. Implementation Plan requirements are described in Title 9, CCR, Sections 1810.305 and 1810.310 and in DMH Information Notice No. 97-06 which can be found at http://www.dmh.ca.gov/DMHdocs/docs/notices97/97-06not.pdf (see attachment 14) The Implementation Plan process assists in monitoring the waiver program by ensuring that each MHP has the basic systems in place prior to the enrollment of beneficiaries with the MHP.**

In accordance with CCR Title 9 section 1810.310(c) MHPs are also required to submit proposed changes to their Implementation Plan to the State for review and approval . Proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan must be submitted prior to implementing the proposed changes.

Frequency of use: **MHPs will submit their most recent version of their Implementation Plan this current waiver cycle, to ensure that the State has reviewed and approved the current Implementation Plan for each MHP.**

MHPs must submit an updated Implementation Plan when changes are proposed that would modify the MHPs Implementation Plan .

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

Strategy 3: Onsite Triennial System Review: MHP's Quality Improvement (QI) Program

Personnel responsible: **MHPs and State staff**

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

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

- **Collecting and analyzing data to measure the goals, or prioritized areas of improvement that have been identified;**
- **Identifying opportunities for improvement and deciding which opportunities to pursue;**
- **Identifying relevant internal or external committees to ensure appropriate exchange of information with the QI Committee;**
- **Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;**
- **Designing and implementing interventions to improve performance;**
- **Measuring effectiveness of the interventions;**
- **Incorporating successful interventions into the MHP's operations as appropriate; and**
- **Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by CCR, title 9, section 1810.440(a)(5).**

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

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

Frequency of use: **The MHP's are required to review the QI Work Plan and revise as appropriate on an annual basis. During the triennial System Review state staff review both the QI Work Plan itself and evidence that activities identified in the Work Plan were implemented. Refer to section k. "Onsite Reviews" under the heading "New or Enhanced Monitoring and Oversight Activities" for options being considered regarding frequency of reviews on Page 90.**

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

- **Service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system and set goals for the number, type, and geographic distribution of mental health services;**
- **Timeliness of routine mental health appointments;**
- **Timeliness of services for urgent conditions;**
- **Access to after-hours care;**
- **Responsiveness of the 24/7 toll-free number;**
- **Beneficiary satisfaction;**
- **Beneficiary grievances, appeals, and fair hearings;**
- **Requests for changing persons providing services;**
- **Relevant clinical issues, including the safety and effectiveness of medication practices;**
- **Interventions when occurrences of potential poor care are identified;**
- **Identification and evaluation of barriers to improvement related to clinical practice and/or administrative aspects of the delivery system by providers, beneficiaries, and family members; and**
- **Provider appeals**

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

Personnel responsible: **State staff**

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

of the waiver program in 1995 and from year-to-year. The year-to-year changes are more significant than the changes since the beginning of the waiver program, because of the length of time the waiver has been in operation.

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

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

Frequency of use: **Information on contract hospitals is gathered annually.**

How it yields information about the area(s) being monitored: **Monitoring the number of hospitals contracting with the MHPs provides information about access and provider selection.**

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

p. ___ Provider Self-report data
- **___ Survey of providers**
- **___ Focus groups**

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

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

MHP Utilization Management Program (UMP): Payment Authorization System

Personnel responsible: **MHPs/State staff**

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

MHPs are required to establish MHP payment authorization systems consistent with Title 9, CCR, Section 1810.350, 1820.215, 1820.220, 1820.225 and 1820.230 for psychiatric inpatient hospital services and Section 1830.215 for all other services.

MHPs may determine whether or not to require prior authorization of services, with a few exceptions. MHPs may not require prior authorization of emergency services. However, as specified in the MHP contract Exhibit A, Attachment 1 item 8A, MHPs shall require providers to request payment authorization for day treatment intensive and day rehabilitation services:

1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.
2) At least every three months for continuation of day treatment intensive.
3) At least every six months for continuation of day rehabilitation.
4) Contractor shall also require providers to request authorization for mental health services, as defined in Cal. Code Regs., tit. 9, § 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in Cal. Code Regs., tit. 9, §1810.216 and § 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.

Additionally, MHPs must complete TARs for FFS/MC hospitals to allow payment by the Medi-Cal fiscal intermediary. In most cases the TARs are completed after the beneficiary is discharged.

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

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

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

s. X Other: (please describe)

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

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

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

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

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

- **PIP: Reviewing the validity of two MHP PIPs.**
- **Information Systems Capability Assessment (ISCA): Utilizing a California-specific ISCA protocol to review the integrity of the MHPs' information systems and the completeness and accuracy of the data produced by those systems.**
- **Technical Assistance and Training: Providing technical assistance and training as part of the site review and as well as post review.**

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

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

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

- **Organizational contract providers**

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

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

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

Additional information on EQRO related monitoring activity can be found in section III.1 pages 52-54.

Frequency of use: **Annual**

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

The EQRO will be completing quarterly PIP status reports on all active PIPs within the state. These reports shall include:

- **Issuance of the PIP Guidelines for Plans or update existing PIP approval guidelines to the county MHPs.**
- **Development of a PIP Validation Tool.**
- **Provision of training and technical assistance to county MHPs and SMHS subcontracting providers on the PIP Guidelines.**
- **Review of county MHP, small group and statewide PIPs.**
- **Evaluation of each county MHP's PIPs in clinical and non-clinical areas.**

- **Measurement of each county MHP's PIP performance using objective indicators.**
- **Evaluation of each county MHP's implementation of PIP system interventions to achieve improvement in quality.**
- **Evaluation of effectiveness of the MHP's PIP interventions.**
- **Planning and initiation of activities for increasing and sustaining PIP improvement.**

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

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

2. Cultural Competence Plans (CCPs)

Personnel responsible: **MHPs and State staff**

***Detailed description of activity*: Title 9, CCR, Section 1810.410 requires each MHP have and comply with a CCP approved by the State and submit a CCP annually to the State. The 2010 CCP requirements are included in DMH Information Notices Nos. 10-02 and 10-17 which can be found on the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf (see attachment9) and http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf (see attachment 10**

During the 9th waiver period, the department will implement the revised Cultural Competence Plan Requirements (CCPRs). The process will be such that Mental Health Plan (MHP) staff will submit new CCPs to the department six (6) months after the MHPs have been informed about the submission requirements via an Information Notice. Then a review team will review the plans for content. After the review process, the MHPs will receive feedback on their plans and may have to provide additional information to the department.

While the MHP staff are preparing the plans, DHCS staff will provide technical assistance (TA) and work with the MHPs via conference call and/ or webinar, so that the CCPs can be completed and reviewed in a timely fashion. Currently monthly TA calls/webinars are planned to provide MHP staff with necessary information to guide the process.

Finally, DHCS will establish a Cultural Competence Advisory Committee and enlist subject matter experts' expertise to consolidate and streamline the current CCP criteria even more. A membership selection process will determine the composition. Members will include representation from client/family members, provider organizations, MHP and departmental staff as well as subject matter experts in the field of cultural competence.

Frequency of use: **Annually**

How it yields information about the area(s) being monitored: **The county CCPs provide the State with baseline race and ethnicity data by county and enable MHPs to identify issues around disparities within their system. The CCP update approval process provides information on the MHP's progress in improving cultural competence and provides an opportunity for feedback to the MHPs on problem areas. TA will be provided to MHPs regarding the problem areas. DHCS will require MHPs to provide updates and evidences regarding the problem areas.**

CCPRs include access to mental health services by race, ethnicity, gender and language in order to reduce disparities; MHPs are required to report on their workforce, provider networks, and population needs. Among other requirements, access needs to be provided through an effective 24/7 telephone language line as well as the availability of beneficiary informing materials in the MHP's respective threshold languages.

3. Advisory Groups

Strategy 1: Compliance Advisory Committee (CAC)

Personnel responsible: **State staff**

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

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

- **Access**
- **Authorization**
- **Beneficiary protection**
- **Funding, reporting and contracting requirements**
- **Target populations and array of services**
- **Interface with physical health care**
- **Provider relations**
- **Program Integrity**
- **Quality improvement**
- **Chart review—non-hospital services**
- **Chart review—sd/mc hospital services**

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

The State will continue with the plan and practice of consultation and collaboration with the CAC annually in 2015-2020 regarding the Compliance Review Protocol.

Strategy 2: Cultural Competence Advisory Committee

Personnel responsible: **State staff**

Detailed Description of Activity: **DHCS will establish a Cultural Competence Advisory Committee and enlist subject matter experts' expertise to consolidate and streamline the current CCP criteria even more. A membership selection process will determine the composition. Members will include representation from client/family members, provider organizations, MHP and departmental staff as well as subject matter experts in the field of cultural competence.**

Strategy 3: California Mental Health Planning Council (CMHPC)

Personnel responsible: **State staff and CMHPC**

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

In addition to the above, the CMHPC has a legislative mandate to review and approve performance outcome measures for system accountability.

4. Provider Appeals

Personnel responsible: **MHPs and State staff**

Strategy 1: Inpatient Service Treatment Authorization Requests (TAR) State Appeals: FFS Hospitals

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

When the appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, the providers may appeal to the State if the MHP denies the appeal in whole or in part. Appeals to the State are generally referred to as "State/second-level TAR appeals." A review fee is assessed for each State/second-level TAR appeal filed. The fee is charged to the MHP if the State reverses the MHP's initial denial or to the provider if the State upholds the MHP's initial denial. If there is a split decision the fee is prorated according to the number of days decided in each party's favor.
Frequency of use: **Providers determine the frequency of appeals filed. For example, from July 2010 to December 31, 2012 providers filed an average of 10 ten State second level TAR appeals each month. This was a decrease from the period July 1, 2009 through June 30, 2010 when an average of 22 State second level TAR appeals were filed per month.**

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

Strategy 2: Appeals re Specialty Mental Health Services

Detailed description of activity: **In accordance with CCR Title 9 sections 1810.203.5 and 1850.3 05, the State has established a progressive appeals process that includes a two-level (informal and formal) appeal process. MHPs and other legal entity providers may appeal claims that were disallowed for services delivered to EPSDT beneficiaries pursuant to the State's review of the MHP or other provider's client records. DHCS is currently promulgating regulations which will govern the formal appeals process for EPSDT and anticipates having them in place during the 9th waiver period.**

Frequency of use: **During the next waiver period. (July 1, 2015 – June 30, 2020), it is anticipated that overall approximately 50 inpatient appeals, 50 outpatient appeals and 12 EPSDT appeals will be processed.**

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

5. **County Support Unit**

Personnel responsible: **State staff**

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

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

Participation in triennial reviews
CSU staff has increased monitoring efforts before, during and after each Triennial Program Oversight and Compliance Review conducted by the DHCS Program Oversight and Compliance Branch to ensure that plans of corrections from the previous reviews have been implemented and to provide technical assistance, if necessary. During the waiver period, CSU staff will attend the onsite triennial systems reviews. After the review, CSU staff will offer assistance to MHPs in implementing plans of correction required by the review and contact the MHPs as needed to monitor the status of the plans of correction following the review.

On an ongoing basis, evidence of correction will be collected to ensure corrective measures continue to be implemented and the MHPs improve their procedures to ensure they are complying with state and federal requirements. When barriers to MHP implementation of their plans of correction are identified, CSU staff will continue to provide technical assistance and share successful practices from other MHPs until ongoing compliance can be assured.

Critical areas of focus for technical assistance
In the new waiver period, CSU staff will focus technical assistance activities on areas of DHCS and CMS concern, including 24/7 access lines, systems to track timeliness of access, Treatment Authorization Requests adjudicated within 14 days, systems for logging grievance and appeal information, and provider certification and re-certification. Examples of technical assistance activities will include conference calls, webinars, Information Notices, and focused interaction between CSU staff and key MHP contact persons.

Specific to the 24/7 access line, CSU collects and updates information from all the MHPs on the mechanisms used in each county to meet the linguistic access requirements, both during business hours and after hours. This information will assist DHCS to organize our technical assistance calls on 24/7 access line issues such as linguistic capability, answering mechanisms during business hours and after hours, access line scripts, and MHP internal test call frequency and scripts.

Quality Improvement Plans
MHPs submit Quality Improvement Work Plans which include evidence of internal MHP monitoring activities in key areas such as grievance and appeals, performance improvement projects, and mechanisms to assess the accessibility of services. The work plans will be reviewed and DHCS will provide feedback and technical assistance where necessary for each MHP. CSU staff will attend the MHP QI Committee meetings and regional meetings of QI Coordinators. This will allow the state to provide ongoing monitoring and assistance to increase MHP quality improvement programs.

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

Frequency of use: **Daily and ongoing**

How it yields information about the area(s) being monitored: **The assignment of CSU staff to each MHP provides the MHPs with a single point of contact with whom to raise issues of concern and obtain technical assistance, and**

provides the State with an individual who knows specifics about the operation of particular MHPs. The direct, personalized relationship between State staff and MHPs allows the State to monitor the MHPs activities, be aware of MHP concerns and offer assistance.

CSU tracking of county information related to system reviews, 24/7 access line processes and other areas of MHP performance yields additional detail about the areas being monitored and changes made over time leading to improved performance. When problems are identified that would present barriers to the MHP compliance with state and federal requirements, DHCS staff provides technical assistance and recommendations as soon as the challenges are noted.

Section C: Monitoring Results

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

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

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

_X_ **This is a renewal request.**

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

X **The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.**

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

Confirm **it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.**

Summarize the results **or findings of each activity. CMS may request detailed results as appropriate.**

Identify problems **found, if any.**

Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.**

Describe system-level program changes**, if any, made as a result of monitoring findings.**

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

Strategy:

Confirmation it was conducted as described:

___ **Yes**

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

1. ***Monitoring Activity*: <u>Consumer Self Report Data</u>**

Strategy <u>1</u>: <u>Consumer Perception Survey (CPS)</u>

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

Summary of results: **<u>During waiver period eight, the CPS was conducted using the convenience sampling method.</u>**

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

Percentage of Positive Responses
Adults and Older Adults Receiving Services in FY 2013-14

Domain	Adult/Older Adult % Positive
Access	85%
Quality and Appropriateness	88%
Outcomes	69%
Participation In Treatment Planning	78%
General Satisfaction with Services	90%
Functioning	70%
Social Connectedness	67%

Total Number of Responses (N)
Adults and Older Adults Receiving Services in FY 2013-2014

Domain	Adult/Older Adult Responses
Access	25,988
Quality and Appropriateness	25,585
Outcomes	24,756
Participation In Treatment Planning	24,725
General Satisfaction with Services	26,402
Functioning	24,893
Social Connectedness	24,430

Percentage of Positive Responses
Youth Receiving Services in FY 2013-2014

Domain	Youth % Positive
Access	84%
General Satisfaction	86%
Outcomes	68%
Family Member Participation in Treatment Planning	85%
Cultural Sensitivity of Staff	94%
Functioning	73%
Social Connectedness	86%

Total Number of Responses (N) Youth Receiving Services in FY 2013-2014

Domain	Youth Responses
Access	22,985
General Satisfaction	23,523
Outcomes	2,735
Family Member Participation in Treatment Planning	22,882
Cultural Sensitivity of Staff	21,867
Functioning	22,823
Social Connectedness	22,721

***Problems identified*: None.**

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

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

Strategy 2: Onsite Triennial Review: MHP Beneficiary Satisfaction Policies/procedures

Confirmation it was conducted as described:

_X_ Yes

__ No. Please explain:

Summary of results: **All MHP's are required to have mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. MHPs are required to have baseline statistics with goals for each year. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. During the triennial onsite reviews, state staff reviewed the strategies used by the MHP related to beneficiary satisfaction including but not limited to beneficiary satisfaction surveys or focus groups.**

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

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

4c. Monitoring beneficiary satisfaction as evidenced by:

1) **A mechanism or activity is in place that regularly gathers and measures beneficiary satisfaction.**

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by both counties.

In FY 2013/14, 1/19 (5%) County MHPs were found to be out of compliance with this requirement. A POC was submitted by the MHP.

Problems identified: **The MHP's Quality Improvement work plans did not include evidence the MHP monitored beneficiary satisfaction nor did the MHP provide documentation of policies and procedures to provide a mechanism to measure beneficiary satisfaction.**

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit followed up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

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

Strategy 3: Assess Feasibility of collecting and reviewing results of beneficiary satisfaction strategies

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results/Problems identified:
During waiver period 8, DHCS collected information regarding strategies MHPs use to assess beneficiary satisfaction and whether it would be feasible to collect this information, review on a statewide basis and report on findings. However, since MHPS use a variety of strategies including focus groups and surveys it was determined that it would not be feasible to collate such data in any meaningful way.

Corrective Action (plan/provider level): **None**

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

2. ***_X_*** ***Data Analysis (non-claims)***

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

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

During waiver period 8, DHCS required each MHP to submit an annual report summarizing the number of grievances, appeals and state fair hearings by the general category of the complaint (e.g., access, denial of services, change of provider, quality of care, confidentiality or other). The grievance and appeals data was analyzed to identify potential trends and/or issues that should be addressed with the individual MHPs or that indicate statewide trends that may require technical assistance or policy clarification.

Summary of results/Problems identified:
County Support Unit (CSU) staff reviewed all incoming reports, which are submitted on the Annual Beneficiary Grievance and Appeal Report

(ABGAR) form. Before accepting the reports as final, if the reported numbers appeared unusual, staff confirmed with the MHP if they were reporting correctly. Some problems and inconsistencies were noted in the way some MHPs reported grievance and appeals; for example, reporting numbers totals that did not match the sum of the individual categories, or the total listed under Disposition. Once the accuracy of the information reported was confirmed, CSU staff examined the statewide data and identified MHPs that had reported either unusually high or low numbers of grievance and appeals, in the grand totals or in individual categories. The staff contacted individual MHPs that were identified for follow up to obtain the MHP's perspective on the reasons for the high or low reported numbers.

The analysis of statewide trends and themes did not provide any conclusive information to base follow up activity, except that there was indication that some counties do not consistently understand the information they need to report under the general categories on the ABGAR form. Due to the number of MHPs with data that needed to be corrected, DHCS concluded that clarification should be made by revising the ABGAR form to include definitions and sub-categories to serve as examples of what should be reported under each general category.

Corrective Action (plan/provider level)
If an MHP reported high or low numbers of grievances and appeals, CSU staff contacted the MHP to better understand the reasons for the numbers reported. Depending on the MHP's explanation on the reasons for the numbers, CSU staff may provide technical assistance. For example, if the numbers reported are high, CSU staff ensure that the MHP is analyzing its local trends through their Quality Improvement Committee and developing strategies to improve the quality of services based on the grievance and appeal information. If a MHP has unusually low numbers reported, CSU staff work with the MHP to ensure that its beneficiaries are well informed about their rights to file a grievance or appeal, and the procedure and forms are understood. These technical assistance activities are provided by CSU staff on a case by case basis, and are occurring concurrently at the time of the submission of this waiver renewal request.

Program change (system-wide level
In the initial ABGAR forms submitted to DHCS, it was noted that some counties appeared to have inconsistent understanding about what information to report, and what general categories to enter the information under. For example, under the category "Change of Provider," the intention is for MHPs to report grievances filed that are related to change of provider requests. Some MHPs reported all their change of provider requests, regardless of whether the request resulting in a grievance. This led to the need for CSU staff to clarify with MHPs what information should be included.

To address problems due to lack of clarity and inconsistent understanding of the information to be reported, DHCS staff developed a draft revised ABGAR reporting form during waiver period 8. The department intends to finalize the revised ABGAR form during waiver period 9.

Strategy 2: Onsite Triennial Review: Grievances and Appeals Policies/procedures

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results: **All MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. During the triennial onsite reviews, state staff reviewed documentation of these strategies and evidence that the annual evaluation occurred. Staff also asked the MHP to provide 1-2 examples of grievances or appeals from receipt through resolution. Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:**

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

4c. Monitoring beneficiary satisfaction as evidenced by:

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

In FY 2012/13, 5/17 (29%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Problems identified: **See above**

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit monitors Plans of Correction and collects evidence of compliance following the triennial reviews.**

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

Strategy 3 :Fair Hearing Data

Confirmation it was conducted as described:

_X_ Yes

__ No. Please explain:

Summary of results: **In FY 2012-2013, 48State Fair Hearings concerning Mental Health issues were reported.**

In FY 2013-2014, 57 State Fair Hearings concerning Mental Health issues were reported.

In FY 2014-2015, 10State Fair Hearings concerning Mental Health have been reported through December 2014.

The summary results from the fair hearing database are provided below

	FY 2012-2013	FY 2013-2014	FY) 2014-2015 (through December 2014)
Number of Hearings Filed	48	57	10
Case Granted	1	10	0
Case Dismissed:	3	12	1
Case Denied	11	5	1
Withdrawals	22	22	5
Non-appearances	8	9	1

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

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

During waiver period 8, State staff were not contacted by the MHPs for technical assistance.

Problems identified: **None**

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

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

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

Strategy 1: Review/Analysis of Data

Confirmation it was conducted as described:

_X_ Yes

___ **No. Please explain**

Summary of results: **During waiver period 8 DHCS worked with multiple partners at state and local levels to address disparities in California. During this time, the CA EQRO also looked at statewide mental health disparities. Within the EQRO report FY 2010-2013, the EQRO produced disparity data, measuring Race/Ethnicity and other aspects of discrepancies.**

The following series of figures present disparity inquiry from the perspective of gender, Race/Ethnicity and age group, based on identifying claims per beneficiary, penetration rates, ratios of penetration rate and of approved claims.

Figure 1 shows that approved claims appear higher for males than females for all measured service type categories.

Figure 1. Penetration Rates, Approved Claims, and Penetration Rate Ratios Comparison by Gender, CY10-CY12

Calendar Year	Penetration Rate		Approved Claims per Beneficiary Served		Ratio of Females vs. Males for:	
	Female	Male	Female	Male	Penetration Rate	Approved Claims
CY12	5.31%	6.66%	$4,593	$5,640	0.80	0.81
CY11	5.21%	6.49%	$4,379	$5,418	0.80	0.81
CY10	5.34%	6.61%	$4,213	$5,249	0.81	0.80

Figure 2 shows approved claims per beneficiary served, broken down by Race/Ethicity. CAEQRO Annual Statewide Reports have previously noted progress in reducing disparities in average approved claims between race/ethnicity groups. However, both Asian/Pacific Islander and Hispanic beneficiary access to services remains a key disparity when compared to White beneficiaries.

Figure 2 Approved Claims Per Beneficiary Served by Race/Ethnicity, CY10-CY12

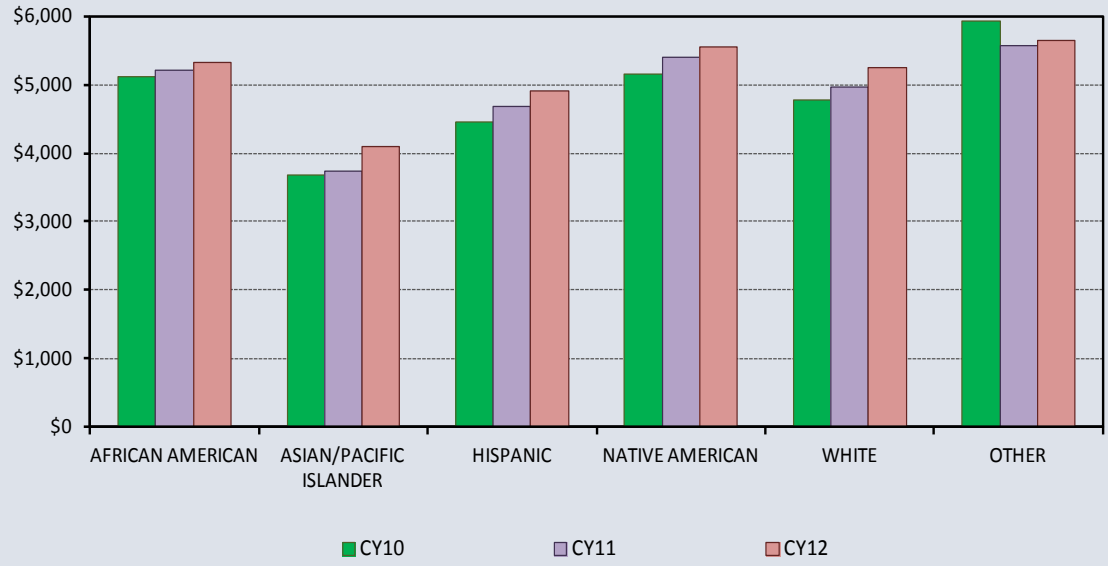
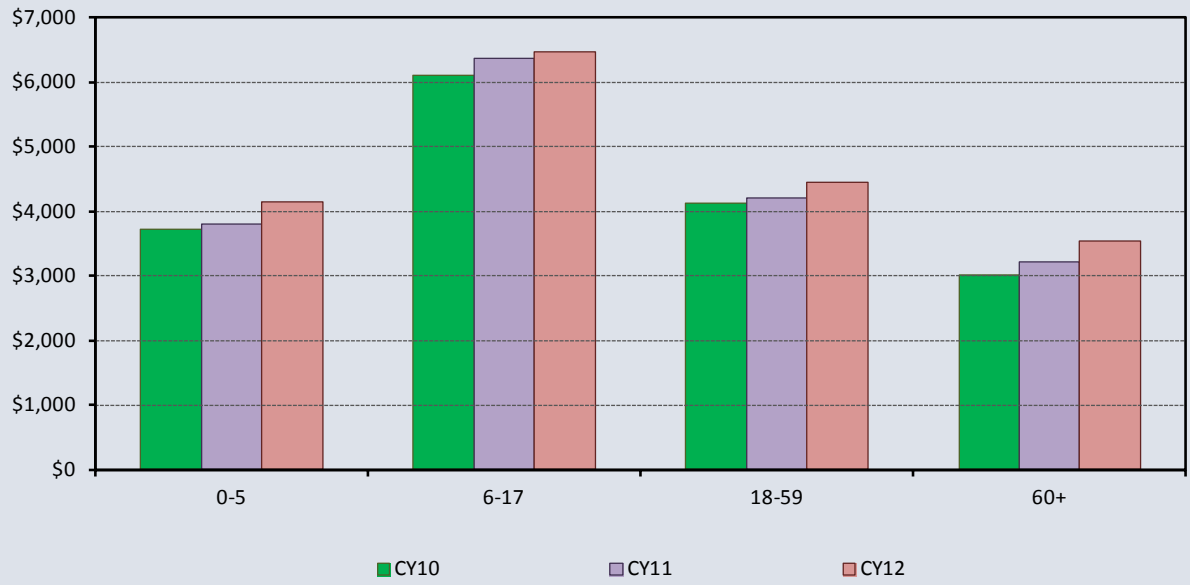


Figure 3 displays statewide trends in average approved claims based on age. Consistent with findings in previous CAEQRO Annual Statewide Reports, Youth 6-17 have the highest average annual claims and Older Adults 60+ have the lowest annual claims.

Figure 3 Approved Claims per Beneficiary Served by Age Categories, CY10-CY12



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

Figure 4 shows the distribution of the total state populations in 2012.

Figure 4. California population in 2012 by Race and Age Group

Race/Ethnicity	Total	Age Group 0-17	Age Group 18-64	Group65+
Total	37,826,161	9,170,526	24,111,486	4,544,149
White	14,953,617	2,504,870	9,681,137	2,767,610
Hispanic	14,501,606	4,716,718	8,944,926	839,962
Asian/Pacific Islander	5,157,029	1,000,576	3,525,845	630,608
Black	2,203,540	507,530	1,459,910	236,100
American Indian	164,382	36,590	109,035	18,757
Multi Race	967,414	404,243	512,059	51,112

Based on Department of Finance figures accessed at

website:http://epicenter.cdph.gov

Performance Measures
Review of performance measures data includes analyzing indicators by race/ethnicity to determine potential disparities. Information on recent performance measures data on the use of specialty mental health services by race/ethnicity can be found on section 8 page 137. For more specifics see "Summary of Department of Mental Health Specialty Mental Health Services by Race/Ethnicity" (attachment 17).

Problems identified: **None**

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

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

Strategy 2 Onsite Triennial Review: MHP's Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

Confirmation it was conducted as described:

X **Yes**

___ **No. Please explain**:

Summary of results: **In the CCPR (DMH Information Notice 10-02), MHPs are required to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of**

racial, ethnic, cultural, and linguistic characteristics. Further, all MHPs are required to have mechanism(s) or activity(ies) in place whereby the MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the MHP. Such mechanism(s) include but are not limited to:

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

In addition to reviewing the CCPR submissions, DHCS staff monitor MHPs' compliance with the CCPR during the triennial onsite reviews. During these onsite reviews, DHCS staff reviewed information provided by the MHP to ensure that the above mechanisms were implemented by the MHPs. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted.

Problems identified: **The Annual Review Protocol, Section A "Access" (see attachment 11) covers many of the mechanisms required in the CCPR. While some counties continue to have challenges related to specific protocol items, DHCS found statewide improvement in the compliance findings for the Access Section of the Annual Review Protocol. For both FY2012/13 and FY2013/14, many of the questions in this section had high compliance rates with only 1-2 counties being out of compliance with specific requirements. The biggest area of concern is the continued challenge for MHP's to provide a statewide toll-free 24/7 access line. The findings related to the 24/7 access line are described in detail in Waiver Section C, Monitoring Activity "Onsite System Reviews", Strategy "Systems Review."**

The following are examples of items in the Annual Review Protocol, Access Section A, (see attachment 11) directly related to the monitoring of the CCPR:

Section A, Question 11. Is there evidence that Limited English Proficient (LEP) individuals are informed of the following in a languages they understand: a) LEP individuals have a right to free language assistance services;

In FY 2012/13, 1/17 (6%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

Section A, Question 13. Has the MHP developed a process to provide culturally competent services as evidenced by: a) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP, to provider interpreter or other support services to beneficiaries; b) Implementation of training programs to improve the cultural competence skills of staff and contract providers; and c) A process that ensures the interpreters are trained and monitored for language competence.

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with these requirements. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 1/19 (5%) County MHPs were found to be out of compliance with requirement 13a and 3/19 (16%) County MHPs were found to be out of compliance with requirement 13c. Plans of Correction were submitted by the MHPs.

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with these requirements. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

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

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

Strategy 1: MHP Contract

Confirmation it was conducted as described:

_X_ Yes

_No_. Please explain:

Summary of results: **In accordance with their contract (Exhibit A, Attachment 1, Item 2), MHPs are required to report to the Department when a significant change occurs in the MHPs operation that could impact network adequacy. Significant change is defined as a change in the MHP's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries or a reduction of an average of 25 percent or more in outpatient provider rates. No MHP reported any such change in operations during the 8th waiver period i.e. July 1, 2013 – June 30, 2015 .**

Problems identified **None**

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

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

Strategy 2: Onsite Triennial Review: MHP's Policies/Procedures Regarding Numbers and Types of Providers

Confirmation it was conducted as described:

X **Yes**

___ **No**. Please explain:

Summary of results: **Each MHP is required to have a Quality Improvement Work Plan that includes its plan to monitor its service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system. Further, the plan must include goals established for the number, type, and geographic distribution of mental health services. During the triennial onsite reviews, state staff reviewed each MHP's QI Work Plan and Work Plan Evaluation to verify that goals have been established regarding the number, type and geographic distribution of mental health services within the MHP's delivery system.**
In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. Items specific to this issue in the System Review Protocol, Quality Improvement (QI) section (see attachment 11) are the following:

4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities to meet the following work plan areas?
4a Monitoring the service delivery capacity of the MHP as evidenced by:

1) **Goals are set for the number, type, and geographic distribution of mental health services.**

In FY 2012/13, 5/17 (29%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 7/19 (37%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Problems identified: **In some cases, there was evidence the MHPs were reviewing data related to number, type and geographic distribution of mental health services with the Quality Improvement Committee; however, County MHPs found to be out of compliance with this requirement did not**

specifically have goals set for the number, type, and geographic distribution of mental health services in the QI work plans.

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance with this requirement. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.**

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

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

Confirmation it was conducted as described:

_X Yes
__ No. Please explain:

Summary of results: **Note: Although the Ombudsman Unit continued its primary function to be a bridge between the mental health system and individuals and family members providing information and presenting options to consumers in accessing mental health services, the database used to record calls and their nature as originally designed has proved to be insufficient as volume increased. Therefore information as to numbers and nature of the calls received during this waiver period are estimates.**
For the period July 2013 through December 2014it is estimated that the Ombudsman toll free number received approximately 6767 calls. Approximately ½ of all the calls were related to Medi-Cal and of those calls approximately a quarter were in the nature of complaints primarily regarding providers and patient's rights advocates.

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

In about 9 percent of calls, the caller either hung up before the staff could answer the phone or the call was routed to voicemail and the caller left no follow up information.

Problems identified: **None**
Corrective action (plan/provider level): **NA**

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

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

Confirmation it was conducted as described

X Yes

___ No Please explain:

There were three strategies that together constituted the State's on site review activities during waiver period 8.

1 Systems Reviews

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

3) SD/MC Hospital Reviews

Results for each component are described below

Strategy 1. Systems Review

Summary of Results**. The findings obtained from FY 2012-2013 and FY 2013-2014 Annual Reviews for Consolidated Specialty Mental Health Services and Other Funded Services are summarized below. In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted.**

Problems identified**:**

For each Fiscal Year in this reporting period, the highest out-of-compliance areas across MHPs fall into three categories: (1) 24/7 toll-free telephone access (Protocol, Section A: Access, Question 9a1-4); (2) the written log of initial requests for SMHS (Protocol, Section A: Access, Questions 10a-c);and, (3) the MHP's ongoing monitoring system to ensure contracted organizational providers and county owned and operated providers are certified and recertified (Protocol, Section G: Provider Relations, Question 2),

For FY12/13:

1. **71% (12) MHPs were out of compliance on Section A 9a 1-4 as determined by test calls made by the department: 1) whether the MHP's statewide, toll free number has language capability in all languages spoken by beneficiaries in the county; 2) whether the number provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met; 3) whether the number provides information to the beneficiaries about services needed to treat a beneficiary's urgent condition; and 4) whether the number provides information to beneficiaries about how to use the beneficiary problem resolution process.**
2. **76% (13) MHPs were out of compliance on Section A 10 regarding the written log of initial requests for SMHS containing the name of the beneficiary, the date, and the initial disposition of the request.**

3. **76% (13) MHPs were out of compliance on Section G2 regarding whether the MHP has an ongoing monitoring system in place that ensures contracted organizational providers are certified and recertified per Title 9 regulations.**

For FY13/14:

1. **84% (16) MHPs were out of compliance on Section A 9a 1-4 (See description above under FY 12/13, number 1)**
2. **95% (19) MHPs were out of compliance on Section A 10 (See description above under FY 12/13, number 2)**
3. **68% (13) MHPs were out of compliance on Section G2 (See description above under FY 12/13, number3)**

In FY 2014-2015, 20MHPs are scheduled for review. Data will be available after the completion of the reviews for FY 2014-2015 ending June 2015.

***Corrective action (plan/provider level*):**
Following the onsite review, MHPs are notified in writing of all out of compliance items. MHPs are required to submit a POC for all out of compliance items which is due within 60 days after receipt of the Final Report. If the MHP wishes to appeal any of the out of compliance items, the MHP may do so by submitting an appeal in writing within 15 working days after receipt of the Final Report. Once the POC is received, the MHP works with Program Oversight and Compliance Branch and DHCS Quality Assurance Section, County Support Unit staff to implement the POC.

In addition, during onsite reviews, DHCS staff provide feedback and technical assistance to MHP's related to out of compliance issues, as well as other critical issues for which performance can be improved. The DHCS County Support Unit has started participating in the triennial system reviews in order to establish consistency between the compliance findings and the follow up and technical assistance provided by the Department.

During FY 2012-2013, Program Compliance received 17 POCs from the MHPs. In FY 2013-2014, 18 POCs have been received.

Program change (system-wide level):): **In 2014, the Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services was revised to include an indication of partial compliance, as appropriate, for select items on the protocol which was effective beginning with the FY 14/15 review cycle. For example, DHCS conducts test calls of the MHP's 24/7 Access line to determine compliance with the regulations. In many cases, the MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows the State, as well as the MHP, to have a fuller**

understanding of the compliance issues by specifying the exact nature of the problem (i.e. time of calls out of compliance, staff taking calls, etc.). The revisions to the protocol will allow DHCS to establish benchmarks related MHP compliance in key areas, including those areas identified above as having the highest out of compliance rates across MHPs.

Strategy 2: Non-Hospital Services Outpatient Chart Review/Adult and Children/youth Chart Reviews

***Summary of results*: Results are reported for July 1, 2012 – December 31, 2015. The chart review team, consisting of licensed mental health clinicians, review the MHP's non-hospital services provided to Medi-Cal beneficiaries both adult and children/youth on a triennial basis. The principal focus of these reviews is to ensure federal and state requirements are being met along with MHP contractual requirements. The State provides oversight to ensure that the SD/MC claims submitted by the MHPs meet medical necessity criteria for reimbursement.**

DHCS Program Compliance and Oversight Branch completed 20 MHP outpatient chart reviews in FY 201-22013; For FY 2013 – 2014, 19 chart reviews were completed. For FY 2014-2015, 8 of 20 scheduled reviews have been completed. Half of the claim sample is adults and the other half is children/youth.

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

***Corrective action (plan/provider level):* A written POC for all out of compliance items found in the chart reviews is required from the MHP within 60 days of the receipt of the report of the audit findings. The POC must specify the corrective actions taken to address the items out of compliance. The DHCS County Support Unit reviews the POCs, provides follow up and technical assistance and ensures the POCs are implemented. POCs were required for all reviews completed within waiver period 8.**

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

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

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

***Summary of results*: Findings from the FY 2012-2013 and FY 2013-2014 reviews of SD/MC psychiatric inpatient hospitals are provided in attachment 16.**

Problems identified: **The principal deficiencies identified during the FY FY2012-2013 and 2013-2014 reviews were: (1) Documentation which failed to meet medical necessity criteria for continued stay services; and (2) Documentation which failed to meet criteria for administrative day services.**

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

During FY 2012-2013 six (6) inpatient reviews were conducted, and all six of these hospitals were required to submit POCs.

During FY 2013-2014 , six (6) inpatient reviews were conducted, and all six of these hospitals were required to submit POCs.

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

Strategy 4

Monitoring Activity: **Provider Certification On-Site Reviews**

Confirmation it was conducted as described:

__X_ Yes

____ No. Please explain:

Summary of results: **Results are reported for July 1 2013-December 31, 2014. . DHCS has conducted 112 provider onsite reviews of county owned and operated providers, and certified or re-certified 369 providers as eligible to bill for the provision of specialty mental health services from July 1, 2013through December 31, 2014 . The number of onsite certification reviews of county owned and operated providers, has nearly doubled from the last waiver report period which may be due in part to the increased need for services resulting from the ACA Medicaid Expansion in California. i.**

MHPs monitor and track the recertification for their contracted organizational providers. During the review period, July 1, 2013-December 31, 2014, DHCS has processed 1, 278 certifications and recertifications from the MHPs for their contracted providers. As specified in the contract between the DMH and MHPs, the MHP/contractor shall comply with CCR, Title 9, Section 1810.435 in the selection of providers and shall review its providers for continued compliance with standards at least once every three years, except as otherwise provided in the contract. (Refer to Exhibit A-

Attachment 1 Item 4 Provider Selection and Certification of the Boilerplate MHP Contract).

***Problems identified*: There were no problems identified.**

***Corrective action (plan/provider level)* Any Plans of Corrections (POCs) issued as a result of an onsite review (see strategies 1-3 above) are reviewed and out of compliance items must be resolved prior to certifying and/or re-certifying a provider's eligibility to bill Medi-Cal for the provision of specialty mental health services. An MHP has 30 days from receipt of the written request for POCs (which in most cases is the date of the site review) to submit their POCs.**

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

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

Confirmation it was conducted as described:

_X_ Yes
___ No Please explain:

***Summary of results:* The EQRO reviews two PIPs (one clinical, one non clinical) during their reviews of MHPs. The EQRO also provides DHCS with information regarding the PIPs: including topics, activity level, and status of interventions. Lastly, the EQRO, reports to DHCS on MHP compliance with the PIP requirement. 25 of the PIPs submitted in FY 2013-2014 are in the areas of Access (20) and Timeliness (5).**

For more information regarding the EQRO process and results see section 11 page 145.

***Problems identified:* N/A**

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

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

8. ***Monitoring Activity*: Performance Measures**

Strategy 1: Measurement of Indicators of Mental Health System Performance on an Ongoing and Periodic Basis

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results:
Expenditures and Penetration Rates for Medi-Cal Recipients
As seen in data from the report, "Summary of Department of Health Care Medi-Cal Specialty Mental Health Services by Race/Ethnicity", (see attachment 17) from FY2006/07 to FY2012/13 California served between 191,810 to 232,483 Medi-Cal clients with specialty mental health services each month. More adults were served than children until the last two quarters of Fiscal Year 12/13. For the third quarter of FY 12/13, more children (115,132) received specialty mental health services than adults (111,046). For the fourth quarter of FY 12/13, more children (120,866) received specialty mental health services than adults (111,617) as well.

The Medi-Cal penetration rates fluctuated slightly from 6.2% to 6.9% between FY 2006/07 to FY2012/13. The number of individuals enrolled in Medi-Cal and clients served increased during this seven year period. Penetration rates were highest for the White population through Fiscal Year 2011/12. The penetration rate was lowest for the Hispanic population through Fiscal Year 2010/11. The penetration rate for the Asian/Pacific Islander population was almost similar to the Hispanic population beginning in Fiscal Year 2011/12. The penetration rate for the Other category shows an increase beginning in Fiscal Year 2010/11. The drop in the penetration rate for the Asian/Pacific Islander population may be due to an error in coding.

The mean annual client cost had a gradual and moderate increase between FY2006/07 and FY2012/13 for all races.

Reporting for clients and services for Fiscal Year 2012/2013 was more than 99% complete at the time of this report.

Consumer perception of care indicators
The results of the consumer perception indicators are reported above under item 1 Consumer Self Report Results page 117.

***Problems identified*: None.**

***Corrective action:* None.**

***Program change*: None**

Strategy 2:Implementation Plans
***Confirmation it was conducted as described*:**
_X_ Yes
___ No. Please explain:

***Summary of results*: The Implementation Plan is required by state regulation when an MHP begins operation. The State has approved the Implementation Plans for all current MHPs. State regulations require MHPs to submit proposed changes to their Implementation Plans to the State in writing. The State reviewed Implementation Plan updates received during the waiver period in accordance with CCR Title 9 section 1810.310(c).**

Problems identified:* *None

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

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

Strategy 3: Onsite Triennial Review: MHP's Quality Improvement (QI) Program

Confirmation it was conducted as described:

X **Yes**

__ **No. Please explain**:

***Summary of results:* Each MHP is required (in accordance with the MHP/DHCS contract (Exhibit A, Attachment 1, Section 23), CCR, title 9, Section 1810.440 and CFR Title 42 Section 438.204, 240 and 358) to have a Quality Improvement (QI) program. The purpose of the QI program is to review the quality of specialty mental health services provided to beneficiaries by the MHP. The QI Program must have active participation by the MHP's practitioners and providers, as well as beneficiaries and family members. During the triennial System Reviews, state staff reviewed each County MHP's QI work plan for evidence of QI activities that the MHP has engaged in including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The MHPs also provided evidence of mechanisms in place to evaluate the effectiveness of the QI program and how QI activities have contributed to improvements in clinical care and beneficiary services. The MHP's are required to review the QI Work Plan and revise as appropriate on an annual basis. During the triennial System Review state staff reviewed both the QI Work Plan itself and evidence that activities identified in the Work Plan were implemented.**

In FY 2012-2013, 17 onsite MHP reviews were conducted. In FY 2013-2014, 19 onsite MHP reviews were conducted. Specific protocol items related to this issue can be found in the Annual Review Protocol Section I, Quality Improvement (see attachment 11).

***Problems identified:* The findings from the reviews for FY2012/13 and FY2013/14 are summarized below:**

1. **Is the QIC involved in or overseeing the following QI activities:**
    a. **Recommending policy decisions?**

In FY 2012/13, 2/17 (12%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

    b. **Reviewing and evaluating the results of QI activities?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

    c. **Instituting needed QI actions?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 0/19 (0%) County MHPs were found to be out of compliance with this requirement.

    d. **Ensuring follow up of QI processes?**

In FY 2012/13, 3/17 (18%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

2. **Regarding the annual QI Work Plan, Does the MHP evaluate the effectiveness of the QI program and show how QI activities have contributed to improvement in clinical care and beneficiary service?**

In FY 2012/13, 4/17 (24%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

In FY 2013/14, 2/19 (10%) County MHPs were found to be out of compliance with this requirement. Plans of Correction were submitted by the MHPs.

Corrective action (plan/provider level): **MHP's were required to submit Plans of Correction to inform DHCS of actions taken to resolve noncompliance**

with these requirements. DHCS' County Support Unit follows up with the county MHPs to monitor implementation of the Plans of Correction and to provide technical assistance between triennial onsite reviews.

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

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

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results:

During waiver period 8, it was determined that it is not feasible at this time to develop a data base utilizing NPI numbers to determine the total number of individual providers under contract with MHPS and the total number of those provider who actually deliver SMHS. Therefore, the data on providers will continue to be reported as it has been in the past.

Please note: While transferring the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions from DMH to DHCS there have been significant difficulties migrating the data associated with the SMHS program such that staff have been unable to date to access certain data. Therefore some of the data provided in previous wavier periods is not available and this has been so noted in the following charts and information by NA – not available.

Table 1 Hospitals

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

Table 1 Hospitals (continued)

FISCAL YEAR:	11/12	12/13	13/14
TOTAL FFS/MC HOSPITALS	99	103	110
FFS/MC HOSPITALS PROVIDING SERVICE	76	72	NA
FFS/MC CONTRACT HOSPITALS	71	69	72
SD/MC HOSPITALS	18	18	18

As shown in table 1 above, the total number of FFS/MC psychiatric inpatient providers decreased from FY 1996-97 (prior to the first waiver period) through FY 2013-14.. Research during prior waiver periods indicated that this is in part due to a number of hospitals statewide who, as a component of their restructuring efforts, closed their psychiatric units.

The number of FFS/MC hospitals actually providing psychiatric inpatient hospital services to Medi-Cal beneficiaries had continued an overall decrease from FY 1996-97 to FY 2010-11 but has remained fairly consistent since FY 2009-10 . One hundred and twenty one (121) FFS/MC psychiatric inpatient hospitals provided services in FY 1996-97, while 77 FFS/MC psychiatric inpatient hospitals provided services in FY 10-11. 76 FFS/MC psychiatric inpatient hospitals provided services in FY 11/12 and 72 provided services in FY 12/13. Data for FY 13/14 is not yet available. The slight increase in the number of FFS/MC hospitals providing service between FY 2001-2002 and FY 2002-03 can be attributed to the identification of out-of-state non-border hospitals providing inpatient mental health services to Medi-Cal beneficiaries.

In FY 1996/97, 103 FFS/MC hospitals were under contract with MHPs. This number has shown a small increase from a low of 67 in FY 08-09 through FY 2013-2013. There were 7 2FFS hospitals under contract to the MHPs in FY 2012-2013 .

As shown below, recent paid claims data shows that, despite the decrease in the number of FFS/MC hospitals under contract and/or providing services, the number of unduplicated clients receiving care in those facilities rose in the years between FY 2006/2007 and FY 2012-2013.

FFS/MC Hospitals Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$154,544,462	20,867
FY 07/08	$149,146,681	20,762
FY 08/09	$156,111,674	22,057
FY 09/10	$163,635,421.	22,794
FY 10/11	$175,815,037.	23,901
FY 11/12	$188,168,445	23,228
FY12/13	$206,469,124	26,624

The number of Short-Doyle/Medi-Cal (SD/MC) hospitals has also decreased from 29 in 1996-97 to 18 in FY 2013-2014 . Recent paid claims data shows that the number of unduplicated clients has varied only slightly between FY 2006/2007 and FY 2012-2013 although total claims have increased

SD/MC Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$78,461,862	8343
FY 07/08	$71,106,397	7638
FY 08/09	$73,009,647	8320
FY 09/10	$70,535,824	8211
FY 10/11	$68,055,913	8135
FY 11/12	$67,893,065	8200
FY 12/13	$89,944,888	8343

Table 2
Professional and Rehabilitative Service Providers

FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
TOTAL SD/MC ORGANIZATIONAL PROVIDERS	1014	1225	1401	1649	1882	2101	2369	2527	2645	2952	3125	3195	3318	3387	3604
SD/MC ORGANIZATIONAL PROVIDERS PROVIDING SERVICE	939	1072	1154	1309	1491	1548	1852	1915	1913	2187	2271	2395	2435	NA	2006
FFS/MC PRACTITIONERS	3314	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	NA

Table 2 (continued)
Professional and Rehabilitative Service Providers

FISCAL YEAR:	11/12	12/13	13/14
TOTAL SD/MC ORGANIZATIONAL PROVIDERS	2208	2257	2329
SD/MC ORGANIZATIONAL PROVIDERS PROVIDING SERVICE	2024	2065	NA
FFS/MC PRACTITIONERS	NA	N/A	N/A

As can be seen in table 2, the total number of SD/MC Organizational providers showed a steady increase from 1,014 in FY 96/97 to 3,604 in FY 10/11. The numbers have decreased somewhat since FY 10-11 with a low of 2208 in FY11/12. The number of SD/MC organizational providers actually providing services increased from 939 in FY 1996-97 to 2,435 in FY 2008-09. The numbers have decreased since then. The most current data available (FY 2012-2013) shows that 2065 SD/MC Organizational Providers actually provided services. It should be noted that SD/MC organizational providers consist of a varying number of actual practitioners who serve Medi-Cal beneficiaries. Information is not available at the State as to the actual total number of SD/MC practitioners who are employed by SD/MC organizational providers.

Data on paid claims for FFS/MC psychiatrists and psychologists for FY 1996-97, prior to the first waiver renewal period, indicate that 3,314 psychiatrists and psychologists received Medi-Cal payments during that year. It should be noted that since FY 1996-97 was prior to Medi-Cal Specialty Mental Health Services Consolidation, some of these claims may be for services to beneficiaries who would not have met medical necessity criteria developed for consolidation, so the number may be somewhat inflated.

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

Problems identified: **None**

Corrective action (plan/provider level): **None**

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

10. *Monitoring Activity*: **Utilization review**

Strategy **MHP Utilization Management Plan**

Confirmation it was conducted as described:

_X_ Yes
___ No Please explain:

***Summary of results*: All MHP's Utilization Management Plans reviewed during waiver period 8contained requirements related to consistent application of medical and service necessity in payment authorization systems.**

***Problems identified*: None**

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

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

11. *Monitoring Activity*: **External Quality Reviews (EQR)**

Confirmation it was conducted as described:

_X_ Yes
___ No Please explain:

Summary of results: **FY 2012-2013**
Note: **Information regarding FY 2013 -2014 is not yet available**

FY 2012-2013 EQR activities focused its activities on three monitoring areas:

- **Access**
- **Timeliness**
- **Quality**

A variety of factors were used to analyze these three areas including factors associated with the three overarching principles of cultural competence, wellness/recovery and consumer/family involvement.

PIPs

- **66 percent of MHPs had two active PIPs as required, only half of those or 31 percent of all MHPs had PIPs that had study results which include the interpretation of the findings and the extent to which the study demonstrates true improvement. .**
- **29 PIPs reached completion in FY 2012-2103.**
- **In cases where the MHP had struggled with the same issue over a number of years they were provided technical assistance in selecting a new PIP**

topic for which the infrastructure needed to support successful setup and follow through was available.

- **MHPs may contact the department's County Support Unit to initiate meetings with EQRO staff and resolve issues with developing and implementing PIPs.**

Performance Measures

The Performance Measure for FY 13-14 focused on psychiatric inpatient follow-up services and readmission (CY12 data). The following results were found.

- **In terms of total claims dollars, inpatient services alone accounted for 11.5 percent of claims dollars, providing inpatient services to 7. 6 percent of beneficiaries.**
- **There was an increase in the number of beneficiaries receiving inpatient services, though the average approved claims for inpatient services decreased.**
- **Rehospitalization rates were 6 percent within seven days and 14 percent within thirty days.**
- **For youth 6-17, rehospitalization rates were lowest and outpatient follow-up highest.**

ISCA

CMS mandates administration of an ISCA each year at each MHP for which the EQRO is responsible.

During this period there have been many changes to legacy systems, and consequently in the selection, acquisition and implementation status of new enterprise systems. With all of the newer systems offering modules specific to electronic health records (EHR) the presence of various EHR functionalities at different MHPs has also changed.

- **Most MHPs have moved to newer systems or are currently implementing them. MHPs without plans for new systems already have relatively new systems in place because they updated their system within the previous 5 years.**
- **The system changes and adjustments that emerged throughout FY10-11 and FY11-12 are reported as largely resolved.**
- **During FY12-13, timely submissions of claim files by most MHPs substantially improved. However, a small number of counties continued to experience some level of operational challenges in claim submission during the past year.**
- **DHCS claim processing lag issues seen in FY11-12 were resolved during FY12-13 by improving system capacity to process claims in a timely manner.**

In addition to those activities described in the monitoring plan for the 8th waiver period focus groups were used to gain valuable information. Findings of the focus groups are included in EQRO reports. Beneficiary feedback

continues to be an important aspect of the EQRO process. The CFM focus groups allow site reviewers to gain valuable perspectives concerning:

- **Underserved racial/ethnic and other demographic groups**
- **Experiences acquiring services initially**
- **Utilization of acute care services or outpatient modes of service delivery**
- **Consumer involvement in decision making, progress through levels of care, and discharge**
- **Family member participation in treatment as well as system planning**
- **Consumer career opportunities both within and beyond the service delivery system**
- **Interface between mental health care systems and medical, alcohol/drug, or other service delivery systems**

- **During FY13-14, 625 individuals participated in 85 focus groups. Interpreters were included in 32% focus groups**
- **39% of the consumer/family member focus group participants were Latino, an increase from 31% in FY12-13.**
- **Of the Latino participants, 57% identified Spanish as their preferred language.**

- **Spanish-speaking beneficiaries generally reported longer wait times to access services.**

Problems identified: **The overall results of the site review process were presented to the State and MHPs in the individual and statewide reports based on comparative analysis of claims data for CY12. Some key findings include:**

- **Changes in the size of the average monthly Medi-Cal eligibles population significantly affect penetration rates. Increased Medi-Cal program enrollment resulted in decrease in penetration rates, despite increases in the number of beneficiaries served.**
- **Females continue to have lower penetration rates. Approved claims continue to be higher for males than females for all measured service type categories i.e. TBS, Crisis Intervention, Medication Support, Mental Health Service, Case Management, Day Treatment, Crisis Stabilization, Residential Services, Inpatient Services**
- **Both Asian/Pacific Islander and Hispanic beneficiary access to services, based on their percentage of the eligible population, remains a key disparity when compared to White beneficiaries. Asian Pacific Islanders and Hispanics have the lowest approved claims per beneficiary among the race/ethnicity categories.**
- **Consistent with findings in previous reports, Youth 6-17 have the highest average annual claims and Older Adults 60+ have the lowest annual claims**

- **High cost beneficiaries (greater than $30,000 in services in the CY) continue to consume a disproportionate amount of services, slightly increased over prior years. High cost beneficiaries were more likely to be male and child.**
- **While approved claims per beneficiary for foster care population increased and the number of eligibles increased, the number of foster care beneficiaries receiving services decreased. The combination of increasing numbers of eligibles and decreasing beneficiaries served is reflected in the downward trend in the penetration rate for the foster care population.**
- **As noted above, Spanish –speaking beneficiaries generally reported longer wait times as did children seeking particularly psychiatric service**

Corrective Action (plan/provider level): **Every MHP is given 5 recommendations of strategies to consider for improvement. Those items are then reviewed during the following year's review. Opportunities and Recommendations for MHP improvement note are:**

- **Increase stakeholder involvement in quality monitoring and improvement processes.**
- **Increase and improve the quality of consumer and family member employment within the MHP.**
- **Increase the use of outcome data, including implementation of evaluation tools.**
- **Increase consumer and family member involvement in system and program planning.**
- **Develop more collaborative processes with primary care.**
- **Evaluate consumer satisfaction with service delivery.**

72 percent of all recommendations were either fully addressed or partially addressed.

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

12. ***Monitoring Activity***: **Cultural Competence Plans**

Confirmation it was conducted as described:

___ Yes

_X_ No Please explain: See S*ummary of Results* below

Summary of Results: **Title 9, CCR, Section 1810.410 requires each MHP to complete and submit a CCP including annual updates to the department. Previously, the 2010-2011 CCP requirements were included in the former DMH Information Notices No 10-02 and 10-17. They can be found now on the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf (see Attachment 9)**

http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf. (see Attachment 10)

The last submission of CCPs to DMH occurred between July 28, 2010 and March 15, 2011. Shortly thereafter, Assembly Bill (AB) 102 was signed into law which required that Medi-Cal related mental health functions be transferred from DMH to DHCS by July 1, 2012. Consequently, DMH staff who were initially assigned to review and score the CCPs were reassigned to other functions that supported the inter-departmental transfer efforts. Since DMH staff were reassigned to facilitate the transfer efforts, CCP review and scoring efforts were suspended

During the last Waiver renewal period, the department has worked with subject matter experts and stakeholders including staff from the California Department of Public Health's (CDPH) Office of Health Equity (OHE) to revise and streamline the previous requirements in order to provide MHPs with guidance to ensure appropriate access for beneficiaries from ethnically, culturally and linguistically different backgrounds. To that end, DHCS hired two (2) employees who are dedicated to cultural competence tasks. Also, DHCS executed an Interagency Agreement (IA) with the CDPH OHE. As part of the agreement, OHE staff provided their technical expertise to the CCPR revisions. The revisions were geared toward addressing mental health disparities to vulnerable communities. The collaboration of the two departments facilitated the provision of appropriate CCPRs to achieve appropriate access to mental health care for individuals from different cultural, ethnic and linguistic backgrounds including those that live in geographically isolated communities. The requirements were updated and only minor changes were made to the previous requirements. The revisions included removal of references to former Department of Mental Health (DMH), the inclusion of tables to display demographic information, and references to the nationally published 2013 Cultural and Linguistic Appropriate Services (CLAS) standards. The revised requirements will be implemented in the beginning of 2015,

***Problems identified*: NA (since the plans could not be reviewed as planned)**

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

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

13. ***Monitoring Activity*: Advisory Groups**

***Confirmation it was conducted as described*:**

_X Yes

__ No Please explain:

Strategy 1 Compliance Advisory Committee (CAC)

Summary of result: **The Compliance Advisory Committee (CAC) offers stakeholders an invaluable opportunity to provide feedback and recommendations relative to DHCS' compliance protocol and review process. This ongoing relationship between DHCS and the CAC ensures stakeholders have a significant voice in how quality and access are monitored. The CAC meeting for FY2014/15, held in August 2014, resulted in the stakeholder approval of critical revisions to the Annual Review Protocol. These revisions, recommended initially by the County Behavioral Health Directors Association of California (CBHDA), include an indication of partial compliance, as appropriate, for select items on the protocol. For example, DHCS conducts test calls of the MHP's 24/7 Access line to determine compliance with the regulations. In many cases, the MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows the State, as well as the MHP, to have a fuller understanding of the compliance issues by specifying the exact nature of the problem (i.e. time of calls out of compliance, staff taking calls, etc.). The CAC's feedback and recommendations helped shaped the discussion around the proposed changes to the protocol and determined the process for implementing the recommended changes.**

Problems identified: **The revisions to the protocol approved by the CAC will allow DHCS to establish benchmarks related MHP compliance in key areas.**

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

Program change (system-wide level): **Changes implemented with significant input from the CAC include revisions to the Compliance Review Protocol, which is used by the State to review MHPs on-site for system compliance with the relevant state and federal regulations and contractual requirements.**

Strategy 2 California Mental Health Planning Council (CMHPC)

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

A. **The CMHPC is working closely with the California Association of Local Mental Health Boards and Commissions (CALMHB/C) to monitor access through an annual data notebook development and training.**
B. **The CMHPC staff has participated on reviews of County CCPs to ensure compliance with Plan requirements.**
C. **The CMHPC represented the interest of stakeholders in meetings held by the state during the transition from DMH to DHCS.**

D. **As part of our commitment to rehabilitative services the CMHPC actively opposed legislation to continue involuntary outpatient services. The Council takes positions on legislation and advocates for community-based care in lieu of institutional care.**

E. **The CMHPC holds quarterly meetings, open to the public, and encourages robust stakeholder input.**

Problems identified: **None**

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

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

14. ***Monitoring Activity***: **Provider Appeals Inpatient Services and EPSDT Services**

***Confirmation it was conducted as described*:**

__X__ Yes

____ No. Please explain:

Strategy 1: Provider Appeals Inpatient Services: FFS Hospitals

***Summary of results*: Results are reported for July 1, 2013-December 31, 2014. MHPs are required to have a provider problem resolution process pursuant to CCR, title 9, section 1850.305. When an appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, the providers may appeal to the State if the MHP denies the appeal in whole or in part. Such appeals to the State are generally referred to as "State/second-level TAR appeals".**

In FY 2012/13, DHCS received 119 State/second level TAR appeals from providers. During this time period, a majority of second level TAR appeals were filed by a single provider. DHCS upheld the MHP's decision for 98% of days appealed through the State/second level TAR appeal process. DHCS rejected 21 of the appeals received because they did not meet criteria for a second level TAR appeal.

In FY 2013/14, DHCS received 349 State/second level TAR appeals from providers. During this time period, a majority of second level TAR appeals were filed by a single provider. DHCS upheld the MHP's decision for 87% of days appealed through the State/second level TAR appeal process.

***Problems identified*: The high percentage of 2nd level TAR appeal denial decisions is primarily based upon the failure of providers to meet documentation standards related to medical necessity criteria for acute and administrative days.**

Corrective action (plan/provider level)**: Feedback via the State/second level TAR appeals process to the providers on medical necessity criteria.**

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

Strategy 2: Provider Appeals: Specialty Mental Health Services

Summary of results: **Overall, the number of provider appeals have been low within the last two years. From July 1, 2013 - -January 31, 2015, three inpatient appeals were filed, fourteen outpatient appeals were filed; and two AB 1780 EPSDT informal appeals were filed; The resolution of one informal appeal is still pending. One provider has inquired about a formal hearing but the process to handle formal appeals is in development. As of January 2015, no new requests for either informal or formal appeals have been filed.**

Problems identified **None**

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

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

17. *Monitoring Activity:* **County Support Unit (formerly County Technical Assistance Section)**

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results: **During waiver period 8, the County Support Unit (CSU) has functioned as the central point of contact for the MHPs, provided resources and technical assistance for the administration and provision of community mental health service programs. CSU staff are assigned as the liaison to specific counties. Beginning in January 2014, CSU staff has participated in the Program Oversight and Compliance Branch triennial system review in their assigned counties that were scheduled for reviews. CSU staff provided technical assistance to MHP contact staff on the development of the Plans of Correction (POCs) in response to review items that were out of compliance with standards.**

Prior to upcoming system reviews, CSU staff contacted MHPs to request updates on evidence of correction from the previous triennial review. Based on MHP status, CSU staff offered consultation and technical assistance as the MHP prepared for the review. CSU staff continued to regularly follow up with MHP staff until the time of the system review.

Problems identified: **After submission of the POC(s), CSU staff worked with MHPs to obtain evidence of correction for POCs in priority areas including Access, Beneficiary Protection, Quality Improvement, Program Integrity, and any repeat POCs from the previous review. After evidence of correction was submitted, CSU staff continued to interact with MHPs and request evidence of continued correction as needed to confirm continued implementation of POCs**
CSU staff determined that the following were of the highest priority for follow up: 24/7 access lines, grievance and appeal process, timeliness of access to services, Treatment Authorization Requests, and provider certification, as well as quality improvement activities. Staff tracked MHP progress in these specific areas.

Corrective action (plan/provider level): **The County Support Unit collaborated with the Program Oversight and Compliance Branch to conduct a focused review on one county that needed additional assistance to maintain compliance with state requirements. The technical assistance in the form of regularly schedule contacts continued ongoing for several months and CSU staff worked with the county to obtain evidence of correction and ensure that requirements are met. The MHP was found to have made significant improvement.**

Based on CSU analysis of statewide trends from the system reviews during the last three years, we have identified 24/7 access line requirements as an area for focused statewide technical assistance. As a result, DHCS has conducted a survey of the 24/7 access line mechanisms used in each county to meet the linguistic access requirements, both during business hours and after hours. We have used this information to develop draft training materials to assist MHPs to meet requirements, including information and recommended strategies on linguistic capability, answering mechanisms during business hours and after hours, access line scripts, and MHP internal test call frequency and scripts.

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

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. In its application and each quarter during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost effective and efficient*. The State must project waiver expenditures for the upcoming waiver period, called Prospective Years (PY) (e.g Prospective Year 1 (P1); Prospective Year 2 (P2); Prospective year 5 (P5) etc.). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective waiver period.

For waivers that include recipients who are eligible for both Medicare and Medicaid benefits (duals) the State may request a waiver period of up to 5 years. Initial waivers and continuation of a waiver beyond its initial approval period requires that the state submit a five-year waiver renewal application and a determination by CMS that, the State's projections demonstrate costs appropriate for the effective and efficient provision of services or for renewals, that while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other Federal requirements, including the submission of mandatory quarterly waiver reports. Each subsequent renewal of the waiver also requires the submission of a renewal application and a CMS determination that the state has continued to meet Federal requirements.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Definitions and Terminology

The following terms will be used throughout this document and are defined below:

For Initial Waivers:

Historical Period:

- BY = Base Year

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

For Renewal Waivers:

Retrospective Waiver Period

- RY = Retrospective Year(s)
- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2 when changing from a two year waiver period
- R3 = Retrospective Year 3
- R4 = Retrospective Year 4
- R5 = Retrospective Year 5 Project forward from end of R5 using experience/trends from RY 1 through R5

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: _____

c. Telephone Number:_____

d. E-mail:_____

e. The State is choosing to report waiver expenditures based on ___ date of payment. __ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c._X_ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced*

payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. NOT APPLICABLE. **Capitated portion of the waiver only: Type of Capitated Contract**

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b.___ PIHP
c.___ PAHP
d.___ Other (please explain):

The county MHPs under the Medi-Cal specialty mental health services (SMHS) waiver are not paid on a capitated basis. Counties pay with non-federal funds at the time of service. The counties then submit certified public expenditures (CPEs) to the State in order for the State to draw down eligible federal financial participation (FFP) for these services based on the State's adjudication of claims to determine Medi-Cal eligibility. In accordance to the CMS approved CPE protocol, see Section D: Part II: CPE Protocol, County MHPs receive interim CPE reimbursement of FFP on a fee-for-service (FFS) basis pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes; the state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year (SFY) and the final cost reconciliation of county MHP interim Medicaid payments occurs within 36 months after the certified reconciled state–developed cost report is submitted.

D. NOT APPLICABLE **PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1.___ First Year: $____ per member per month fee
2.___ Second Year: $____ per member per month fee
3.___ Third Year: $____ per member per month fee
4.___ Fourth Year: $____ per member per month fee
5.___ Fifth Year: $____per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: NOT APPLICABLE

a.___ Population in the BY data
1.___ BY data is from the same population as to be included in the waiver.
2. __ BY data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to the final PY _____

e.____ [Required] List the year(s) being used by the State as a BY:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the BY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any BY data is not derived directly from the State's MMIS fee-for-service claims data:

_____

For Renewal Waivers:

a._X_ [Required] Population in the BY and the Retrospective years R1, through the end of the waiver period data is the population under the waiver.

b._X__ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete final RY to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for the final RY of the previous waiver period.*

c.__X_ [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time: **Member months under the waiver equal the full-scope Medi-Cal enrolled population. Actual member months are included in the waiver renewal for all of R1 (which is the four-quarter period July 1, 2013through June 30, 2014) and the first two quarters of R2 (which is the period July 1, 2014 – December 31, 2014) as reported to CMS in the quarterly "MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORT" Member Months Report) for the SMHS waiver through the December 2012 quarter.**

Member months for the "Disabled", " Foster Care" , " MCHIP" and "Other" Medicaid Eligibility Groups (MEGs) for the twenty -two quarters beginning January 1, 2015 through June 30, 20 20are estimated to change based on the average quarterly percentage change in member months from the quarter ending December 31, 2012 through the quarter ending December 31, 2014. Member months for the "Medicaid Expansion" Meg are estimated to change based upon the annual percentage change in the estimated number of Medi-Cal beneficiaries enrolled in Medicaid Expansion aid codes from State Fiscal Year 2014-15 to State Fiscal Year 2015-16 as reported in the January 2015 Governor's Budget
The quarterly member months reports currently report: i) all Medi-Cal enrolled beneficiaries with eligibility during the quarter and; ii) all Medi-Cal enrolled beneficiaries who received "adjusted" eligibility during the quarter for any other months of the waiver term.

_____

d. _X_ [Required] Explain any other variance in eligible member months from the BY through the R year(s) to the final Prospective year: **No other changes were applied.**

e.__X_Required] Specify whether the BY/RY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **R1 is SFY 2013-14 (July 1, 2013 through June 30, 2014) and R2 is SFY 2014-15 (e.g. July 1, 2014 to June 30, 2015). Actual data, as reported in the "MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORTs" (Member Months Reports) are displayed in this waiver renewal for R1 and the first two quarters of R2 (July 1, 2014to December 31, 2014). Only this actual data, as reported in the Member Months Reports is used in the waiver renewal to calculate the Base Year (BY) PMPM costs. Only member months in the October 2013 through December 201 4Member Months Reports with dates of Medi-Cal eligibility between July 1, 2013 through December 31, 201 4(i.e. who had Medi-Cal eligibility within the R08 term) are included as actual member months in Appendix D1 and elsewhere in the Section D Appendices.**

Medi-Cal eligibility can be established retroactively for beneficiaries based on any of the following factors: i) Social Security Act section 1902 (a) (34); ii) retroactive Medi-Cal eligibility as legally ordered by courts or administrative law judges; and c) retroactive Medi-Cal eligibility based on the determination and approval of federal SSI/SSP eligibility (e.g. Medi-Medi or dual-eligible status) for the beneficiary. For Medi-Cal beneficiaries who obtain retroactive eligibility, retroactive member months are reported in the quarter in which the eligibility first appears in DHCS' Medi-Cal eligibility system for months included in the current waiver term. Also, as discussed above, only retroactive member months that fall within the current waiver term are included in the Member Months Reports. Thus, any retroactive eligibility for months prior to the current waiver term are not included in the Member Months reports. Member months are reported to CMS quarterly, sixty days after the end of the quarter. For example, for the quarter ending March 31, the member months are sent to CMS by June 1 of the same calendar year. Once quarterly member months are reported to CMS, they are not changed in subsequent quarters.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers: NOT APPLICABLE

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming

waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: **DHCS expects mental health plans will begin to provide Therapeutic Foster Care (TFC) during the upcoming waiver period. An additional program adjustment of 4.4% has been included in D5 to account for additional expenditures related to TFC.**

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **All State of California Medi-Cal mental health service costs are included in this waiver. Other non-mental health costs of serving Medi-Cal clients are accounted for in other State of California waivers and/or state plan programs.**

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal waivers will enter all waiver and FFS administrative costs in the RY or BY.*

For Initial Waivers: NOT APPLICABLE

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$65,625 or .03 PMPM P2* *$72,166 or .03 PMPM P3* *$79,361 or .03 PMPM P4* *$87,274 or .03 PMPM P5*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The MHP's allocate their administrative costs among the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of three methods. These allocation methods are to apply: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report. MHPs may be allowed to change annually the allocation methodology for administrative costs.

As indicated in the above paragraph, MHP's have three options regarding allocation of their administrative costs among its various programs. **T**he allocation method for either initial or renewal waivers is explained below **including notes regarding the appropriateness of each method to various programs:**

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._X_ Other (Please explain). **For SFY 2013-14 and SFY 2014-15 DHCS directly identified DHCS's costs associated with this waiver.** ~~**DHCS costs are based on actual percentages of time spent by State staff on this waiver.**~~ **Finally, county Mental Health Plans (MHP) Administration costs for: i) county administration; ii) quality assurance and utilization review (QA-UR); and iii) Medi-Cal Administrative Activities (MAA), are also included as part of the State Administrative costs. MHPs allocate costs between the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of the three following methods: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report.**

H. Appendix D3 – Actual Waiver Cost

a.___ NOT APPLICABLE The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for PY on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$65,625 or .03 PMPM P2* *$72,166 or .03 PMPM P3* *$79,361 or .03 PMPM P4* *$87,274 or .03 PMPM P5*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for the RY on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for PY on **Column W in Appendix D5**.

Chart: Renewal Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ NOT APPLICABLE The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.___ NOT APPLICABLE Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the

effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____NOT APPLICABLE Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. NOT APPLICABLE **Appendix D4 – Initial Waiver – Adjustments in the Projection for DOS within DOP**

Initial Waiver Cost Projection & Adjustments (If this is a Renewal waiver for DOP, skip to J. Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the BY in order to accurately reflect the waiver program in PY. If the State has made an adjustment to its BYBY, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (PY). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

   1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

   2.___ [Required, to trend BY to PY in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

      i. ____ State historical cost increases. Please indicate the years on which the rates are based: BYs_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

      ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation

includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between PY.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during PY that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the

administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: BYs_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section**

D.I.H.a above. The BY already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future),* the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a**

_____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from BY data.

2.___ We assure CMS that GME payments are included from the BY data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the BY data was completed, the BY data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the BY costs should be reduced by the amount to be collected.

Basis and method:

1.___ No adjustment was necessary
2.___ BY costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the BY costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the fee-for-service or capitated base. If the BY costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the BY costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to

MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from BY data.
2.___ We assure CMS that DSH payments are excluded from the BY data using an adjustment.
3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the BY costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
a. ___Potential Selection bias was measured in the following manner:
b.___The BY costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** BY costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The BY costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the

CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM BY Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported

(IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

    1.___ No adjustment was made.

    2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State

should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The RY data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from RY to the end of the waiver (PY). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. _X_ [Required, if the State's BY or RY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used **varies by time period**. Please document how that trend was calculated: **For R1 (i.e. the waiver year July 1, 2013 to June 30, 2014), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2013, December 2013, March 2014, and June 2014 quarterly CMS-64 Reports for waiver year CA17.R07.01 and dividing those expenditures by actual Member Months as reported in the Member Months Reports summed for the same 4 quarters. For the first two (2) quarters of R2 (i.e. the period July 1, 2014 to December 31, 2014), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2014 and December 2014 quarterly CMS-64 Reports for waiver years CA17.R07.01 and CA17.R07.02 and dividing these expenditures by the actual member months per MEG as reported in the Member Months Report summed for the same two quarters. The State then included a two quarter gap for the last two quarters of R2 from January 1, 2015 to June 30, 2015. The BY PMPM costs per MEG for R2 are then trended for prospective years utilizing DHCS'**

forecast methodology for each MEG in order reflect medical service (cost) inflation under the CA.17 waiver program . The DHCS forecast methodology utilizes the federal Centers for Medicare and Medicaid Services (CMS) Home Health Agency Market Basket (HHAMB) Index, prepared by CMS' Office of the Actuary (OACT), computing the annual percentage change in the 4 Quarter Moving Average for each PY.

Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R08 was cost effective for R1 in terms of total expenditures and the PMPM per MEG. CA17.RO8 waiver Amendment #1 projected total waiver expenditures for Prospective Period 1 (July 1, 2013 – June 30, 2014) to be $3,710,210,096. Appendix D7 of this waiver renewal shows the actual waiver costs for R1 (July 1, 2013 – June 30, 2014) to be $1,355,162,869. CA17.R08 waiver amendment #1 projected the prospective period 1 PMPM for each MEG to be the following: Disabled ($116.84), Foster care ($468.98), MCHIP ($11.51), Other ($16.65), and Medicaid Expansion ($28.12). Appendix D7 of this waiver renewal shows the actual PMPM for each MEG to be the following: Disabled ($37.69), Foster Care ($117.50), MCHIP ($5.61), Other ($6.63), and Medicaid Expansion ($2.34).
Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R08was cost effective for R2 in terms of the projected PMPM for the Disabled, Foster Care, Other, and Medicaid Expansion MEGs. The PMPM for the MCHIP MEG was slightly higher than the projected PMPM for that MEG. The projected PMPM for the cost-effective MEGS were as follows: Disabled ($120.33), Foster Care ($482.99), Other ($17.15), and Medicaid Expansion ($29.53). Appendix D7 to this waiver shows the PMPM for these MEGs to be as follows: Disabled ($112.97), Foster Care ($414.61), Other ($16.85), and Medicaid Expansion ($14.56). Amendment #1 to CA17.R08 projected the PMPM for the MCHIP MEG to be $11.85 in Prospective Year 2 (July 1, 2014 – June 30, 2015). Appendix D7 to this waiver shows the actual PMPM for the MCHIP MEG for the first two quarters to be ($15.00). California experienced a significant increase in approved claims reported in the quarter ending September 30, 2014 that is contributing to the high PMPM for the MCHIP MEG in R2.

2. _X_ [Required, to trend BY/RY to PYin the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. _X__ State historical cost increases. Please indicate the years on which the rates are based: BYs **The BY PMPM costs per MEG are based on R2 as the BY and are trended for P1, P2, P3, P4 and P5 utilizing the percentage change in the CMS' HHAMB 4 Quarter Moving Average for each PY. DHCS' projected increase in costs per member per month does not include other factors. No expenditures or member months for the third or fourth quarters of R2 are included in Appendices D1-D7. Only the first and second quarter R2 actual expenditures and member months are included. The two quarter period January 1, 2013 to June 30, 2013 is a gap period in Section D.**

The State Plan service trend percentage increases for P1 is 2.6% P2 is 2.9%, P3 is 3.1%, P4 is 3.0%, and P5 is 2.9%. These percentages are reported on Appendix D5 as the State Plan Inflation Adjustment for State Plan Services and administrative costs.

Estimated costs per member per month for each MEG for P1, P2, P3, P4 and P5 were multiplied by the estimated Medi-Cal beneficiaries for PY to compute estimated expenditures by MEG in Appendix D6 for each prospective year.
Because of the lag in including costs in the CMS-64 Reports for R2 subsequent to the county MHPs paying for services, as described in Section J.a.1., items A. and B., the projections contained in this Section D may be inaccurate once complete costs for each Prospective Year in this waiver renewal are reported to CMS through the CMS-64 Reports.

For the CA.17 waiver, the actual expenditures from the CMS-64 Reports do not predictably account for the normal and expected lag in claims processing. The typical lag in the CA.17 waiver program is that about 95 percent of claims in a given waiver year quarter are reported to CMS from 5 to 8 quarters subsequent to the waiver quarter in which the county MHPs pay for the services. In contrast, 95 percent of member months for each quarter are reported within that waiver quarter. This lack of alignment between the reporting of costs versus the reporting of member months for the CA.17 waiver program results in an uneven PMPM due to expenditures being reported far later, and in an unpredictable fashion, than member months are reported.

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential

smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. **As described above, PMPM costs are trended for PYs utilizing the HHAMB. The State's cost increase calculation does not include any factors other than a price increase.**

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between RY and P1 and between years P1 and PY.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. _X_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The RY data was adjusted for changes that will occur after the R2 and during PY that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)

- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from RY to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._X_ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv._X_ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.__X_Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D._____ Other (please describe):

The State is implementing a State Plan Services Programmatic/Policy/Pricing Change Adjustment for P1 and on-going to implement provisions of the KATIE A, etc., et al, v. DIANA BONTA, etc. et al, CLASS ACTION SETTLEMENT AGREEMENT (Case No. CV-02-05662 AHM [SHx]). The State expects county mental health plans to provide therapeutic foster care services during the waiver renewal period and costs associated with these services are not included in the expenditure data reported for R2. The State has estimated the annual cost of this service to be $15 million. Users of this service will be in the Foster Care MEG. The per member per month increase in the foster care MEG is expected to be $1.04, which is a *4.4 ~~.26~~%* increase over the R2 PMPM of $391.37. The State is included a Programmatic/Policy/ Pricing Change Adjustment for *~~P1 of~~ 4.4.26%*.

v._X__Changes in legislation (please describe):
For each change, please report the following:
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B._X__ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.____X_Other (please describe):

vi.___ Other (please describe):
A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D.___Other (please describe):

c. _X__**Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all*

relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of PY. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

iii._X_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: BYs **Actual State administrative costs were trended forward at the State Plan services trend rate, which utilized the percentage change in the HHAMB index.** In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

CA17 administration inflation rates for P1, P2, P3, P4 and P5 are based on the percentage change in the HHAMB 4 quarter moving average for each PY, which is the state plan services trend rate. These rates are reported on Appendix 5 as the Administration Inflation Adjustment. PMPM costs for Administration for R1 and the first two quarters of R2 were calculated by apportioning total administration costs for waiver years R1 and R2 to each

MEG based on the ratio of each MEGs State Plan Service costs for the waiver year to the total State Plan Service costs for that same waiver year as contained in Appendix D3. This calculated ratio of each MEGs Administration costs are then divided by the actual Member Months per MEG as reported in Appendix D1 for the same waiver year to obtain the Administration PMPM for each RY.

Estimated costs per member per month for each MEG for Administration for P1, P2, P3, P4 and P5 are then multiplied by the estimated Medi-Cal beneficiaries projected for each PY to compute estimated administration expenditures by MEG for each prospective year in Appendix D6.
NORMAL LAG IN REPORTING ADMINISTRATION COSTS – The same "normal" lag as described for reporting State plan services costs in the CMS-64 Reports applies to the reporting of CA17 Administration costs for R1 and R2. As a result, actual Administration costs reported for R1 and R2 of the CA17.R07 waiver renewal do not properly reflect expected Administration cost claiming.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** NOT APPLICABLE The State must document the amount of 1915(b)(3) services in the RY/BY **Section D.I.H.a** above. The RY/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the RY/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (PY). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or last RY is more than 3 months prior to the beginning of P1 to trend BY or RY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or last RY is trended to the last PY. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: BYs_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** NOT APPLICABLE
Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe): NOT APPLICABLE

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust PY to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
    - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
    - **Pharmacy Rebate Factor Adjustment**: Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the capitated base. If the BY costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

      Basis and Method:

      1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the BY costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume

that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

The State utilizes a cost effectiveness monitoring process whereby any variances in PMPM cost by MEG are identified, researched and discussed so that the State can discuss such findings with CMS and prepare any necessary waiver amendments.

The State monitors retrospective year costs based on all actual costs for each waiver year reported in the CMS-64 Reports during that waiver year. The State updates and reviews cumulative costs for each RY at the time each final quarterly CMS-64 Report during that waiver year is transmitted by the State to CMS. The State compares both the aggregate and PMPM costs per MEG for State Plan Services and Administration for each retrospective waiver year to the Appendix D6, RO Targets. If the PMPM per MEG for any waiver year within a particular waiver term exceeds the Appendix D6 targets, the State determines what factors caused the PMPM to exceed the waiver year projection – including State Plan Trend and Administration Cost factors such as: i) changes in the CMS-64 Reporting lag and those factors causing the change; ii) reporting of costs by county; iii) reporting of costs by service type; iv) the number of beneficiaries that received services per waiver quarter/year compared to member months for the same waiver quarter/year *(e.g.. "caseload" or penetration rate)*; v) the number of services per beneficiary *(e.g. utilization)*; vi) rate changes; vii) administrative/statutory/legal changes; and/or viii) other changes that may impact quarterly or annual PMPM costs.

The unpredictable lag in reporting payments made by the county MHPs in the CMS-64 Reports due to both the "normal" lag and any "unique" lag factors makes it difficult to align actual waiver year expenditure data with actual member months

for the same waiver years. Collating, reviewing and trending State plan service and Administration costs over more retrospective years may better identify actual costs for each waiver year. Without reviewing waiver costs over a greater number of retrospective years, the projections contained in this Section D for waiver renewal CA.17.R08 may be inaccurate until complete costs for each RY are reported to CMS in future CMS-64 Reports.

The State may request additional amendments to this Section D in the future to properly align actual costs and member months for each waiver year and address any other programmatic/policy/pricing changes to either the State Plan Trend or Administration Costs that occur during this waiver term.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to PY.

As described in Part I Section J.a.1. and I.Ja.2, and included in Appendix D5, Column J, the State has included the HHAMB inflation factor for State Plan services in each PY.

As described in Part I Section J.b.2.iv. and reflected in Appendix D5, Column L, rows 13 through 16, the State has included a Programmatic/Policy/Pricing Change Adjustment for the Katie A. court settlement.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

As described in Part I., Section E.c for Renewal Waivers, member months are projected to change based upon the average quarterly rate of change experienced from the quarter ending March 31, 2013 through the quarter ending December 31, 2014. This trend in member months is not expected to impact the annualized rate of change in Appendix D7, Column I.

~~2.~~ Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**: **Unit cost changes are anticipated to increase by the percentage change in the HHAMB 4 quarter moving average for each PY. This factor impacts the annualized rate of change in Appendix D7 Column I. The change**

due to this unit cost increase for P1 is 2.6%, for P2 is 2.9%, for P3, is 3.1%, for P4 is 3.0%, and for P5 is 2.9%.

~~3.~~ Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**: **The State is expecting utilization of therapeutic behavioral services to increase during the period of the waiver renewal. The cost of this increased utilization in the Foster Care MEG is factored into P1. This increase in utilization impacted the annualized rate of change for the Foster Care MEG by .3.**

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I. No other principle factors other than those described above contributed to the overall annualized rate of change in the cost per member per month.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.