CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)

Section 1115 Waiver Annual Report

Demonstration Reporting Period:
Demonstration Year: Fourteen (July 1, 2018 – June 30, 2019)

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INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 14 to the Centers for Medicare & Medicaid Services (CMS), in accordance with Item 28 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 14:

- Accomplishments
- Program Highlights
- Qualitative and Quantitative Findings
- Policy and Administrative Issues or Challenges
- Progress on the Evaluation and Findings

DHCS submitted an application to renew the State's Section 1115 Waiver Demonstration to CMS on March 27, 2015 after many months of discussion and input from a wide range of stakeholders and the public to develop strategies for how the Medi-Cal program will continue to evolve and mature over the next five years. A renewal of this waiver is a fundamental component to California's ability to continue to successfully implement the Affordable Care Act beyond the primary step of coverage expansion. On April 10, 2015, CMS completed a preliminary review of the application and determined that the California's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

On October 31, 2015, DHCS and CMS announced a conceptual agreement that outlines the major components of the waiver renewal, along with a temporary extension period until December 31, 2015 of the past 1115 waiver to finalize the STCs. The conceptual agreement included the following core elements:

- Global Payment Program for services to the uninsured in designated public hospital (DPH) systems
- Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals, known as PRIME
- Dental Transformation Incentive program
- Whole Person Care pilot program that would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations
- Independent assessment of access to care and network adequacy for Medi-Cal managed care members
- Independent studies of uncompensated care and hospital financing

- The continuation of programs currently authorized in the Bridge to Reform waiver, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Coordinated Care Initiative, and Community-Based Adult Services (CBAS)

Effective on December 30, 2015, CMS approved the extension of California's section 1115(a) Demonstration (11-W-00193/9). Approval of the extension is under the authority of the Section 1115(a) of the Social Security Act, until December 31, 2020. The extension allows the State to extend its safety net care pool for five years, in order to support the State's efforts towards the adoption of robust alternative payment methodologies and support better integration of care.

To build upon the State's previous Delivery System Reform Incentive Payment (DSRIP) program, the new redesigned pool, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program aims to improve the quality and value of care provided by California's safety net hospitals and hospital systems. The activities supported by the PRIME program are designed to accelerate efforts by participating PRIME entities to change care delivery by maximizing health care value and strengthening their ability to successfully perform under risk-based alternative payment models (APMs) in the long term, consistent with CMS and Medi-Cal 2020 goals. Using evidence-based, quality improvement methods, the initial work will require the establishment of performance baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions. PRIME has three core domains:

- Domain 1: Outpatient Delivery System Transformation and Prevention
- Domain 2: Targeted High-Risk or High-Cost Populations
- Domain 3: Resource Utilization Efficiency

The Global Payment Program (GPP) streamlines funding sources for care for California's remaining uninsured population and creates a value-based mechanism. The GPP establishes a statewide pool of funding for the remaining uninsured by combining federal DSH and uncompensated care funding, where county DPH systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high-cost, avoidable services to providing higher-value, preventive services.
To improve the oral health of children in California, the Dental Transformation Initiative (DTI) will implement dental pilot projects that will focus on high-value care, improved access, and utilization of performance measures to drive delivery system reform. This strategy more specifically aims to increase the use of preventive dental services for children, to prevent and treat more early childhood caries, and to increase continuity of care for children. The DTI covers four domains:

- Domain 1: Increase Preventive Services Utilization for Children
- Domain 2: Caries Risk Assessment and Disease Management
- Domain 3: Increase Continuity of Care

- Domain 4: Local Dental Pilot Programs

Additionally, the Whole Person Care (WPC) pilot program will provide participating entities with new options for providing coordinated care for vulnerable, high-utilizing Medicaid recipients. The overarching goal of the WPC pilots is to better coordinate health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC will help communities address social determinants of health and will offer vulnerable beneficiaries with innovative and potentially highly effective services on a pilot basis.

Assembly Bill (AB) 1568 (Bonta and Atkins, Chapter 42, Statutes of 2016) established the "Medi-Cal 2020 Demonstration Project Act" that authorizes DHCS to implement the objectives and programs, such as WPC and DTI, of the Waiver Demonstration, consistent with the STCs approved by CMS. The bill also covered having the authority to conduct or arrange any studies, reports, assessments, evaluations, or other demonstration activities as required by the STCs. The bill was chaptered on July 1, 2016, and it became effective immediately as an urgency statute in order to make changes to the State's health care programs at the earliest possible time.

Operation of AB 1568 is contingent upon the enactment of Senate Bill (SB) 815 (Hernandez and de Leon, Chapter 42, Statutes of 2016). The bill, chaptered on July 8, 2016, establishes and implements the provisions of the State's Waiver Demonstration as required by the STCs from CMS. The bill also provides clarification for changes to the current Disproportionate Share Hospital (DSH) methodology and its recipients for facilitating the GPP program.

On June 23, 2016, DHCS submitted a waiver amendment request to CMS to expand the definition of the lead entity for WPC pilots to include federally recognized Tribes and Tribal Heath Programs. On August 29, 2016, DHCS proposed a request to amend the STCs to modify the methodology for determining baseline metrics for incentive payments and provide payments for a revised threshold of annual increases in children preventive services under the DTI program. On December 8, 2016, DHCS received approval from CMS for the DTI and WPC amendments.

On November 10, 2016, DHCS submitted a waiver amendment proposal to CMS regarding the addition of the Health Homes Program (HHP) to the Medi-Cal managed care delivery system. Under the waiver amendment, DHCS would waive Freedom of Choice to provide HHP services to members enrolled in the Medi-Cal managed care delivery system. Fee-for-service (FFS) members who meet HHP eligibility criteria may choose to enroll in a Medi-Cal managed care plan to receive HHP services, in addition to all other state plan services. HHP services will not be provided through the FFS delivery system. DHCS received CMS' approval for this waiver amendment on December 9, 2017.

On February 16, 2017, DHCS submitted a waiver amendment proposal to CMS for the addition of the Medi-Cal Access Program (MCAP) population to the Medi-Cal managed care delivery system, with a requested effective date of July 1, 2017. MCAP provides comprehensive coverage to pregnant women with incomes above 213 up to and including 322 percent of the federal poverty level. The MCAP transition will mirror the benefits of Medi-Cal full-scope pregnancy coverage, which includes dental services coverage.

During a conference call on April 26, 2017, CMS advised the state to convert DHCS' amendment proposal into a Children Health Insurance Program (CHIP) SPA in its place. In response to CMS' guidance, DHCS sent CMS an official letter of withdrawal for the MCAP amendment request on May 24, 2017.

On May 19, 2017, DHCS submitted a waiver amendment proposal to CMS to continue coverage for California's former foster care youth up to age 26, whom were in foster care under the responsibility of a different state's Medicaid program at the time they turned 18 or when they "aged out" of foster care. DHCS received CMS' approval for the former foster care youth amendment on August 18, 2017.

On June 1, 2017, DHCS also received approval from CMS for the state's request to amend the STCs in order to allow a city to serve in the lead role for the WPC pilot programs.

TIME PERIODS:

Demonstration Year

The periods for each demonstration year of the Waiver will consist of 12 months, except for DY 11 and DY 16, which will be 6 months respectively. The DY timeframes are indicated below:

- DY 11: January 1, 2016 through June 30, 2016
- DY 12: July 1, 2016 through June 30, 2017
- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020
- DY 16: July 1, 2020 through December 31, 2020

Annual Report

This report covers the period from July 1, 2018 through June 30, 2019.

GENERAL REPORTING REQUIREMENTS

- **Item 8 of the STCs – Amendment Process**

No waiver amendments occurred during DY 14.

- **Item 18 of the STCs – Post Award Forum**

The purpose of the Stakeholder Advisory Committee (SAC) is to provide DHCS with valuable input from the stakeholder community on ongoing implementation efforts for the State's Section 1115 Waiver, as well as other relevant health care policy issues impacting DHCS. SAC members are recognized stakeholders/experts in their fields, including, but not limited to, beneficiary advocacy organizations and representatives of various Medi-Cal provider groups. SAC meetings are conducted in accordance with the Bagley-Keene Open Meeting Act, and public comment occurs at the end of each meeting.

In DY 14, DHCS hosted four SAC Meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- July 18, 2018
- October 25, 2018
- February 13, 2019
- May 23, 2019

Meeting information, materials, and minutes are available on the DHCS website at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx.

- **Item 25 of the STCs – Contractor Reviews**

Seniors and Persons with Disabilities (SPDs)

Under the authority of the Section 1115 Medicaid Demonstration Waiver titled "California Bridge to Reform Demonstration," California transitioned the SPD population from the Medi-Cal Fee-For-Service delivery system into the managed care delivery system. This transition occurred between June 2011 and May 2012. In order to evaluate the success of California's Bridge to Reform waiver, the Medi-Cal 2020 demonstration waiver requires the State to provide evaluations on several waiver programs, including the SPD program. The SPD program evaluation must include:

- An evaluation of the impact of the program on member experience as well as the impact of the State's administration of the program overall using measures that describe three specific content areas: access to care, quality of care, and costs of coverage.

- A focused evaluation on the specific health care needs of SPDs, including specific needs associated with multiple complex conditions.

DHCS has contracted with the Regents of the University of California on behalf of its Los Angeles campus (UCLA) to conduct the SPD program evaluation.[1] UCLA began its contracting work on July 1, 2018. The interim SPD evaluation report is due to CMS on December 31, 2019. Additionally, the final SPD evaluation report is due to CMS by December 31, 2021 at the completion of the Medi-Cal 2020 Waiver.

- **Item 26 of the STCs – Monthly Calls**

CMS and DHCS schedule monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. During DY 14, the conference calls were held on the following dates:

- July 9, 2018
- August 13, 2018
- October 15, 2018
- December 10, 2018
- January 14, 2019
- February 11, 2019
- March 11, 2019
- April 8, 2019
- May 13, 2019

The main discussion topics included: Whole Person Care program updates, Health Homes program updates, DMC-ODS program updates, and various waiver program deliverables.

- **Item 27 of the STCs – Demonstration Quarterly Reports**

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 14, DHCS submitted three quarterly reports to CMS electronically on the following dates:

- Quarter 1 (July 1, 2018 – September 30, 2018): Submitted November 29, 2018
- Quarter 2 (October 1, 2018 – December 31, 2018): Submitted February 28, 2019
- Quarter 3 (January 1, 2019 – March 31, 2019) – Submitted May 23, 2019

[1] The SPD program evaluation design can be found on DHCS' website at: https://www.dhcs.ca.gov/provgovpart/Documents/SPDFinalEvalDesign.pdf.

Per CMS' guidance, the fourth quarterly reporting information have been folded into the annual reports beginning in this demonstration year.

- **Item 28b of the STCs – Primary Care Access Measures for Children**

Each year, DHCS selects a set of performance measures, previously known as the External Accountability Set (EAS), to assess the quality of care Medi-Cal managed care health plans (MCPs) provide. For Measurement Year (MY) 2019/Reporting Year (RY) 2020, DHCS has selected a set of quality measures from the CMS Adult and Child Core Sets. The DHCS-selected measures are now known as the Managed Care Accountability Set (MCAS). For applicable measures, DHCS continues to utilize benchmarks from the National Committee for Quality Assurance Quality Compass, for setting the Minimum Performance Level (MPL) for MCP performance. For MY 2019/RY 2020, DHCS has increased the MPL from the 25th to the 50th percentile. DHCS contracts require MCPs to reach the MPL as a minimum, meaning they must perform at least as well as the bottom 50 percent of all Medicaid programs nationwide on each MCAS measure for which a benchmark exists for RY 2020. The High-Performance Level (HPL) remains at the 90th percentile.

During DY 14, data for the relative RY 2019 included data from January 1, 2018 – December 31, 2018. The MCPs' EAS included measures on rates for *Children's and Adolescents' Access to Primary Care Practitioners*. These measures were distributed by the following age groups:

- 12 - 24 months (Corrective Action Plan (CAP)-1224),
- 25 months - 6 years (CAP-256),
- 7 - 11 years (CAP-711), and
- 12 - 19 years (CAP-1219).

In RY 2019, the difference between the MPL and the HPL was less than 9 percentage points for the EAS measures listed above, making it difficult for MCPs to demonstrate significant quality improvement. Therefore, DHCS chose not to hold MCPs to the MPL for these EAS measures during this RY.

- **Item 30 of the STCs– Revision of the State Quality Strategy**

DHCS is in the process of drafting a *DHCS Comprehensive Quality Strategy (CQS)* report, which combines and updates the previous *Med-Cal Managed Care Quality Strategy Report* submitted to CMS on June 29, 2018 and the previous *DHCS Strategy for Quality Improvement in Health Care* report, which covers quality improvement activities in both DHCS managed care and fee for service delivery systems. The CQS outlines the Department's process for developing and maintaining a broader quality strategy to assess the quality of care that beneficiaries receive, regardless of delivery system, defines measurable goals, emphasizes CMS Core Set measures, and tracks improvement while adhering to regulatory managed care requirements of 42 Code of Federal Regulations

(CFR) 438.340. The CQS describes DHCS' quality improvement infrastructure; development of the comprehensive quality strategy; managed care state standards, assessment, and evaluation requirements, including state-defined network adequacy standards; continuous program quality improvement and interventions; the state's plan to identify, evaluate, and reduce health disparities; the state's definition of ''significant change''; and other quality improvement efforts in DHCS programs that are not part of the managed care delivery system. The report also highlights DHCS' coordinated delivery system reform efforts, including CalAIM, a multi-year initiative by DHCS to implement overarching policy changes across all Medi-Cal delivery systems, with the objective of: 1) Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health; 2) Move
Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and 3) Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The CQS covers all Medi-Cal managed care delivery systems, including Medi-Cal managed care health plans, county mental health plans, DMC-ODS, and dental managed care plans, as well as other non-managed care departmental programs.

- **Item 31 of the STCs – External Quality Review**

Medical Managed Care

Every April, DHCS releases an annual External Quality Review (EQR) technical report to CMS and the public. These reports are compliant with federal regulations (Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E). The most recent EQR technical report is available on DHCS' Medi-Cal Managed Care – Quality Improvement & Performance Measurement webpage.[2]

DMC-ODS

Behavioral Health Concepts External Quality Review Organization (EQRO) has completed reviews for the following counties:

- Santa Clara County on August 1-3, 2018
- Contra Costa County on August 28th-30th, 2018
- Los Angeles County on November 5-8, 2018
- San Luis Obispo County on December 4-5, 2018
- San Francisco County on December 11-13, 2018

[2] The EQR technical report is available at: htt://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.

- Marin County on January 15-16, 2019
- Napa County on March 7, 2019
- Santa Cruz County on March 20-21, 2019
- Nevada County on June 18, 2019
- Imperial County on May June 27, 2019

Sixteen performance measures will be reviewed during the second year reviews. Reviews focused on access, timeliness, and quality. The DMC-ODS EQRO reports are made available here: https://caleqro.com/dmc-eqro#!dmc-reports_and_summaries/Fiscal

- **Item 33 of the STCs – Certified Public Expenditures (CPE)**

Nothing to report.

- **Item 34 of the STCs – Designated State Health Programs**

Program costs for each of the Designated State Health Programs (DSHP) are expenditures for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols under the Medi-Cal 2020 Waiver. The federal funding received for DSHP expenditures may not exceed the non-federal share of amounts expended by the state for the DTI program.

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the Safety Net Care Pool. To implement this limitation, 13.95 percent of total certified public expenditures for services to uninsured individuals will be treated as expended for non-emergency care to non-qualified aliens.

The STCs allow the State to claim Federal Financial Participation (FFP) using the CPE of approved DSHP. The annual FFP limit the State may claim for DSHPs during each demonstration year is $75 million for a five-year total of $350 million.

Figure 1

Payment	CPE	FFP	Service Period	Total Claim
(Qtr. 1 July - Sept)	$37,437,178	$18,718,589	DY 13	$18,718,589
(Qtr. 2 Oct-Dec)	$0	$0		$0
(Qtr. 3 Jan-Mar)	$0	$0		$0
(Qtr. 4 Apr - Jun)	$0	$0		$0
Total	$37,437,178	$18,718,589		$18,718,589

Figure 1 shows that in DY14-Q4, the Department claimed $0 in federal fund payments for DSHP-eligible services. DSHP claiming has been on hold since DY14-Q2 due to the fact that DSHP claiming currently exceeds the non-federal share of amounts expended by the state for the DTI program.

- **Item 37 of the STCs – Managed Care Expansions**

Nothing to report.

- **Item 38 of the STCs – Encounter Data Validation Study for New Health Plans**

DHCS annually performs an Encounter Data Validation (EDV) study with its contracted EQRO, Health Services Advisory Group, Inc. (HSAG). During each study, DHCS pulls encounter data from its Management Information System/Decision Support System (MMIS/DSS) and provides it to the EQRO. The EQRO then examines, through review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs.

In March 2019, DHCS published the DY 13 EDV Study, titled *SFY 2017-18 Encounter Data Validation Study Report*.[3] In the report, HSAG provided recommendations to DHCS to improve encounter data quality.

In early 2019, HSAG began work on the DY 14 EDV study. HSAG has completed the study plan; data collection and sampling; medical record procurement; and review associated with the DY 14 EDV study. Analysis of the medical record review results is in process by HSAG, and written reports corresponding to DY 14 activities are scheduled to be published on the DHCS website in early DY 15.

[3] The EDV report is available on DHCS' website at: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CA2017-18_EDV_Report_F3.pdf.

- **Item 39 of the STCs – Submission of Encounter Data**

In May 2017, CMS approved DHCS to move into production for data transmission to the Transformed Medicaid Statistical Information System (T-MSIS), which replaced the Medicaid Statistical Information System. During DY 14, DHCS continued to work with CMS to identify and resolve concerns with its production encounter data transmissions through T-MSIS.

- **Item 41 of the STCs – Contracts**

Nothing to report.

- **Item 43 of the STCs – Network Adequacy**

DHCS performs extensive ongoing and scheduled monitoring activities as well as network certification and network readiness reviews when expansion occurs or there is a significant change. DHCS annually submits network certification reports on the status of MCP network adequacy to CMS.

MCPs must obtain written approval from DHCS prior to making significant changes in their networks that would impact the availability or location of covered services or before they begin enrollment of new populations. MCPs are also required to submit provider data to DHCS monthly so that DHCS and MCPs can actively work together to resolve any network adequacy issues as they arise.

DHCS conducts comprehensive ongoing reviews of MCP networks and sends data analysis and inquiries to MCPs for responses and necessary resolutions. DHCS then evaluates MCP responses to identify any deficiencies or outliers to address during the next review of MCP networks. Network adequacy indicators, include, but are not limited to:

- Primary Care Provider (PCP) Capacity (PCPs accepting new members);
- PCP-to-member ratios;
- Physician-to-member ratios;
- Termination of contracts;
- PCP time and distance standards;
- Specialist time and distance standards;
- Mental health time and distance standards;
- Hospital time and distance standards;
- Pharmacy time and distance standards;
- Timely access to PCPs, specialists, mental health providers, and ancillary providers;
- MCP alternate access standards;

- Out of network requests/approvals/denials;
- State Fair Hearings; and
- Independent Medical Reviews.

Beginning in DY 14, MCPs are now required to submit comprehensive data to DHCS annually that reflects the MCP's entire contracted provider network for each service area. DHCS will evaluate the data to confirm that each MCP's network is sufficient to meet the anticipated needs of its members with adequate availability and accessibility of services including an appropriate range of providers.

- **Item 44 of the STCs – Network Requirements**

In DY 13, DHCS implemented new network adequacy standards, in addition to the existing network requirements. These standards consider elements specified in 42 CFR Sections 438.68, 438.206, and 438.207, Welfare and Institutions Code Section 14197, the Knox-Keene Health Care Service Plan Act of 1975, and the MCP contract. DHCS initially released its Network Adequacy Standards pursuant to the Medicaid Managed Care Final Rule on July 19, 2017; however, they were subsequently revised to account for changes pursuant to state law.[4]

In DY 13, DHCS issued All Plan Letter (APL) 18-005, *Network Certification Requirements*, to provide guidance to MCPs regarding Annual Network Certification, other network reporting requirements, associated network adequacy standards, and alternative access standards and requirements. Then, in DY 14, DHCS released APL 19-002, also titled *Network Certification Requirements*, which superseded APL 18-005. APL 19-002 clarified MCP responsibilities regarding 274 file submissions; DHCS' authority to determine significant changes to a network; the process for submitting Alternative Access Standard (AAS) requests; DHCS' provider validation process; the use of telehealth; and out-of-network monitoring and oversight.[5]

In DY 14, DHCS published two reports pertaining to the Annual Network Certification on the DHCS website. The first report, titled *Approved Alternative Access Standards Report,* contains all MCP AAS requests that were approved by DHCS during the Annual Network Certification of MCPs.[6] The second report, titled *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report*, identifies all

[4] DHCS' Network Adequacy Standards are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacyStandards.aspx
[5] APLs, including APL 19-002, are available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[6] The 2019 *Approved Alternative Access Standards Report,* updated as of January 30, 2019, is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Documents/AB_205_AAS_Report_2019.pdf.

MCPs that were subject to a CAP due to non-compliance with network adequacy standards, as well as each MCP's response to the CAP.[7]

On June 28, 2019, DHCS submitted the report titled *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report* to CMS in accordance with 42 CFR 438.207(d). The report confirmed that MCPs contracting with DHCS are compliant with the network certification requirements set forth in 42 CFR Sections 438.206, 438.207, and 438.68.[8]

- **Item 45 of the STCs – Certification (Related to Health Plans)**

DHCS updated statewide provider network adequacy standards in APL 19-002, *Network Certification Requirements* to guide the MCPs through the Annual Network Certification process.[9] Based on DHCS' assessment, all MCPs contracted with DHCS have demonstrated the capacity to service the expected enrollment in each service area in accordance with standards for access to care established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) sections 438.68, 438.206, and 438.207, and therefore meet all network certification requirements or have been deemed to meet the requirements for 2019.

DHCS continues to work with the MCPs to improve and automate the submission process. However, any changes to the submission process will not detract from the requirements placed on DHCS to report documentation to CMS that demonstrates each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and Long Term Support Services (LTSS) that is adequate for the anticipated number of members for the service area in compliance with 42 CFR, Section 438.68 (network adequacy standards) and Section 438.206 (c)(1) (availability of services);

- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area;

- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services.

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[7] The *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report,* updated as of January 30, 2019, is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Documents/AB205ReportCAPsFinalADAMCQMD.pdf.

[8] The *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report* is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Documents/AnnualNetCertReportJuly2019.pdf.

[9] APL 19-002 can be found on DHCS' website at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

- **Item 58 of the STCs – 2016 CCS Pilot Update**

As of June 2019, DHCS is working with CMS to finalize the CCS protocols. The report will meet the STCs' requirements and includes:

- Brief description of the pilot program
- Description of HPSM as a MCP
- HPSM DP status update
- Description of RCHSD as an ACO
- RCHSD DP status update
- Number of children enrolled and cost of care

- **Items 69-73 of the STCs – Access Assessment**

California's Section 1115(a) Medicaid Waiver Demonstration STCs required DHCS to contract with its EQRO, HSAG, to conduct a one-time assessment to care.

This assessment evaluated primary, core specialty, and facility access to care during 2017-18 for Medi-Cal managed care members based on requirements in the Knox-Keene Health Care Service Plan Act of 1975 and existing MCP contracts.

HSAG began working with DHCS in October 2016 to develop the overall access assessment evaluation design. An advisory committee was formed to provide input on the assessment structure. The advisory committee included representatives from consumer advocacy organizations, providers, provider associations, MCPs, health plan associations, and legislative staff. With participation from the advisory committee, DHCS submitted a draft evaluation design to CMS for review in April 2017. The evaluation design included:

- Network Capacity;
- Geographic Distribution;
- Appointment Availability;
- Service Utilization; and
- Grievances and Appeals.

HSAG hosted a final access assessment advisory committee meeting in June 2019 to review the results and provide guidance to the committee for submitting its feedback to HSAG. DHCS and HSAG then presented an initial draft of the California 2017-18 Access Assessment Report for public comment.[10]

Summary of results:

- No critical access issues were identified that would require immediate attention; and

[10] An initial draft of the CA 2017-18 Access Assessment Report is available on the DHCS website at: https://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx.

- Although some MCPs did not meet all standards, no single MCP consistently performed poorly.

The following activity will complete this project:

- HSAG has presented DHCS with a final report; DHCS will submit the final report to CMS by the end of October 2019.

- **Items 211-216 of the STCs – Evaluation of the Demonstration**

Detailed information about the CCS, DTI, GPP, SPD, PRIME, and WPC evaluations are available in their respective program updates provided below. Copies of the program evaluation designs are available on the DHCS website at: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S SERVICES (CCS)

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

The CCS Program is administered as a partnership between local CCS county programs and DHCS. Approximately 75 percent of CCS-eligible children are Medi-Cal eligible.

The pilot project under Medi-Cal 2020 is focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction, and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improvement of care for all 189,312 children enrolled in CCS.

DHCS is piloting two (2) health care delivery models of care for children enrolled in the CCS Program. The two demonstration models include provisions to ensure adequate protections for the population served, including a sufficient network of appropriate providers and timely access to out-of-network care when necessary. The pilot projects will be evaluated to measure the effectiveness of focusing on the whole child, not just the CCS condition. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the demonstration period decisions can be made on permanent restructuring of the CCS Program design and delivery systems.

The two (2) health care delivery models include:

- Provider-based Accountable Care Organization (ACO)
- Medi-Cal Managed Care Plan (existing)

In addition to Health Plan San Mateo (HPSM), DHCS contracted with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning in FY 2018.

Accomplishments:

Figure 2: Pilot Accomplishments

Date	Pilot Accomplishment Items
September 19, 2016	The draft CCS evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at: https://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx
November 2017	DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and received the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.
Date	**HPSM Pilot Accomplishment Items**
October 2017 – November 2017	Submitted and received CMS approval of contract amendment A02.
October 2017 - Present	Preparing contract amendment A03 for signature.
June 2018	Transitioned CCS beneficiaries from demonstration pilot plan to managed care plan.
Date	**RCHSD Pilot Accomplishment Items**
July 1, 2018	RCHSD was implemented as a full risk plan. RCHSD began enrolling members into their plan.

Program Highlights:

RCHSD CCS DP

RCHSD – San Diego pilot demonstration was implemented on July 1, 2018. RCHSD was brought up as a full-risk Medi-Cal managed care health plan that services CCS beneficiaries in San Diego County that have been diagnosed with one of five eligible medical conditions. Members are currently being enrolled into RCHSD.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

The monthly enrollment for RCHSD CCS DP is reflected in Figure 3 below. Eligibility data is extracted from the Children's Medical Services Network (CMS Net) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to RCHSD. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Figure 3: Monthly Enrollment for RCHSD CCS DP

Month	RCHSD Enrollment Numbers	Difference Prior Month
July 2018	0	-
August 2018	44	+44
September 2018	128	+84
October 2018	151	+23
November 2018	209	+58
December 2018	324	+115
January 2019	363	+39
February 2019	368	+5
March 2019	372	+4
April 2019	365	-7
May 2019	367	+2
June 2019	368	+1

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

Regents of the University of California, San Francisco (UCSF) was selected as the evaluator for the California Children's Services (CCS) evaluation design. This evaluation will run from July 1, 2019, to June 30, 2021, and will be completed in two phases. Phase one will include Health Plan San Mateo (HPSM), and phase two will include RCHSD. In July 2019, UCSF began its contracting work on the evaluation and has received applicable data sets. UCSF is working on the Interim Report due to CMS on December 31, 2019, which is mandated by California's Section 1115(a) Medicaid Waiver.

The final evaluation design is available on:
http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

In anticipation of the end of the CBAS BTR Waiver period, DHCS and the California Department of Aging (CDA) facilitated extensive stakeholder input regarding the continuation of CBAS. DHCS proposed an amendment to the CBAS BTR waiver to continue CBAS as a managed care benefit beyond August 31, 2014. CMS approved the amendment to the CBAS BTR waiver, which extended CBAS for the duration of the BTR Waiver through October 31, 2015.

CBAS will continue as a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver approved by CMS on December 30, 2015.

Program Requirements

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria.

CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020; and 4) exhibit ongoing compliance with the requirements listed above.

Initial eligibility for the CBAS benefit is determined through a face-to-face assessment by a Managed Care Plan (MCP) registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the plan possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every 12 months for individuals determined

by the MCP to be clinically appropriate. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment.

The State must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[11]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service benefit. On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model (available in 14 counties) Geographic Managed Care plans (available in two counties) and the final COHS County (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

Effective April 1, 2012, eligible participants can receive unbundled services (i.e. component parts of CBAS delivered outside of centers with a similar objective of supporting participants, allowing them to remain in the community) if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services include local senior centers to engage members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist participants with Activities of Daily Living or Instrumental Activities of Daily Living.). If the participant is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Program Highlights:

As a result of stakeholder processes during 2015 and 2016, the California Department of Aging (CDA) and Department of Health Care Services (DHCS) in collaboration with CBAS providers, managed care plans and other interested stakeholders developed the following documents which impacted CBAS program activities during DY 14 (July 2018 through June 2019): (1) New CBAS Individual Plan of Care (IPC); (2) CBAS Quality Assurance and Improvement Strategy: A Five-Year Plan (dated October 2016); and (3) Revised CBAS Home and Community-Based (HCB) Settings Transition Plan (dated January 11, 2018).

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

These documents were developed in response to the following directives by CMS in the CBAS provisions of the 1115 Demonstration Waiver: (1) STC 48(c) and STC 49(c) requiring all CBAS settings to comply with the federal Home and Community-Based (HCB) Settings requirements (42 CFR 441.301(4)) and Person-Centered Planning requirements (42 CFR 441.301(c)(1)(2)(3)); and (2) STC 53 requiring the State to develop a quality strategy to assure the health and safety of Medi-Cal beneficiaries receiving CBAS. The following is an update on CBAS program activities during DY 14 related to each of these documents:

IPC

The target date for implementation of the new IPC was initially projected for March/April 2017; however, its implementation was effective as of June 1, 2019, after the CBAS sections of the DHCS Medi-Cal Provider Manual were published which includes the IPC instructions. CDA distributed All Center Letters (ACLs) related to implementation of the new IPC, provided a webinar training on the new IPC in October 2018 and will continue to provide technical assistance to CBAS providers during CDA's on-site CBAS Medi-Cal certification surveys of all CBAS centers and at training conferences sponsored by the California Association for Adult Day Services (CAADS).

CBAS Quality Assurance and Improvement Strategy

The CBAS Quality Assurance and Improvement Strategy (dated October 2016) is a five-year plan to assure CBAS participant health and safety by addressing the following: (1) the quality and implementation of the CBAS beneficiary's person-centered IPC, (2) provider adherence to state and licensure and certification requirements, (3) quality metrics for person- centered care/continuity of care, (4) clinical and program outcome measures/indicators, (5) CBAS center staff training on best practices and quality improvement, and (6) improved use of existing enforcement provisions for CBAS centers that do not meet licensing or certification standards. The *CBAS Quality and Improvement Strategy* is designed to assure federal partners, beneficiaries and the public that CBAS providers meet program standards while they continue to develop new approaches to improving service delivery.

CDA and DHCS continue to implement the goals and objectives of this report within specific timeframes in partnership with a CBAS Quality Advisory Committee comprised of CBAS providers, managed care plans, and advocates. The short- and medium-term objectives identified in Goals I and II guided CBAS program activities for DY14. For example, during DY 14, CDA achieved the following quality objectives: implemented the new CBAS IPC to align with federal and state program requirements; modified the CBAS Participant Characteristics Report (PCR) to improve program monitoring and reporting; developed user-friendly checklists/job aids (Center Assessment Tools) to help CBAS providers evaluate their compliance with program requirements; developed a

standardized CBAS History & Physical (H&P) form in collaboration with CAADS to promote CBAS center consistency in data collection, reporting and compliance with program requirements; and convened quarterly calls with MCPs that contract with CBAS providers to promote communication, provide updates on CBAS activities and policy directives, and request feedback on CBAS provider issues requiring CDA assistance.

CBAS Home and Community-Based (HCB) Settings Transition Plan Update

All CBAS centers must comply with the federal HCB settings and person-centered planning requirements by March 17, 2022, and thereafter, or risk losing their CBAS Medi-Cal certification. The State submitted *California's Statewide Transition Plan (STP)* to the CMS on November 23, 2016, which included as an attachment the *Revised Draft CBAS HCB Settings Transition Plan* (dated November 23, 2016). CMS requested additional information from the State, which resulted in DHCS submitting revised STPs including revised CBAS Transition Plans on September 1, 2017 and January 11, 2018. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions to the STP and CBAS Transition Plan before it will grant final approval. The State continues to implement the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA is evaluating each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

In addition, in June 2019, CDA launched the Peach Provider Portal, an internet-based application that requires login credentials and is encrypted to meet the Health Insurance Portability and Accountability Act (HIPAA) requirements. This allows CBAS centers to securely submit files containing confidential and protected health information (PHI) to CDA such as the Monthly Statistical Summary Report (MSSR), the CBAS Plan of Correction (POC) and the PCR. CDA provided a webinar training on using the new portal when submitting MSSRs, POCs and PCR.

Qualitative and Quantitative Findings:

Enrollment and Assessment Information

Per STC 52(a), the CBAS Enrollment data for both MCP and FFS members per county for DY 14 represents the period of July 2018 to June 2019 as shown in the table entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* The table entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into the table. Per the data presented, enrollment for CBAS has been consistent in DY 14.

The CBAS enrollment data as described in the table below is self-reported quarterly by

the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. Enrollment with County Capacity data identified in the table below, reflects data through July 2018 to June 2019.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY14-Q1		DY14-Q2		DY14-Q3		DY14-Q4	
	Jul - Sept 2018		Oct - Dec 2018		Jan -Mar 2019		Apr - Jun 2019	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	539	82%	532	81%	533	81%	528	80%
Butte	37	36%	34	33%	34	33%	36	35%
Contra Costa	240	73%	212	64%	217	67%	202	63%
Fresno	602	46%	658	50%	614	47%	638	46%
Humboldt	95	24%	107	28%	97	25%	4	1%
Imperial	308	51%	305	51%	309	51%	387	64%
Kern	72	21%	96	28%	73	22%	76	11%
Los Angeles	21,414	63%	21,591	64%	21,595	64%	21,978	63%
Merced	94	45%	95	45%	97	53%	90	49%
Monterey	106	57%	105	56%	113	61%	106	57%
Orange	2,369	54%	2,440	55%	2,475	55%	2,519	56%
Riverside	470	43%	465	43%	464	36%	508	39%
Sacramento	367	59%	332	40%	442	43%	500	48%
San Bernardino	677	91%	694	93%	709	95%	768	103%
San Diego	2,238	60%	2,079	56%	2,100	56%	2,647	70%
San Francisco	684	44%	705	45%	660	42%	688	44%
San Mateo	65	28%	63	28%	66	29%	78	34%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	611	43%	606	42%	644	45%	626	47%
Santa Cruz	108	71%	107	70%	104	68%	101	66%
Shasta	*	*	*	*	*	*	*	*
Ventura	898	62%	909	63%	906	63%	910	63%
**Yolo	287	76%	290	76%	287	76%	279	74%
Marin, Napa, Solano	83	17%	79	16%	81	16%	84	17%
Total	**32,364**	**59%**	**32,504**	**59%**	**32,625**	**59%**	**33,765**	**60%**
								FFS and MCP Enrollment Data 06/2019

Figure 4: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*

The data provided in the previous table shows that while enrollment has slightly increased throughout DY 14, it has remained consistent with over 30,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers with the exception of the centers located in San Bernardino County. San Bernardino County is currently operating over its center capacity due to a steady increase in participant enrollment. However, a majority of CBAS participants are able to choose an alternate CBAS Center in nearby counties should the need arise for ongoing CBAS services.

Unduplicated Participant Data for Humboldt County reveals a substantial decrease between DY 14 Q3 & Q4.This change is due to a discrepancy in the methodology behind reporting numbers for Humboldt County. The data that is available from the health plan only accounts for members who were new to CBAS services and not all who had received services. This issue has since been remedied and will be validated thoroughly through an internal process that will apply for all quarters going forward.

It is important to note the amount of member participation also plays a significant role in the percentage of overall licensed capacity used throughout the State. From July 2018 to June 2019 there was a one percent (1%) increase in the total number of participants enrolled in CBAS centers. As a result, Imperial, San Bernardino, and San Diego Counties experienced an increase of more than five percent (5%) in their licensed capacity used throughout DY 14. The increase of capacity utilization observed in Imperial and San Diego Counties are reportedly due to a change in how a specific health plan gathers and reports their number of members provided CBAS. San Bernardino's increases are likely due to increased interest and participation, as San Bernardino has been operating close to 100% utilization for most of DY 14.

Humboldt and Kern Counties experienced an overall decrease in participation, which resulted in a decrease of more than five percent (5%) of licensed capacity used. Kern County's increase of capacity utilization can be attributed to the opening of a new CBAS Center. As stated previously, Humboldt County's sharp decrease in capacity utilization is likely due to a reporting error.

<u>CBAS Assessments for MCPs and FFS Participants</u>

Individuals who request CBAS services will be given an initial face-to-face assessment by a registered nurse with qualifying experience to determine eligibility. An individual is not required to participate in a face-to-face assessment if an MCP determines the eligibility criteria is met based on medical information and/or history the plan possesses.

Figure 5 below lists the number of new assessments reported by the MCPs. The FFS

data for new assessments illustrated in the table is reported by DHCS.

Figure 5: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY14-Q1 (07/01-09/30/2018)	2,369	2305 (97.3%)	64 (2.7%)	4	4 (100%)	0 (0%)
DY14-Q2 (10/01-12/31/2018)	2,256	2,208 (97.9%)	48 (2.1%)	6	6 (100%)	0 (0%)
DY14-Q3 (01/01-03/31/2019)	2,146	2,089 (97.3%)	57 (2.7%)	6	4 (66.7%)	2 (33.3%)
DY14-Q4 (04/01-06/30/2019)	2,343	2,296 (98%)	47 (2%)	4	1 (25%)	3 (75%)
5% Negative change between last Quarter		No	No		Yes	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous table, for DY 14, 9,114 assessments were completed by the MCPs, of which 8,898 were determined to be eligible, and 216 were determined to be ineligible. For DHCS, it was reported that 20 participants were assessed for CBAS benefits under FFS and of these, 15 were determined to be eligible and five were determined to be ineligible. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

CBAS Provider-Reported Data (per CDA) (STC 52.b)

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. The table entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY14. As of DY 14, the number of counties with CBAS Centers and the ADA of each center are listed below in figure 6. On average, the ADA at the 253 operating CBAS Centers is approximately 23,867 participants,

which corresponds to 71 percent of total capacity. Provider-reported data identified in the table below, reflects data through July 2018 to June 2019.

Figure 6: CDA - CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	253
Non-Profit Centers	54
For-Profit Centers	199
ADA @ 253 Centers	23,867
Total Licensed Capacity	33,549
Statewide ADA per Center	71%

CDA - MSSR Data 06/2019

Outreach/Innovative Activities: Stakeholder Process

CDA conducted a webinar training in October 2018 for CBAS providers and other stakeholders on implementation of the revised IPC effective June 1, 2019. In addition, CDA provided trainings sponsored by CAADS for CBAS providers and MCPs related to the revised IPC and compliance with the federal HCB Settings and Person-Centered Planning requirements in Spring 2019.

CBAS Beneficiary/Provider Call Center Complaints (FFS / MCP) (STC 52.e.iv)

DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the Press, and members of the Legislature on various aspects of the CBAS program. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBAS@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in Figure 7 entitled "*Data on CBAS Complaints"* and Figure 8 entitled "*Data on CBAS Managed Care Plan Complaints*." According to the table below, no complaints were submitted to CDA for DY 14.

Figure 7: Data on CBAS Complaints

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY14-Q1 (Jul 1 - Sep 30)	0	0	0
DY14-Q2 (Oct 1 – Dec 31)	0	0	0
DY14-Q3 (Jan 1 - Mar 31)	0	0	0
DY14-Q4 (Apr 1 - Jun 30)	0	0	0

CDA Data - Complaints 06/2019

For complaints received by MCPs, the table below illustrates there were 24 beneficiary complaints and 21 provider complaints submitted for DY 14. The data reflects that for DY14, complaints increased for both beneficiaries and providers. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 8: Data on CBAS Managed Care Plan Complaints

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY14-Q1 (Jul 1 - Sep 30)	2	8	10
DY14-Q2 (Oct 1 - Dec 31)	2	13	15
DY14-Q3 (Jan 1 - Mar 31)	8	0	8
DY14-Q4 (Apr 1 - Jun 30)	12	0	12

Plan data - Phone Center Complaints 06/2019

CBAS Grievances / Appeals (FFS / MCP) (STC 52.e.iii):

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in

Figure 9 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 49 grievances were filed with MCPs during DY 14. 11 of the grievances were solely regarding CBAS providers. One grievance was related to contractor assessment or reassessment. Two grievances were related to excessive travel time to access CBAS services. 35 grievances were designated as "other". Overall, total grievances have decreased from the prior DY 13: 79 to 49. . DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Figure 9: Data on CBAS Managed Care Plan Grievances

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY14-Q1 (Jul 1 - Sep 30)	1	0	0	5	6
DY14-Q2 (Oct 1 - Dec 31)	5	1	0	19	25
DY14-Q3 (Jan 1 - Mar 31)	3	0	2	3	8
DY14-Q4 (Jan 1 - Mar 31)	2	0	0	8	10

Plan data - Grievances 06/2019

Figure 10: Data on CBAS Managed Care Plan Appeals

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CBAS	Other CBAS Appeals	Total Appeals
DY14 – Q1 (Jul 1 – Sep 30)	13	1	0	2	16
DY14 – Q2 (Oct 1 – Dec 31)	1	0	0	2	3
DY14 – Q3 (Jan 1 – Mar 31)	0	0	0	0	0
DY14 – Q4 (Apr 1 – Jun 30)	3	0	0	3	6

Plan data - Grievances 06/2019

During DY 14, Figure 10 entitled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 25 CBAS appeals filed with the MCPs. The table illustrates that 17 of the appeals were related to "denial of services or limited services", one was due to denial to see requested provider, and the other seven were categorized as "other CBAS appeals".

The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 14, there were five requests for hearings related to CBAS services, three from Los Angeles County and two from Orange County. Of these five hearings, one was granted and the rest were denied or dismissed.

Quality Assurance/Monitoring Activity

The CBAS Quality Assurance and Improvement Strategy, developed through a year- long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Figure 11 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 14. Quality Assurance/Monitoring Activity reflects data through July 2018 to June 2019.

Figure 11: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity						
	DY14-Q1 Jul-Sep 2018	DY14-Q2 Oct-Dec 2018	Percent Change Between Last Two Quarters	DY14-Q3 Jan-Mar 2019	DY14-Q4 Apr-Jun 2019	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	0.0%	390	**390**	0.0%	80%
Butte	60	60	0.0%	60	**60**	0.0%	35%
Contra Costa	195	195	0.0%	190	**190**	0.0%	63%
Fresno	772	772	0.0%	772	**822**	+6.1%	46%
Humboldt	229	229	0.0%	229	**229**	0.0%	2%
Imperial	355	355	0.0%	355	**355**	0.0%	64%
Kern	200	200	0.0%	200	**400**	+50.0%	11%
Los Angeles	19,974	19,984	+0.1%	20,026	**20,578**	+2.7%	63%
Merced	124	124	0.0%	109	**109**	0.0%	49%
Monterey	110	110	0.0%	110	**110**	0.0%	57%
Orange	2,608	2,638	+1.2%	2,638	**2,638**	0.0%	56%
Riverside	640	640	0.0%	760	**760**	0.0%	39%
Sacramento	369	489	+33.0%	609	**609**	0.0%	48%
San Bernardino	440	440	0.0%	440	**440**	0.0%	103%
San Diego	2,198	2,198	0.0%	2,233	**2,233**	0.0%	70%
San Francisco	926	926	0.0%	926	**926**	0.0%	44%
San Mateo	135	135	0.0%	135	**135**	0.0%	34%
Santa Barbara	60	60	0.0%	60	**100**	+40.0%	*
Santa Clara	830	850	+2.4%	850	**780**	-9.0%	47%
Santa Cruz	90	90	0.0%	90	**90**	0.0%	66%
Shasta	85	85	0.0%	85	**85**	0.0%	*
Ventura	851	851	0.0%	851	**851**	0.0%	63%
Yolo	224	224	0.0%	224	**224**	0.0%	74%
Marin, Napa, Solano	295	295	0.0%	295	**295**	0.0%	17%
SUM	32,160	32,340	+0.6%	32,637	**33,409**	+2.3%	60%

CDA Licensed Capacity as of 06/2019

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42*

CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.

The previous table reflects that the average licensed capacity used by CBAS participants is 60% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of San Bernardino County. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. Santa Clara County experienced a decrease of more than 5 percent in licensed capacity, due to the conversion of one CBAS Center into a Program of All-Inclusive Care for the Elderly (PACE) Center only.

Both Santa Barbara and Kern Counties experienced increases in licensed capacity. In Kern County, a new CBAS Center opened, which doubled the total licensed capacity for that county. CDA approved an increase of overall licensed capacity for Santa Barbara County, which would account for their increase. No other significant increases or decreases were noted over the last quarter. Over DY14, total licensed capacity has slightly and steadily increased statewide.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the first table for CBAS, CBAS capacity is adequate to serve Medi-Cal members in almost all counties with CBAS Centers with the exception of San Bernardino County. San Bernardino County is serving in excess of its allotted capacity. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to the beneficiaries. There are other centers in nearby counties that can assist should the need arise to allow for ongoing care of CBAS participants.

Unbundled Services (STC 48.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, the managed care plans will work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for each of the CBAS participants to which they provide services. CBAS participants affected by a center

closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY14, CDA had 253 CBAS Center providers operating in California. According to Figure 12 entitled "*CBAS Center History*," One CBAS Center closed and ten new centers were opened in DY 14.

Figure 12: CBAS Center History

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
June 2019	253	1	0	-1	252
May 2019	253	0	0	0	253
April 2019	251	0	2	2	253
March 2019	251	0	0	0	251
February 2019	250	0	1	1	251
January 2019	248	0	2	2	250
December 2018	248	0	0	0	248
November 2018	248	0	0	0	248
October 2018	247	0	1	1	248
September 2018	245	0	2	2	247
August 2018	244	0	1	1	245
July 2018	243	0	1	1	244
June 2018	243	0	0	0	243

The previous table shows there was no negative change of more than five percent in DY 14, from June 2018 to June 2019, so no analysis is needed to address such variances.

Financial/Budget Neutrality Development/Issues

Pursuant to STC 54(b), MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP, to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the center's capacity to date and adequate networks remain for this population.

The extension of CBAS under the Medi-Cal 2020 Demonstration will have no effect on budget neutrality as it is currently a pass-through, meaning that the cost of CBAS remains the same with the waiver as it would be without the waiver. As such, the program cannot quantify savings and the extension of the program will have no effect on overall waiver budget neutrality.

- **Policy/Administrative Issues and Challenges:**

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY14. As previously identified in the Program Highlights section, DHCS did delay implementation of the revised CBAS IPC from April 2017 to June 1, 2019. This delay was determined necessary by DHCS and CDA to align the IPC changes with existing IPC instructions in the CBAS Provider Manual. Moving forward, DHCS and CDA have updated the CBAS form/template revision process to include identification of all related forms/templates/publications that will require corresponding update.

Both agencies worked together to develop a legislative proposal to identify Adult Day Health Care (ADHC)/CBAS program statutory language and make the revisions necessary to reflect the current program standards. Outcomes from this action will eliminate obsolete requirements, identify ADHC language in the Health and Safety Code and Welfare and Institution Code to address the shift from ADHC to the CBAS program, and ensure statutory language and program revisions reflect current program standards. The submission date of this legislative proposal is to be determined.

In addition, DHCS and CDA continue to work with CBAS providers and MCPs to provide ongoing clarification regarding CBAS benefits, CBAS operations, and policy issues.

- **Progress on the Evaluation and Findings:**

Not applicable.

COORDINATED CARE INITIATIVE (CCI)

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income SPDs, including beneficiaries who are dually-eligible for Medi-Cal and Medicare (Duals). The CCI's aim is to achieve substantial savings by rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015), and SB 97 (Chapter 52, Statutes of 2017).

The three major components of the CCI are:

1. A Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs). Originally this was a three-year demonstration that has been extended to the end of 2019;
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of LTSS, with the exception of In-Home Supportive Services (IHSS), which has transitioned back to counties, as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal MediConnect (CMC).

The seven CCI counties participating in CMC are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Four counties implemented CCI in April 2014 (San Bernardino, San Diego, San Mateo, and Riverside). Los Angeles County launched CCI in July 2014. Santa Clara County began in January 2015 and Orange County implemented in July 2015.

Accomplishments:

Figure 13: CCI Pilot Accomplishments

Date	Pilot Accomplishments
Implementation of Streamlined Enrollment	
2018	Since DHCS implemented streamlined enrollment in August 2016, MMPs have been able to submit enrollment changes to DHCS on behalf of their members. This provides a simpler method for members to enroll in CMC and has continued through DY 14 to contribute to a modest increase in enrollment for all demonstration MMPs.
Monthly Conference Calls	
2018	DHCS and CMS continue to support MMPs in simplifying enrollment for all services, including Managed Long Term Services and Supports (MLTSS) by holding bi-monthly conference calls.
Bi-Weekly Conference Calls	
2018	DHCS and CMS assist MMPs in resolving any enrollment or plan issues by holding bi-weekly conference calls.
Duals Plan Letters (DPLs) Released	
August 12, 2018	DPL 18-002 “Performance Improvement Project Requirements” (Supersedes DPL 16-001)
November 20, 2018	DPL 18-003 “Care Plan Option Services” (Supersedes DPL 13-006)

Program Highlights:

DHCS, in collaboration with MMPs, and CMS, formed a data sharing workgroup in late April 2018 to provide recommendations to DHCS leadership regarding MMP capabilities in sharing data between MMPs. The goal of this data sharing workgroup was to allow MMPs to share enrollee data between MMPs when enrollees transition between counties. This will promote a smoother transition and continuity of care for enrollees between CMC counties, and will allow MMPs to utilize the information as a baseline to assist new members and understand their level of need.

In the second half of 2019, a data sharing instructional document was developed by DHCS and shared with the MMPs, and data sharing began in September 2019.

Qualitative and Quantitative Findings:

Enrollment

As of March 1, 2019, approximately 108,154 members were enrolled in MMPs across the seven participating CCI counties. Detailed enrollment information for each CCI county can be found below in figure 14:

Figure 14: Enrollment Information for Each CCI County

County	Number of Members Enrolled
Los Angeles	32,223
Orange	13,942
Riverside	15,110
San Bernardino	14,581
San Diego	13,697
Santa Clara	9,894
San Mateo	8,707

DHCS updates the CMC dashboard quarterly to include updated enrollment numbers and tables on key aspects of the CMC program that assist MMPs in improving their performance and quality standards.[12]

CMC Ombudsman Call Volume

From July 1, 2018, to June 30, 2019, the CMC Ombudsman received approximately 5,148 calls from enrollees. Below is a breakdown of the CMC Ombudsman call data by each county's corresponding Ombudsman Service Provider:

- Legal Aid Society of San Diego (San Diego): 1,007
- Neighborhood Legal Services (Los Angeles): 1,269
- Inland Counties Legal Services (San Bernardino and Riverside): 748
- Bay Area Legal Aid: 549
- Legal Aid Society of Orange County: 259
- Legal Aid Society of San Mateo: 68
- Other Health Consumer Alliance programs: 1,045
- Abandoned calls: 203

[12] The latest CMC Performance Dashboard can be found at the following link: https://www.dhcs.ca.gov/Documents/CMCDashboard9.19.pdf.

Continuity of Care Data

DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. From Quarter 3 of 2018 to Quarter 2 of 2019, there was a total of 110 continuity of care requests. Overall, 97.3% of the requests were approved, 1.8% were denied, and 0.9% were in process. The continuity of care requests were denied due to reasons such as providers refusing to work with managed care and requests for non-covered service.

Policy and Administrative Difficulties in the Operation of this DY:

The CMC demonstration has encountered the following difficulties that continued during DY 14:

- The "unable to reach" reporting metric reached an all-time high for several MMPs;
- The resistance from providers to participate in the CMC program; and
- The unknown future of the CMC program.

MMPs have encountered a high level of "unable to reach" percentages for enrollees within the CMC demonstration due to several external factors. There are many possible reasons for this, such as enrollees moving, phones being disconnected, and enrollees not responding to attempted contacts. MMPs have attempted multiple workarounds to reach their enrollees for Health Risk Assessment and Individual Care Plan completion. However, negative reporting metrics remain high, and efforts have not been as beneficial as the MMPs had hoped. To respond, CMS and DHCS partnered with MMPs to first understand the extent of this issue and second, to conduct short-term focused quality improvement efforts.

Some providers continue to misunderstand CMC and discourage enrollment in the program. This resistance has created difficulties maintaining enrollment in a few counties; however, most counties have been able to create positive CMC relationships that assist members in accessing services in a collaborative manner.

Lastly, the unknown future and longevity of the CMC program has created difficulties with gaining support and garnering enrollment growth for the demonstration. DHCS continues to provide education of MMPs and providers to allow them to understand CMC and the benefits that it provides to their patients.

Progress on the Evaluation and Findings:

Research Triangle Institute International

CMS contracted with the Research Triangle Institute International (RTI) to monitor the implementation of demonstrations, including CMC, under the federal Medicare-Medicaid Financial Alignment Initiative and to evaluate their impact on enrollee experience, quality,

utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide.
The goals of the evaluation are to monitor demonstration implementation, the impact of the demonstration on enrollee experience, unintended consequences, and the impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI collects qualitative and quantitative data from DHCS each quarter; analyzes Medicare and Medi-Cal enrollment and claims data; conducts site visits, conducts enrollee focus groups and key informant interviews; and incorporates relevant findings from any enrollee surveys conducted by other entities.

MMPs are required to conduct a Medicare Advantage – Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey annually, which is designed to measure important aspects of an individual's health care experience, including the accessibility to and quality of services. MMPs are also required to include supplemental questions as part of their annual survey in order to assist with RTI's independent evaluation. In January 2018, RTI added supplemental questions to the 2017 CAHPS survey and released the additional questions to the MMPs ahead of time to allow them to prepare appropriately. RTI assesses their questions as necessary to ensure they are gathering pertinent information to the demonstration. The first annual evaluation report provided by RTI, titled *Financial Alignment Initiative California Cal MediConnect: First Evaluation report,* was released on November 29, 2018.[13]

The SCAN Foundation

The SCAN Foundation (TSF) funded two evaluations of the CMC program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of CMC, as described below. While TSF funded these evaluations, DHCS has been working collaboratively with TSF and stakeholders to develop and update the content of both evaluations.

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of CMC on California's Duals population in as close to real time as possible. FRC completed four waves of the project, and the University of California San Francisco completed the fifth and sixth waves. The study compared the levels of confidence and satisfaction of CMC enrollees with Duals who are eligible for CMC but are not participating, or live in a non-CMC county within California.

The results of the sixth wave, released in October 2018, found that CMC enrollees' confidence in navigating their healthcare increased.[3] This increase shows a large majority of enrollees express confidence that they know how to manage their health conditions (82%), how to get

[13] The report is available on the CMS website at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf

questions about their health needs answered (84%), and who to call if they have a health need or question (89%). In alignment with the first finding, a large majority of CMC enrollees expressed satisfaction and confidence with their health care services, similar to the results in previous waves. Of particular note, between 10% and 16% of CMC enrollees reported that they encountered problems with their health service. CMC enrollees are also reporting longer relationships with their personal doctor. This is a key indicator of the care continuum that is especially important when transitioning to managed care.

In 2014, an evaluation team comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health was formed. The evaluation team engaged stakeholder input and built upon the national evaluation conducted in 2014, by the University of California San Francisco Community Living Policy and the University of California Berkeley Health Research for Action Center to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects. The following evaluations, which often include data from previous years, were conducted for DY 14. These are outlined below.

In September 2018, TSF released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging to assess CMC enrollees' experiences with care, including access, quality, and coordination over time.[14] A total of 2,100 dually eligible beneficiaries completed the first telephone survey in 2016. Of those, 1,291 beneficiaries completed a second survey in both 2016 and 2017. Key findings include:

- Very few people (less than 0.5%) changed MMPs or disenrolled from CMC after one year in the program;
- CMC satisfaction overall was very high (94%) with enrollees reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among CMC enrollees compared to those who opted out or those in non-CCI counties;
- In both 2016 and 2017, one in five CMC enrollees reported delays or problems in getting care or services. Of those, 61% reported the problems were unresolved;
- Primary care visits decreased among CMC enrollees between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period;
- Two-thirds of CMC enrollees used specialty care;
- Over 70% of CMC enrollees reported the ability to go to their hospital of choice all the time, and almost 90% of those hospitalized reported being ready to go home when discharged;
- One in five CMC enrollees used behavioral health services, and a majority of those took medication for mental health conditions;

[14] The evaluation, titled *Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey,* can be found at: https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf

- CMC enrollees took an average of six prescription medications. About two-thirds reported having paid out of pocket for prescriptions; this is lower than the out-of-pocket expenses reported by non-CCI beneficiaries, of whom three-quarters reporting paying out of pocket;
- Less than one-third of CMC enrollees reported having a care coordinator;
- Over three-quarters of CMC enrollees said their primary care provider seemed informed and up-to-date about their care from specialists; and about 54% said their providers usually or always share information with each other;
- Compared to opt-outs, more CMC enrollees reported getting a ride from their health plan to medical appointments;
- Half of non-English speaking CMC enrollees reported they could “never” get a medical interpreter when they needed one;
- Among CMC enrollees, those who need LTSS had lower satisfaction overall, and were almost four times more likely to rate their overall quality of care as fair or poor; and
- Approximately 37% of CMC enrollees who needed help with routine needs (e.g., household chores, doing necessary business, shopping, and getting around outside the home) reported they needed more help, or got no help at all with those activities.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Introduction

Given the importance of oral health to the overall physical well-being of an individual, California views improvements in dental care as a critical component to achieving overall better health outcomes for Medi-Cal members, particularly children.

Through the DTI, DHCS aims to:

- Improve the member's experience so individuals can consistently and easily access high quality dental services supportive of achieving and maintaining good oral health;
- Implement effective, efficient, and sustainable health care delivery systems;
- Maintain effective, open communication and engagement with our stakeholders; and
- Hold ourselves and our providers, plans, and partners accountable for performance and health outcomes.

DTI is a five year program from Calendar Year (CY) 2016 to 2020, also known as Program Year (PY) 1 to 5. DTI covers four areas, otherwise referred to as domains:

Domain 1[15]
– Increase Preventive Services for Children

This domain was designed to increase the statewide proportion of children ages 1 to 20 enrolled in Medi-Cal for at least 90 continuous days, who receive preventive dental services. Specifically, the goal is to increase this proportion at least ten percentage points over a five-year period.

Domain 2[16]
– Caries Risk Assessment (CRA) and Disease Management

This domain is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages six and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this domain, a provider must take a training and elect to opt into this domain via an attestation form and provide confirmation of completed CRA training specifically created for this domain.

The following 11 counties were selected as pilot counties and continue to participate in this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba.

Beginning in January 2019, Domain 2 was expanded to include 18 additional counties, which

[15] DTI Domain 1 Home Page https://www.dhcs.ca.gov/provgovpart/Pages/dtidomain1.aspx
[16] DTI Domain 2 Home Page https://www.dhcs.ca.gov/provgovpart/Pages/dtidomain_2.aspx

include: Contra Costa, Fresno, Imperial, Kern, Los Angeles, Madera, Merced, Monterey, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Sonoma, Stanislaus, and Ventura.

The additional counties selected reported a high percentage of restorative procedures and a low percentage of preventive procedures. DHCS also applied lessons learned from the initial pilot selection by focusing on the available provider population and larger member pools in the expansion counties.

Domain 3[17] – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing ongoing relationships between a member and a dental provider. Incentive payments are made to dental service office locations that have maintained continuity of care through providing qualifying examinations to members ages 20 and under for two, three, four, five, and six continuous year periods. For PYs 1-3, DHCS began this effort as a pilot in 17 select counties: Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus, and Yolo.

Based on the positive outcomes of the first three years through PY 3, DHCS improved Domain 3 in a couple of ways effective January 1, 2019. DHCS expanded this domain to an additional 19 counties, bringing the total to 36 pilot counties. Providers with service office locations in 19 expansion counties are now able to receive incentive payments under this domain, which includes: Butte, Contra Costa, Imperial, Merced, Monterey, Napa, Orange, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Solano, Sutter, Tehama, Tulare, and Ventura. Also, Domain 3 annual incentive payment amounts increased by $60 per member with dates of service of January 1, 2019 or later. DHCS anticipates greater provider and member participation and incentives in the expansion counties.

Domain 4[18] – Local Dental Pilot Projects (LDPPs)

LDPPs support the aforementioned domains through 13 innovative pilot programs, using strategies focused on targeted populations, such as rural and underserved areas as well as local case management initiatives, education partnerships, and care coordination. Local pilots are required to have broad-based providers, community supports, and collaboration with programs such as Tribes and Indian health programs. In addition, LDPPs have goals and metrics that contribute to the overall objectives of Domains 1 through 3.

The approved lead entities for the LDPPs are as follows: Alameda County, California Rural Indian Health Board, Inc., California State University in Los Angeles, First 5 San Joaquin, First 5 Riverside, Fresno County, Humboldt County, Orange County, Sacramento County, San Luis Obispo County, San Francisco City and County Department of Public Health, Sonoma County, and University of California in Los Angeles.

[17] DTI Domain 3 Home Page https://www.dhcs.ca.gov/provgovpart/Pages/dtidomain3.aspx
[18] DTI Domain 4 Home Page https://www.dhcs.ca.gov/provgovpart/Pages/DTIDomain4.aspx

Accomplishments/Outcomes:

- January 2019
    - Domain 2 expanded to include 18 additional counties.
    - Domain 3 expanded to include 19 additional counties.
    - Domain 3 increased incentive amounts by $60 per member with dates of service on January 1, 2019 or later.

- June/July 2019
    - January 2019 Domain 1 PY 2 incentive payments issued to providers based on rebaselined methodology.
    - For Domain 2, outreach efforts to expansion counties: Los Angeles, Orange, and Riverside have proven effective with approximately 847 providers in Los Angeles, 288 providers in Orange, and 231 providers in Riverside who have opted-in.
    - Since January 2019, the total number of opted in providers increased from 209 to 2,116 in June 2019, resulting in an increase of 912 percent in the provider population.
    - Domain 3 incentive payments issued to providers included second and final payment of PY 2 and first payment for PY 3 for the 17 original counties.

- Throughout DY 14, DHCS reallocated $14.4M to nine LDPPs who requested additional funding based on program and/or needs not previously identified by the LDPPs.

Program Highlights:

Domain 1

- On July 31, 2018, a scheduled Domain 1 incentive payment was disbursed. This payment covered 2017 (PY 2) dates of service.
- DHCS delayed the January 2019 payment to June 2019 to ensure participating providers with historical claims data were not negatively impacted by the rebaseline methodology applied to the scheduled payment.
- Providers were notified of the payment delay via a notification letter, provider bulletin, and stakeholder meetings held in February. Also, impacted providers received a letter with their new baselines and benchmarks in early June.

Domain 2

- DHCS has shifted outreach efforts towards the 18 expansion counties that were added effective January 2019.
- DHCS worked closely with the Administrative Services Organization (ASO) contractor, Delta Dental, to conduct Domain 2 specific outreach during planned trips and events for the *Smile, California* campaign.
- The majority of the outreach efforts to the expansion counties were very successful considering increase in opted in providers in expansion counties verses original pilot counties.

Domain 3

- DHCS' ASO conducted DTI outreach and shared Domain 3 information with providers during events that occurred in Domain 3 counties.
- In DY 14, the ASO's outreach team visited 24 of the 36 pilot counties (Alameda, Butte, Contra Costa, Fresno, Imperial, Kern, Madera, Marin, Merced, Monterey, Orange, Riverside, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Shasta, Sonoma, Stanislaus, Tehama, Tulare, Ventura, and Yolo).
- Beginning 2019, ASO visited eight of the 19 extended counties (Butte, Contra Costa, Orange, San Bernardino, San Diego, San Joaquin, Santa Barbara, and Ventura).

Domain 4

- There are 13 total executed LDPP contracts and the contract status for each is available in the DTI DY 13 Annual Progress Report[19].
- DHCS set up an email inbox LDPPinvoices@dhcs.ca.gov to allow for electronic submission of invoices. DHCS developed invoicing guidelines, an invoice template, and an FAQ document to assist the LDPPs with their invoicing processes. DHCS instructed the pilots to submit invoices on a quarterly basis with a due date of 45 days after the end of each quarter.
- DHCS received CMS' approval to reallocate $14.4M Domain 4 funds from the First 5 Kern County and Northern Valley Sierra Consortium LDPPs that did not proceed with their DTI projects. These funds allowed the 13 LDPPs to apply for an increased budget allocation to expand on their projects.
- During DY 14, DHCS reviewed and approved nine requests for additional funding based on program and/or needs not previously identified by the LDPPs during the original selection process. A total of $14.4M was reallocated. Many of the LDPPs further enhanced their pilot through modifications of their existing pilots. Some of them include:
    - Orange County: Collaborated with Children's Hospital of Orange County to reduce the wait time for children with special needs. This collaboration would include a ten-chair set up with six open bays and four enclosed management rooms. In addition, they are expanding its current Smile Mobile services from one day of service a week to five.
    - California State University Los Angeles: Focused on the American Indian Alaska Native community, partnered with a Sioux chief to revitalize and re-identify Native American cuisine.
    - Humboldt: Services the most geographically remote region. Realizing the urgency for a higher degree of care coordination, they hired two additional care coordinators as well as trained five AmeriCorps members at local resource centers in oral health to provide information to high-risk families on how to navigate dental services.
    - Riverside: Has purchased, as well as leased, additional vans to support rural health clinics during inclement weather.
    - First 5 San Joaquin: Has added an additional Virtual Dental Home team to serve

[19] DTI DY 13 Annual Progress Report

school sites in the city of Tracy and other areas based on the success of oral health screenings at schools and community sites.

- During this reporting period, DHCS conducted site visits represented in figure 15 below to observe the administrative and clinical initiatives as outlined in each LDPP's executed contract:

Figure 15: Domain 4 Site Visits

Date	Sites
February 21, 2019	California Rural Indian Health Board, Inc.
March 15, 2019	First 5 San Joaquin
March 18, 2019	Sacramento County
April 29, 2019	San Francisco City and County Department of Public Health
May 17, 2019	Sonoma County
June 18, 2019	University of California, Los Angeles
June 10, 2019	California State University, Los Angeles

- In the next demonstration period, DHCS will conduct site visits on the remainder LDPPs. They include:
  - Humboldt
  - San Luis Obispo County
  - Fresno County
  - First 5 Riverside
  - Orange County
  - Alameda County

Qualitative Findings:

To increase the public awareness of DTI, DHCS presented the goals, incentive payments methodologies, implementation efforts, and outcomes in numerous events and meetings statewide. Figure 16 below is a list of events and meetings where DHCS shared information on DTI.

Figure 16: DTI Outreach Presentations

Date	DTI Outreach Presentations
August 2, 2018	Medi-Cal Dental Advisory Committee (MCDAC) (agenda)
August 16, 2018	Los Angeles Dental Stakeholders Meeting (agenda)
August 17, 2018	National Academy for State Health Policy – Jacksonville, FL (agenda)
September 6 - 7, 2018	California Dental Association (CDA) Presents, San Francisco, CA (agenda)
October 5-6, 2018	University of California, Los Angeles Oral Health Innovation Forum (website)
October 18, 2018	Los Angeles Dental Stakeholders Meeting (agenda)
November 6, 2018	Oral Health Subcommittee
December 6, 2018	MCDAC (agenda)
December 13, 2018	Los Angeles Dental Stakeholders Meeting (agenda)
December 21, 2018	San Francisco DTI Access Collaborative Expert Meeting
January 11, 2019	Contra Costa County Oral Health
January 24, 2019	Humboldt Dental Society Meeting
February 21, 2019	Los Angeles Dental Stakeholders Meeting (agenda)
March 5, 2019	Mariposa County Oral Health Advisory Meeting
March 7, 2019	Loma Linda University Dental School Presentation
March 14, 2019	Oral Health Committee of the Public Health Commission
March 15, 2019	Healthy Smiles for Kids of Orange County Event
March 26, 2019	Solano County Oral Health Advisory Committee
March 28, 2019	Mendocino Oral Health Committee
February 7, 2019	MCDAC (agenda)
April 4, 2019	MCDAC (agenda)
April 18, 2019	Los Angeles Dental Stakeholders Meeting (agenda)
May 2, 2019	Medi-Cal Tribal and Indian Health Program Meeting
May 17, 2019	CDA Presents, Anaheim, CA
June 1 – 3, 2019	MSDA, Washington, DC
June 6, 2019	MCDAC (agenda)
June 12, 2019	Merced County Oral Health Forum
June 13, 2019	San Diego County Oral Health Forum
June 20, 2019	Los Angeles Dental Stakeholders Meeting (agenda)

DTI Small Stakeholder Workgroup

The objective of these meetings is to share updates on all DTI domains and gather feedback from provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a monthly basis, each third Wednesday of the month, which changed to bi-monthly starting in 2018 as DTI continued with ongoing operations and minimal discussion items were received from stakeholders. When there are no agenda items for discussion, updates are sent via email in lieu of the meeting. The following were the scheduled meetings:

- July 19, 2018 – email sent in lieu of meeting
- September 20, 2018 – email sent in lieu of meeting
- November 15, 2018
- January 17, 2019
- March 21, 2019
- May 16, 2019 – email sent in lieu of meeting

Other Small Stakeholder Sub-workgroups

In addition to the DTI small stakeholder workgroup, DHCS has continued to offer assistance through the following sub-workgroups:

Domain 2 Caries Risk Assessment Workgroup

This sub-workgroup has been repurposed and renamed Domain 2 Subgroup to discuss Domain 2 in general and not specifically Caries Risk Assessment.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup convened on December 18, 2018 and February 19, 2019. The topics for discussion included the Domain 2 expansion, program outreach efforts, and performance metrics. The subgroup initially planned to meet on a bi-monthly basis. However, at the February meeting, the subgroup decided to meet on a quarterly basis as needed. A subsequent meeting was scheduled for June 11, 2019; however, updates on program metrics were sent via e-mail in lieu of a meeting. The subgroup will continue to meet on a quarterly basis as needed.

DTI Clinic Workgroup

This sub-workgroup met on May 7, 2018. DHCS shared updates on each domain and the group discussed Domain 1 payments and outreach efforts for Domain 2. The group met again on May 28, 2019 and discussed DTI questions from stakeholders regarding incentive payments to SNCs, exact dates of payments, claims submission and process, as well as clarification on payment years and baseline. The group will continue to meet as needed.

Domain 3 Subgroup

The purpose of this subgroup is to report on the domain's current activity and discuss ways to increase participation from providers who are eligible to participate in the domain. There was no need for this subgroup to meet in this demonstration year but can meet upon stakeholder request or as needed.

DTI Data Subgroup

This DTI data subgroup garners stakeholder feedback on the usefulness of data reported in the DTI Annual Reports. The subgroup met on September 14, 2018 and discussed the results and analysis of DTI PY 1 Annual Report. In March 2019, DHCS received feedback on the DTI PY 2 Annual Report, which will be considered for the next PY 3 Annual Report. This subgroup will convene as needed to discuss DTI data and analysis.

Domain 4 Subgroup

DHCS holds bi-monthly calls with the LDPPs to address questions and encourage collaboration between the LDPPs. The purpose of the teleconferences expanded to include rotating presentations from one or two of the LDPPs to share both their best practices, outcomes, and struggles, if any, with other lead entities. During this reporting period, LDPP conference calls were held on the following dates:

- August 22, 2018
- October 24, 2018
- December 19, 2018
- February 20, 2019
- April 17, 2019
- June 24, 2019

Quantitative Findings:

Domain 1

- In June 2019, the January 2019 payment was disbursed based upon performance based baselines, benchmarks, and any encounters submitted during the interim period. This payment represented the final payment for PY 2 and the first payment for PY 3.
- There were two payments made during this period issued July 31, 2018 (PY 2) and June 10, 2019 (PY 2 and PY 3). Please refer to Figure 17 below for payment details.

Figure 17: Domain 1 Payments by Delivery System and PY in DY 14[20]

Delivery System	PY 2	PY 3
FFS	$4,124,463	$45,857,103
DMC	$809,202	$1,886,966
SNC	$2,602,029	$1,049,918
Total	**$7,535,694**	**$54,793,986**

[20]Data Source: ASO DTI Reports as of June 2019.

Most notably, outreach efforts to Los Angeles, Orange, and Riverside counties have proven to be the most fruitful, with approximately 847 providers in Los Angeles, 288 providers in Orange, and 231 providers in Riverside counties who have opted-in. Since January 2019 the overall total number of opted in providers increased from 209 to 2,116 in June 2019, resulting with an increase of 912 percent in the provider population.

FFS providers are paid weekly whereas SNC and DMC providers are paid on a monthly basis. Figure 18 represents Domain 2 incentive claims paid for FFS, SNC and DMC providers during the DY 14 reporting period. During this time, the total incentive claims paid equaled $13,018,494.39. Figure 19 represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program until the end of DY 14. The total incentive claims paid from the beginning of Domain 2 until the end of DY 14 equals $16,190,406.74.

Figure 18: Domain 2 Payments by County and Delivery System Paid in DY 14[21]

County	FFS
Contra Costa	$40,127
Fresno	$508,481
Glenn	Suppressed
Humboldt	Suppressed
Imperial	$8,154
Kern	$944,082
Kings	$7,056
Los Angeles	$2,839,721
Madera	$7,917
Merced	$22,570
Monterey	$32,852
Orange	$687,077
Riverside	$350,214
Sacramento	$589,161.75
San Bernardino	$425,110
San Diego	$863,468
San Joaquin	$58,841
Santa Barbara	$329,037
Santa Clara	$242,929
Sonoma	$28,957
Stanislaus	$196,875
Tulare	$2,365,376.64
Ventura	$472,080
Total	**$11,023,054.39**

County	DMC
Los Angeles	$35,784
Sacramento	$1,508,864
Total	**$1,544,648**

County	SNC
Humboldt	Suppressed
Los Angeles	$35,280
Mendocino	$297,244
Sonoma	$96,722
Total	**$450,792**

[21]Data Source: ASO DTI Reports as of June 2019.

Figure 19: Domain 2 Payments by County and Delivery System Between February 2017 and June 2019 (End of DY 14)[22]

County	FFS	County	FFS
Contra Costa	$40,127	Sonoma	$28,957
Fresno	$508,481	Stanislaus	$196,875
Glenn	Suppressed[23]	Tulare	$4,240,100.49
Humboldt	Suppressed	Ventura	$472,080
Imperial	$8,154	**Total**	**$13,399,977.74**
Kern	$944,082		
Kings	$16,348.50	**County**	**DMC**
Los Angeles	$2,839,721	Los Angeles	$35,784
Madera	$7,917	Sacramento	$2,240,524
Merced	$22,570	**Total**	**$2,240,524**
Monterey	$32,852		
Orange	$687,077	**County**	**SNC**
Riverside	$350,214	Humboldt	Suppressed
Sacramento	$1,078,327.75	Inyo	$28,728
San Bernardino	$425,110	Los Angeles	$35,280
San Diego	$863,468	Mendocino	$388,923
San Joaquin	$58,841	San Diego	Suppressed
Santa Barbara	$329,037	Sonoma	$96,722
Santa Clara	$242,929	**Total**	**$549,905**

Domain 3

- Upon review of the June and July 2018 payment data, DHCS identified 42 SNCs enrolled in Domain 1 that are also eligible for Domain 3 in August 2018. DHCS contacted these SNCs and emailed outreach letters, Domain 3 program information, claim submission guidelines, and the Domain 3 opt-in form to the eligible SNCs on August 28, 2018 and October 2, 2018, to encourage them to participate in PY3. Of these 42 SNCs, two responded to DHCS and verified their participation status, increasing the number of participating SNCs to 68.
- Outreach efforts also included increasing provider participation and promoting Domain 3 expansion in the 19 new counties. As a result, an additional 15 SNCs elected to opt-in for participation, bringing the total from 68 to 83 by this end of this DY.
- Incentive payments for Domain 3 are issued to providers once a year in June. In July 2019, DHCS issued the third payment of this domain which included the second and final payment of PY 2 and the first payment for PY 3 for the 17 original counties. Figure 20 lists payments issued to counties for PY 2 and Figure 21 lists payments issued to counties for PY 3.

[22] Data Source: ASO DTI Reports as of June 2019.
[23] Suppressed: Data were de-identified due to HIPPA.

Figure 20: Domain 3 Payments by Delivery System and County for PY 2[24]

County	FFS	SNC	Total
Alameda	$1,080,770	$73,240	$1,154,010
Del Norte	$390	$0	$390
El Dorado	$97,690	$0	$97,690
Fresno	$1,989,300	$31,010	$2,020,310
Kern	$2,190,700	$78,350	$2,269,050
Madera	$342,070	$0	$342,070
Marin	$6,860	$0	$6,860
Modoc	$830	$7,600	$8,430
Nevada	$2,070	$0	$2,070
Placer	$209,020	$0	$209,020
Riverside	$3,574,530	$0	$3,574,530
San Luis Obispo	$270,660	$0	$270,660
Santa Cruz	$280,280	$271,710	$551,990
Shasta	$72,870	$0	$72,870
Sonoma	$284,760	$179,440	$464,200
Stanislaus	$1,041,840	$0	$1,041,840
Yolo	$55,160	$25,560	$80,720
Total	**$11,499,800**	**$666,910**	**$12,166,710**

Figure 21: Domain 3 Payments by Delivery System and County for PY 3[25]

County	FFS	SNC	Total
Alameda	$1,217,520	$34,150	$1,251,670
Del Norte	$280	$0	$280
El Dorado	$128,570	$0	$128,570
Fresno	$2,076,750	$39,170	$2,115,920
Kern	$2,524,900	$89,580	$2,614,480
Madera	$383,400	$0	$383,400
Marin	$6,570	$0	$6,570
Modoc	$1,400	$7,980	$9,380
Nevada	$2,610	$0	$2,610
Placer	$260,250	$10,600	$270,850
Riverside	$3,934,500	$0	$3,934,500
San Luis Obispo	$324,600	$0	$324,600
Santa Cruz	$169,820	$249,430	$419,250
Shasta	$83,100	$0	$83,100
Sonoma	$303,790	$89,010	$392,800
Stanislaus	$1,241,890	$0	$1,241,890
Yolo	$61,800	$13,600	$75,400
Total	**$12,721,750**	**$533,520**	**$13,255,270**

[24] Data Source: ASO DTI Reports as of June 2019.
[25] Data Source: ASO DTI Reports as of June 2019.

Domain 4

- For DY14, paid amounts for each LDPP are shown in Figure 22. DHCS paid a total of $21,119,629.

Figure 22: Domain 4 Payments by LDPP[26]

LDPPs	Total Paid
Alameda County	$3,079,734
California Rural Indian Health Board, Inc.	$459,427
California State University, Los Angeles	$3,537,350
First 5 San Joaquin	$1,267,266
First 5 Riverside	$1,969,361
Fresno County	$1,787,352
Humboldt County	$752,574
Orange County	$2,153,526
Sacramento County	$1,983,089
San Luis Obispo County	$79,006
San Francisco City and County	$320,395
Sonoma County	$858,423
University of California, Los Angeles	$2,872,125
Total	**$21,119,629**

Preventive Dental Services Utilization

DHCS reported preventive dental services utilization for Medi-Cal members age 1-20 with report end date of each month in DY 14 Quarterly Progress Reports. Figure 23 summarizes utilization reported from quarters 1 through 4. The preventive dental services utilization fluctuated each month but steadily remained within the 45 percentile.

[26] Data Source: ASO Invoices as of September 2019.

Figure 23: Statewide Continuously Enrolled Medi-Cal Members Age 1-20 and the Preventive Dental Services Utilization[27]

Measure End Month	Measure Period	Numerator[28]	Denominator[29]	Utilization
Jul 2018	08/2017-07/2018	2,529,352	5,591,279	45.24%
Aug 2018	09/2017-08/2018	2,520,026	5,575,959	45.19%
Sep 2018	10/2017-09/2018	2,532,860	5,532,860	45.50%
Oct 2018	11/2017-10/2018	2,530,503	5,563,744	45.50%
Nov 2018	12/2017-11/2018	2,518,110	5,549,171	45.40%
Dec 2018	01/2018-12/2018	2,526,194	5,538,675	45.61%
Jan 2019	02/2018-01/2019	2,515,516	5,529,791	45.49%
Feb 2019	02/2018-03/2019	2,499,936	5,509,072	45.38%
Mar 2019	04/2018-03/2019	2,515,593	5,506,180	45.69%
Apr 2019	05/2018-04/2019	2,512,229	5,488,036	45.78%
May 2019	06/2018-05/2019	2,510,957	5,473,022	45.88%
Jun 2019	07/2018-06/2019	2,505,054	5,455,264	45.92%

Provider Enrollment

The numbers of active FFS service offices increased by 187 from 5,543 to 5,730; rendering providers increased by 582 from 9,626 to 10,208. The numbers of active DMC service offices slightly increased. Geographic Managed Care (GMC) plans rendering providers remained the same with a peak during the DY and Prepaid Health Plans (PHP) rendering providers slightly decreased. These numbers do not indicate whether a provider provided dental services during the reporting month. The numbers of SNCs who provided at least one dental service in the recent one year increased by 30 from 532 to 562. Figure 24 lists monthly provider counts across all delivery systems.

[27] Data Source – DHCS Data Warehouse MIS/DS Dental Dashboard September 2019 Update. Utilization does not include one-year full run-out allowed for claim submission.
[28] Numerator: Eligible Children Age 1-20 - members who were enrolled in the same dental plan for at least three continuous months and received at least one preventive dental service during the measure period.
[29] Denominator: Eligible Children Age 1-20 - members who were enrolled in the same dental plan for at least three continuous months.

Figure 24: Statewide Active Dental Service Offices, Rendering Providers and Safety Net Clinics[30]

Measure Month	FFS Offices	FFS Rendering	GMC Offices	GMC Rendering	PHP Offices	PHP Rendering	Safety Net Clinics
Jul 2018	5,780	10,270	118	268	874	1,930	565
Aug 2018	5,781	10,347	113	376	933	1,955	564
Sep 2018	5,800	10,439	118	394	885	1,997	562
Oct 2018	5,777	10,518	155	397	1,090	2,095	561
Nov 2018	5,793	10,400	158	399	1,043	2,112	556
Dec 2018	5,814	10,479	155	396	1,158	2,039	566
Jan 2019	5,843	10,536	197	521	1,112	2,302	566
Feb 2019	5,850	10,591	143	566	1,317	2,357	567
Mar 2019	5,901	10,662	148	361	1,132	1900	567
Apr 2019	5,812	10,690	140	308	927	1663	570
May 2019	5,826	10,706	126	302	974	1745	569
Jun 2019	5,827	10,783	127	299	950	1703	569

Policy/Administrative Issues and Challenges:

The Domain 1 January 2019 payment was delayed until June 2019 to ensure participating providers with historical claims data were not negatively impacted by the rebaseline methodology applied to the scheduled payment. The Department maintained open lines of communications with the provider communities to notify them of the delay. The July 2019 payment was disbursed normally without issue. The next scheduled payment in January 2020 is on schedule without expectations of delay.

Progress on the Evaluation and Findings:

Since the DTI Evaluation Contract approval, DHCS has been working with the evaluation contractor, Mathematica, on a bi-weekly basis via conference calls. The group discussed sharing of DTI data to Mathematica for their evaluation efforts, and DHCS has continued to answer any questions that have arisen during the evaluation effort. In addition, Mathematica continues to maintain a presence in the Domain 4 LDPP regular calls to inform LDPPs of Domain 4 evaluation design. The DTI interim report is due to CMS in December 2019.

[30] Active service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008A, PS-O-008B and DMC Plan deliverables of each month. This table does not indicate whether a provider provided services during the reporting month.
The count of Safety Net Clinics is based on encounter data from the DHCS Data Warehouse MIS/DSS as of September 2019. Only Safety Net Clinics who submitted at least one dental encounter within one year were included.
Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net and LIBERTY.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides an evidence-based benefit design covering the full continuum of care, requires providers to meet industry standards of care, has a strategy to coordinate and integrate across systems of care, creates utilization controls to improve care and efficient use of resources, reporting specific quality measures, ensuring there are the necessary program integrity safeguards and a benefit management strategy. The DMC-ODS allows counties to selectively contract with providers in a managed care environment to deliver a full array of services consistent with the American Society of Addiction Medicine (ASAM) Treatment Criteria, including recovery supports and services. As part of their participation in the DMC-ODS, CMS requires all residential providers to meet the ASAM requirements and obtain a DHCS issued ASAM designation. The DMC-ODS includes residential treatment service for all DMC beneficiaries in facilities with no bed limit.

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of 40 implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings, and Partnership Health Plan of California. As of January 18, 2018, DHCS has approved all counties' implementation plans. With the 40 submitted implementation plans, 97.54% of California's population will be covered under the DMC-ODS. Thirty counties are currently providing DMC-ODS services.

Accomplishments:

The following counties have begun providing DMC-ODS services during this period:

- Placer County on November 1, 2018
- Ventura County on December 1, 2018
- Santa Barbara County on December 1, 2018
- Fresno County on January 1, 2019
- Merced County on January 1, 2019
- Kern County on March 1, 2019
- Stanislaus County on April 1, 2019
- Eldorado County on June 1, 2019
- Sacramento County on June 28, 2019
- San Benito County on June 28, 2019
- Tulare County on June 28, 2019

Program Highlights:

Please refer to previous quarterly reports to find additional activities that occurred during DY 14.

- Monthly Technical Assistance (TA) Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- May 16, 2019: Quarterly CAADPE (California Association of Alcohol and Drug Program Executives, Inc) and Coalition of Alcohol & Drug Associations (CADA) Meeting
- May 20, 2019 Indian Health Program Organized Delivery System (IHP-ODS) Conference Call
- May 21, 2019: Treatment Starts Here: California Health Care Foundation (CHCF) MAT Advisory Group
- May 24, 2019: DHCS 1115 Waiver Evaluations Meeting
- May 31, 2019 IHP-ODS Conference Call
- June 3, 2019: CAADPE Bi-Monthly Call
- June 4, 2019 IHP-ODS Conference Call
- June 11, 2019: Statewide Opioid Safety (SOS) Workgroup
- June 13, 2019 IHP-ODS Meeting with Indian Health Services (IHS) and California Rural Indian Health Board (CRIHB)
- June 18, 2019: DHCS Opioid Workgroup Meeting

Qualitative Findings:

<u>Outreach/Innovative Activities</u>

DHCS staff conducted documentation trainings for DMC-ODS. The trainings included technical assistance for county management as well as general trainings for county staff. The focus of these trainings was to address requirements for all DMC-ODS treatment services and commonly identified deficiencies. The training occurred in the following counties listed in Figure 25:

Figure 25: Counties with Documentation Trainings for DMC-ODS

County	Training Dates	Training Attendees
Contra Costa County	December 5-6, 2018	10
Monterey County	January 16, 2019	8
Orange County	October 17-18, 2018	15
Placer County	February 21, 2019	10
San Bernardino County	March 13, 2019	22
San Francisco	July 11-12, 2018	22
San Mateo	September 10-11, 2018	10
Santa Barbara	May 16-17	7
Ventura	April 16-17	38

Quality Assurance/Monitoring Activities

DHCS conducted compliance monitoring reviews for the following Counties:

Figure 26: Counties with Compliance Monitoring Reviews

County	Date
Alameda	April 22-24, 2019
Contra Costa	May 14-15, 2019
Fresno	June 17-18, 2019
Imperial	March 12-15, 2019
Kern	February 5-6, 2019
Los Angeles	June 3-6, 2019
Marin	May 16, 2019
Merced	June 20-21, 2019
Monterey	January 9-10, 2019
Napa	November 13-14, 2018
Nevada	April 3, 2019
Orange	June 11-12, 2019
Placer	February 14-15, 2019
Riverside	April 5, 2019
San Bernardino	April 9-12, 2019
San Diego	February 27-March 1, 2019
San Francisco	May 28-29, 2019
San Joaquin	May 21-22, 2019
San Luis Obispo	December 18-19, 2018
San Mateo	January 8-10, 2019

County	Date
Santa Barbara	May 21-22, 2019
Santa Clara	March 26-27, 2019
Santa Cruz	December 11, 2018
Stanislaus	April 5, 2019
Ventura	May 14-16, 2019
Yolo	May 8-9, 2019

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

All counties that are actively participating in the DMC-ODS Waiver track grievance and appeal claims. An appeal is defined as a request for review of an action (e.g. adverse benefit determination) while a grievance is a report of dissatisfaction with anything other than an adverse benefit determination. Grievance and appeal data is as follows.

Figure 27:
Grievances

Grievance	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals
Alameda	0	5	2	1	0	0	**8**
Contra Costa	0	2	2	0	0	2	**6**
El Dorado	0	0	0	0	0	0	**0**
Fresno	0	2	0	0	0	0	**2**
Imperial	1	0	0	1	0	0	**2**
Kern	0	6	2	0	0	0	**8**
Los Angeles	24	11	68	7	6	20	**136**
Marin	0	2	0	0	2	2	**6**
Merced	0	3	0	0	0	0	**3**
Monterey	0	0	0	0	0	0	**0**
Napa	0	0	0	0	0	0	**0**
Nevada	0	2	0	0	0	2	**4**
Orange	1	7	2	0	2	0	**12**
Placer	0	1	0	1	6	0	**8**
Riverside	7	9	0	0	0	1	**17**
San Bernardino	2	4	3	1	1	9	**20**
San Diego	3	101	0	16	0	15	**135**
San Francisco	0	0	3	0	1	4	**8**
San Joaquin	0	2	1	0	0	8	**11**
San Luis Obispo	4	5	1	5	8	19	**42**
San Mateo	0	7	1	3	0	0	**11**
Santa Barbara	0	0	0	0	1	1	**2**
Santa Clara	1	7	3	2	4	1	**18**
Santa Cruz	0	2	0	2	0	3	**7**
Stanislaus	0	0	0	0	0	3	**3**
Ventura	0	0	0	0	0	0	**0**
Yolo	0	1	0	0	0	0	**1**

Figure 28:
Resolutions

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Transition of care requests	Approved	Denied
Alameda	8	1	0	1	0	0	0
Contra Costa	5	1	1	0	0	0	0
El Dorado	0	0	0	0	10	10	0
Fresno	0	0	0	0	0	0	0
Imperial	2	0	0	0	0	0	0
Kern	7	0	0	0	0	0	0
Los Angeles	78	0	0	0	0	0	0
Marin	5	0	0	0	0	0	0
Merced	3	0	0	0	0	0	0
Monterey	0	0	0	0	0	0	0
Napa	0	0	0	0	0	0	0
Nevada	3	0	0	0	0	0	0
Orange	10	5	2	1	0	0	0
Placer	3	0	0	0	0	0	0
Riverside	13	1	1	0	0	0	0
San Bernardino	15	1	1	0	0	0	0
San Diego	126	2	2	0	0	0	0
San Francisco	8	0	0	0	0	0	0
San Joaquin	9	0	0	0	0	0	0
San Luis Obispo	32	5	0	1	0	0	0
San Mateo	11	0	0	0	0	0	0
Santa Barbara	2	0	0	0	1	0	1
Santa Clara	17	2	0	2	0	0	0
Santa Cruz	6	15	15	0	0	0	0
Stanislaus	1	1	1	0	0	0	0

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in f favor of Beneficiary	Transition of care requests	Approved	Denied
Ventura	0	0	0	0	2	2	0
Yolo	1	0	0	0	0	0	0

Appeal: Defined as a review of a beneficiary adverse benefit determination.

Grievance: Defined as a report of beneficiary dissatisfaction with any matter other than an adverse benefit determination. Grievances are reported by type of dissatisfaction.

Los Angeles County: DHCS continues to work with Los Angeles County to correct the numbers of reported grievances. The County has not provided DHCS with a revised number of grievances filed. DHCS has assigned an analyst who is working specifically with LA County on this issue until it is resolved.

San Diego County: DHCS continues to work with San Diego County on the high numbers of grievances reported. All reports are submitted timely by the County and reviewed by DHCS. While DHCS is satisfied with the outcomes, an analyst has been assigned to work specifically with San Diego County and provide technical assistance regarding the high number of grievances filed.

San Luis Obispo County: DHCS continues to work with San Luis Obispo County to address the grievances, however the County has not submitted all information at this time. DHCS has assigned an analyst who is providing technical assistance to San Luis Obispo County.

Quantitative Findings:

Nothing to report.

Enrollment Information:
Prior quarters have been updated based on new claims data. For State Fiscal Year (SFY) 18-19, DY14-Q3 and DY14-Q4, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Figure 29: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY14-Q1	27,557	13,708	40,767
DY14-Q2	29,612	14,264	43,408
DY14-Q3	33,864	16,154	49,504
DY14-Q4	24,863	12,230	36,705

Member Months:

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. “Current Enrollees (to date)” represents the total number of unique clients for the quarter. Prior quarters’ statistics have been updated, and for SFY 18-19, DY14-Q3 and DY14-Q4, there is only partial data available at this time since counties have up to six months to submit claims after the month of service.

Figure 30:

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	19,991	20,697	20,626	DY14-Q1	27,557
	19,594	20,965	22,529	DY14-Q2	29,612
	24,931	24,506	21,259	DY14-Q3	33,864
	20,208	17,557	12,748	DY14-Q4	24,863
Non-ACA	11,063	11,167	11,279	DY14-Q1	13,708
	10,037	11,159	11,705	DY14-Q2	14,264
	12,716	12,714	10,962	DY14-Q3	16,154
	10,598	9,108	7,195	DY14-Q4	12,230

Figure 31: Aggregate Expenditures: ACA and Non-ACA

DY14-Q1					
Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
ACA	1,716,390.00	$47,491,547.58	$41,637,378.86	$3,509,995.18	$2,344,173.54
Non ACA	974,087.00	$19,032,945.42	$9,602,283.89	$2,592,027.20	$6,838,634.33
DY14-Q2					
ACA	1,796,375.00	$51,015,321.69	$44,731,360.31	$3,671,183.29	$2,612,778.09
Non ACA	972,172.00	$19,820,047.91	$10,013,708.67	$2,961,080.29	$6,845,258.95
DY14-Q3					
ACA	2,152,825.00	$57,193,779.74	$49,391,936.56	$4,619,506.43	$3,182,336.75
Non ACA	1,096,347.00	$21,106,245.32	$10,662,094.35	$2,683,103.86	$7,761,047.11
DY14-Q4					
ACA	1,476,463.00	$39,937,998.37	$34,359,613.64	$3,072,633.59	$2,505,751.14
Non ACA	833,801.00	$16,231,501.25	$8,197,234.73	$1,685,926.53	$6,348,339.99

ACA and Non-ACA Expenditures by Level of Care

For the detail of ACA and Non-ACA expenditures by level of care, please refer to the attached Excel file, tabs 'ODS Totals ACA' and 'ODS Totals Non-ACA'. Beginning with DY 14-Q1 (FY 18-19), a revised reporting format is being used to report expenses. A level of care is now reported on one line, rather than reported by location. For example, Case Management can be provided in Intensive Outpatient Treatment (IOT) and

Outpatient (ODF) settings. Rather than report two lines for Case Management under IOT and ODF, all Case Management expenses are reported on one line.

There are now thirty counties participating in the DMC ODS waiver as of July 1, 2019, with fifteen new counties implementing the waiver in DY 14. Of the fifteen counties, eight started providing services in Q1, three counties in Q2, and three counties in Q3. (One county started on April 1, 2019, and is included in the total count.)

Because of the six month lag in claiming, DY14-Q1 and DY14-Q2 represent a more complete billing perspective in comparison to DY14-Q3 and Q4. To date, approved claims for the four quarters equal $271,829,387. In these four quarters, claims for Methadone dosing and Residential 3.5 comprise 24.25% and 19.86%, respectively, of the $271 million in approved claims.

Policy/Administrative Issues and Challenges:

During this reporting period, CMS continued to assist DHCS with program and fiscal questions on Attachment BB for the IHP-ODS.

Progress on the Evaluation and Findings:

On June 20, 2016, CMS approved the evaluation design for the DMC-ODS component of California's Medi-Cal 2020 Demonstration. The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) will conduct an evaluation to measure and monitor outcomes of the DMC-ODS demonstration project.

The evaluation focuses on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. UCLA will utilize data gathered from a number of existing state data sources as well as new data collected specifically for the evaluation.

UCLA's approved evaluation plan is available online at: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

UCLA continues to hold monthly conference calls with updates, activities, and meetings. The evaluation design and surveys are posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/ca-policy/html/evaluation.html

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) assists public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCSs in their key role of providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Under the GPP, participating PHCSs receive GPP payments that are calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforces structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. Care being received in appropriate settings is valued relatively higher than care provided in inappropriate care settings for the type of illness.

The total amount of funds available for the GPP is a combination of a portion of the state's Disproportionate Share Hospital (DSH) Program's allotment that would otherwise be allocated to the PHCSs, and the amount associated with the Safety Net Care Pool under the Bridge to Reform demonstration.

Accomplishments:

The RAND Corporation (RAND) conducted the independent evaluation of the GPP that includes a Final Evaluation Report. The Final Evaluation Report determined whether, and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Furthermore, STC 177 (c) state the evaluation "will examine the purpose and aggregate impact of the GPP, care provided by the PHCS, and patients' experience, with a focus on understanding the benefits and challenges of this innovative payment approach."

The Final Evaluation Report was sent to the CMS on June 28, 2019. The Final Evaluation Report has been published on two DHCS webpages:

1. DHCS Medi-Cal 2020 Evaluations
   https://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx
2. DHCS GPP
   https://www.dhcs.ca.gov/provgovpart/Pages/GlobalPaymentProgram.aspx

DHCS successfully utilized the GPP Encounter Data Collection SharePoint Extranet site as a method of data transmission. Each PHCS submitted encounter level data on their uninsured services using excel templates provided in accordance with the STCs, Attachments EE and FF. The encounter level data documents for PY 3 were submitted to DHCS on March 31, 2019.

The contract between DHCS and RAND in the amount of $999,968 ended on

June 30, 2019. RAND has completed all deliverables. RAND conducted two evaluations of PHCS expenditures and activities under the GPP methodology. The midpoint evaluation examined early trends and described the infrastructure investments the PHCSs have made. The final evaluation determined whether, and to what extent, changing the payment methodology resulted in a more patient-centered system of care.

Program Highlights:

DHCS successfully completed the PY 3 SFY 2017-18 Final Reconciliation and Redistribution process. PHCS were notified of the payment amount and Inter-Governmental Transfer (IGT) Notification on June 19, 2019.

Qualitative Findings:

The GPP Final Evaluation concluded the following:

- PHCSs are building and strengthening infrastructure to support the goals of the GPP.
- Strategies and services delivered through GPP are having a positive impact on healthcare outcomes.

Quantitative Findings:

The GPP Final Evaluation concluded the following:

- Utilization data shows an increase in outpatient non-emergent non-behavioral health services for most PHCSs.
- Increased access to care among the uninsured and changes in service utilization did not increase costs during the GPP's first year.

Two DY 14 final reports, (1) PY 3 final year-end summary aggregate report and (2) PY 3 encounter level data reports, were due to DHCS from all participating GPP PHCS on March 31, 2019. DHCS received all reports on time, conducted thorough evaluations of the reports, and completed the final reconciliation and redistribution process for PY 3.

On September 13, 2018, San Francisco General Hospital (SFGH) submitted a revised SFY 2015-16 PY 1 final year-end summary report and SFY 2016-17 PY 2 final year-end summary report. DHCS reviewed the changes following the resubmission. Adjustments were made to the amounts earned by SFGH.

The SFY 2015-16 PY 1 final year-end summary revised report was compared with the final year-end summary report submitted to DHCS on March 31, 2017. The threshold points earned for SFGH decreased by 2%, from 99% to 97%. The GPP points earned decreased from 12,780,655 to 12,565,335 GPP points. The

decrease placed SFGH in a position of repayment because they were initially paid based on meeting 99% of their GPP threshold. SFGH originally received $139,774,247 in federal fund payments, however, with the correction, the revised PY 1 final year-end summary report reflects SFGH earned $137,608,230 in federal fund payments. The difference created a situation where DHCS overpaid SFGH in the amount of $2,166,017 and SFGH overpaid their IGT in the amount of $604,227.

On October 18, 2018, DHCS recouped $2,166,017 from SFGH. On November 13, 2018, DHCS returned the associated IGT funds to SFGH in the amount of $604,227.

The SFY 2016-17 PY 2 final year-end summary revised report was compared with the final year-end summary report submitted to DHCS on March 31, 2018. The threshold points earned for SFGH increased by 1%, from 89% to 90%. The GPP points earned increased from 11,883,254 to 12,004,644 GPP points. SFGH was initially paid based on meeting 89% of their GPP threshold. SFGH originally received $123,688,489 in federal fund payments, however with the correction, the revised PY 2 final year-end summary report reflects SFGH earned $131,467,860. The additional 1% payment difference in the amount of $1,507,942 will be paid during the SFY 2016-17 Round 6 at the end of this year.

In SFY 2016-17 PY 2 Final Reconciliation, DHCS recouped $15,633,705 in total funds. The recoupment process is a result of four PHCS that submitted final year-end reports with revisions to the interim report. Figure 32 below shows the PHCSs requiring recoupment and their associated PY 2 Interim and Final reporting differences in the percent of GPP threshold met.

Figure 32: PHCSs Requiring Recoupment and their Associated PY 2 Interim and Final Reporting Differences in the Percent of GPP Threshold Met

Public Health Care System	Interim Report % of threshold met	Final Report % of threshold met
Los Angeles County Health System	104%	99%
Natividad Medical Center	101%	96%
San Mateo Medical Center	100%	98%
Ventura County Medical Center	71%	65%

The four PHCS received interim quarterly (IQ) GPP payments based on their percent of threshold met as reported in the interim report. Their final report indicates a decrease in percent of threshold met. The payments previously received by the PHCS exceeded the amounts earned as reported in the final report. DHCS adjusted the payments previously made to the PHCS for GPP PY 2 and recouped the difference in the amount of $15,633,705. The final year-end report served as the basis for the final reconciliation of GPP payments and recoupments for GPP PY 2.

In SFY 2017-18 PY 3, DHCS recouped $12,773,167 in total funds from Ventura County Medical Center (VCMC). The recoupment was due to overpayment to VCMC. In PY 3, IQs 1 – 3 (July 1, 2017 – March 30, 2018), VCMC was paid 75% of its total annual budget. On August 15, 2017, VCMC submitted an interim year-end summary aggregate report. The threshold points earned for VCMC was 6,161,963, or 63.71% of GPP thresholds. The 63.71% is less than 75% of its total annual budget. DHCS adjusted the payments previously made to VCMC for GPP PY 3 and recouped the difference in the amount of $12,773,167.00 in total funds from VCMC. Figure 33 below shows the GPP payments made to the PHCSs in DY 14.

Figure 33: GPP Payments to PHCSs for DY 14

Payment	FFP	IGT	Service Period	Total Funds Payment
Global Payment Program (GPP)				
PY 2 Final Rec. (July – June)	$25,178,285.00	$25,178,285.00	DY 12	$50,356,570.00
PY 2 (July – June) Overpayment collection	($7,816,852.50)	($7,816,852.50)	DY 12	($15,633,705.00)
PY 3, IQ4 (April – June)	$226,102,839.50	$226,102,839.50	DY 13	$452,205,679.00
PY 3 (July – June) Overpayment collection	($6,386,583.50)	($6,386,583.50)	DY 13	($12,773,167.00)
PY 1 Final DSH GPP Round 6 (July – June)	$2,600,048.50	$2,600,048.50	DY 11	$5,200,097.00
PY 1 Final DSH GPP Round 6 (July – June) Overpayment collection	($1,083,008.50)	($1,083,008.50)	DY 11	($2,166,017.00)
PY 4, IQ 1 (July – September)	$301,281,907.00	$301,281,907.00	DY 14	$602,563,814.00
PY 4, IQ 2 (October – December)	$301,281,907.00	$301,281,907.00	DY 14	$602,563,814.00

Payment	FFP	IGT	Service Period	Total Funds Payment
PY 4, IQ 3 (January – March)	$301,281,907.00	$301,281,907.00	DY 14	$602,563,814.00
Total	$1,142,440,449.50	$1,142,440,449.50		$2,284,880,899.00

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

The GPP evaluations assessed whether changing the payment methodology resulted in more cost-effective and higher-value care as measured by:

- Delivering more services at lower level of care as measured by diagnosis codes
- Expansion of the use of non-traditional services
- Reorganization of care teams to include primary care and mental health providers
- Better use of data collection
- Improved coordination between mental health and primary care
- Costs that could have been avoided
- Additional investments in infrastructure to improve ambulatory care

RAND surveyed PHCS leaders and their GPP teams about their most important priorities for changing their health systems to meet GPP goals, the health system strategies for change that they adopted, and the services they provide for patient care. RAND used utilization data from PY 1 through PY 3 to examine early trends in service use in both high- and low-intensity care settings. On February 15, 2019, all PHCSs submitted their completed Final Evaluation Survey to DHCS and RAND. The self-report leader survey results included an analysis of the PHCSs experiences transforming care provided to the uninsured.

From February 14, 2019, through February 26, 2019, RAND conducted phone interviews with each of the 12 PHCS leaders. Questions focused on how the PHCS responded to GPP's experiences and goals of: 1) Delivering care in more appropriate settings and 2) Improving patient experiences.

The GPP Final Evaluation Report addressed the following research questions:

1. Was the GPP successful in driving a shift in provision of services from inpatient to outpatient settings (including non-traditional services) over the course of the GPP?

Findings from the Final Report: PHCSs increased the use of outpatient services over the course of the GPP. The total points for outpatient non-behavioral services increased by 12.2 percent across the 12 PHCSs over the GPP's first three years. Point totals increased for all categories and tiers of outpatient services. Along with increased utilization of outpatient services, utilization of non-behavioral emergency and inpatient services decreased, with total points across all PHCSs decreasing by 13 percent by the end of year 3.

2. Did the GPP allow PHCS to leverage investments in primary care, behavioral health, data collection and integration, and care coordination to deliver care to the remaining uninsured?

   Findings from the Final Report: PHCSs improved care to the uninsured. The GPP promoted allocating resources wisely and is more effectively tailoring care to the appropriate settings.

   PHCSs used the flexibility provided by the GPP's payment system to implement a diverse set of strategies to establish the foundation for meeting GPP goals. From 2018 to 2019, strategy use increased across PHCSs for the domains of data collection and tracking, coordination of care, access, contracted staffing, team-based care, and delivery system change.

   The GPP promoted efficient use of resources as PHCSs use federal matching dollars to support the provision of services using a wider range of settings, provider types, and care delivery strategies prior to the beginning of the GPP.

3. Did the percentage of dollars earned based on non-inpatient, non-emergent services increase across PHCS?

   Findings from the Final Report: The percentage of dollars earned based on non-inpatient, non-emergent services increased across PHCSs. The GPP allowed the PHCSs flexibility in the use of federal funding. As a result of this, PHCSs were able to more effectively tailor services to the appropriate settings. Over the first three years of the GPP, points earned for all outpatient non-ER and residential services, which includes both, non-traditional and traditional services, increased by 4.4 percentage points.

OUT-OF-STATE FORMER FOSTER CARE YOUTH (OOS FFY)

On August 18, 2017, CMS approved an amendment to the 1115 Demonstration Waiver to allow the DHCS to continue providing Medicaid coverage for former foster care youth under age 26, consistent with federal requirements for coverage of this population. Given the waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category. The evaluation design was approved on December 22, 2017, using the most current data representing 2015. The amendment authorized the OOS FFY 1115 Demonstration Waiver to start on 11/1/2017. This year's submission uses the most current data from 2017 as instructed by CMS.

Accomplishments:

California was the first state approved by CMS to provide Medi-Cal eligibility to FFY who were in foster care in a state other than California. Under the FFY Program, the OOS FFY under age 26 who qualify, consistent with the federal requirements, receive full scope benefits in Medi-Cal until they turn 26. These youths do not have to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

Program Highlights:

California successfully increased enrollment of FFY in Medi-Cal from 10,764 in 2016, to 14,442 in 2017, providing these youths with ready access to full-scope Medi-Cal benefits. Of the 14,442 FFY enrolled each of the 12 months in 2017, there were 111 OOS FFY. The data analyzed in Attachment QQ is based upon the 15,177 FFY who remained enrolled at least 11 months of the 12-month period in 2017, and of those 123 were OOS FFY (See Attachment QQ - 2017 Enrollment, Utilization, and Health Outcomes Evaluation).

Qualitative Findings:

Nothing to report.

Quantitative Findings:

According to the 2017 Enrollment, Utilization, and Health Outcomes evaluation- , the FFY population continues to show greater use of ED visits (emergency room visits) and behavioral health visits when compared to the 18-25 year old Medi-Cal population. Quality measures for Chlamydia Screening in Women (CHL) and Cervical Cancer Screening (CCS) also continues to be accessed more by the FFY group than the 18-25 year old Medi-Cal population.

Policy/Administrative Issues and Challenges:

FFY are a group of individuals who move often, and are accustomed to having their health care needs taken care of by the foster care system and/or caretakers. A youth new to California will have limited knowledge on where to access health care resources. They may also be unaware that California offers Medi-Cal for the former foster youth from ages 18 to 25 inclusive, until they are in need of services. Administratively, California lacks the ability to track OOS FFY entering or exiting the state or transitioning to other programs. Engagement with FFY stakeholders to convey information on access to services is conducted monthly.

Many FFY are also eligible for other programs that offer cash aid in addition to Medi-Cal. When these youths lose their eligibility for the cash aid programs, they are not always placed back into the FFY program, potentially creating a gap in their Medi-Cal coverage. DHCS is working on developing a system alert for counties to flag these cases, in an effort to prevent any gaps in Medi-Cal coverage.

On October 24, 2018, Congress passed the SUPPORT Act. Section 1002 of the Act extends Medicaid coverage for the OOS FFY regardless of the state they were in when they were in foster care. This amendment becomes effective for all foster youth who attain 18 years of age on or after January 1, 2023.

Progress on the Evaluation and Findings:

Please see Attachment QQ - Out-of-State Former Foster Youth DY 14 Data

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL (PRIME)

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program is building upon the foundational delivery system transformation work, expansion of coverage, and increased access to coordinated primary care achieved through the prior California Section 1115 Bridge to Reform Demonstration. The activities supported by the PRIME Program are designed to accelerate efforts by participating PRIME entities to change care delivery, to maximize health care value, and to strengthen their ability to successfully perform under risk-based alternative payment models (APMs) in the long-term, consistent with CMS and Medi-Cal 2020 goals.

The PRIME Program aims to:

- Advance improvements in the quality, experience, and value of care that Designated Public Hospitals (DPH)/District/Municipal Public Hospitals (DMPH) provide
- Align projects and goals of PRIME with other elements of Medi-Cal 2020, avoiding duplication of resources and double payment for program work
- Develop health care systems that offer increased value for payers and patients
- Emphasize advances in primary care, cross-system integration, and data analytics
- Move participating DPH PRIME entities toward a value-based payment structure when receiving payments for managed care beneficiaries

PRIME Projects are organized into three domains. Participating DPH systems will implement at least nine PRIME projects and participating DMPHs will implement at least one PRIME project, as part of the participating PRIME entity's Five-year PRIME Plan. Participating DPH systems must select at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project.

Projects included in Domain 1 – Outpatient Delivery System Transformation and Prevention – are designed to ensure that patients experience timely access to high quality and efficient patient-centered care. Participating PRIME entities are improving physical and behavioral health outcomes or care delivery efficiency and patient experience, by establishing or expanding fully integrated care with culturally and linguistically appropriate teams delivering coordinated comprehensive care for the whole patient.

The projects in Domain 2 – Targeted High-Risk or High-Cost Populations – focus on specific populations that would benefit most significantly from care integration and coordination: populations in need of perinatal care, individuals in need of post-acute

care or complex care planning, foster children, individuals who are reintegrating into society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

Projects in Domain 3 – Resource Utilization Efficiency – are reducing unwarranted variation in the use of evidence-based diagnostics and treatments (antibiotics, blood or blood products, and high cost imaging studies and pharmaceutical therapies) by targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects also eliminate the use of ineffective or harmful targeted clinical services.

The PRIME program is intentionally designed to be ambitious in scope and time-limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions.

Accomplishments:

The following are highlighted accomplishments based on entity reporting up to Demonstration Year (DY) 14 Mid-Year (MY):

<u>Domain 1</u>

- Tobacco Assessment and Counseling: Of the 22 entities reporting for this metric, eight achieved the 90th percentile benchmark or above.
- Colorectal Cancer Screening: Of the 23 entities reporting for this metric, 11 entities achieved the 90th percentile benchmark or above.
- Health Disparities: Of the 23 entities reporting for this metric, 15 met their annual improvement target for their disparities reduction projects. Common key themes among these projects are incorporating equity into strategic goals and priorities, staff training to provide culturally responsive care, patient participation in care delivery design, data driven performance achievement and partnerships with community leaders and organizations. Examples of these disparities reduction projects include: Contra Costa Regional Medical Center piloted group medical visits for African Americans co-led by African American Health Conductors, and Kern Medical Center launched a culturally tailored campaign for Spanish-speaking patients with heart disease about the benefits of taking aspirin.

<u>Domain 2</u>

- Prenatal Care: Of the 20 entities reporting for this metric, eight achieved the 90th percentile or above.
- Postpartum Care: Of the 20 entities reporting for this metric, 11 entities achieved the 90th percentile or above.

Domain 3

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Of the 14 entities reporting for this metric, 12 entities achieved the 90th percentile or above.
- Use of Imaging Studies for Low Back Pain: Of the nine entities reporting for this metric, five achieved the 90th percentile or above.

DHCS continues to update and maintain the PRIME Reporting Information System for entity reporting activities throughout the duration of PRIME. The platform contains data entry fields for more than 90 PRIME metrics across the 18 PRIME projects. Data fields include numerators, denominators, qualitative narratives, and radio buttons. With a few exceptions, the platform automatically calculates metric achievement rates, achievement values and next DY target rates.

DHCS continues to maintain a secure shared learning website via Microsoft SharePoint called PRIMEone. The shared learning website contains PRIME project discussion boards, libraries for documents and learning collaboratives materials, metric policies, and helpful links. Entities collaborate with each other on best practices, strategies for using their respective electronic health record systems and leveraging resources. DHCS monitors the site and provides administrative oversight when needed.

DHCS collaborated with the California Association of Public Hospitals Safety Net Institute (SNI) and the District Hospital Leadership Forum (DHLF) on the release of DY 13 Year End (YE) Reporting Manual, released on July 9, 2018.

DHCS released the DY 14 benchmarks on July 5, 2018, and established procedures to allow entities to reclaim unearned funds as outlined in Attachment II of the STCs.

Program Highlights:

Total Fund payments, in the amount of $1,318,006,725.33, were made during DY 14. These payments consisted of five DY 12 Supplemental payments, one DY 12 Annual Adjustment payment, five DY 13 Semi-Annual payments, 52 DY 13 Annual payments, and 40 DY 14 Semi-Annual payments.

General Program Webinars

On July 16, 2018, DHCS presented a webinar with NCQA to provide PRIME entities with an overview of the DY 13 YE Reporting Manual including changes to any of the metrics and updates to the manual.

On August 30, 2018, DHCS hosted a webinar on claiming unearned funds.

On January 22, 2019, DHCS hosted a webinar for questions and answers with SNI and the measure stewards for DY 14 measure specifications on SBIRT (Screening, Brief Intervention, Referral to Treatment).

PRIMEd Annual Conference 2018

On October 29-30, 2018, DHCS hosted the DY 13 in-person PRIME Learning Collaborative (called the PRIMEd Annual Conference) in Sacramento at the Holiday Inn Hotel with 52 PRIME entities in attendance. The event focused on a major theme of sustaining quality improvement efforts to improve the health care delivery system.

For the theme of sustaining quality improvement, Donald Goldmann, MD, the Chief Scientific Officer, Emeritus and Senior Fellow at the Institute for Healthcare Improvement, delivered the keynote speaker address on the topic of Quality Improvement in Changing Times. His keynote presentation was followed by a panel discussion featuring speakers from three health systems across the country, from California, Massachusetts and New York, who participated or are participating in DSRIP (Delivery System Reform Incentive Payments) program, who shared their experiences and lessons learned from integrating quality improvement efforts into their organizations' operations and cultures over time.

Following a series of breakout sessions, the event ended with a compelling patient panel discussion on patient engagement and integration of care, coordinated and facilitated by Contra Costa Regional Medical Center. This PRIME entity provided an update from last year's conference on their patient engagement efforts, in addition to sharing thoughts about how health systems can leverage PRIME in order to address the social determinants of health.

DHCS hosted a networking session on the evening of the first day of the two-day event, October 29, 2018. PRIME entities were able to meet contacts within other PRIME entities for help collaborating on similar PRIME projects.

PRIMEd Semi-Annual Meeting 2019

On May 31, 2019, DHCS hosted the PRIMEd Semi-Annual Meeting in Sacramento at DHCS headquarters. All 52 PRIME entities attended this optional, in-person meeting. The keynote speaker was Richard Figueroa, Deputy Cabinet Secretary, Office of the California Governor. Mr. Figueroa described Governor Newsom's priorities for health care across the state of California. PRIME entities had the opportunity to ask Mr. Figueroa questions, with many focusing on California's overall plan for behavioral health care integration. The meeting featured two breakout sessions for the six TLC groups to have an opportunity for an in-person convening of their ongoing and pressing discussion topics. Lastly, office hours were hosted by DHCS's health disparities expert

to discuss best practices of addressing health disparities, and the California Quits team provided best practices on tobacco cessation initiatives.

Future In-Person Meetings

DHCS also began to plan for the annual PRIME Learning Collaborative in person conference (PRIMEd) that will be held in Sacramento on October 29 30, 2019. TLC workgroups will have the opportunity to again convene face-to-face.

Additional and continuing Learning Collaborative Activities

On March 20, 2019, DHCS presented a webinar hosted by Zuckerberg San Francisco General Hospital and Trauma Center on the topic of Patient Safety and Transparency to discuss the need for transparency regarding medical mistakes in health care quality and systems redesign.

In March 2019, DHCS finalized plans for the continuation of selected Topic-Specific Learning Collaboratives (TLCs), which originally began in Q4 of DY13. These TLC workgroups offered to help PRIME entities meet their project goals and improve care delivery through peer-to-peer learning, an exchange of ideas, and the dissemination of best practices on common topics. Six TLC workgroups were selected for continuation in DY14. DHCS selected these six based on survey results and review of workgroup attendance in DY13, which both took place in Q3 of DY14. Six TLC workgroups launched kickoff meetings in Q4, all welcoming the new members who joined for the 2019 calendar year.

The six ongoing TLC topics include:

- Health Homes for Foster Children
- Reducing Health Disparities
- Care Transitions
- Maternal and Infant Health
- Tobacco Cessation (facilitated by the CA Quits Team)
- Behavioral Health (former Substance Use Disorder TLC merged with former Mental Health TLC)

Below are several examples of the types of activities that occurred across the TLCs in DY14:

Reducing Health Disparities – During the PRIMEd Semi-Annual Meeting on May 31, 2019, the TLC Health Disparities workgroup briefly discussed project data analysis across participating entities and shared action plans on how to reduce disparity with their respective populations. The workgroup also conducted a webinar series on topics

requested by participants, including: Social Determinants of Health (SDOH), Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool and case studies from the California Health Centers.

Integrated Health Homes for Foster Children – This TLC met seven times during DY 14. Topics covered included: approaches to improving foster children's oral health, comprehensive medical evaluations following foster youth placement, mental health screenings for foster youth and changes to California's child welfare system. In January of 2019, the TLC group invited the Center for Medicaid and CHIP Services (CMCS), Division of Quality and Health Outcomes, to join for an overview of the learning collaborative activities and PRIME metric data for DY 11 through DY 13 and an overview of each participating hospital system's effort and progress. The TLC members were excited to present on the innovative work improving healthcare delivery for the vulnerable population of foster children.

Care Transitions – The Care Transitions TLC continued to be one of the largest TLC groups in DY14, with approximately 40 members. The group discussed changes in performance on the Care Transitions metrics between DY 12 YE and DY 13 MY. Two entities presented on their hospital's care transitions activities and strategies to improve care transitions. At the PRIMEd Annual Conference, the group discussed strategies to ensure a positive and seamless patient experience as well as strategies for communicating with outpatient providers. TLC members were asked to virtually participate in CMS' inaugural National Care Transitions Awareness Day and Summit, so the team could debrief on the summit during in-person meeting at the PRIMEd Semi-Annual Conference.

Behavioral Health – During the in-person PRIMEd Semi-Annual meeting in May 2019, Ventura County Medical Center presented on Integrating Substance Use Screening in Primary Care, outlining a model for SBIRT, the importance of training staff, and effective tools for patients.

Maternal and Infant Health – The topics covered for this TLC included: data and performance, implementation of donor breastmilk programs, reduction in rates of Caesarean births (C-Sections), strategies to improve exclusive breastfeeding rates among African American mothers, and increasing rates of exclusive breast milk feeding overall. Lastly, the group held an in-person meeting that focused on balancing recent clinical guidance on postpartum visits with the PRIME postpartum care metric, which resulted in an opportunity for PRIME entities to vote on potential changes to the measure in the next DY.

Qualitative Findings:

In accordance with DHCS' monitoring responsibilities, DY 13 Final YE Reports were due to DHCS from all participating PRIME entities on September 30, 2018. DHCS conducted its administrative reviews of all reports, and approved them for payment, appropriate to the demonstrated achievement values.

DY 14 Interim MY Reports were due to DHCS from all participating PRIME entities on March 31, 2019. DHCS conducted its administrative reviews of all reports for mid-year interim payments and approved them for payment, appropriate to the demonstrated achievement values.

Per DHCS outreach efforts, PRIME entities receive a monthly newsletter that is distributed to over 200 PRIME contacts across all 52 PRIME entities. The newsletter works to keep contacts apprised of deadlines and developments within the PRIME program. On average, approximately 25 to 30 percent of recipients read these monthly newsletters.

Quantitative Findings:

Figure 34

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$9,471,663.13	$9,471,663.13	DY 13	$18,943,326.26
(Qtr. 2 Oct – Dec)	$330,002,762.77	$330,002,762.77	DY 13	$660,005,525.54
(Qtr. 3 Jan – Mar)	$67,339,773.15	$67,339,773.14	DY 13	$134,679,546.29
(Qtr. 4 Apr – Jun)	$252,189,163.68	$252,189,163.56	DY12/14	$504,378,327.24
Total	**$659,003,362.73**	**$659,003,362.60**		**$1,318,006,725.33**

In DY14–Q4, 16 DPHs and 27 DMPHs received payments. In DY14 Q4, 13 DPHs and 27 DMPHs received their DY 14 Semi-Annual payments, four DPHs received their DY 12 Supplemental payment, and one DPH received a DY 12 Annual Adjustment payment in DY 14 Q4. During this quarter, Designated Public Hospitals and District/Municipal Public Hospitals received $252,189,163.68 in federal fund payments for PRIME-eligible achievements.

Policy/Administrative Issues and Challenges:

In DY14, the main challenge experienced was due to the administrative process of calculating and distributing the funds in the DY 13 High Performance Pool. Since it was a shared pool of funds, all DY 13 YE reports had to be completely closed out, with all reporting questions and clinical review questions sufficiently addressed. Additionally, entities had to correctly identify their High Performing Metrics, which was a challenge. DHCS provided technical assistance with respect to these issues and worked with entities to finalize their unearned funds claims. Claims to the shared pool of funds were prorated based on the funds actually available for payment. DHCS made changes to the claiming form in an effort to have a smoother process in DY 15.

Progress on the Evaluation and Findings:

Draft Interim Report Status and Findings

DHCS delivered the Draft Interim Evaluation to CMS on September 27, 2019, and is awaiting feedback.

UCLA used a combination of qualitative and quantitative data sources in their interim evaluation analysis: surveys and key-informant interviews (qualitative data), PRIME hospital self-reported data (deemed by evaluator as qualitative), Medi-Cal enrollment and encounter data from the DHCS Information Management Division (IMD) (quantitative), and patient discharge data from California's Office of Statewide Healthcare Planning and Development (quantitative).

The overview on metric achievements thus far (DYs 11 through 13) demonstrates hospitals' metric payment attainment declines by project domain. Domain 1 has the highest rate of metric payments attained and Domain 3, the least. This pattern was observed for both DPHs and DMPHs. The evaluator observed that this could be attributable to the high number of process-oriented metrics in Domain 1, whereas hospitals have less control over outcomes-based metrics more prevalent in Domain 2, and provider practice pattern metrics in Domain 3.

A Difference in Difference (DinD) analysis examined the achievements of PRIME hospitals in comparison to non-PRIME hospitals using administrative data provided by the state. PRIME hospitals achieved greater progress in the process measures in Domains 1 and 2 indicating greater improvements in the delivery of preventive and prenatal services for patients of DPHs and DMPHs than their respective comparison groups. However, the DinD analysis did not show improvement in outcome measures when examining achievements in PRIME hospitals versus comparison hospitals.

Limitations of the Draft Interim Evaluation

The report is an interim PRIME evaluation, which limits quantitative data conclusions and conclusive lessons learned. As indicated within the report, PRIME will be more comprehensively assessed for success in the Final Evaluation.

Additionally, there were data referred to in the CMS-approved evaluation design that UCLA was unable to obtain. The evaluation was limited by managed care assignment data availability and therefore did not include the second Prime Eligible Population (PEP) criteria, “Individuals of all ages who are in Medi-Cal Managed Care with 12 months of continuous assignment to the PRIME Entity during the Measurement Period” for any data analyses. The evaluators did not have access to this data because IMD did not have access to which hospitals Medi-Cal beneficiaries are assigned. The managed care health plan is responsible for assignment to the hospital and this data is not merged back into the Medi-Cal claims or enrollment databases. As such, Managed Care enrollees were included in UCLA’s analysis if they met PEP 1 criteria, but not included if they only met PEP 2 criteria.

SENIORS AND PERSONS WITH DISABILITIES (SPDs)

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

Figure 35: DY 14 Total Member Months for Mandatory SPDs by County

County	DY14-Q1 (July – Sept.)	DY14-Q2 (Oct. – Dec.)	DY14-Q3 (Jan. – March)	DY14-Q4 (April – June)	DY 14 Total Member Months
Alameda	85,582	84,816	83,836	82,570	336,804
Contra Costa	52,267	52,163	51,876	51,477	207,783
Fresno	72,520	72,226	71,869	71,182	287,797
Kern	58,212	57,757	57,682	57,485	231,136
Kings	8,021	8,033	8,037	7,950	32,041
Los Angeles	589,275	582,478	566,714	540,095	2,278,562
Madera	7,095	7,077	7,068	6,989	28,229
Riverside	107,016	107,267	107,080	106,347	427,710
San Bernardino	108,552	107,908	107,303	106,070	429,833
San Francisco	116,683	116,397	115,975	115,051	464,106
San Joaquin	121,384	120,123	118,659	117,153	477,319
Santa Clara	42,620	42,058	41,434	41,069	167,181
Stanislaus	49,531	49,604	49,586	48,932	197,653
Tulare	65,893	65,445	65,197	65,017	261,552
Sacramento	36,015	35,693	35,228	34,726	141,662
San Diego	32,076	31,710	31,471	31,284	126,541
Total	**1,552,742**	**1,540,755**	**1,519,015**	**1,483,397**	**6,095,909**

Figure 36: DY 14 Total Member Months for Existing SPDs by County

County	DY14-Q1 (July – Sept.)	DY14-Q2 (Oct. – Dec.)	DY14-Q3 (Jan. – March)	DY14-Q4 (April – July)	DY 14 Total Member Months
Alameda	65,665	66,470	67,216	67,220	266,571
Contra Costa	30,968	31,466	31,906	32,181	126,521
Fresno	41,039	41,649	42,084	42,173	166,945
Kern	28,072	28,713	29,168	29,696	115,649
Kings	4,197	4,298	4,301	4,330	17,126
Los Angeles	1,045,931	1,046,818	1,035,910	1,011,051	4,139,710
Madera	4,231	4,296	4,313	4,419	17,259
Marin	19,278	19,285	19,360	19,185	77,108
Mendocino	17,930	17,968	17,881	17,709	71,488
Merced	48,996	49,133	49,226	48,803	196,158
Monterey	49,778	49,377	48,716	48,451	196,322
Napa	14,874	14,905	14,962	14,960	59,701
Orange	334,366	335,447	336,594	336,249	1,342,656
Riverside	117,336	117,679	117,732	116,552	469,299
Sacramento	65,676	66,841	67,658	67,956	268,131
San Bernardino	113,522	113,634	113,575	112,810	453,541
San Diego	193,617	194,066	193,786	191,728	773,197
San Francisco	43,756	44,718	45,419	45,812	179,705
San Joaquin	28,395	28,898	29,232	29,323	115,848
San Luis Obispo	25,083	24,882	24,883	24,733	99,581
San Mateo	42,635	41,710	41,353	40,972	166,670
Santa Barbara	46,771	46,858	46,843	46,689	187,161
Santa Clara	124,839	124,375	123,538	122,824	495,576
Santa Cruz	31,935	31,864	31,628	31,437	126,864
Solano	61,044	61,060	60,892	60,480	243,476
Sonoma	53,496	53,562	53,392	52,743	213,193
Stanislaus	16,672	16,997	17,352	17,443	68,464
Tulare	18,999	19,251	19,495	19,658	77,403
Ventura	87,388	87,486	87,440	87,231	349,545
Yolo	26,269	26,129	26,004	25,727	104,129
Total	**2,802,758**	**2,809,835**	**2,801,859**	**2,770,545**	**11,184,997**

Figure 37: DY 14 Total Member Months for SPDs in Rural Non-COHS Counties

County	DY14-Q1 (July – Sept.)	DY14-Q2 (Oct. – Dec.)	DY14-Q3 (Jan. – March)	DY14-Q4 (April – July)	DY 14 Total Member Months
Alpine	57	53	54	53	217
Amador	1,097	1,112	1,122	1,105	4,436
Butte	19,067	18,710	18,281	17,657	73,715
Calaveras	1,756	1,724	1,652	1,666	6,798
Colusa	848	838	818	820	3,324
El Dorado	5,206	5,193	5,182	5,161	20,742
Glenn	1,667	1,692	1,694	1,675	6,728
Imperial	10,711	10,789	10,799	10,775	43,074
Inyo	535	521	509	482	2,047
Mariposa	679	684	680	690	2,733
Mono	183	180	177	179	719
Nevada	3,177	3,120	3,097	3,047	12,441
Placer	9,833	9,963	10,035	10,074	39,905
Plumas	1,085	1,070	1,077	1,098	4,330
San Benito	290	306	322	317	1,235
Sierra	110	119	129	122	480
Sutter	5,975	5,948	5,962	5,930	23,815
Tehama	5,344	5,207	5,218	5,213	20,982
Tuolumne	2,654	2,660	2,611	2,525	10,450
Yuba	6,396	6,285	6,200	6,067	24,948
Total	**76,670**	**76,174**	**75,619**	**74,656**	**303,119**

Figure 38: Total Member Months for SPDs in Rural COHS Counties

County	DY14-Q1 (July – Sept.)	DY14-Q2 (Oct. – Dec.)	DY14-Q3 (Jan. – March)	DY14-Q4 (April – July)	DY 14 Total Member Months
Del Norte	8,210	8,161	8,101	8,052	32,524
Humboldt	26,539	26,397	26,266	26,148	105,350
Lake	19,798	19,784	19,760	19,594	78,936
Lassen	4,369	4,344	4,277	4,302	17,292
Modoc	2,137	2,141	2,132	2,084	8,494
Shasta	40,834	40,513	40,336	39,959	161,642
Siskiyou	11,194	11,141	11,053	10,928	44,316
Trinity	2,800	2,717	2,718	2,694	10,929
Total	**115,881**	**115,198**	**114,643**	**113,761**	**459,483**

WHOLE PERSON CARE (WPC)

The Whole Person Care (WPC) pilot is a five-year program authorized under the Medi-Cal 2020 Demonstration. WPC provides, through more efficient and effective use of resources, an opportunity to test local initiatives that coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and have poor health outcomes.

The local WPC pilots identify high-risk, high-utilizing target populations; share data between systems; provide comprehensive care in a patient-centered manner; coordinate care in real time; and evaluate individual and population health progress. WPC pilots may also choose to focus on homelessness and expand access to supportive housing options for these high-risk populations.

An organization eligible to serve as the lead entity (LE) develops and locally operates the WPC pilots. LEs must be a county, a city, a city and county, a health or hospital authority, a designated public hospital or a district/municipal public hospital, a federally recognized tribe, a tribal health program operated under contract with the federal Indian Health Services, or a consortium of any of these entities.

WPC pilot payments support infrastructure to integrate services among local entities that serve the target population; provide services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing components; and other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Eighteen LEs began implementing and enrolling WPC members on January 1, 2017. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. DHCS received and approved fifteen WPC pilot applications the second round.

The WPC evaluation report, required pursuant to the STCs 127 of the California Medi-Cal 2020 demonstration waiver will assess: 1) if the LEs successfully implemented their planned strategies and improved care delivery, 2) whether these strategies resulted in better care and better health, and 3) whether better care and health resulted in lower costs through reductions in avoidable utilization.

The midpoint report, due to CMS in 2019, will include an assessment of population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, though only preliminary outcome data will be available. The final report, due to CMS in 2021, will provide the complete assessment of care and outcome improvements, including an assessment of the impact of the various packages of interventions for specific target populations. The final report will also include

assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

Accomplishments:

Figure 39: Pilot Accomplishments

Date	Pilot Accomplishments
STC 117 & 130 WPC Payments	
June 2019	All twenty-five LEs received WPC payments totaling $542,091,560.86 in DY 14.
	DY 12-14 total-to-date payments of $1,399,328,699.54 represents payments through 2018 annual invoice and 47% of the $3 billion allocated for WPC over the five years of the program until December 31, 2020. There are four scheduled payments remaining (2019 PY 4 mid-year, 2019 PY 4 annual, 2020 PY 5 mid-year, and 2020 PY 5 annual). Payments are slated to go out no later than October 21, 2019, for Mid-Year PY 4 activities.
STC 118 Housing and Supportive Services	
June 2019	All twenty-five LEs are providing a range of housing services including individual housing and tenancy sustaining services and individual housing transition services. These housing services include tenant screening, housing assessments and individualized housing support plans, work with landlords, identification of community resources, and training tenants to maintain housing once it is established. As of June 30, 2018, LEs reported 53% (40,697) of WPC members were homeless.
STC 119 Lead and Participating Entities	
June 2019	Participating entities have increased from 350 to more than 540 for the twenty-five LEs since program implementation began in 2017.
STC 123 Learning Collaborative	
July 2018-June 2019	The Learning Collaborative (LC) supports the WPC LEs with the following goals: • Enhance the permanent capacity of providers to effectively care for high-risk, high-utilizing populations targeted by the WPC LEs; • Inform state oversight and policy making relevant to the WPC pilot, their target populations, and related delivery system reforms; and • Grow and sustain a peer network among LEs to encourage the continued spread of best practices. The LC structure includes a variety of learning activities, such as webinars, in-person convenings, and access to a resource portal as a means to address the topics and questions from LEs.
March - December 2018	Beginning in 2018, the LC launched five topic-specific affinity groups focused on the following areas: data, care coordination, sustainability, housing, and reentry. Affinity groups were led by LC staff who were responsible for working with their

	groups to understand the challenges pilots faced in each area, and then helped the pilots share best practices and work towards finding solutions. All five affinity groups launched in March 2018 and ramped down at the end of 2018 to make way for other LC activities in 2019, including quarterly webinars, a site visit in Los Angeles, and two in-person meetings.
STC 125 Progress Reports	
September 2018	All twenty-five LEs submitted the PY 3 mid-year report for 2018.
April 2019	All twenty-five LEs submitted the PY 3 annual report for 2018.
STC 126 Universal and Variant Metrics	
August 2018	All twenty-five LEs submitted their baseline, PY 2 annual, and PY 3 mid-year variant and universal metric reports.
STC 127 Mid-Point and Final Evaluations	
July 2019	The WPC Interim Evaluation report due date to CMS is December 31, 2019. UCLA is expected to submit a draft to DHCS September 30, 2019.

Program Highlights

On April 3, 2019, approximately 100 WPC participants attended the Los Angeles WPC site visit hosted by DHCS and the LC. The site visit consisted of overviews of the Los Angeles WPC pilot including Substance Use Disorder Engagement/Navigation and Overdose Prevention, WPC Mental Health Programs focused on WPC members with Serious Mental Illness, Reentry Care Coordination, Community Health Worker-driven Complex Care Management Model, and Housing Transition of Care Programs.

On April 4, 2019, DHCS, in collaboration with the LC, held an in-person convening for all WPC pilots. More than 160 people attended, including representatives from all twenty-five pilots. The agenda focused on WPC lessons learned, promising practices and pilot accomplishments. The convening included time for LEs to network and meet with DHCS for one-on-one discussions on operational issues and program activities.

On April 19, 2019, the LC partnered with the California Health Care Foundation (CHCF) to hold a webinar sharing findings from a CHCF-funded paper by Intrepid Ascent about opportunities and challenges surrounding data sharing entitled: *Catalyzing Coordination: Technology's Role in California's Whole Person Care Pilots*. The webinar included an overview of common challenges and critical decisions encountered by WPC pilots as they seek to implement technology solutions including how to design data-sharing agreements and whether to adapt existing technologies or procure new ones.

During April-June 2019, DHCS held two administrative teleconferences with LEs. The administrative teleconferences focused on administrative topics and technical assistance, allowing the LEs to ask questions about DHCS' guidance and various

operational issues such as deliverable reporting, timelines, budget adjustments, sustainability, closeout, and DHCS expectations.

During the DY 14 fourth quarter, all LEs submitted the following reports:

- PY 3 Annual Narrative and Plan Do Study Act;
- PY 3 Annual Variant and Universal Metrics; and
- PY 4 first quarter Enrollment & Utilization.

By way of background, after two rounds of applications, the WPC program consists of twenty-five LEs with eighteen legacy LEs that implemented on January 1, 2017 and seven LEs (counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma, the City of Sacramento, and the Small County WPC Collaborative (SCWPCC), which includes San Benito and Mariposa Counties) that implemented on July 1, 2017. Eight of the legacy LEs (Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura) continued their original programs and were approved to expand their programs with additional or expanded target populations, services, and administrative/delivery infrastructure to support the expansions in the second round. By June 30, 2019, WPC touched more than 134,000 unique lives with more than 1,245,000 member months.

Qualitative and Quantitative Findings

DHCS uses the mid-year and annual narrative reports, quarterly enrollment and utilization reports, and invoices to monitor and evaluate the programs and to verify invoices for payment. Seven LEs that required more time to enroll members and fully develop their programs have met in-person with DHCS' management and developed CAP as needed to increase enrollment, maximize expenditures, and/or increase the provision of services. Program implementation for several LEs, Sonoma in particular, was impacted by the devastating effects of multiple fires during program implementation. All CAPs were closed by May 31, 2019 except for Kern County, which is expected to meet their milestones by early September 2019. DHCS continues to monitor LEs closely and provide technical assistance.

Enrollment Information[31]

Quarterly enrollment counts are the cumulative number of unique new members enrolled during the reported quarter with year-to-year totals reflected in the table below for DY 14 representing the period of July 2018 to June 2019 by each LE. The total-to-date column includes data from program implementation in DY 12 submitted previously. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and

[31] DHCS is engaged in ongoing conversations with LA's WPC pilot and providing additional technical assistance to promote the successful provision of WPC services. LA's primary target populations have proven more difficult to engage than anticipated. Additional growth is expected in years 4-5 of LA's pilot.

Utilization Reports. The data reported is point-in-time as of September 6, 2019. Enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Figure 40: Quarterly Enrollment Counts

LE	DY14-Q1 (July - Sept. 2018) Unduplicated	DY14-Q2 (Oct. – Dec. 2018) Unduplicated	DY14-Q3 (Jan. - March 2019) Unduplicated	DY14-Q4 (April - June 2019) Unduplicated	Jan. 2017 – June 2019 Total to Date Unduplicated
Alameda	764	4,370	720	527	10,208
Contra Costa	2,272	3,701	2,220	2,962	36,097
Kern	62	319	224	296	1,094
Kings*	53	78	66	96	410
LA	4,111	3,544	5,725	4,970	40,836
Marin*	30	652	263	246	1,248
Mendocino*	50	16	22	4	287
Monterey	2	1	39	48	183
Napa	41	44	49	47	376
Orange	1,045	800	1,105	783	9,252
Placer	37	7	17	31	320
Riverside	954	1,391	675	664	4,460
Sacramento*	251	173	236	214	1,352
San Bernardino	95	62	73	106	885
San Diego	77	73	37	103	383
San Francisco	1,321	1,145	948	1,130	15,167
San Joaquin	55	463	135	228	1,196
San Mateo	107	53	189	86	3,371
Santa Clara	134	243	313	655	3,771
Santa Cruz*	15	31	29	14	448
SCWPCC*	18	15	8	14	96
Shasta	37	22	28	33	297
Solano	14	12	14	7	176
Sonoma*	101	290	485	289	1,379
Ventura	120	95	50	28	1,126
Total	**11,766**	**17,600**	**13,670**	**13,581**	**134,418**

**Indicates one of the seven LEs that implemented on July 1, 2017.*

The data provided in the table above shows the count of unduplicated members has steadily increased since implementation began in 2017. The program began with 11,286 unduplicated members by March of 2017 and has increased by more than tenfold with 134,418 unduplicated members as of June 30, 2019. Additionally, the data reflects continued outreach and engagement to increase enrollment as disenrollment occurs on a monthly basis.

Member Months[32]

Quarterly and cumulative year-to-date member months are reflected in Figure 41 below for DY 14 representing the period July 2018 to June 2019 by each LE. The cumulative year-to-date column includes data from program implementation in DY 12 submitted previously. Member months are extracted from the LE's self-reported Quarterly Enrollment and Utilization Reports. The data reported is point-in-time as of September 6, 2019. Member months are updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Figure 41: Quarterly and Cumulative Year-to-date Member Months

LE	DY14-Q1 (July - Sept. 2018)	DY14-Q2 (Oct. - Dec 2018)	DY14-Q3 (Jan. - March 2019)	DY14-Q4 (April - June 2019)	Jan. 2017 – June 2019 Cumulative Year-to-Date
Alameda	1,430	16,933	25,553	25,990	106,783
Contra Costa	44,838	43,938	40,709	39,976	358,434
Kern	634	1,243	2,023	2,914	7,838
Kings*	273	354	424	504	1,963
LA	32,510	34,735	41,511	44,200	272,780
Marin*	197	1,593	2,678	3,360	8,127
Mendocino*	616	571	512	431	2,900
Monterey	188	172	232	323	1,557
Napa	486	491	546	544	3,291
Orange	10,776	10,887	11,600	11,055	78,488
Placer	400	352	301	312	2,925

[32] DHCS is engaged in ongoing conversations with LA's WPC pilot and providing additional technical assistance to promote the successful provision of WPC services. Additional growth is expected in years 4-5 of LA's pilot.

LE	DY14-Q1 (July - Sept. 2018)	DY14-Q2 (Oct. - Dec 2018)	DY14-Q3 (Jan. - March 2019)	DY14-Q4 (April - June 2019)	Jan. 2017 – June 2019 Cumulative Year-to-Date
Riverside	2,087	3,324	8,470	10,158	25,592
Sacramento *	1,427	1,790	1,990	2,141	9,810
San Bernardino	1,603	1,550	1,542	1,569	10,250
San Diego	426	645	602	698	2,588
San Francisco	23,646	25,542	12,697	18,740	186,943
San Joaquin	783	2,027	2,210	2,673	9,521
San Mateo	6,455	6,456	6,713	6,611	63,090
Santa Clara	6,812	7,282	8,893	10,526	61,972
Santa Cruz*	984	1,034	1,137	1,105	6,999
SCWPCC*	87	118	136	151	632
Shasta	249	231	255	230	1,703
Solano	276	267	277	260	2,083
Sonoma*	252	486	1,512	1,642	4,147
Ventura	2,490	2,725	2,543	1,980	14,968
Total	**149,925**	**164,746**	**175,066**	**188,093**	**1,245,384**

**Indicates one of seven new LEs that implemented on July 1, 2017.*

The data provided in the table above shows the count of member months has dramatically increased since implementation began in 2017 as the unduplicated members and enrollment increased. The program began with 28,974 member months by March of 2017, and has increased to 1,245,384 member months as of June 30, 2019. Over 60% of WPC enrollees were continuously enrolled through June 2018. It is important to note that the number of member months plays a significant role in the utilization of services.

DHCS has been providing additional technical assistance to the LA WPC pilot to promote the successful provision of WPC services. LA WPC's target population is driven towards the homeless and those who are post-incarcerated, secondary are those with mental health/Substance Use Disorder issues and the medically complex; LA's primary target populations have proven more difficult to engage than anticipated. Many of LA's per member per month bundles have short-term enrollment of 3-6 months. The longer-term bundles in LA experience continual drop off because of the nature of the

target population who are difficult to keep engaged and are transitory. Additional growth is expected in years 4-5 of LA's pilot.

Payments

During DY4-Q4, all 25 LEs received WPC payments totaling $338,129,158.00.

In DY 14, WPC received $271,045,780.43 in federal financial participation (FFP) with a total of $542,091,590.86 in payments to LEs. This results in a total-to-date by the end of DY 14 for the program of $1,339,328,729.23 in total funds payments to the twenty-five LEs including DY 12 total funds payments of $478,008,042.75 and DY 13 total funds payments of $379,229,095.92.[33]

Figure 42: WPC Payments for DY 12-13

DY 12 Payments	FFP	IGT	Service Period	Total Funds Payment
Qtr. 3 (Jan - March)	$216,787,499.88	$216,787,499.88	DY 11 (PY 1)	$433,594,999.76
Qtr. 4 (April - June)	$22,206,521.50	$22,206,521.50	DY 11 (PY 1)	$44,413,043.00
DY 13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (July - Sept)	$9,730,650.50	$9,730,650.50	DY 12 (PY 1)	$19,461,301.00
Qtr. 2 (Oct - Dec)	$63,309,652.68	$63,309,652.68	DY 12 (PY 2)	$126,619,305.36
Qtr. 3 (Jan – March)	$0	$0	DY 12 (PY 2)	$0
Qtr. 4 (April – June)	$116,574,244.78	$116,574,244.78	DY 13 (PY 2)	$233,148,489.56
DY 12-13 Total	**$428,608,569.34**	**$428,608,569.34**		**$857,237,138.68**

[33] Please note that funds have been reallocated through a rollover process to maximize program activities. DHCS expects all program to expend their full rollover requests.

Figure 43: WPC Payments for DY 14

DY 14 Payments	FFP	IGT	Service Period	Total Funds Payment
Qtr. 1 (July - Sept)	$0	$0	DY 14 (PY 3)	$0
Qtr. 2 (Oct - Dec)	$101,981,216.28	$101,981,216.28	DY 14 (PY 3)	$203,962,432.56
Qtr. 3 (Jan – Mar)	$0	$0	DY 14 (PY 3)	$0
Qtr. 4 (Apr – June)	$169,064,564.15	$169,064,564.15	DY 14 (PY3)	$338,129,128.30
Total DY 14	**$271,045,780.43**	**$271,045,780.43**	DY 14	**$542,091,560.86**

Policy/Administrative Issues and Challenges

During the third and fourth quarters of DY 14, DHCS completed approval of both the optional Budget Adjustment and Rollover requests from LEs. The Budget Adjustment process allowed adjustments to future PY budgets within each LE budget, while the Rollover process allowed an LE to move budgeted funds from the current year to the next year's budget. The budget adjustment and rollover enable the LE to overcome operational challenges and barriers. Furthermore, these processes allow LEs the flexibility to more fully maximize funding integral to the success of the WPC and support the activities aligned with WPC goals and objectives, including the expansion of services and enrollment. Additionally, LEs have been able to add services new to their program, which have been CMS approved and successful in other WPC programs during these processes.

According to LE narrative reports, most challenges implementing WPC were associated with:

- Difficulty identifying, engaging, and enrolling eligible target populations;
- Issues implementing care coordination related to limited availability of needed services such as housing, staffing issues and engaging appropriate interdisciplinary partners; and
- Concerns regarding data–sharing due to legal and cultural barriers to data sharing, implementing data sharing systems, and implementing data sharing agreements.

DHCS has held discussions on these challenges during monthly, as well as one-on-one, technical assistance calls, encouraged sharing of tools developed by LEs, and worked with the LC to hold webinars on these topics to assist LEs in dealing with these challenges. Additionally, LEs developed their knowledge, collaborated with partners and with all levels of LE leadership, and developed guidelines and processes. Subsequently, LEs have had the following successes:

- Establishing referral pathways into the WPC program;
- Identifying and assessing eligibility of prospective enrollees;
- Increasing WPC enrollment;
- Maintaining enrollment by preventing gaps in Medi-Cal eligibility;
- Employing other pilot-specific strategies to facilitate and improve enrollment processes;
- Implementing new or improved care coordination delivery services;
- Establishing partnerships to overcome silos;
- Using data systems to support care coordination activities; and
- Developing new software/platform/repository.

Progress on the Evaluation and Findings:

During DY 14, UCLA:

- Conducted a questionnaire to collect systematic data from WPC LEs and partner organizations around the following key domains: motivation for participation in WPC, communication and decision-making processes, performance monitoring, and inter-agency collaboration with partner organizations;
- Finalized analysis of the questionnaire and documented main findings to discuss how each LE implemented their program, challenges they encountered, and strategies they used to overcome those challenges;
- Conducted in-person site visits and phone interviews with LE leadership, key management staff, and frontline care coordinators and/or supervisors. These interviews were used to inform the care coordination case studies and the qualitative data report;
- Developed a propensity score model and an optimal matching algorithm based on exact and rank-based distance matching to develop a control group in accordance with the evaluation design. Since receiving the updated Medi-Cal data from DHCS in May 2019, UCLA began applying the developed methodology to identify a final control group for all WPC enrollees through 2018;
- Used previously developed measures to understand program enrollment, enrollment patterns, target populations, and utilization using enrollment and utilization report data from January 2017 to December 2018;

- Used the updated Medi-Cal data to identify additional WPC enrollee demographic and health status measures; and
- Has begun summarizing and analyzing LE self-reported data and updated Medi-Cal data to include in the interim evaluation report.