CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **California Medi-Cal 2020 Demonstration**

AWARDEE: **California Health and Human Services Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California's Medi-Cal 2020 section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The periods for each Demonstration Year (DY) will be as follows:

- 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

The STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through December 31, 2020.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Historical Context
III. General Program Requirements
IV. General Reporting Requirements
V. General Financial Requirements
VI. State Plan and Demonstration Populations Affected by the Demonstration;
VII. Demonstration Delivery Systems
VIII. Continuing Operation of Demonstration Programs
  A. Community Based Adult Services
  B. California Children Services

C. Managed Care Delivery Systems for the Coordinated Care Initiative
IX. Additional Medi-Cal 2020 Demonstration Programs
A. Access Assessment
B. PRIME
C. Dental Transformation Initiative
D. Whole Person Care Pilot
X. Drug Medi-Cal Organized Delivery System
XI. Negative Balance
XII. Global Payment Program
XIII. Uncompensated Care Reporting
XIV. General Financial Requirements Under Title XIX
XV. General Financial Requirements Under Title XXI
XVI. Monitoring Budget Neutrality for the Demonstration
XVII. Evaluation of the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A. (Reserved)
Attachment B. SPD Discharge Planning Checklist form (reserved)
Attachment C. Global Payment Program Participating Public Health Care Systems
Attachment D. Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME entities
Attachment E. (Reserved)
Attachment F. Funding and Reimbursement Protocol for Designated State Health Programs and IHS
Attachment G. (Reserved)
Attachment H. Accounting Procedures
Attachment I. Quarterly Report Guidelines
Attachment J. (Reserved)
Attachment K. Reserved Budget Neutrality Projections and Allotment Neutrality Requirements
Attachment L. Managed Care Enrollment Requirements
Attachment M. Geographic Distribution and Delivery System Model
Attachment N. Capitated Benefits Provided in Managed Care
Attachment O. County Listing for SPD Enrollment
Attachment P. Demonstration and Program Years
Attachment Q. PRIME Projects and Metrics
Attachment R. Alternative Payment Methodologies
Attachment S. PRIME Evaluation and Monitoring
Attachment T. 2013 Managed Care Expansion Monitoring Elements
Attachment U. Coordinated Care Initiative (CCI) Enrollment Timeline by Population and County
Attachment V. Coordinated Care Initiative (CCI) MLTSS Monitoring Elements Attachment
Attachment W. Community-Based Adult Services (CBAS) Provider Standards of

		Participation
Attachment	X	Drug Medi-Cal Organized Delivery System (DMC-ODS) Operational Protocol
Attachment	Y	DMC-ODS Department of Health Care Services (DHCS) Appeals Process
Attachment	Z	DMC-ODS County Implementation Plan
Attachment	AA	DMC-ODS County Certified Public Expenditures (CPE) Protocol (Reserved)
Attachment	BB	DMC-ODS Tribal Delivery System
Attachment	CC	DMC-ODS Financing and Availability of Medication Assisted Treatment (MAT) Services
Attachment	DD	DMC-ODS University of California, Los Angeles (UCLA) Evaluation
Attachment	EE	Global Payment Program Funding and Mechanics
Attachment	FF	Global Payment Program Valuation
Attachment	GG	Whole Person Care Reporting and Evaluation Attachment
Attachment	HH	Whole Person Care Requirements and Application Attachment
Attachment	II	PRIME Funding and Mechanics
Attachment	JJ	Medi-Cal 2020: Dental Transformation Incentive Program
Attachment	KK	California Children's Services Pilot Protocol
Attachment	LL	Historical Information- Budget Neutrality Test Attachment
Attachment	MM	WPC Pilot Metrics
Attachment	NN	DSH Coordination Methodology
Attachment	OO	CBAS Program Integrity
Attachment	PP	Negative Balance Payment Schedule (reserved)
Attachment	QQ	Out-of-state Former Foster Care Youth Evaluation (reserved)

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

In November 2010, the Federal government approved California's five-year Medicaid section 1115 Bridge to Reform waiver, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The Bridge to Reform Demonstration achieved the goals of simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system, and reinforcing California's safety net to meet the needs of the uninsured.

Medi-Cal 2020 embodies the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. Bridge to Reform waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) will continue through in Medi-Cal 2020, and with the foundation of the successes of the Bridge to Reform Demonstration, Medi-Cal 2020 initiatives will continue to improve the quality and value of care provided to California's Medi-Cal beneficiaries.

Medi-Cal 2020 initiatives include:

1. A Public Hospital Redesign and Incentives in Medi-Cal program (PRIME), which will

improve the quality and value of care provided by California's safety net hospitals and hospital systems;

2. A Global Payment Program that streamlines funding sources for care for California's remaining uninsured population and creates a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services;
3. A Whole Person Care Pilot program to support local and regional efforts to integrate the systems and improve the care provided to Medi-Cal's most high-risk beneficiaries; and

4. A Dental Transformation Initiative to improve access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.

On June 15, 2016, California submitted an amendment to the Demonstration to expand the definition of a Whole Person Care (WPC) Pilot lead entity to include federally recognized tribes and tribal health programs operated under a Public Law 93-638 contract with the Federal Indian Health Services.

On August 15, 2016, the state submitted an amendment to the Demonstration to revise the methodology for determining the baseline metrics for purposes of receiving incentive payments for new and existing dental service office locations under the Dental Transformation Initiative (DTI). California also sought authority to provide incentive payments for specified dental services delivered at provider service office locations at two levels: a 37.5 percent above the state's Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet at least a 1 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children served in the previous year with a preventive dental service; and a 75 percent above the state's SMA incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children receiving a preventive dental service in the previous year.

California submitted an amendment on November 10, 2016, as a companion to the HHP SPA 16-007, to request a waiver of freedom of choice in the non-COHS counties in order to provide the Health Homes Program (HHP) services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Managed care plans (MCPs) will be responsible for the overall administration of the HHP, which will be structured as a HHP network with members functioning as a team to provide care coordination. Fee-For-Service (FFS) members who meet the eligibility criteria for HHP may choose to voluntarily enroll in a MCP to receive HHP services along with other state plan services provided through MCPs. HHP services will not be provided through a FFS delivery system; therefore, beneficiaries in FFS in non-COHS counties will have to enroll in a MCP to receive HHP services.

III. GENERAL PROGRAM REQUIREMENTS

1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all

applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 8. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to discuss the language changes necessary to ensure compliance with Law, Regulation, and Policy. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

4. **Coordination with the Medicare Program.** The state must have processes in place to coordinate with the Medicare program for Medicare-Medicaid beneficiaries, including:

    a. The state must provide contact information to Medicare-Medicaid beneficiaries on how they can obtain assistance with their Medicare coverage at any point of enrollment or disenrollment from Medi-Cal managed care or upon request by the beneficiary.

    b. The state must provide accurate reports to CMS of the eligibility and enrollment of Medicare-Medicaid beneficiaries in the demonstration.

    c. The state must comply with requirements for Medicaid payment of Medicare cost-sharing for Medicare-Medicaid enrollees, including ensuring any organization delegated with that responsibility adheres with the requirements.

    d. The state must provide CMS with requested financial information and other demonstration aspects that have a specific impact on the Medicare-Medicaid population. Requests for information will include a reasonable timeframe for responses as agreed to by CMS and the state.

5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a

modified budget neutrality agreement for the demonstration as well as a modified allotment neutrality worksheet as necessary to comply with such change. The modified agreement[s] will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation actually becomes effective, on the first day of the calendar quarter beginning after the legislature has met for six months in regular session after the effective date of the change in federal law, or such other date provided for in the applicable federal law.

6. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, reimbursement methodologies, cost sharing, evaluation design, federal financial participation (FFP), sources of non-federal share funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state will not implement changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive except as otherwise specified in these STCs and FFP will not be available for changes to the demonstration relating to these elements that have not been approved through the amendment process set forth in STC 8 below.

8. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 16, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed

amendment on the current budget neutrality agreement. Such analysis will include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

10. Extension of the Demonstration. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of California must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR section 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 11.

11. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b. The state must obtain CMS's approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. Phase-out Plan Requirements. The state must include, at a minimum, in its phase-

out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230.

e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

12. Expiring Demonstration Authority and Transition. For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. *Expiration Requirements*. The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. *Expiration Procedures.* The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c. *Federal Public Notice.* CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the

demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must begin no sooner than 14 days after CMS approval of the plan.

d. *Federal Financial Participation (FFP).* FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

13. CMS Right to Terminate or Suspend. CMS may suspend, or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the Demonstration, or any withdrawal of an expenditure authority, together with the effective date.

14. Findings of Non-Compliance or Disallowance. The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

15. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

16. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

17. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 Code of Federal Regulations (CFR) section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section

431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

18. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 25, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 26.

19. **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

20. **Federal Financial Participation (FFP) for Designated State Health Programs and Indian Health Services** Payments for Designated State Health Programs (DSHP) and Indian Health Services, are limited to the costs incurred by the certifying entity. This restriction does not preclude Public Hospital Redesign and Incentives in Medi-Cal (PRIME), the Global Payment Program (GPP) and Whole Person Care (WPC) payments funded through intergovernmental transfers (IGTs) or capitated payments received by county health systems or public hospitals funded through IGTs or general fund payments. Additionally, cost limitations do not apply to payments received by government operated hospitals from Medi-Cal managed care organizations, consistent with Federal law as these payments cannot be funded by CPEs.

21. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. GENERAL REPORTING REQUIREMENTS

22. **General Financial Requirements.** The State will comply with all general financial requirements under title XIX and XXI set forth in these STCs.

23. **Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The State will comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in these STCs. The State must submit corrected budget and/or allotment neutrality data upon request.

24. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for the Medi-Cal 2020 to ensure oversight and monitoring of demonstration claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after the extension approval to account for changes and expansions to the waiver as described within these STCs for the California Medi-Cal 2020 Demonstration.

25. **Contractor Reviews.** The state will forward to CMS summaries of the financial and operational reviews that the state completes on applicants awarded contracts through the demonstration's Seniors and Persons with Disabilities Program (SPD), the California Children's Services Program (CCS), Healthy Families Program Children Transition to the Medicaid Expansion Demonstration and Managed Care Health Plans operating in the State.

26. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to:
    a. The health care delivery system,
    b. PRIME
    c. Global Payment Program
    d. Access Assessment
    e. Whole Person Care
    f. Drug Medi-Cal and Mental Health
    g. Dental Transformation Initiative
    h. The Seniors and Persons with Disabilities (SPD) Program;
    i. The Community Based Adult Services (CBAS) Program;
    j. California Children's Services (CCS) Program;
    k. Designated State Health Programs (DSHP) receiving federal financial participation. – as defined within these STCs;
    l. Enrollment, quality of care, access to care;
    m. The benefit package, cost-sharing;
    n. Audits, lawsuits;
    o. Financial reporting and budget neutrality issues;
    p. Progress on evaluations;
    q. State legislative developments; and,
    r. Any Demonstration amendments, concept papers or State plan amendments the State is considering submitting.

CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

27. **Demonstration Quarterly Reports.** The state will submit progress reports 60 days following the end of each quarter (Attachment I). The intent of these reports is to present the state's analysis and the status of the various operational areas. The state may report data in later quarterly reports if data lags require it, with CMS approval. These quarterly reports will include, but are not limited to:

a. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
b. Action plans for addressing any policy, operational and administrative issues identified.
c. Monthly enrollment data during the quarter and Demonstration Year to Date by:
   i. County of participation, the number of persons enrolled in the CCS Program based on Medi-Cal eligibility and DSHP;
   ii. County of participation, the number of persons participating in any Demonstration programs receiving FFP.
d. Budget and CHIP Allotment neutrality monitoring tables.
e. Access Advisory Committee Minutes
f. Other items as requested:
   i. Quarterly reports of any Designated State Health Program (DSHP) obtaining Federal Matching funds through this Demonstration.
   ii. By County of participation Demonstration population complaints, grievances and appeals
   iii. Biannually, by plan, the Medicare-Medicaid population enrolled in Medi-Cal managed care in the demonstration that are also enrolled in Medicare Advantage plans operated by Medi-Cal managed care plans that provide services to Medicare-Medicaid beneficiaries.

28. **Demonstration Annual Report.** The state will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state will submit the draft annual report no later than 120 days after the end of each demonstration year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the demonstration year to CMS. The annual report will also contain:

a. The previous State fiscal year appropriation detail for all Designated State Health Programs.
b. Identify the plans that do not meet the contractually required minimum performance levels on the following 4 primary care access measures for children (CAP-1224, CAP-256, CAP-711, and CAP-1219), as well as specific actions the state commits to taking to ensure children in California have access to health plans that meet minimum performance levels unless the difference between the MPL and HPL is 10 percentage points or less.
c. The progress and outcome of program activities related to the:
   i. PRIME
   ii. Global Payment Program

iii. Access Assessment, including progress on evaluation
iv. Whole Person Care
v. Drug Medi-Cal and Mental Health
vi. Dental Transformation Initiative
vii. CCS Program
viii. Coordinated Care Initiative (CCI) Program experience of dual eligibles
ix. Progress on the evaluation of the demonstration and findings.
iv. SPD program
xi. Out-of-State Former Foster Care Youth

29. Final Report. Within 120 days following the end of the current Demonstration period, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments. It will cover:

a. Financial and budget neutrality reports
b. Key milestones and analysis of program activities related to:
i. PRIME
ii. Access Assessment
iii. Whole Person Care
iv. Drug Medi-Cal and Mental Health
v. Global Payment Program
vi. Dental Transformation Initiative
vii. CCS Program
viii. Coordinated Care Initiative (CCI) Program experience of dual eligibles
ix. Out-of-State Former Foster Care Youth

30. Revision of the State Quality Strategy. In accordance with federal regulations at Subpart D 438.200 regarding Quality Assessment and Performance Improvement to ensure the delivery of quality health care and establishment of standards, the State must update its Quality Strategy to reflect all managed care plans being proposed through this demonstration and submit to CMS for approval. The state must obtain the input of recipients and other stakeholders in the development of its revised Quality Strategy and make the Strategy available for public comment before adopting it as final, and submitting to CMS for approval. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. The state will also provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy as it impacts the demonstration.

31. External Quality Review. The state is required to meet all external quality review (EQR) requirements found in 42 C.F.R. Part 438, subpart E. The state should generally have available its final EQR technical report to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

32. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
    1) CMS may decline the extension request.
    2) Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
    3) If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

V. GENERAL FINANCIAL REQUIREMENTS

33. **Certified Public Expenditures (CPEs).** Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include, PRIME Payments, patient care revenue received as payment

for other services rendered under programs such as DSHP, Medicare or Medicaid. To ensure that there is no double claiming of federal funding under the DSHP, a detailed protocol will be developed outlining the procedures to be followed for claiming under this paragraph.

34. Designated State Health Programs (DSHP). The state may claim FFP for the following state programs subject to the annual limits described below. Expenditures are claimed in accordance with CMS-approved claiming protocols in Attachment F.

a. The annual limit the state may claim FFP for DSHP shall not exceed $75,000,000 FFP per DY11-15 (or $375,000,000 total for the 5 years), except as provided herein. In the event that the state does not claim FFP up to the $75,000,000 annual limit in a given DY under this demonstration period, the state may exceed the $75,000,000 annual limit for claiming FFP for DSHP expenditures in a subsequent DY by an amount equal to the difference of $75,000,000 and the amount of FFP claimed for DSHP in that applicable prior DY. The total amount of DSHP FFP that the state may claim in DY 11 through 15 combined may not exceed the non-federal share of amounts expended by the state for the Dental Transformation Incentive Program.

b. Approved Designated State Health Programs (DSHP) for which FFP can be claimed subject to the limits in this paragraph are:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIALTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song Brown HealthCare Workforce Training Program • Steven M. Thompson Physician Corp Loan Repayment Program • Mental Health Loan Assumption Program

c. *Prohibited DSHP Expenditures.* Allowable DSHP expenditures do not include any expenditures that are funded by federal grants (for example, grants from the Health Resources and Services Administration, or the Centers for Disease Control, or from the Global Payment Program) or that are included as part of the maintenance of effort or non-federal share requirements of any federal grant. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to non-qualified aliens. To

implement this limitation, 13.95 percent of total provider expenditures or claims through DSHP identified below will be treated as expended for non-emergency

care to non-qualified aliens.

i. Expenditures for the Medically Indigent Adult Long Term Care (MIA/LTC) program will not be reduced by 13.95 percent because there are no non-qualified aliens receiving services under this program.
ii. Expenditures for the Breast and Cervical Cancer Treatment Program (BCCTP) will be reduced by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens; however, the 13.95 percent reduction will not be applied otherwise.
iii. Expenditures for the California Children Services (CCS) program will be reduced by 13.95 percent as specified in subparagraph (a).
iv. Expenditures for the Genetically Handicapped Persons Program (GHPP) will be reduced by 13.95 percent as specified in subparagraph (a).
v. Expenditures for the AIDS Drug Assistance Program (ADAP) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
vi. Expenditures for the California Department of Developmental Services will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
vii. Expenditures for the Prostate Cancer Treatment Program (PCTP) will be reduced by 13.95 percent as specified in subparagraph (a).

35. Supplemental Payments to IHS and 638 Facilities. The state shall make supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care and support the IHS and tribal 638 service delivery network. Supplemental payments shall be computed based on the uncompensated cost for services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing services to non- IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment F. The annual limit for the IHS uncompensated care cost shall be $ 1,550,000 total computable per year (DY 11 – 15).

VI. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

36. Eligibility. Certain state plan eligibles are affected by the Demonstration, as described below.

State plan eligibles derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are affected by the demonstration by being required to use the managed care network and gaining access to additional benefits not described in the state plan.

The following population groups are affected by the Demonstration:

a. State Plan California Children's Services (CCS) Affected by the Demonstration are those children with Special Health Care Needs who are:
   i. Under 21 years of age; and
   ii. Meet the medical eligibility criteria as defined in the California Code of Regulations such as congenital anomalies, cerebral palsy, hearing loss, cancer and diabetes; and
   iii. Meet financial eligibility criteria for CCS if they are:
      i. Enrolled in Medi-Cal (per the Medicaid State Plan);
      ii. Persons in families with an adjusted gross income of $40,000 or less in the most recent tax year, as calculated for California state income tax purposes; or
      iii. Projected to expend more than 20 percent of their annual, adjusted gross family income for treatment of the CCS-eligible condition.

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

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

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

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

f. Out-of-State Former Foster Care Youth, defined as youth under age 26, who were in foster care under the responsibility of a state other than California or a tribe in such

other state when they turned age 18 or such higher age as the state elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid at that time; and are now applying for Medicaid in California. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory Title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

g. Community Based Adult Services (CBAS) Populations are persons who are age 18 or older and meet CBAS eligibility under STC 44(a) and (d).

h. New Adult Group. The new adult group, described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR 435.119, pursuant to the approved state plan will be required to obtain services through this demonstration's managed care delivery system as described in these STCs. Benefits for the new adult group are described in the state's approved alternative benefit plan state plan amendment.

i. Cal MediConnect eligible beneficiaries are defined in the California-CMS Financial Alignment Memorandum of Understanding signed March 27, 2013 and further clarified in the three-way contracts between the State, CMS, and the participating plans.

j. Coordinated Care Initiative (CCI) Eligible Beneficiaries: are individuals age 21 and older and includes dual eligible beneficiaries who opt out or are excluded from the Cal MediConnect program, Medi-Cal only Seniors and Persons with Disabilities (SPDs) who were previously excluded from the mandatory managed care SPD transition program, and Medi-Cal managed care enrollees who reside in one of the following 7 counties:, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, excluding: Beneficiaries enrolled in PACE; Beneficiaries enrolled in the AIDS Healthcare Foundation; Medi-Cal-only beneficiaries excluded due to an approved Medical Exemption Request, and; Beneficiaries enrolled in SCAN.

k. Low-income Pregnant Women, defined as pregnant women with incomes up to and including 138 percent of the FPL will be required to obtain services through this demonstration's managed care delivery system. Beneficiaries who are pregnant women in fee-for-service prior to August 1, 2015 may remain in fee-for-service for the duration of their pregnancy and post-partum period to ensure continuity of care. Any pregnant women voluntarily moving from FFS to managed care will be provided appropriate care coordination.

l. Health Home Program (HHP) service coverage is limited to only those beneficiaries specified in the CMS-approved HHP State Plan Amendments (SPAs), including any subsequent amendments to the CMS-approved HHP SPAs. HHP services will be provided only through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Individuals receiving benefits through the fee-for-service

(FFS) delivery system who meet HHP eligibility criteria, and who wish to receive HHP services, must instead enroll in a MCP to receive all services, including HHP services. HHP services will not be provided through a FFS delivery system. The HHP-specific provisions of the Medi-Cal 2020 demonstration freedom of choice waiver, and managed care delivery system implementation Medicaid authority, are in effect for any CMS-approved HHP SPAs - including SPA requirements specific to eligible populations, geographic limitations, approved providers, and any other SPA requirements, including any subsequent amendments to the HHP SPAs- for the duration of the Medi-Cal 2020 demonstration.

All Medicaid populations served by public hospital systems that participate in the PRIME program may be affected by payment incentives for such systems that are designed to further efforts to restructure care delivery to improve quality and appropriateness of care settings.

VII. DEMONSTRATION DELIVERY SYSTEMS

If the State chooses to use a managed care delivery system to provide benefits to the affected populations (defined in STC 33), any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438.

Health Insuring Organizations are managed care delivery systems unique to California and operate under the authority of section 9517(c) of COBRA 1985, which was subsequently amended by section 4734 of OBRA 1990 and MIPAA 2008. HIOs are exempt from the managed care requirements of section 1932 of the Act (implemented through 42 CFR Part 438) because they are not subject to the requirements under 1903(m)(2)(A) that apply to MCOs and contracts with MCOs. 42 CFR 438.2 identifies these as county-operated entities and California state law that passed simultaneously with OBRA 1990 identifies these as county-organized health systems (COHS). The entities covered by the 1915(b) waivers operate under the HIO authority to deliver benefits to State plan populations; the HPSM is considered a COHS, but is not considered an HIO by Federal standards because it became operational after January 1, 1986.

A COHS plan must enroll all Medicaid beneficiaries residing in the county in which it operates. In Humboldt County, beneficiaries may be subsequently disenrolled from COHS to be enrolled in the Program of All Inclusive Care for the Elderly (PACE), if eligible. Medicaid beneficiaries residing in COHS counties may not be enrolled in any other alternative delivery system without prior approval from CMS and an amendment to this demonstration.

The counties participating in the Two Plan Model offer a choice of two types of MCOs – a local initiative plan (a county-organized plan which includes local Safety Net providers and clinics) and a commercial plan. The counties participating in the Geographic Managed Care (GMC), Imperial, and Regional Models of managed care offer a choice of two or more MCOs. San Benito County offers a choice of one MCO or the States Fee-For-Service delivery system,

enrollment in managed care is voluntary.

37. **Managed Care Expansions.** The State has been granted the authority to operate managed care programs in the counties in Attachment M. Therefore, a Demonstration amendment is not required to implement expansions in these counties. However, any new service area expansions, proposed changes in Demonstration authorities, or changes in the populations included or excluded in the authorized counties will require an amendment to the Demonstration as outlined in STC 8, including updated Attachment L. All managed care expansions, with beneficiary protections and contract requirements described under the 2010-2015 "Bridge to Reform" Demonstration must maintain the required beneficiary protections and contract requirements with the renewal.

38. **Encounter Data Validation Study for New Health Plans.** When a managed care entity begins serving the populations in STC 33in the Demonstration, the State will be responsible for conducting a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study will include validation through a sample of medical records of Demonstration enrollees.

39. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law, policy and regulation. The State must assure that encounter data maintained at managed care entities can be linked with eligibility files maintained at the State.

40. **Standard Transaction Formats for Transmission of Payment and Enrollment to Managed Care Entities.** The State must ensure that regular capitation payments and plan enrollment rosters provided to the managed care entities serving Demonstration populations are generated through an automated process that is compliant with the appropriate standard HIPAA ANSI X12 transaction file format.

41. **Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State will provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as an alternative to withholding all FFP for a contract when CMS determines that the state and the contractor are making good faith efforts to come into compliance, to withhold FFP in part until the contract compliance and approval requirement is met for that contract.

42. **Capitation Payments.** The State must ensure that regular capitation payments made to the Medicaid health plans that are covered under this Demonstration are done through an automated process that is compliant with the standard HIPAA ANSI X12 820 electronic transaction format. Likewise, the State must ensure that regular plan enrollment rosters are provided to the Medicaid health plans covered under this Demonstration through an automated process that is compliant with the standard HIPAA ANSI X12 834 electronic transaction format.

43. **Network Adequacy.** The State must ensure that each managed care entity has a provider network that is sufficient to provide access to all covered services in the contract.

To the extent that the state applies an exception alternate access standard to its Knox-Keene Medi-Cal managed care health plan contract network standards the state shall provide the CMS with the following information no later than 30 days after approval:

a. The geographic zip codes where the exception is applied;
b. The reason(s) for applying this exception; and
c. A description of how the health plan network being certified for network adequacy compares to the number of FFS provider in the region where the exception is applied or the previous plan network, whichever is applicable.
d. And annually thereafter:
   i. The geographic zip codes where the exception is applied; and
   ii. The reason(s) for applying this exception.

If reports are not submitted on time CMS reserves the right as a corrective action to withhold FFP (either partial or full) for managed care capitation payments for the Demonstration until the requirement is met.

44. **Network Requirements.** The State must through its health plans deliver adequate primary care, including care that is delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population, and coordinate health care services for Demonstration populations.

a. **Special Health Care Needs** - Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual's health care condition.
b. **Out of Network Requirements** - The State through its health plans must provide Demonstration populations with the corresponding Demonstration program benefits described within these STCs and must adequately cover these benefits and services out of network in a timely fashion, for as long as it is necessary to provide them, at no additional cost to the enrollee.
c. **Timeliness** - The Medi Cal managed care health plans must comply with timely access requirements and ensure their providers comply with these requirements. Providers must meet State standards for timely access to care and services, considering the urgency of the service needed. Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week when medically necessary. The State, through the health plan contracts must establish mechanisms to ensure and monitor provider compliance and must take

corrective action when noncompliance occurs.

d. **Credentialing -** The State through its health plans must demonstrate that the health plan providers are credentialed. The State must also require these health plans to participate in efforts to promote culturally competent service delivery.

e. **Demonstrating Network Adequacy -** Annually the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.

i. The State must provide supporting documentation that must show that the health plan offers an adequate range of preventive, primary, and specialty services care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees.

ii. The State through its health plans must submit this documentation when it enters into a contract.

iii. The State must submit this documentation any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services.

iv. Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.

45. **Certification** – Prior to enrollment and annually, the State is required to certify to CMS that each health plan has complied with State standards for service availability and must make all documentation available to CMS upon request.

46. **Concurrent Operation of the Multipurpose Senior Services Program (MSSP) 1915 (c) Home and Community Based Services (HCBS) program (CA 0141).** Payment for the MSSP 1915 (c) waiver services will be included in the plan capitation payments from the State starting July 1, 2014. Eligible beneficiaries in the seven CCI counties who are participating in the MSSP waiver will be allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in a plan. The Cal MediConnect plans and Medi-Cal only managed care plans will be required to contract with MSSP providers to ensure on-going access to MSSP waiver services for MSSP enrolled beneficiaries at the time of transition through December 31, 2017. MSSP waiver providers will continue to provide the same services to MSSP Waiver participants/clients; however, they will receive payment for Medi- Cal managed care members from the plans. These requirements shall be outlined in the plan and MSSP Waiver provider contracts

47. **Operation of the Health Home Program.** Health Home Program (HHP) service coverage is limited to only those beneficiaries specified in the CMS-approved HHP SPA, including any subsequent amendments to the CMS-approved HHP SPAs. Individuals receiving benefits through the fee-for-service (FFS) delivery system who meet HHP eligibility criteria, and who wish to receive HHP services, must instead enroll in a MCP to receive all services, including HHP services. HHP services will not be provided through a FFS delivery system.

a. HHP services and eligibility criteria are specified in the CMS-approved HHP SPAs, including any subsequent amendments to the CMS-approved HHP SPAs.
b. HHP services will be provided only through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. HHP is an opt-in and opt-out program. MCPs will inform members of their assigned Community-Based Care Management Entity (CB-CME) and the option to choose a different CB-CME.
c. Individuals receiving benefits through the FFS delivery system who meet HHP eligibility criteria, and who wish to receive HHP services, must instead enroll in a MCP to receive all services, including HHP services. HHP services will not be provided through a FFS delivery system. The HHP-specific provisions of the Medi-Cal 2020 demonstration freedom of choice waiver, and managed care delivery system implementation Medicaid authority, are in effect for any CMS-approved HHP SPAs - including SPA requirements specific to eligible populations, geographic limitations, approved providers, and any other SPA requirements, including any subsequent amendments to the CMS-approved HHP SPAs- for the duration of the Medi-Cal 2020 demonstration.
d. HHP does not modify the policies that govern transitions between the FFS and Managed Care delivery systems. A beneficiary who is a voluntary enrollee in managed care, chooses to opt-out of HHP, and chooses to leave managed care and enter FFS, can return to FFS in any month during the year according to the timeframes in the existing processes to return to FFS.
e. The program assigns care managers, such as nurses or other trained professionals, to help members find the right health care or other services in their communities. HHP services are specified in the CMS-approved HHP SPAs.

VIII. CONTINUING OPERATION OF DEMONSTRATION PROGRAMS

A. Community-Based Adult Services (CBAS) for Medi-Cal State Plan Populations

48. Community-Based Adult Services (CBAS) Eligibility and Delivery System. Community Based Adult Services" is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training andsupport, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

a. CBAS Recipients are those persons who:
   i. Are age 18 years and older;
   ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.
   iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care.
   iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 44(b), or

are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 44(b) and STC 47(a)(ii).

b. Delivery System.

i. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 47(a)(ii) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. The State must ensure that plans have mechanisms to provide care coordination, person-centered planning continuity-of-care, out-of-network care, and other provisions related to newly enrolled managed care beneficiaries as described in STC 58

ii. CBAS shall be available as a Medi-Cal fee-for-service benefit for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS is provided.

iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the State Medicaid Agency must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:

i. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the MCO will authorize unbundled services and facilitate utilization through care coordination.

ii. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:

- DHCS will work with the local CBAS Center network and beneficiary's physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS the beneficiary needs.
- DHCS will work with the beneficiary's physician to arrange for
  - needed nursing services,
  - referral to, or reassessment of, In-Home Supportive Services as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).
- If the beneficiary needs therapeutic services, DHCS will work with the beneficiary's physician to coordinate the authorization of needed services.
- If the beneficiary needs mental health services, DHCS will work with the beneficiary's physician to refer the beneficiary to the local mental health services program.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 45(a) and 45(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state will engage in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the 1115 Demonstration and submit to CMS no later than September 1, 2015, to ensure complete compliance with HCB Settings by March 17, 2019.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 44(a) and for whom CBAS is available based on STC 44(b) who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v):

i. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations; OR

ii. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders

published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f)) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilia, (m) Eating Disorders, (n) Impulse Control Disorders Not Elsewhere Classified (o) Adjustment Disorders, (p) Personality Disorders, or (q) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:

A. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

B. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; OR.

iii. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 of the Alzheimer's Type; OR

iv. Have a mild cognitive disorder such as dementia, including Dementia of the Alzheimer's Type, AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; OR

v. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

e. CBAS Eligibility Determination.

Eligibility determination for the CBAS benefit will be performed as follows:

i. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by the State Medicaid Agency unless criteria under STC 44 (e)(ii) are met. The eligibility determination will be conducted by the beneficiary's managed care plan, or by the State Medicaid Agency or its contractor(s) for beneficiaries exempt from managed care.

ii. An initial face-to-face review is not required when a managed care plan determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses.

iii. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

iv. Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by a managed care plan requires a face-to-face

review.

f. Grievances and Appeals

i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.

ii. A CBAS participant may file a grievance with their Managed Care Organization as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Managed Care Organization at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the MCO.

49. CBAS Benefit and Individual Plan of Care (IPC).

CBAS benefits include the following:

a. Core Services: Professional nursing care, personal care and/or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows.

i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.

ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.

iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities.

v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed and as specified on the person's IPC:

i. Physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice.
ii. Occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice.
iii. Speech therapy provided by a licensed, certified, or recognized speech therapist within his/her scope of practice.
iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.
v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits.
vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).

The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The whole person-centered project will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the State Medicaid Agency.

Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person- Centered Planning includes consideration of the current and unique bio-psycho-social- cultural and medical needs and history of the individual, as well as the

person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

i. Medical diagnoses.
ii. Prescribed medications.
iii. Scheduled days at the CBAS center.
iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).
vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
vii. Participation in specific group activities.
viii. Transportation needs, including special transportation.
ix. Special diet requirements, dietary counseling and education, if needed.
x. A plan for any other necessary services that the CBAS center will coordinate.
xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

50. CBAS Provider Specifications. CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The State Medicaid Agency maintains Standards of Participation for all CBAS providers are found in Attachment W to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

51. Responsibilities of Managed Care Plans for CBAS Benefits

The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and with these STCs and shall include that plans do the following.

a. Contract Requirements for Managed Care Plans:

i. Contract with sufficient available CBAS providers in the managed care plans' covered geographic areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in STC 44(d). Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.

ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on or afterApril 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012;

iii. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.

iv. Confirm that every contracted CBAS provider is licensed, certified, operating, and meets the managed care plan's credentialing and quality standards.

A. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing or quality standards, is terminated pursuant to the terms of the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.

B. The managed care plan shall provide the State Medicaid Agency a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 44, the processes and timelines in State law, and all of the following:

i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.

ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than 30 calendar days from the initial eligibility inquiry request. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the

member in writing of his/her CBAS eligibility determination within two business days of the decision.

iii. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

A. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.

B. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.

C. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with STC 44(f).

iv. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

v. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.

vi. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.

vii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.

c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:

i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.

ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant, and significant changes in participant condition are conducted in a timely manner and facilitate care coordination.

iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.

iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

52. CBAS Center Provider Oversight, Monitoring, and Reporting.

The State shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

a. Enrollment Information: to include the number of CBAS FFS and MCO beneficiaries in each county the capacity of each county -, total determined eligible an ineligible beneficiaries per county quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.

b. The quarterly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.

c. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 49, inclusive of all amendments.

e. CBAS FFS and Managed Care Access Monitoring. The State Medicaid Agency will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.

i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

iii. Review of FFS and MCO grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or MCO staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.

iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the MCOs. CMS

requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.

v. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.Evidence of sufficient access monitoring and corrective action plans must be provided to the regional office annually and at any other time a significant impact to the MCO's operations are administered

vi. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

53. CBAS Quality Assurance and Improvement Strategy. Quality assurance and monitoring of CBAS shall be consistent with the managed care Quality Strategy required by 42 CFR Part 438 Subpart D which is integrated into the DHCS contracts with managed care plans statewide. Such a Quality Assurance and Improvement strategy shall assure the health and safety of Medi-Cal beneficiaries receiving CBAS and shall address, at a minimum, all of the following:

a. The quality and implementation of the CBAS beneficiary's person-centered IPC.
b. The provider's adherence to State licensure and certification requirements.
c. Financial oversight by the State Medicaid Agency, and
d. Administrative oversight of the managed care plans by the State Medicaid Agency.

54. CBAS Provider Reimbursement.

a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are exempt from enrollment in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.
b. Managed care plans shall reimburse contracted CBAS providers pursuant to a rate structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Plan payments must be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their rate structure in paying CBAS providers.

55. CBAS Program Integrity

a. Following a determination that a credible allegation of fraud exists involving a CBAS provider, the state shall notify managed care plans promptly of the finding. The state must require managed care plans to report, in a timeframe and

manner as specified by the state, but no less frequently than quarterly, to the state all payments made to the applicable CBAS provider for CBAS services provided after the date of notification; the state must disclose this information to CMS beginning with payments made on or after April 1, 2016.

b. If the credible allegation of fraud is proven:

i. For purposes of claiming FFP, the state must adjust its claiming associated with payments to a managed care plan to account for an amount equal to what the managed care plan has paid to an applicable CBAS provider for dates of services occurring after the state has notified the managed care plan that the CBAS provider has been referred for investigation. The state shall refund the federal share associated with such payments in accordance with Attachment OO.

ii. The state may recoup from its payment to a managed care plan an amount equal to what the managed care plan has paid to the applicable CBAS provider for dates of service after the state has notified the managed care plan that the CBAS provider has been referred for investigation.

iii. Additional specifications pertaining to these requirements including information about how payments and claiming will be adjusted and MCPs will be notified are set forth in Attachment OO in accordance with the Medicaid Managed Care proposed rule at 80 FR 31097 or the finalized 42 CFR 438. The state must submit Attachment OO by June 30, 2016.

B. California Children's Services (CCS)

56. CCS Demonstration Project Approval. The demonstration project will test two health care delivery models for children enrolled in the California Children's Services (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 plan shall also include specific criteria for evaluating the models. These CCS pilot models shall be eligible for FFP from the Date of CMS approval through the term of the demonstration. In addition, the pilot programs are limited to the two current counties that are authorized as of the date of this approval.

57. CCS Demonstration Project Protocol. The overarching goal of the CCS pilot project is for the State to test two models of health care delivery for the CCS population that results in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness. The demonstration will be analyzed on the following:

a. A Program Description – inclusive of eligibility, benefits, cost sharing;
b. Demonstration Program Requirements - inclusive of eligibility, enrollment, benefits, and cost-sharing;

c. Budget/Allotment Neutrality projections
d. Outcomes for:
    i. Ensuring that the CCS population has access to timely and appropriate, high quality and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.
    ii. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
    iii. Increasing satisfaction with both the delivery of and the reimbursement of services.
    iv. The State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
    v. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
    vi. Reducing the annual rate of growth of expenditures for the CCS population.
e. Use up to two models of care for care delivery:
    i. A Provider-based Accountable Care Organization (ACO);
    ii. Existing Medi-Cal Managed Care Plans.

58. 2016 CCS Pilot Update.

a. The CCS Pilot Protocol has been appended to the STCs as Attachment KK
b. On or before September 30, 2016, the state must submit to CMS a report detailing the following:
    i. The current number of pilot programs,
    ii. A description and status update on each active pilot, including number of children enrolled, average CCS and total Medi-Cal cost of care,
    iii. Evaluation findings to date (if any).
    iv. On or before September 30, 2016, California must submit to CMS an updated CCS Pilot Protocol with additions to the list performance measures, to be implemented in 2017. Specifically, the state must propose
        A. One provider satisfaction measure,
        B. One patient satisfaction measure,
        C. Whole person average cost of care,
        D. Two measures of participant health outcomes.

C. Managed Care Delivery Systems for the Coordination Care Initiative

59. CCI Enrollment Processes

a. Cal MediConnect Enrollment. Effective no sooner than April 1, 2014, according to the schedule described in Attachment U, dependent on the effective date of the 3-way contract, the State may begin enrollment of beneficiaries eligible for the Cal

MediConnect program. Enrollment is described in the plan-specific three-way contracts signed by CMS, the State, and the Cal MediConnect plan. Beneficiaries who opt out of Cal MediConnect, will remain in their existing Medicare program and be enrolled in a Medi-Cal managed care plan for coverage of their Medi-Cal benefits, including LTSS. Beneficiaries may opt out of the Cal MediConnect program at any time.

b. CCI Eligible Beneficiary Enrollment. Dual eligibles who opt out or are excluded from the Cal MediConnect program, and Medi-Cal only SPDs who were previously excluded from the SPD mandatory enrollment program will be mandatorily enrolled into a Medi-Cal managed care plan The enrollment may be tailored for each county as appropriate to address the specific demographics and population of each county.

   Notwithstanding the provisions under this STC, for Two-Plan and GMC counties dual eligibles enrolled in a Medicare Advantage plan shall be mandatorily enrolled in a Medi-Cal managed care plan that is not operated by the same parent organization for their Medi-Cal and Medicare wrap around benefits. The State shall ensure dual eligibles enrolled in a Medicare Advantage plan will be provided coordination of benefits based off current practice. This is applicable only in the eight authorized CCI counties.

c. CCI Eligible Beneficiary Enrollment Choice. For counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of enrollment, the individuals will have an opportunity to choose from the managed care health plans and providers, if applicable, available to the specific population groups. If the beneficiary does not choose a health plan, they will receive a default plan assignment as described below. For counties that operate a COHS, the State will ensure individuals have a choice of providers, upon enrollment.

d. Noticing - Beneficiary and Provider Notices and Information Sharing

   i. Noticing for Cal MediConnect eligible beneficiaries is described in the MOU, the Cal MediConnect three-way contracts, and the enrollment guidance. For beneficiaries that are not a part of the MOU transition, the noticing requirements are described below:

      A. *Initial and On-going Outreach and Communication Strategy*. The State shall develop an outreach and education strategy to explain the changes to individuals who are impacted by the Coordinated Care Initiative. The State will establish a stakeholder process to solicit input and recommendations from a broad array of advocates, providers, plans, beneficiaries, and families for the development of a CCI Eligible Beneficiary program. The process will address beneficiary protections, person-centered care coordination, consumer- directed IHSS program protections, and quality. The strategy shall describe the State's planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific populations. The strategy will further articulate the State's efforts to ensure that the individuals have access to information and human assistance to

understand the new systems and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for initial implementation and on- going operation of the CCI. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review, prior to implementation.

B. *CMS Review of Enrollee Communication.* The State will submit to CMS, 10 days in advance of finalizing the notice for production, any written communication from the state to enrollees to be used to explain the transition for CMS review and comment. The availability of resources for individual assistance should be clearly set forth in materials developed by both the State and the health plans. The State will also submit to CMS for review and comment any directional memoranda or guidance documents provided to the counties, plans, and providers.

C. *Readability and Accessibility.* All informing and educational materials should be clear and easy to read, provide information beneficiaries need to help them navigate the transition, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

D. *Timing*. CCI Eligibles transitioning from Fee-For-Service will be notified at least 90-days in advance of the effective date of enrollment of upcoming changes in delivery systems; will be mailed reminder notices 30 and 60 days prior to enrollment, and final enrollment confirmation notices prior to the enrollment effective date. The State must attempt to contact the beneficiaries who have not made a plan selection by phone, at least two times, prior to 15 days before the transition.

E. *Validation of Beneficiary Addresses.* The state will submit to CMS, 45 days in advance of the transition, a comprehensive plan for ensuring mailings will be sent to the most appropriate beneficiary address (this plan should include the use of address validation software).

ii. For beneficiaries that are currently enrolled in Medi-Cal managed care and are now going to receive MLTSS through the managed care plan, the noticing requirements are as follows:

A. *CMS Review of Enrollee Communication.* The State will require the plans to notify their members at least 30 days in advance of implementation of the benefit. The plan will notify all members of the availability of the benefit for those members who are accessing the services prior to implementation, including information about continuity of care.

B. The plan will notify all members of the availability of the benefit through member informing materials for those who are not accessing

the services prior to implementation.

C. *Readability and Accessibility*. All informing and educational materials should be clear and easy to read, provide information beneficiaries need to help them navigate the implementation, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

iii. *Provider and Community Based Organization (CBO) Notice*. The State shall develop and distribute written informing materials via a provider bulletin no later than 45 days prior to the transition. The State will submit these materials to CMS at least10 days prior to finalizing the notice for production.

iv. The State will ensure that the Medi-Cal managed care plans include in regular provider training key elements of operating a successful MLTSS program, including such topics as the applicable assessment tools and processes, person- centered care planning, coordination with the IHSS program, population specific training and self-direction, information technology, billing, and systems operations.

e. Approaches to Default

i. For CCI Eligible Beneficiaries who are now being mandatorily enrolled in Medi-Cal managed care and do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data (from Medi-Cal and, where appropriate, Medicare) to make a default selection into a plan based on usual and known sources of care, including previous providers (including prescribing providers), and utilization history. Default enrollees will have the opportunity to see their existing Medi-Cal providers for a period of 12 months after enrollment, as defined by the State. The default shall not occur until education and outreach efforts are conducted as noted above. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.

ii. For individuals currently enrolled in Medi-Cal managed care and who will have MLTSS integrated, the default will be to keep the enrollee in the current Medi-Cal managed care plan. Default enrollees will have the opportunity to change to another Medi-Cal managed care plan, in non-COHS counties.

iii. The State shall inform individuals of their opportunity to change plans at any time.

60. Benefit Package

a. Beneficiaries enrolled in a Medi-Cal managed care plan will receive through the managed care delivery system Medi-Cal benefits as identified in Attachment N – Capitated Services List/Managed Care Benefit Package. Attachment N has been updated to include the long term services and supports as a plan benefit. The State will assure that enrolled individuals have referral and access to State plan services

that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package. The health plans are responsible for referrals and coordination of services in the State Plan, regardless of whether the services are included in the plan benefit package.

b. Assessments. The State shall require plans to incorporate into their current policy and procedure a process to assess members who can benefit from LTSS. The plan MLTSS assessment does not preclude the use of specific tools for the determination of eligibility or level of service for MSSP, CBAS and IHSS.

i. *MSSP Assessment Tool:* The plans shall enter into a contract with each MSSP Site within the county so that the members have their choice of MSSP Site providers. The MSSP Site shall perform assessments and reassessments of potential MSSP beneficiaries pursuant to the 1915(c) Home and Community-Based Waiver CA.0141.R04.00 requirements. The MSSP Sites will manage their respective waitlists.

ii. *CBAS Assessment Tool:* The State shall ensure that the plans shall comply with STCs 44-51.

c. Effective in the authorized CCI counties, managed care benefits for the eligible MLTSS populations will be expanded to include the following long term services and supports (LTSS) as specified in Attachment N:

i. In-home supportive services (IHSS);
ii. Multipurpose Senior Services Program (MSSP) services as defined in the 1915(c) waiver; and
iii. Skilled Nursing Facility services and Intermediate Care Facility services.

All services will be provided in compliance with the Americans with Disabilities Act (ADA). The State will assure compliance with the criteria for home and community based settings as referenced in the regulations implementing 1915(c) and 1915(i) and in accordance with the implementation/effective dates published in the Federal Register.

61. Efforts to Ensure Seamless Transitions for New CCI Eligible Beneficiaries: The State shall provide data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees prior to the effective date of coverage.

62. Plan Readiness and Contracts

a. Plan Readiness –Ongoing At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply.

i. *Care Coordination*. Care coordination activities should reflect the capacity to address the unique needs (medical, support and communication) of individuals in the CCI population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network and benefit package.

ii. *MLTSS Assessments*. By using the CBAS, IHSS, MSSP, and NF assessment tools, the state ensures that these tools include such elements as current health status and treatment needs; social, and transportation needs and preferences; personal goals; participant and caregiver preferences for care; and back-up plans for situations when caregivers are unavailable. Additionally by using the CBAS, IHSS, MSSP, and NF assessment tools the state ensures that these instruments are capable of producing a similar assessment result from assessor to assessor (i.e. inter-rater reliability).

The State shall direct the plans to engage in a preliminary assessment process that assesses each new enrollee's risk level and needs; assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings; and uses a mechanism or algorithm to determine the health risk level of members. Based on the results of the health risk assessment, the plans shall be directed to develop individual care plans for higher risk beneficiaries.

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments.

iii. *Care Continuity: Initial and Ongoing*. The State shall ensure that the plans have mechanisms to provide continuity of care to enrolled individuals in order to furnish seamless care with existing Medi-Cal providers for a period of 12 months after enrollment and established procedures to bring providers into network. Enrollees may keep current CBAS and Nursing Facility providers and services in their approved service plans, even if those providers are not in the network, for 12 months from first day of coverage, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.

iv. *Person-Centered Planning and Service Design.*

A. For Medi-Cal only and partial Duals without Medicare Part B, the State shall ensure that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee. While definitions and models of person-centered planning vary, the

protocols shall, at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

B. For MSSP and all 1915(c) HCBS waiver programs which CCI Eligible Beneficiaries will be enrolled, the service plan will reflect the participant's or caregiver's needs and preferences and address how their needs will be met by a combination of covered services and available community supports. Person-centered service planning is holistic in addressing the full array of medical and non- medical services and supports provided both by the health plan or available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. CBO providers will coordinate the HCBS service plan with the health plans service plan. Participants must be permitted to include individuals of their choosing, along with their service providers, as part of their interdisciplinary team. CMS expects participants will have the ability to choose which team members should serve as the lead and the participant's main point of contact; if the participant does not want to choose a team lead, the interdisciplinary team will make the decision.

v. *Physical Accessibility.* The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

vi. *Interpreter Services - Information Technology*. The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.

vii. *Transportation – Specialized.* The State will ensure that each plan offers non-emergency medical transportation so that individuals have easily accessible and timely access for scheduled and unscheduled medical care

appointments.

viii. *Fiscal Solvency.* The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis. California uses the Tangible Net Equity (TNE) standard for plan solvency.

The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c). Rates will be designed to support the population's ability to support and retain community placement. The state will have a process for oversight and evaluation of payment structures and to inform areas of exploration for future program modifications.

ix. *Transparency*. The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to the LTSS eligible population. The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.

x. *Timing.* For Medi-Cal only enrollees, the State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

63. Contract Requirements. Each of the elements noted above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains, for applicable populations. To the extent the plans already comply with any of the following requirements, the state shall identify for CMS how they comply.

a. <u>For Medi-Cal only and Partial Duals without Medicare Part A</u>. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:
   i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and
   ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution.

b. <u>For Medi-Cal only and Partial Duals without Medicare Part B</u>:

   i. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using FFS claims data as a source of clinical data on

CCI enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

ii. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.

iii. Comprehensive health assessments for newly enrolled CCI Eligible Beneficiaries into a plan.

c. For CCI Eligible Beneficiaries:

i. Each plan shall be required to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion within 90 days after initial plan enrollment.

ii. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.

iii. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable and as referenced in Attachment N.

For IHSS, the County will comply with 42 CFR 431, Subpart E. For MSSP, the MSSP Site will comply with 42 CFR 431, Subpart E.

iv. CCI Eligible Beneficiaries will be substantially involved in plan advisory groups and committees.

v. Provisions outlining when out-of-network care will be provided.

vi. Coordination of carved out services.

vii. To the extent possible, plans should incorporate the existing LTSS providers as health plans network providers. In the case of the IHSS program, plans shall coordinate with the counties in the administration of the IHSS program. The state shall provide support to traditional LTSS providers, in areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.

viii. Contract Termination Protections for participants:

State contracts with health plans must include expectations around health plans and provider phase-down when health plans or providers are terminating their contract with, or having their contract terminated by, the State or the health plans. These expectations must include the required amount of time for provider and participant notification and rules around the prohibition of new enrollments during the phase-down period.

64. Participant Rights and Safeguards.

a. Information. All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and

explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

b. Safeguards to Prevent Abuse, Neglect and Exploitation and Critical incident management systems**.** The state shall have a system in place to identify, report, and track critical incidents that occur within the delivery of MLTSS, as appropriate.

c. MLTSS shall continue to be provided in the same amount, duration, and scope while a modification, reduction, or termination is on appeal in accordance with state processes. The State will track the number of appeals of service authorization reductions or expirations. The state will use then use this collected data to intervene when appropriate.

d. All 1915(c) Waiver requirements and safeguards apply to the individuals receiving MSSP Waiver services.

e. Independent Consumer Supports. To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the State shall create and ensure a permanent system of consumer supports independent from the managed care plans to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.

   i. Core Elements of the Independent Consumer Supports System:

      i. Organizational Structure. The Independent Consumer Supports system shall operate independently from any managed care plan. The organizational structure of the supports system shall facilitate transparent and collaborative operation with beneficiaries, and health plans.

      ii. Accessibility. The services of the Independent Consumer Supports system are available to all Medicaid beneficiaries receiving managed long-term services and supports (institutional, residential and community based).

      iii. The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, electronic mail) and must reach out to beneficiaries and/or authorized representatives through various means (e.g. mail, phone), as appropriate.

      iv. Functions. The Independent Consumer Supports system assists beneficiaries to navigate and access covered health care services and supports. The below list encompasses the system's scope of activity. The State shall have the flexibility to offer these consumer reports through various venues.

         1) The program shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information, as well as training on referrals to other counseling and Ombudsman services available, including HICAP, 1-800-Medicare, and the Cal MediConnect Ombudsman, as

applicable.

2) The program shall service as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.

3) The program shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.

4) The program has a process in place to ensure that Consumer Support employees have adequate training and/or informational materials about Medicare benefits; how to obtain assistance accessing benefits, plans, and Medicare Ombudsman support; and care coordination efforts between Medicare and Medicaid in the state and provide referrals to the appropriate Medicare entity.

v. *Staffing and Training*. The State shall ensure the appropriate training is provided to Consumer Support employees. In addition, the Independent Consumer Supports system shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.

vi. *Data Collection and Reporting.* The Independent Consumer Supports system shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the State, but no less frequently than quarterly. This information will inform the State of any provider or contractor issues and support the reporting requirements to CMS.

vii. *Consumer Supports Assessment.* The State shall report to CMS on the assessment of the Cal MediConnect Independent Consumer Supports program and incorporate efficient processes and lessons learned into the CCI Consumer Supports program.

viii. *Independent Consumer Supports Plan.* The State shall submit a plan to CMS describing the structure and operation of the Independent Consumer Supports system that aligns with the core elements provided in STC 60(e)(i) within 90 days of approval of the CCI managed long term services and supports program.

f. The State shall conduct trainings with plans as well as providers on community-based resources and supports that can be linked with covered plan benefits.

65. Quality Oversight and Monitoring. In addition to all quality requirements set forth in 42 CFR 438, the state will ensure the following:

a. Encounter Data. The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by impacted beneficiaries in the CCI Eligible Beneficiary counties, in a manner that enables the State to assess performance by Demonstration plan, by county, and

Demonstration wide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities.

i. The State shall share these trends and quality improvement activities with CMS quarterly within 60 days of analysis.

ii. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans.

iii. The State shall have a process in place to monitor that encounter data from each plan in the authorized CCI Eligible Beneficiary counties is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data.

iv. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion.

v. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the CCI Cal MediConnect and CCI Eligible Beneficiary program. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

b. Stratification and Analysis by County and Plan. For all data collected from the plans and COHS the State will be able to stratify information by Demonstration population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the plans by county.

66. Monitoring and Reporting. The state will collect data and information on the Coordinated Care Initiative as described in Attachment V in order to monitor, measure and report on this initiative.

67. Notice of Change in Implementation Timeline. The state must notify CMS of any potential changes in the implementation and deliverables timelines as specified above.

68. Withholding Approval. At any time, CMS reserves the right to withhold approval of contracts/contract amendment and/or Federal financial participation (FFP) if CMS determined that implementation timelines for MLTSS authorized in this demonstration are not being met. Any available statutory or regulatory appeal procedures will apply.

IX. ADDITIONAL MEDI-CAL 2020 DEMONSTRATION PROGRAMS

A. Access Assessment

69. Access Assessment Document. Within 90 days of legislation in 2016 being passed providing the state with authority, the Department of Health Care Services (DHCS) will amend its contract with its External Quality Review Organization (EQRO), Health Services

Advisory Group, an independent contractor currently under contract with the state and approved by CMS, to complete an Access assessment. If legislative authority is not available the state will need to develop another method for completing this required assessment. This one-time assessment will evaluate primary, core specialty, and facility access to care for managed care beneficiaries based on the current health plan network adequacy requirements set forth in the state's Knox-Keene Health Care Service Plan Act of 1975 (KKA) and Medicaid managed care contracts, as applicable. It will consider State Fair Hearing and Independent Medical Review (IMR) decisions, and grievances and appeals/complaints data. It will report on the number of providers accepting new beneficiaries. The state will also establish an Advisory Committee that will provide input into the structure of the Access assessment.

a. **Design Approval.** CMS will approve the Access assessment design, which the state will submit to CMS no later than 180 days after approval by CMS of the EQRO contract amendment.

b. **Advisory Committee.** The EQRO will work with the State to establish the Advisory Committee, which will provide input into the assessment structure including network adequacy requirements and metrics that should be considered.

c. **Advisory Committee Members.** The Advisory Committee must include one or more representative(s) of each of the following stakeholders to ensure diverse and robust input into the assessment structure and feedback on the initial draft Access assessment report: consumer advocacy organizations, providers/provider associations, health plans/health plan associations, and legislative staff.

d. **Advisory Committee Responsibility.** The Advisory Committee will:

   i. Begin to convene within 60 days of approval by CMS of the EQRO contract amendment;

   ii. Participate in a minimum of two meetings including an entrance and exit event, with all events and meetings open to the public; and,

   iii. Provide feedback on the Access assessment structure, an initial draft Access assessment report and recommendations that will be published on the state's Medicaid website.

70. **Access Report.** The EQRO will produce and publish an initial draft and a final Access assessment report that includes a comparison of health plan network adequacy compliance across different lines of business; and recommendations in response to any systemic network adequacy issues, if identified. The initial draft and final report will describe the state's current compliance with the access and network adequacy standards set forth in the Medicaid Managed Care proposed rule at 80 FR 31097 or the finalized 42 CFR 438 if published prior to submission of the Assessment design to CMS. The assessment will:

a. Measure health plan compliance with network adequacy requirements as set forth in KKA and Medicaid managed care contracts, as applicable. It will consider State Fair Hearing and IMR decisions, grievances and appeals/complaints data; and

other factors as selected with input from the Advisory Committee.

b. Review encounter data including a review of data from sub-capitated plans.

c. Measure health plan compliance with timely access requirements as set forth in KKA requirements and Medi-Cal managed care contracts using a sample of provider-level data on the soonest appointment availability.

d. Review compliance with network adequacy requirements for MCPs, and other lines of business for primary and core specialty care areas and facility access, as set forth in KKA requirements or Medi-Cal managed care contracts, as applicable, across the entire health plan network.

e. Applicable network adequacy requirements of the proposed or final NPRM, as determined under the approved Access assessment design, that are not already required under KKA will be reviewed and reported on against a metric range as identified by the state and approved by CMS in the Access assessment design.

f. Determine health plan compliance with network adequacy through reviewing information/data from a one-year period using validated network data and utilize it for the time period following conclusion of the pre-assessment stakeholder process but no sooner than the second half of Calendar Year (CY) 2016 in order to ensure use of the highest quality data source available.

g. Measure MCP compliance with network adequacy requirements within DHCS/MCP contract service areas using the KKA and network adequacy standards within Medicaid managed care contracts.

h. Accounting for:

    i. Geographic differences including provider shortages at the local, state, and national levels, as applicable;

    ii. Previously approved alternate network access standards as provided for under KKA and DHCS/MCP contracts;

    iii. Access to in- network providers and out-of-network providers separately (presented and evaluated separately) when determining overall access to care;

    iv. The entire network of providers available to beneficiaries at the State contractor plan level; and

    v. Other modalities used for accessing care such as telemedicine.

71. **Initial Draft Report**. The State must post the initial draft report for a 30 day public comment period after it has incorporated the feedback from the Advisory Committee. The initial draft report must be posted for public comment no later than 10 months after CMS approves assessment design.

72. **Publication of Advisory Committee Feedback.** The state must also make publicly available the feedback from the Advisory Committee at the same time it posts the initial draft of the report.

73. **Final Report.** The State will submit the final Access assessment report to CMS no later than 90 days after the initial draft report is posted for public comment.

B. PRIME

74. **Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program Description.** The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pool will build 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 Pool are designed to accelerate efforts by participating PRIME entities (as defined in Attachment D) to change care delivery to maximize health care value and 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 is intentionally designed to be ambitious in scope and time-limited. 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. Participating PRIME entities will consist of two types of entities: Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs).

PRIME Background The purpose of PRIME program is to support the state's efforts to adopt alternative payment methodologies (APMs) for managed care systems to use to shift risk for costs and/or outcomes to participating PRIME entities. The PRIME program will also provide direct incentives to participating PRIME entities to support better integration of physical and behavioral health serves in inpatient and outpatient settings, improved health outcomes and increased access to health care services, particularly for those with complex health care needs.

Funding for the PRIME program will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for DPH systems and DMPHs to support reforms for care delivery, provider organization and the adoption of APMs. The demonstration will provide up to $1.4 billion annually for the DPH systems and up to $200 million annually for the DMPHs for the first three years of the demonstration. The pool will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.

Under the PRIME program, DPH systems and DMPHs will receive payments for achieving certain outcomes that will build on the successes of the Delivery System Reform Incentive Payments (DSRIP) Program under the Bridge to Reform demonstration. DPH systems and DMPHs (that are listed in Attachment D) are eligible to receive incentive payments from the PRIME funding Pool, subject to each DPH system and DMPH submitting a completed 5-year PRIME Project Plan pursuant to Attachment Q (Five-Year PRIME Project Plan Process). DPH systems and DPMHs qualified for PRIME funding pool payments are referred to as "participating PRIME entities". Multiple DPH systems operating under common government ownership may be considered a single participating PRIME entity; the same is true for DMPHs. DMPHs may also submit a joint plan for consideration.

PRIME incentive payments will support participating PRIME entities in their efforts to change care delivery and strengthen those systems' ability to participate under APMs. As these delivery system changes occur, the state has committed to facilitate movement of participating PRIME entities from payment based on a fee-for-service model to APMs that aligns with HHS' delivery system reform goals where the provider is accountable for quality and cost of care. CMS and the state will measure the success of the PRIME pool in part by assessing the progress in shifting participating DPH PRIME entities to APMs through managed care plans (MCPs). The APMs will shift risk to participating DPH system PRIME entities through capitation and other risk sharing arrangements. Contracts between MCPs and participating DPH PRIME providers will be required by the state to include language requiring the DPH system to report on a broad range of metrics to meet quality benchmark goals to ensure improved patient outcomes. PRIME innovations and state payment strategies will allow DPH systems and DMPHs to become self-sustaining entities that are not reliant on pool funds beyond 2020.

To move participating DPH system PRIME providers more toward value-based payments, 50 percent of all Medi-Cal managed care beneficiaries assigned to DPHs by

their MCP, in the aggregate, will receive all of or a portion of their care under a contracted APM by January 2018 (DY 13); 55 percent by January 2019 (DY 14); and 60 percent by the end of the waiver renewal period in 2020 (DY 16). Under PRIME, capitated payments, and other acceptable APMs, would be included to capture all models of APM utilized in calculations that determine overall DPH system advancement toward the established thresholds. Four tiers of capitated or alternative payment would exist: 1) partial (primary care only); 2) partial-plus (primary care and some specialty care (varies)); 3) global (primary, specialty, ancillary and/or hospital care); and 4) additional payment methodologies approved by the state and CMS as set forth in Attachment R.

The PRIME program is focused on the following goals: (1) increasing the capabilities of participating PRIME entities to furnish patient-centered, data-driven, team-based care to Medi-Cal beneficiaries, especially those who are high utilizers or at risk of becoming high utilizers (2) improving the capacity of participating PRIME entities to provide point- of-care services, complex care management, and population health management by strengthening their data analytic capacity to drive system-level improvement and culturally competent care; (3) Improve population health and health outcomes for Medi- Cal beneficiaries served by participating PRIME entities, as evidenced by the achievement of performance goals related to clinical improvements, effective preventive interventions, and improved patient experience metrics; (4) improving the ability of participating PRIME entities to furnish, in the most appropriate setting, high-quality,
care that integrates physical and behavioral health services and coordinates care in different settings for targeted vulnerable Medi-Cal beneficiaries, ; and (5) moving participating PRIME entities towards value-based payments through the adoption of alternative payment models.

75. **Domains.** The PRIME funds provide incentive payments to participating PRIME entities that undertake 5-year projects within Domains 1, 2, and 3 as described below and consistent with the Attachment II PRIME *Funding and Mechanics Protocol*. DPH systems will be required to implement projects under all three domains. DMPHs, given their different demographics, including their size and location, are only required to include a project from a single domain, although they may include additional projects from other domains in their application for consideration. DMPHs may also submit a joint application across DMPHs reflecting a coordinated effort to implement a domain.

There will be a core required set of metrics for each project that will be outlined in Attachment Q: PRIME *Projects and Metrics* Protocol by March 1, 2016. The specific elements will be particular to the project and to the needs of the beneficiaries Incentive payments will be phased down consistent with the overall PRIME phase down in DY 14 and DY 15. The applications for these projects will need to outline how they will be building infrastructure and alignment designed to support sustainability over the course of the 5 years including how they will sustain project innovations in years DY 14 and DY 15 as PRIME funding is phased down.

a. **Domain 1: Outpatient Delivery System Transformation and Prevention.** The PRIME funds provide incentive payments to participating PRIME entities that undertake projects that will ensure that patients experience timely access to high-quality, efficient, and patient-centered care. Through these efforts patients will receive appropriate preventive services, early diagnosis and treatment, and will be supported in improving their ability to care for themselves through access to other needed services including those that support social and well-being needs. In addition, these projects will identify and increase rates of cost-effective standard approaches to prevention services for a select group of high impact clinical conditions and populations (cardiovascular disease, breast, cervical and colorectal cancer, and obesity). They will also aim to reduce disparities and variation in performance of targeted prevention services within their systems. Under this domain, DPH systems will be required to participate in Integration of Physical and Behavioral Health; Ambulatory Care Redesign: Primary Care; Ambulatory Care Redesign: Specialty Care; and must choose one additional project. The menu of projects under this domain include:

i. Integration of Physical and Behavioral Health (required for DPH systems)
ii. Ambulatory Care Redesign: Primary Care (required for DPH systems)
iii. Ambulatory Care Redesign: Specialty Care (required for DPH systems)
iv. Patient Safety in the Ambulatory Setting
v. Million Hearts Initiative
vi. Cancer Screening and Follow-up
vii. Obesity Prevention and Healthier Foods Initiative

b. **Domain 2: Targeted High-Risk or High-Cost Populations.** The PRIME funds provide incentive payments to participating PRIME entities that undertake projects focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings, to optimize the care experience and outcomes. Under this domain, DPH systems would be required to participate in Improved Perinatal Care, Care Transitions: Integration of Post-Acute Care and Complex Care Management for High Risk Medical Populations and must choose one additional project. The menu of projects under this domain include:

i. Improved Perinatal Care (required for DPH systems)
ii. Care Transitions: Integration of Post-Acute Care (required for DPH systems)
iii. Complex Care Management for High Risk Medical Populations (Required for DPH systems)
iv. Integrated Health Home for Foster Children
v. Transition to Integrated Care: Post Incarceration.
vi. Chronic Non-Malignant Pain Management
vii. Comprehensive Advanced Illness Planning and Care

c. **Domain 3: Resource Utilization Efficiency.** The PRIME funds provide incentive payments to participating PRIME entities that undertake projects that will reduce

unwarranted variation in the use of evidence-based, diagnostics and treatments (antibiotics, blood or blood products, and high cost imaging studies and pharmaceutical therapies) targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. DPH systems must select at least one of the projects below. The menu of projects under this domain include:

i. Antibiotic Stewardship
ii. Resource Stewardship: High Cost Imaging
iii. Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
iv. Resource Stewardship: Blood Products.

Project selection for each participating PRIME entity must include an assessment of the number of patients benefiting from, and magnitude of health improvement achievable by, the project selected, pursuant to the PRIME Funding and Mechanics Protocol.

Participating PRIME entities shall not select projects for which the target population is insufficient to accurately measure success and shall not select optional projects to which they are considered "top performers" based on their baseline performance level compared to the project benchmarks identified in the PRIME Funding and Mechanics Protocol. If a participating PRIME entity is ineligible to select a project on the basis of the above criteria, the participating PRIME entity will be required to choose another project from the same domain as necessary to fulfill program minimum project requirements.

76. Statewide APM Targets for DPH Systems. To ensure support for sustainability beyond the demonstration DPH systems must demonstrate, in the aggregate, a shift from a fee for service to value-based managed care payments by 2020. Generally this will be in the form of capitation, though other APMs may be acceptable. APMs must provide payment at the provider level that is, tied to value and quality and provide incentives to clinicians to provide the right care, at the right time, at the right place.

a. Methodology: PRIME is structured to chart a path towards integrating continuous quality improvement in the underlying structure of the Medi-Cal program. This will be evidenced by an increasing shift of managed care payments for DPH systems towards APMs, which include full or partial capitation of services, risk-pool payments or other risk-sharing arrangements at the provider level for assigned Medi-Cal managed care enrollees.

i. In determining whether DPH systems are progressing towards the APM targets stipulated above, the following methodology will be used:

A. Determine the total number of unique MCP beneficiaries who either choose or are assigned to all of the participating DPH systems in aggregate for the applicable demonstration year.

B. Determine the total number of unique MCP beneficiaries who either choose or are assigned to all participating DPH

systems in the aggregate for which the contract between the MCP and DPH system prescribes that a portion of the payment from the MCP to the DPH system is in the form of capitation or some other APM, as described in Attachment R. Both partial and global capitation payments, as well as other accepted forms of risk sharing will be included in calculations to determine aggregate DPH systems progress toward the established thresholds to capture all models of APM utilized. Accepted forms of APM would be classified into four tiers of payment: 1) partial (primary care only); 2) partial-plus (primary care and some specialty care (varies)); 3) global (primary, specialty, ancillary and/or hospital care); and 4) any additional payment methodologies approved by the state and by CMS as set forth in Attachment R.

C. Divide the result of B by A to determine the percentage met.

b. Definition of "alternative payment model:" An APM should include the following features:

i. A defined patient population the DPH system is accountable for, defined through assignment either by DHCS or by a managed care plan.

ii. A set of quality accountability metrics that are aligned with the contracted MCPs quality accountability and clinical outcome metrics, but with adjustments to reflect the socioeconomic and demographic characteristics of the populations served by PRIME entities where possible.

iii. Some contractual level of risk for cost of care. This accountability does not need to be full risk capitation, but must include a form of risk sharing, incentives or shared savings for reduced cost

iv. Models that lack one or more of these three features will not qualify as an APM.

v. The above APM targets are intended to inform CMS and DHCS in their oversight function as to the level of success the DPH systems have had in facilitating the adoption of robust APMs for Medi-Cal. DPH systems will be required to commit to contracting with at least one Medi-Cal MCP in the MCP service area that they operate using APM methodologies as part of their PRIME Project Plan by January 1, 2018. If a DPH system is unable to meet this requirement and can demonstrate that it has made a good faith effort to contract with an MCP in the service area that it operates in and a gap in contract period occurs, DHCS has discretion to waive this requirement.

77. Eligible Participating PRIME Entities. DPH systems (which include their affiliated governmental providers and contracted governmental and non-governmental entities where applicable) and DMPHs, that are identified in Attachment D are eligible to receive PRIME incentive payments, subject to each DPH system or DMPH submitting a

completed 5-year PRIME Project Plan. Multiple DPH systems operating under common government ownership may be considered a single participating PRIME entity, or may submit separate applications and be treated as separate participating PRIME entities. Multiple DMPHs operating under common government ownership may submit separate applications or a single application, however, a lead DMPH must be identified. Incentive funds shall be disbursed solely to eligible DPH systems or DMPHs. A specified amount of incentive funding will be available annually to each participating PRIME entity based on the metrics approved for that entity or, to the extent that the entity is participating as a DMPH, the metrics approved for the associated DMPHs under common government ownership. The actual receipt of funds will be conditioned on reporting by the entity of progress towards and achievement of the specified metrics approved for the defined population of beneficiaries. Aside from early stage process metrics, awards in later years will be based on per beneficiary measures of improvement. Additional criteria for participation shall be outlined in Attachment II.

a. *Designated Public Hospitals (DPHs).* Twenty-two DPHs operate 17 health and hospital systems, with one system comprised of four hospitals in Los Angeles County and another system comprised of three hospitals in Alameda County. DPHs are located in mostly urban areas in Northern, Central and Southern California. These hospitals range in size from approximately 160 to 600 beds. DPHs are similar in that they are academic teaching centers providing a broad range of inpatient and outpatient services including specialty care. More than 50 percent of patients served across these health and hospital systems are Medi-Cal beneficiaries or uninsured. DPHs provide 30 percent of all hospital-based care to the Medi-Cal population in the state and operate more than half of the state's trauma centers and more than two-thirds of its burn centers.

b. *District/Municipal Hospitals (DMPHs).* There are 39 DMPHs spanning 19 counties across California. DMPHs are heterogeneous, varying significantly in size (from approximately 3 to 500 beds) and in the range of services provided. Many of these hospitals serve rural and semi-rural populations. Approximately 21 percent of patients served at DMPHs are Medi-Cal or uninsured and more than a third of the DMPHs provide over 30 percent of their care to low-income Californians, with some facilities treating as many as 50 percent low-income Californians. DMPHs provide 4 percent of the hospital-based care to the Medi-Cal and uninsured populations in California and 20 percent of the care provided to these populations in rural California.

78. State and Participating PRIME Entity Accountability. Overall PRIME project funding is available up to the amounts specified in Attachment II (PRIME Funding and Mechanics Protocol). PRIME funding is available to participating PRIME entities whose project plans are approved and funded through the process described in these STCs and who meet particular metrics' targets described in their approved PRIME project plans. Such funding is subject to the participating PRIME entities meeting ongoing metrics' targets established pursuant to the PRIME projects and Metrics Protocol (Attachment Q),

metrics as described in the STCs and PRIME Funding and Mechanics Protocol (Attachment II). In addition, individual participating PRIME entity achievement of metrics as set forth in the approved PRIME Project Plan must be achieved and maintained for full access to the funding level as specified in the STCs.

a. The state must achieve APM targets to avoid reductions to PRIME funding. If the state fails to meet the specified APM targets in any given year, the amount of the potential reduction is set as follows:

1) Based on the methodology measuring aggregate adoption of APM described in STC 72, the DPH system portion of the PRIME pool will have 5 percent of the yearly allocated pool amount at risk in DY14, and 5 percent at risk in DY15.

2) Each year's potential reduction will consist of two portions. First, 2.5 percent of the pool amount will be contingent on aggregate adoption of the DY14 and DY15 goals of 55 percent and 60 percent APM adoption, respectively. The other 2.5 percent of the penalty would occur if providers fail to meet the aggregate 55 percent or 60 percent thresholds, and fail to meet a lesser aggregate APM adoption rate of 45 percent and 50 percent for DY14 and DY15.

The state may choose how to allocate reductions in the PRIME pool to providers, whether uniformly, with more of the reduction targeted to providers that substantially fail to meet targets, or another methodology if desired.

b. Individual projects are awarded based on the merit of the proposal itself, its support of the overall PRIME goals, and the projected breadth and depth of the impact on Medicaid beneficiaries. Public transparency, a process that allows for community input, including two public meetings, will be part of the state application and review process.

79. Application Process. Five-year PRIME Project Plan. DPH systems must include projects from all three domains and contain the specific elements as required under PRIME Projects and Metrics Protocol. DMPHs, given their different demographics, including their size and location, are only required to include a project from a single domain; DMPHs may include additional projects in their application. DMPHs may also submit a joint application across DMPHs reflecting a coordinated effort to implement a domain.

a. DHCS will review all 5-year PRIME project plans for final approval according to the following timeline:

i. By February 1, 2016, or 30 days after approval of PRIME protocols (whichever is later) each applicant will submit a 5-year PRIME Project plan to DHCS for review. DPH systems will be required to address Domains 1, 2, and 3, and DMPHs will be required to address one

domain at a minimum.

ii. By March 15, 2016, or 45 days, whichever is later, after the submission of the 5-year PRIME project plans, DHCS will complete its review of the 5- year PRIME Project Plan, and will respond to the applicant in writing with any questions, concerns or problems identified.

iii. The participating PRIME entity will respond to any of DHCS' questions and concerns in writing within 3 business days of notification by DHCS.

iv. By April 1, 2016, or 60 days, whichever is later, following the submission of the 5-year PRIME project plans, DHCS will take action on the PRIME Project Plan and will approve or disapprove each plan.

80. PRIME Protocols. Specific standards, measures and evaluation guidelines are described in protocols. Specifically, the protocols are described in Attachments II, Q, and S (PRIME Funding and Mechanics Protocol, PRIME Projects and Metrics Protocol, PRIME Evaluation and Monitoring), which accomplish the following:

a. Detail requirements regarding project metrics (PRIME Projects and Metrics Protocol);
b. Identify metrics, measurement of the metrics, and a target setting methodology (PRIME Projects and Metrics Protocol);
c. Provide parameters for establishing the allocation of incentive funding among participating PRIME entities, which may consider size of the facilities, scope of the public hospital system, geography, number of people served, and complexity of services provided, among other factors (PRIME Funding and Mechanics Protocol);
d. Finalize payment mechanisms and disbursement of pool funds (PRIME Funding and Mechanics Protocol);
e. Finalize a State review process that will assure action on the Five-year PRIME Project Plan within 60 days of submission from the participating PRIME entity;
f. Detail a Five-year PRIME Project Plan modification process (PRIME Projects and Metrics Protocol);
g. Finalize requirements for reporting (PRIME Funding and Mechanics Protocol);
h. Describe evaluation requirements for the program (PRIME Evaluation and Monitoring)

81. PRIME Program Objectives and Metrics. Progress towards achieving the goals specified above will be assessed by specific metrics for each project, which are further defined in the PRIME Projects and Metrics Protocol. Metric achievement will be based on documenting achievement on a set of pre-defined metrics through a method that can be audited. These metrics are organized into the following categories:

a. *PRIME Program Objectives*: The PRIME projects will be designed in ways that promote health systems participating PRIME entities assuming responsibility for the overall health needs of a population of the Medi-Cal beneficiaries and the

low income individuals that they serve, and not simply responding to the patients that arrive at the doors of a hospital. DHCS will approve a defined population for each PRIME project, as described in PRIME Program Funding and Mechanics Protocol.

b. *Integration Across Settings:* The PRIME will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, and importantly behavioral and physical health providers. The PRIME will support coordination and the provision of care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk. The PRIME projects Pool will fund projects that include new and expanded care coordination programs, other evidence based, data driven interventions and programs focused on key health and cost drivers.

   PRIME program metrics will reflect this ongoing transformation, creating better alignment between providers and rewarding providers for improved outcomes.

c. *Transition to APM:* The transition to APM models in which both partial and global capitation payments and other approved APMS would be included in calculations to determine overall DPH achievement of the established thresholds to capture all models of APM utilized.

d. *PRIME Project Metrics:* All participating PRIME entities will produce an interim mid-year and final year report on metric progress specific to the participating PRIME entity's project and its PRIME defined population. Payment for performance on all PRIME metrics will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. PRIME participating entities that already demonstrate high performance on project metrics at baseline, must select alternative projects (as defined in PRIME Projects and Metrics Protocol but within the same domain so to fulfill minimum project requirements, if all projects from the domain are not already included under the PRIME Project Plan. Improvement targets will be based on state or national performance benchmarks, whenever available, but with adjustments to reflect the socioeconomic and demographic characteristics of the populations served by PRIME entities where possible.

e. *Standard Metrics*: These metrics include both System Transformation and Health and Health Care Improvement metrics, and are national and state vetted metrics. The majority of metrics in this category are National Quality Forum (NQF) endorsed. The remaining have an established measure steward, such as National Committee for Quality Assurance (NCQA) or CMS, who have used rigorous metric vetting processes to establish use of the metrics for performance measurement and financial accountability of performance.

f. *System Transformation Metrics*: As detailed in the PRIME Projects and

Metrics Protocol, these metrics reflect the processes and infrastructure necessary to build and strengthen high quality, integrated, patient centered delivery systems, including outcomes that reflect overall improvement in systems of care, care coordination, care integration and patient experience.

g. *Health and Health Care Outcome Metrics*: As described further in PRIME Projects and Metrics Protocol, these are metrics that reflect improved quality of care, as well as the resulting improved clinical outcomes for each participating entity's PRIME defined population. These metrics will also measure each participating PRIME entity's success in reducing avoidable emergency department and hospital use by its defined population.

h. *Innovative Metrics*: As with the Standard Metrics referenced above, this category includes System Transformation Metrics, and Health and Health Care Outcome Metrics. While representing a much smaller proportion of the total PRIME metrics than the Standard Metrics, this category enables participating PRIME entities to demonstrate the transformation of health care towards coordinated, team based, patient centered care, in a manner not afforded by many of the Standard Metrics. As with the Standard Metrics, each PRIME Innovative metric will have only one definition and measure specification across the entire PRIME program. Beginning as reporting only, these metrics will be guided by its PRIME participating entity measure steward and a PRIME Metric Technical Advisory Committee, through a rigorous evaluation and testing process to be developed by DHCS as described in the PRIME Projects and Metrics Protocol. Once through that process, participating PRIME entities will be responsible for improving performance on these metrics. Final approval of all innovative metrics is determined by DHCS, but the final metrics must be provided to CMS for comment before approval.

82. **State Supporting Infrastructure**. DHCS will provide a state-level infrastructure to support the PRIME. The state-level infrastructure will be implemented incrementally over the five- years of the Demonstration. The state-level infrastructure will include:

a. *Information and Data Sharing.* Achieving care integration across Medi-Cal delivery systems is a priority for the state. In particular, since managed care has become the

predominant delivery mode serving 90 percent of all full-scope Medi-Cal members, data linkages and care coordination among MCPs and other partners such as participating PRIME entities is critical. As such, DPHs will be required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME and WPC.

b. *Medi-Cal Managed Care Health Plans (MCPs).* The state must also ensure that its

managed care delivery system recognizes and encourages positive system transformation.

The state will develop a draft MCP and DPH APM Activities Plan, consistent with APMs as defined under these STCs and in Attachment R, by January 1, 2017. The document will outline activities that the state will engage in to support MCPs and DPHs in the adoption of APMs, establishing methods for the state to achieve the APM targets as set forth under these STCs. DHCS will share the draft MCP and DPH APM Activities Plan with MCPs, DPHs, and other stakeholders for public comment and feedback In addition, the state will convene a minimum of one meeting with MCPs and DPHs annually to discuss movement toward use of APMs, share best practices, and discuss successes, challenges and barriers.

DHCS will include in its full-scope managed care contracts language that allows for the implementation of APMs. This language will be required to be included in any participating network provider contract where quality improvement work has been delegated. The language will clarify that APM payments to DPHs are funded through the capitation payments made to MCPs (without separate PRIME funding). MCPs will be required to require DPHs, as a component of an agreement for capitation or other risk- sharing payments, to utilize PRIME projects, goals, and objectives, to assist the MCP in meeting its DHCS required quality metric thresholds; reporting on metrics and performance to the MCP will also be required. DHCS will issue a policy letter that encourages MCPs to adopt APM payment structures for DPHs and other participating network providers, and which provides guidance on the various APM structures that may be implemented including the four tiers as set forth in the PRIME STCs. DHCS will convene meetings with its MCPs to discuss information relating to APMs and promote the sharing of best practices amongst MCPs.

83. **PRIME Transparency.** During the 60 day application/state review process for the PRIME applications, DHCS must have conducted at least two public meetings regarding the state's PRIME Project Plan application approval. The state must utilize teleconferencing or web capabilities to ensure statewide accessibility. The two public meetings must be held on separate dates and must afford the public an opportunity to provide comments.

84. **Administrative Record.** CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

a. The PRIME application from the participating PRIME entities.
b. Written public comments sent to the CMS and any CMS responses.

85. **Submission of Draft Evaluation Design.** The state shall submit a draft PRIME evaluation design to CMS no later than 180 days after the PRIME protocols are approved, including, but not limited to data that the state proposes to be used to evaluate PRIME. The state must employ meaningful state-level standards that align with its managed care approach.

86. **Submission of Final Evaluation Design.** The state shall provide the Final Evaluation

Design within 60 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design and the final evaluation plan will be included as Attachment S.

87. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be evaluated;
c. Specific performance and outcomes measures used to evaluate PRIME's impact;
d. How the analysis will support a determination of improved health outcomes and system transformation including better care, better quality, and enhanced value;
e. An initial assessment of the collection of REAL (Racial, Ethnicity and Preferred Language) data, and documented efforts to provide culturally competent care and address social determinants of health;
f. Data analytic strategy including sources of data, sampling methodology, and how data will be obtained;
g. The unique contributions and interactions of other initiatives; and
h. How the evaluation and reporting will develop and be maintained.
i. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
j. The demonstration evaluation will use the best available data; use controls (when available and appropriate for the evaluation design) and adjustments for and

   reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
k. The state shall contract with an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

88. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Specific aims and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration, including:
b. Safety net system transformation at the system and state level;
c. Accountability for and improvements in health outcomes and other health measures at the system and state level; and

d. Efforts to ensure sustainability of transformation of/in the managed care environment.

The research evaluation questions will be examined using appropriate comparisons. The state and CMS agree that a robust evaluation of PRIME is desired in order to, to the greatest extent possible, determine the causal impacts of PRIME. The state and CMS will work to identify available data sources in order to allow for this type of evaluation, including data sources that would provide the ability to use control and comparison groups, where available, as well as before-and-after studies. The design will include a description of the quantitative and qualitative study design including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

e. *Performance Measures:* This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration in terms of cost or cost avoidance impact, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state will incorporate comparisons to national data and/or measure sets. A broad set of metrics will be selected. To the extent possible, metrics will be pulled from nationally recognized metrics such as from the NQF, Center for Medicare and Medicaid Innovation (CMMI), meaningful use under Health Information Technology (HIT), and the Medicaid Core Adult sets, for which there is sufficient experience and baseline population data to make the metrics a meaningful evaluation of the California Medicaid system.

f. *Data Collection:* This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

   i. Medicaid encounter and claims data in TMSIS,
   ii. Enrollment data,
   iii. EHR data, where available
   iv. Semiannual financial and other reporting data
   v. Managed care contracting data
   vi. Consumer and provider surveys, and
   vii. Other data needed to support performance measurement

g. *Assurances Needed to Obtain Data:* The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available

h. *Data Analysis:* This includes a detailed discussion of the method of data

evaluation, including appropriate statistical methods that will allow for the effects of the PRIME to be isolated, to the extent possible, from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention- specific stratifications, for further depth and to glean potential non-equivalent effects on different sub-groups. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

i. *Timeline:* This includes a timeline for evaluation-related metrics, including those related to procurement of an outside contractor, if applicable, and deliverables.

j. *Evaluator:* This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

89. **Interim Evaluation Report.** The state is required to submit a draft Interim Evaluation Report 90 days following completion of DY 14 of the demonstration. The Interim Evaluation Report shall include the same core components listed above and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The state shall submit the final Interim Evaluation Report within 60 days after receipt of CMS' comments.

90. **Summative Evaluation Report.** The Summative Evaluation Report will include analysis of data from DY 15. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the end for DY 15, the state shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 60 days.

The Final Summative Evaluation Report shall include the following core components:

a. *Executive Summary.* This includes a concise summary of the goals of the Demonstration, the evaluation questions and hypotheses tested, and key findings, including whether, and

to what extent, the evaluators find that PRIME has facilitated sustainable improvements to care outcomes and population health outcomes for Medi-Cal beneficiaries in their systems.

b. *Demonstration Description.* This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to CMS and Medi-Cal 2020 goals.

c. *Study Design.* This includes a discussion of the evaluation design employed including specific aims and hypotheses; type of study design; impacted populations; data

sources; and data collection; analysis techniques, including methods to determine the causality and attribution of results to PRIME. In addition, limitations of the study will be reported.

d. *Discussion of Findings and Conclusions.* This includes a summary of the key findings and outcomes, particularly a discussion of cost or cost avoidance impact, as well as implementation successes, challenges, and lessons learned.

e. *Policy Implications.* This includes an interpretation of the conclusions; the impact of the demonstration within the public health care system; the state obligations for beneficiaries served by participating PRIME entities; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. *Interactions with Other State Initiatives.* This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other waivers and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

91. **State Presentations for CMS.** The state will present to and participate in a discussion with CMS on the final design plan at post approval. The state will present on its interim evaluation report that is described to in STC 84 of this section. The state will present on its summative evaluation in conjunction with STC 85 of this section.

92. **Public Access.** The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medi-Cal website within 30 days of approval by CMS.

93. **CMS Notification.** For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party entity contracted for the evaluation. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 14 days to review and comment on journal articles related to the state's evaluation prior to submission for peer review. CMS may choose to decline some or all of these notifications and reviews.

94. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

95. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of PRIME, the state and its evaluation contractor shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

96. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

97. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation

design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

a. *Deferral for Failure to Provide Summative Evaluation Reports on Time.* If the state does not timely submit a final report, including all requested analyses and recommendations, the state's expenditure authority for the PRIME pool will be reduced by $500,000. The state may seek, and CMS may grant, relief from this reduction, if needed.

98. PRIME Implementation Monitoring. The state must ensure that it is operating its PRIME program according to the requirements of the governing STCs. In order to demonstrate adequate implementation monitoring towards the completion of these requirements, the state will submit the following:

a. A description of PRIME monitoring activities indicating how the state will monitor compliance with demonstration requirements in the implementation of this demonstration, including monitoring and performance reporting templates. The standard reporting mechanism is subject to review and approval by CMS.

99. PRIME Monitoring Activities. As part of the Attachment S, the state will submit its plan for how it will meet the PRIME internal monitoring requirements. The monitoring protocol should provide, at a minimum, the following information:

a. The monitoring activities aligned with the PRIME deliverables as well as the CMS evaluation design to ensure that entities participating in the PRIME process are accountable for the necessary product and metrics and other deliverables for the PRIME.
b. The state shall make the necessary arrangements to assure that the data needed from the participating PRIME entities including deliverables, measurement and reporting are available as required by the CMS approved monitoring protocol.
c. The state shall identify areas within the state's internal PRIME process where corrective action, or assessment of fiscal or non-fiscal penalties may be imposed for the participating PRIME entities, should the state's internal PRIME process or any CMS monitoring process not be administered in accordance with state or federal guidelines.
d. The monitoring protocol and reports shall be posted on the state Medi-Cal website within 30 days of submission to CMS.

100. PRIME Quarterly Progress Reports. The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter. The first PRIME quarterly reports will be due by June 1, 2016, or 60 days, whichever is later, after the end of the quarter first ending after approval of the STCs. The intent of these reports is to present the state's analysis and the status of the various operational areas.

These quarterly reports must include, but are not limited to the following reporting elements:

a. Summary of all PRIME public engagement activities, including, but not limited to the activities required by CMS;
b. Summary of updates on state activities, such as changes to state policy and procedures; and
c. Evaluation activities and interim findings.

101. **Annual Onsite with CMS.** In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

102. **Rapid Cycle Assessments.** DHCS shall submit to CMS guidelines for use of rapid cycle quality improvement in PRIME projects, as appropriate

103. **Demonstration Years.** For purposes of PRIME, demonstration years shall be as follows:

DY 11 July 1, 2015 – June 30, 2016
DY 12 July 1, 2016 – June 30, 2017
DY 13 July 1, 2017 – June 30, 2018
DY 14 July 1, 2018 – June 30, 2019
DY 15 July 1, 2019 – June 30, 2020

PRIME Pool payments shall be based on a PRIME demonstration year that extends from July 1 through June 30 ("PRIME DY"). Payments can be earned and disbursed based on mid- year and year-end achievements.

104. **Monitoring.** The state will be actively involved in ongoing monitoring of PRIME projects, including but not limited to the following activities.

a. *Review of metric target achievement.* Two times per year, participating PRIME entities seeking payment under the PRIME program shall submit reports to the state demonstrating progress on each of their projects as measured by project- specific metrics and targets achieved during the reporting period. The reports shall be submitted using the standardized reporting mechanism approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved PRIME Project Plan, in accordance with the established criteria as set forth in Attachment II. The participating PRIME entities shall have available for review by the state or CMS, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to participating providers for achievement of PRIME metrics. The reports will be due in accordance with the following:

i. Interim Mid-Year Report: Reporting on metrics through December 31. The report and request for payment is due March 31, with payment

occurring no later than April 30. For PRIME DY 11 only, the submission of the Five-year PRIME Project Plan will constitute the submission of the Interim Mid-Year Report.

ii. Final Year- End Report: Reporting on metrics through June 30. The report and request for payment is due September 30, with payment occurring no later than October 31.

iii. Notwithstanding the deadlines in i and ii, in the event of misreported or insufficient data, DHCS reporting and payment deadlines with respect to a participating PRIME entity may be extended by up to 60 days until its reports are adequately corrected for approval for payment. If the data is not fixed and payment is not made within that extended time frame, the participating provider will not receive any PRIME payment for the period in question.

Except with respect to the PRIME DY 11 Mid-Year Report, the reports must be submitted using the standardized reporting mechanism approved by CMS. DHCS must use this documentation in support of PRIME Pool payments made on the MBES/CBES 64.9 Waiver form. For PRIME DY11, approval of the Five-year PRIME project plans will be considered an appropriate metric and serve in-lieu of the mid-year report and will equal up to 25 percent of the PRIME DY 11 total annual amount for which a participating PRIME entity is eligible.

b. *Intergovernmental Transfers.* Within 30 days of submission of the mid-year and final year-end report by participating PRIME entities, DHCS will issue requests to the entities for intergovernmental transfer amounts necessary for the nonfederal share of applicable incentive payments. DPH systems or DMPHs, or their affiliated public agencies, will make intergovernmental transfer of funds to DHCS in the amount specified within 7 days of receiving the DHCS request. Upon receipt of the intergovernmental transfers, DHCS will draw the federal funding and pay both the non-federal and federal shares of the payment to lead DPH systems or DMPHs as applicable. If the intergovernmental transfers are made within the requested timeframe, the incentive payment will be paid within 14 days after the transfers are made, but in no event shall payment be made later than the dates specified in a. above. In the event of misreported or insufficient data, DHCS will not be bound to the 30 day payment timeline with respect to a participating PRIME entity until its reports are adequately corrected for approval for payment, consistent with (a)(iii) above. In the event federal approval is not obtained, DHCS must return the IGT funds to the transferring entities within 14 days.

c. *Learning collaboratives.* As part of this demonstration, the state will work in collaboration with participating PRIME entities to support regular learning collaboratives, which will be a required activity for all participating PRIME entities, and may be organized by the goals of PRIME or by the specific PRIME projects as described in the PRIME Funding and Mechanics

Protocol (Attachment II). Learning collaboratives are forums for participating PRIME entities to share best practices and get assistance with implementing their PRIME projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should coordinate with participating PRIME entities to organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help participating PRIME entities share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals with training in quality improvement who can answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

d. *Application, review, oversight, and monitoring database.* The state will ensure that there is a well maintained and structured database, containing all required elements of the PRIME project plans; including metrics, targets, valuation, and achievement; public comment on project plans; generations of reports, containing the required elements of PRIME reporting and payments and summaries of PRIME project plans submissions, scoring, approval/denial, milestone achievement, and payments that can be accessed by the public.

105. Financial Requirements applying to PRIME payments generally.

a. Funding for DPH systems (total computable) shall not exceed $6.531 billion over five years with the following annual limits:

DY 11 - $1.4 billion
DY 12 - $1.4 billion
DY 13 - $1.4 billion
DY 14 - $1.26 billion
DY 15 - $1.071 billion

b. Funding for DMPHs (total computable) shall not exceed $933 million over five years with the following annual limits:

DY 11 - $200 million
DY 12 - $200 million
DY 13 - $200 million
DY 14 - $180 million
DY 15 - $153 million

c. A specified amount of incentive funding will be available semi-annually to each participating PRIME entity for each approved project based on its progress or achievement of the metric targets approved for the project. The actual receipt of

funds will be conditioned on reporting by the entity of progress towards and achievement of the specified targets to DHCS. Each participating PRIME entity will be individually responsible for progress towards and achievement of the targets for its projects within applicable domains in order to receive its potential incentive funding from the PRIME Sub-Pool, pursuant to the procedures specified in Attachment II (PRIME Funding and Mechanics Protocol). The inability of one participating PRIME entity to meet a specified target will not preclude another participating PRIME entity's receipt of incentive payment for achievement of a separate target.

d. PRIME shall also include mechanisms that recognize the ability of a participating PRIME entity to earn a reduced incentive payment based on proportionate achievement that is at least 50 percent of a designated target as set forth in Attachment II (PRIME Funding and Mechanics Protocol).

e. Notwithstanding the annual limits set forth in a. above, participating PRIME entities will have the opportunity to recapture unused or unclaimed PRIME pool payments as detailed in Attachment II (PRIME Funding and Mechanics Protocol).

f. Incentive payments will be based on the incentive payment amounts that are specified in each participating PRIME entity's approved five-year PRIME Project Plan, and not to the specific costs or resources involved in implementing the specific projects.

g. Incentive payment amounts will be phased down as necessary consistent with the overall PRIME phase down in DY 14 and DY 15.

h. *PRIME Payments Are Not Direct Reimbursement for Expenditures or Payments for Services.* Payments from the PRIME Pool are intended to support and reward participating entities for improvements in the delivery system that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care, and are unrestricted revenue once disbursed. The payments are not direct reimbursement for expenditures incurred by participating entities in implementing reforms. The payments are not reimbursement for health care services that are recognized under these Special Terms and Conditions or under the State plan. PRIME incentive payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, disproportionate share hospital payments or administrative activities as defined under these Special Terms and Conditions and/or under the State plan. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

The non-federal share of payments under PRIME shall be funded by voluntary intergovernmental transfers made by the participating PRIME entities and/or applicable governmental agencies. The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 C.F.R. part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. The State must have permissible sources for the non-federal share of PRIME expenditures, which may include permissible Intergovernmental Transfers (IGTs) from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

i. The state must inform CMS of the funding of all PRIME payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under STC 96of this section. This report must identify the applicable transferring entities and transfer amounts associated with the quarterly payments made.

j. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

k. The state may not claim FFP for PRIME Payments to a participating PRIME entity until the state have concluded that the participating PRIME entity has met the relevant performance indicated for the payment. Participating PRIME entity reports must contain sufficient data and documentation to allow the state and CMS to determine if the specified metric targets have been fully met, and participating PRIME entities must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments pursuant to an approved PRIME Project Plan.

l. Semi-annually, when the State makes PRIME Payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the appropriate amount of the payments. This documentation should be used to support claims made for FFP for PRIME Payments that are made on the CMS-64.9 Waiver forms.

It should be noted that federal funding for PRIME payments is limited in any phase of the demonstration period to the amounts set forth in this demonstration authority, subject to all of the reductions that may be applied based on incomplete achievement of PRIME Plan metrics, even if the state expenditures for PRIME payments exceed the amount for which federal funding is available**.**

106. **Finalize PRIME Protocols.** Within the 60 days following the approval of the Demonstration, CMS and the State will, through a collaborative process, develop and finalize the PRIME Projects and Metrics Protocol (Attachment Q) and PRIME Program Funding and Mechanics Protocol (future Attachment II). The state may not accept a PRIME application until after CMS formally approval of these protocols.

107. Deliverables Schedule.

Due Date/Submission Date	Activity/Deliverable
December 31, 2015	CMS approves STCs
60 days post Demonstration approval	CMS and CA approve PRIME attachments
February 1, 2016 (or 30 days post approval of PRIME attachments, whichever is later)	State accepts PRIME project plan applications from eligible PRIME entities
45 days post submission of PRIME Project Plans	State will complete its review of the applications and issue questions, concerns or problems to the PRIME entity applicant
60 days post submission of PRIME Project Plans	State will take action of the PRIME Project applications to approve or disapprove
During the 60 day period between PRIME Project Plan Submission and State Approval/Disapproval	During the 60 day application/state review process for the PRIME applications, DHCS must have conducted at least two public meetings regarding the state's PRIME Project Plan application approval
June 1, 2016	State submits its first quarterly report
April and October (Twice a year)	State Distributes PRIME Project Plan incentive payments to PRIME participating entities
90 days following completion of demonstration Year 14	State submits Draft Interim Evaluation report
180 days after the expiration of the demonstration	State submits preliminary Summative Evaluation report
360 days after the expiration of the demonstration	State submits Draft Final Summative Evaluation report
Quarterly Deliverables – Quarterly Report (60 days after end of the quarter)	
1st Quarter- June 1st	
2nd Quarter- September 1st	
3rd Quarter- December 1st	
4th Quarter – March 3rd	

C. Dental Transformation Initiative

108. **Special Terms and Conditions for Dental Transformation Initiative** Under the Medi-Cal program, dental services are provided to approximately 5.5 million child Medi-Cal beneficiaries ages twenty (20) and under. Services are provided via two (2) delivery

systems – Fee-for-Service (FFS) and Dental Managed Care (DMC). The Department of Health Care Services (DHCS, Department) conducts oversight of the FFS contractor(s) and six (6) dental managed care contracts in the DMC system.

DHCS facilitates access to oral health services for the FFS and DMC delivery systems in multiple ways, including through telephone service centers and correspondence controls for beneficiaries and providers; conducting beneficiary and provider outreach and education; implementing strategies for monitoring and augmenting provider network adequacy and beneficiary utilization; and providing regular reports to the Legislature, stakeholders, and federal and State government entities. All data and measurement reporting associated with the Dental Transformation Initiative (DTI) will be based on an annual reporting period by Program Year (PY).

The Medi-Cal Dental program aims to improve the beneficiary's experience so individuals can consistently and easily access high quality dental services supportive of achieving and maintaining good oral health; to implement effective, efficient, and sustainable health care delivery systems; to maintain effective, open communication, and engagement with our stakeholders; and to hold DHCS and our providers, plans, and partners accountable for performance and health outcomes. The Department employs performance measures in both delivery systems to gauge the effectiveness of contractor and State efforts. To aid in this performance monitoring, the Department utilizes a public Medi-Cal dental dashboard populated with performance measures posted on the Department's website, regular system reports, and ad hoc queries to the various databases. Benchmarks and quality and access criteria for the DMC and FFS delivery systems are designed to provide programmatic goals and expectation levels for contractors. Additionally, there are contractual checks targeted at ensuring access to care for the beneficiaries, encouraging provider participation, and holding the contractor(s) responsible for being active and proactive participants in ensuring the delivery of medically necessary dental services to the Medi-Cal beneficiary population.

109. **DTI PROGRAM and FUNDING OVERVIEW** The DTI will be funded at a maximum of $148 million annually, except as provided below, for five (5) years totaling a maximum of $740 million (DTI Pool). To the extent any of the funds associated with the DTI are not fully expended in a given PY, those remaining prior PY funds may be available for DTI payments in subsequent years, notwithstanding the annual limits stated above. The program will include three (3) domains: preventive services, caries risk assessment and management, and continuity of care, in addition to making funding available for local pilots that

address one (1) or more of these three (3) domains. Specific incentive payments within each domain will be furnished to qualified providers, along with messaging and education to providers and beneficiaries about programs and efforts in their local communities. The Department intends to allow DTI participation from providers in both the FFS and DMC delivery systems beginning in PY 1 and as outlined in these STCs. The Department will make DTI incentive payments directly to contracted service office locations that participate in the FFS and/or DMC delivery systems that qualify for DTI incentive payments. The service office location is the business or pay-to address where services are rendered by the provider (which may be an individual, partnership, group, association, corporation, institution, or entity that provides dental services). Incentive payments shall be issued to the service office location based on the services rendered at the location and compliance with the criteria enumerated in the STCs.

Incentive payments from the DTI Pool are intended to support and reward participating service office locations for achievements within one (1) or more of the project domains set forth herein. The incentive payments are not considered direct reimbursement for dental services under the State Plan. The non-federal share for DTI incentive payments shall be derived from expenditures associated with those Designated State Health Programs set forth in STC 31.

110. Domain 1: Increase Preventive Services Utilization for Children

In alignment with the CMS Oral Health Initiative, this program aims to increase the statewide proportion of children ages one (1) through twenty (20) enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department's goal is to increase the utilization amongst children enrolled in the FFS and DMC dental delivery systems by at least ten (10) percentage points over a five (5) year period. The Department will commit to re-assessing the goal after PY 2 and increase said percentage, if appropriate, based on the success of the domain. For example, the 2014 rate for the state using the Form CMS-416 methodology was 37.84 percent of children. Thus, if this rate remained the same for the demonstration baseline year, the ten (10) percentage point improvement goal for this five (5) year demonstration would be to increase this rate to 47.84 percent of children statewide. DHCS will use the CMS 416 methodology for reporting purposes, but will pay out incentives using unrestricted eligibility criteria.

DHCS will offer payments as financial incentives for dental service office locations to increase delivery of preventive oral care to Medi-Cal children, and to maintain preventive oral care for children who previously received that service. As of September 2015, there are 5,370 service office locations across California that participate in the Medi-Cal Dental Program. DHCS will stage a messaging campaign to explain the new incentive program to the provider community and to generate interest among beneficiaries. DHCS will leverage existing contract provisions specific to provider and beneficiary outreach to operationalize the commitments of these STCs.

a. Program Criteria. The incentive program will provide semi-annual incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. Eligible providers will receive payments based on them achieving an increased number of Medi-Cal children who received eligible preventive dental services, as compared to a baseline pre-determined by the Department. Providers who render preventive services to a number of children that meets or exceeds a Department pre-determined number of beneficiaries, by service office location, would qualify for the incentive payment.
Further, the program will also disburse incentive payments to providers who were not previously participating in Medi-Cal and rendering preventive services, but who do so during the demonstration, on the condition that they meet or exceed the provision of services based on the Department pre-determined number of beneficiaries, by county, needed to be served to achieve the goal. The new service office location's pre-determined number will be the average number of beneficiaries among all existing service office locations in the county needed to increase the statewide goal of two (2) percentage points. In subsequent demonstration years, the Department will re-evaluate the new service office location and develop a benchmark using the same methodology as described above for existing dental providers in the program.

Safety net clinics would also be eligible for these incentives and would be supplied with incentive payments separate and apart from their Prospective Payment System (PPS) or Memorandum of Agreement (MOA) rates for Federally Qualified Health Centers/Rural Health Centers and Tribal Health Centers, respectively. Each safety net clinic office location would be considered a dental service office location for purposes of this domain.

To illustrate, if a service office location provided preventative services to 1,000 beneficiaries for the selected benchmark year, its baseline benchmark is 1,000. In the first year, the annual target benchmark will be to increase by two percentage points over 1,000 thus, this service office location would need to provide preventive services to an additional 20 new beneficiaries (1,000 x 0.02 = 20).

The Department will determine the number of additional beneficiaries to be served in order to achieve the goal of ten (10) percentage point utilization increase statewide.

Incentive payments will be based on each service office location that meets or exceeds the Department pre-determined goal for increases in preventive services provided to every child within frequency limitations regardless of whether that child is a previously established patient of that service office location.

b. Responsibilities of Providers Service office locations are expected to continue to follow claiming and billing guidelines of the Medi-Cal Dental Program and to

adhere to requirements of this incentive program**.**

c. Performance Metrics The Department will calculate a baseline measure of the rate of children's utilization of preventive services statewide and for each service office location, within the Medi-Cal FFS and DMC dental delivery systems, with a goal of increasing the statewide utilization of preventive services for children by at least ten (10) percentage points over five (5) years. The Department will also calculate the number of service locations that are providing preventive services to an increased number of children. The baseline year will consist of data from the most recent complete year preceding implementation of the waiver. Beneficiary utilization and service office location participation will be reassessed after PY 2.

The first metric that will be used for monitoring domain success is the percentage of beneficiaries who received any preventive dental service during the measurement period, which is calculated as follows:

i. Numerator: Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days who received any Medi-Cal covered preventive dental service (D1000-D1999) in the measurement period.
ii. Denominator: Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days during the measurement period.
iii. The second metric that will be used is claims data to determine the number of service office locations in each county that are providing preventive dental services to children, compared to the number of these locations in the baseline year.
iv. A third metric will track statewide the number and percentage change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

d. State Oversight, Monitoring, and Reporting

i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure that all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's Surveillance Utilization Review System (SURS) to prevent fraud and abuse.
ii. Monitoring Plan/Provisions: To measure the impact on the utilization of preventive services, there will be monitoring of actively participating service office locations and monitoring of preventive services utilization statewide and by county via claims utilization.
iii. Reporting of Activity: The Department will be responsible for reporting on

data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable PY. Content will include, but not be limited to:

i. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
ii. The number of individual incentives paid, and the total amount expended, under this domain in the current PY;
iii. A plan (awareness plan) that describes (a) how the Department has generated awareness of the availability of incentives for providing preventive dental services to children, including steps taken to increase awareness of the DTI among dental as well as primary care providers, and
(b) how the Department has generated awareness among enrollees of the availability of, the importance of, and how to access preventive dental services for children. Specific approaches will break out for example, age groupings, rural and urban residents, or primary language and should be developed in conjunction with interested dental and children's health stakeholders.
iv. An annual analysis of whether the awareness plan has succeeded in generating the necessary utilization, by subgrouping, to meet the goals of this domain, and a description of changes to the awareness plan to address any identified deficiencies;
v. Data describing the use of preventive dental services and, separately, other dental services, and expenditures on preventive dental services and, separately, other dental services;
vi. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
vii. An analysis of changes in cost per capita;
viii. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
ix. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any lessons learned, and any adjustments recommended.

e. Incentives DHCS may earn additional demonstration authority, up to a maximum of $10 million, to be added to the DTI Pool for use in paying incentives to qualifying providers under DTI, by achieving higher performance improvement, as indicated in the below table:

PY	Target	$1 million in additional demonstration authority for achieving:	$2 million in additional demonstration authority for achieving:
1	+ two (2) percentage points over baseline	Not Applicable	+ three (3) or more percentage points over baseline year
2	+ four (4) percentage points over baseline	+5 or more percentage points over the baseline	+ six (6) or more percentage points over baseline year
3	+ six (6) percentage points	+7.5 or more percentage points over the baseline	+ nine (9) or more percentage points over baseline year
	baseline year		
4	+ eight (8) percentage points over baseline	+10 or more percentage points over the baseline	+ twelve (12) or more percentage points over baseline year
5	+ ten (10) percentage points over baseline	+12.5 or more percentage points over the baseline	+ fifteen (15) or more percentage points over baseline year

f. Financing The incentive payment for preventive services will equate to a payment of approximately seventy-five (75) percent above the Schedule of Maximum Allowances (SMA) if the 2 percentage point benchmark increase is achieved or thirty-seven and a half (37.5) percent above the SMA if an increase of at least 1 percentage point but less than 2 percentage points is achieved. To the extent that the projected funding limit is reached for the Domain, a pro-rata share payment amount will be determined based on remaining funds. These payments are subject to annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

g. Evaluation The results of this project will be used to determine if provider incentive payments are an effective method by which to encourage service office locations to provide preventive dental services to more Medi-Cal children and to what extent an incentive payment is an effective method for increasing Medi-Cal provider participation which could then impact better access to care for children.

111. Domain 2: Caries Risk Assessment and Disease Management Pilot

This four (4) year domain will only be available initially to dentists in pilot counties that elect and are approved by the Department to participate in the program. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of PY 2. Through this effort, Medi-Cal dentists voluntarily participating in the domain will be eligible to receive incentive payments for performing pre-identified treatment plans for children based upon the beneficiary's risk level as determined by the dentist via a caries risk assessment (CRA) which will include motivational interviewing and use of antimicrobials, as indicated. The pre-identified treatment plans will be generated by the Department, and will correspond to the varying degrees of caries risk — low, moderate, and high. Pilot counties will be identified and selected by the Department through an analysis of counties with a high percentage of restorative services, a low percentage of preventive services, and indication of likely participation by enrolled service office locations.

Dentists must first complete a CRA to determine the appropriate treatment plan for a child, and report the results of the CRA to DHCS on a claim. Once the risk level and the treatment plan have been determined, the beneficiary may be eligible for increased frequency limitations on prophylaxis, topical fluoride varnish, and exams.

The key elements of this model are to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures.

a. Program Criteria The incentive program will only be available for services performed on child beneficiary's age six (6) and under. The pre-identified treatment plans will be composed of the following procedures: CRA (which will globally include support for behavior change through motivational interviewing and nutritional counseling, and for disease management through use of interim carries arresting medication application), application of topical fluoride varnish, prophylaxis, and exams will be permitted for children evaluated and determined to be a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: "high risk" children will be authorized to visit their provider four (4) times; "moderate risk" children will be authorized to visit three (3) times; and "low risk" children two (2) times. Dentists will receive payment for completion of a CRA and the corresponding treatment plan within the designated time frame.

b. Responsibilities of Providers Dentists participating in the domain must opt-in by completing a no-cost Department recognized training program (which could be developed in partnership with California Dental Association, as an example) and submitting verification documentation. Authorized training programs and acceptable documentation will be posted on the Medi-Cal Dental website. The Department will

have an annual "open enrollment" for the domain in pilot counties and in additional counties when and if this domain is expanded beyond the pilot counties.

c. Performance Metrics The following procedures will be incorporated in the Department-determined treatment plans for child beneficiaries: CRA (which will globally include behavior modification through motivational interviewing and nutritional counseling, as well as antimicrobials), application of topical fluoride varnish, toothbrush prophylaxis, and exams. Increased frequencies for toothbrush prophylaxis, fluoride varnish, and exams will be permitted for children evaluated and determined to be at a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: "high risk" will be authorized to visit their provider four (4) times; "moderate risk" children will be authorized to visit three (3) times; and "low risk" children two (2) times.

The baseline year will consist of collecting data statewide for the most recent state fiscal year preceding implementation of the domain. The Department will collect data and report on the following performance measures, broken down by age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6):

i. Number of, and percentage change in, restorative services;
ii. Number of, and percentage change in, preventive dental services;
iii. Utilization of CRA CDT codes and reduction of caries risk levels (not available in the baseline year prior to the Waiver implementation);
iv. Change in use of emergency rooms for dental related reasons among the targeted children for this domain (use of the ER for dental trauma will be excluded from this analysis if a claims-based methodology for doing so is identified); and
v. Change in number and proportion of children receiving dental surgery under general anesthesia.

The Department will also track and report on, for children in age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6), the utilization rates for restorative procedures against preventive services to determine if the domain has been effective in reducing the number of restorations being performed. Because preventive services do not yield immediate effects, the Department will be required to collect data on these performance measures at annual intervals for a number of years to determine correlation and statistical significance. The Department will inform CMS of the number of additional years this data will be collected and reported no later than the end of PY 1.

The Department will also track and report on the utilization of CRA and treatment plan service to monitor utilization and domain participation.

d. State Oversight, Monitoring, and Reporting

i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's SURS to prevent fraud and abuse.

ii. Monitoring Plan/Provisions: To measure the impact on the utilization of CRA and management of childhood caries, there will be quarterly monitoring of actively participating service office locations and monitoring of CRA and treatment plans in each participating county.

iii. Reporting of Activity: The Department will be responsible for reporting on data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable PY. Content will include, but not be limited to:

A. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
B. The number of individual incentives paid and the total amount expended under this domain, by county, in the current DY;
C. A descriptive assessment of the impact of this domain on the targeted children (broken out by age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6)) for the following:
    1) Provision of CRAs;
    2) Provision of dental exams;
    3) Use of preventive dental services;
    4) Expenditures on preventive dental services;
    5) Use of dental treatment services;
    6) Expenditures on dental treatment services;
    7) Use of dental-related general anesthesia; and
    8) Expenditures on dental-related general anesthesia and facility costs.
D. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
E. An analysis of changes in cost per capita;
F. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
G. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any

lessons learned, and any adjustments recommended.

e. Financing Dentists participating in the domain will be authorized to perform an increased number of services per year in accordance with the pre-identified treatment plan options based upon caries risk level, and are eligible to receive an incentive payment under this program for each additional service not currently covered under the California State Plan and frequency limitations listed in the Manual of Criteria. Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, qualifying service office locations will receive an incentive payment for providing each of these additional services. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation The results of this project will be used to determine if this provider incentive program is effective in encouraging providers to perform a CRA for the targeted population and to ensure completion of the appropriate treatment plan for the management of childhood caries, if the utilization of emergency room visits for dental issues among the targeted children declines, if expenditures of emergency room visits non-traumatic dental issues among targeted children declines, and if the utilization of and expenditures (including anesthesia and facility fees) for the targeted children receiving dental related general anesthesia declines.

112. Domain 3: Increase Continuity of Care

To encourage the continuity of care within the beneficiary population, an incentive paymentwould be paid to service office locations who have maintained continuity of care through providing examinations for their enrolled child beneficiaries, age twenty (20) and under over the course of this Waiver. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of PY 2.

a. Program Criteria This incentive program will be available to service office locations that provide examinations (D0120, D0150, or D0145) to an enrolled Medi-Cal child for two (2), three (3), four (4), five (5), and six (6) year continuous periods. The incentive will be a flat payment for providing continuity of care to the beneficiary. Incentive payments will be made annually.

b. Responsibilities of Providers Service office locations are expected to continue to follow claim and billing guidelines of the Medi-Cal Dental Program and to adhere to requirements of this incentive program.

c. Performance Metrics The baseline year will be based on data from the most recent

complete state fiscal year. Using claims data, DHCS will determine the number of beneficiaries who have remained with their same service office location for two (2), three (3), four (4), five (5), and six (6) year continuous periods following the establishment of the baseline year throughout the demonstration period. The metric described above is calculated as follows:

i. Numerator: Number of children age twenty (20) and under who received an examination from the same service office location with no gap in service for two (2), three (3), four (4), five (5), and six (6) year continuous periods from the baseline.
ii. Denominator: Number of children age twenty (20) and under enrolled in the delivery system during the measurement periods.
iii. This measure is similar to the Dental Quality Alliance measure Usual Source of Services, with the exception that the Department would incent over a longer continuous period.

d. State Oversight, Monitoring, and Reporting

i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns, and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's SURS to prevent fraud and abuse.
ii. Monitoring Plan/Provisions: To measure the impact on the continuity of care, there will be annual monitoring of the performance measure, usual source of care by service office location.
iii. Reporting of Activity: The Department will be responsible for reporting on data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY. Content will include, but not be limited to:
    A. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
    B. The number of individual incentives paid and the total amount expended under this domain, by county, in the current DY;
    C. A descriptive assessment of the impact of this domain on provision of the following to targeted children
        1. Dental exams;
        2. Use of and expenditures on preventive dental services; and
        3. Use of and expenditures on other dental services.
    D. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
    E. An analysis of change in cost per capita;

F. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
G. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any lessons learned, and any adjustments recommended.

e. Financing Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, incentive payment amounts will be made available in tiers based on the length of time a beneficiary maintains continuity of care with the same service office location. Tier one (1) payments will be provided on a per-child basis for beneficiaries who receive at least two (2) examinations from the same service office location for two (2) consecutive years. In each subsequent year, the dollar amount of the incentive payment for an exam of the same child within that period would be increased. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation The results of this project will be used to determine if incentive payments are effective in promoting continuity of care for the targeted children under this domain.

113. Local Dental Pilot Program

Local dental pilot projects (LDPPs) will address one (1) or more of the three (3) domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS will require local pilots to have broad-based provider and community support and collaboration including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of the Department in any of the domains specified above. DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments to LDPPs in accordance with the requirements outlined in Attachment JJ; a maximum of fifteen (15) LDPPs shall be approved. DHCS will work in collaboration with the CMS in the development of evaluation criteria for the LDPPs.

The Department will begin this effort as pilots in select counties and will then, subject to the availability of funding under the DTI Pool, seek to implement on a statewide basis any pilot that is determined to be successful. DHCS will evaluate the pilots and consider expansion no sooner than nine (9) months following the end of PY 2.

a. Program Criteria. DHCS intends to review, approve, and make incentive payments available to pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established jointly by the Department and CMS and deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment

methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department. DHCS shall approve only those applications that meet the requirements to further the goals of one (1) or more of the three (3) dental domains. Each pilot application shall designate a responsible county, Tribe, Indian Health Program, UC or CSU campus as the entity that will coordinate the pilot. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met. The application process is outlined in Attachment JJ.

b. Responsibility of Providers. The responsibility of the providers would be contingent upon the design of the pilot program being proposed as outlined in Attachment JJ.

c. Performance Metrics. Performance metrics for each pilot shall mirror the metrics delineated in this STC document.

d. State Oversight, Monitoring, and Reporting
   i. The Department shall designate someone within the Department as the person with primary responsibility for oversight of the pilots.
   ii. The Department shall routinely monitor the progress made by the responsible county of the accepted dental pilot proposal.
   iii. Reporting requirements shall be delineated in the submitted proposals.
   iv. The Department will ensure that the terms of the proposal are abided by. The Department will be responsible for reporting on the pilots to CMS on an annual basis in the demonstration annual report.
   v. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY.
   vi. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY. Content will include, but not be limited to:
      A. A detailed description of how DHCS has operationalized this aspect of the demonstration, including the solicitation and selection process;
      B. The number of pilot projects funded and the total amount expended under this domain in the current DY;
      C. A description of the pilot projects selected for award; including but not limited to their specific strategies, target populations, payment methodologies, annual budget, and expected duration, the performance metrics with which they will be measured; as well as the goals they intend to achieve;
      D. An assessment of the pilot projects selected for award, including their performance and outcomes, replicability, any challenges encountered, actions undertaken to address those challenges, as well as information on payments made to each pilot project by the Department;
      E. A descriptive assessment of the impact of this aspect of the demonstration on achieving the goals in domains one (1) through

three (3); and

F. A descriptive analysis of any program integrity challenges generated by this aspect of the demonstration, and how those challenges have been, or will be, addressed.

e. Financing. DHCS will to make available funding to the LDPP only on the basis of an approved application pursuant to (a) above. Total funding for LDPPs is limited to a maximum of twenty-five (25) percent of the annual funding amounts listed in STC 105. The incentive funding available for payments will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation Local dental pilot projects will be evaluated consistent with the performance metrics of the aforementioned dental domains and the goals outlined in the individual proposals. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met.

D. Whole Person Care Pilots

114. **Whole Person Care Pilots.** The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of 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 Pilots will provide an option to a city, county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

The investment in this localized effort will build and strengthen relationships, and improve collaboration among participating WPC Pilot entities. The results of these WPC Pilots will also provide learnings for potential future local efforts beyond the term of this waiver. The specific strategies, target populations, payment methodologies, and participating entities shall be established by the entity submitting the application in consultation with participating entities. Each WPC Pilot is intended to be in operation from the date of approval through the end of the demonstration. Additional funds for existing WPC Pilots or new WPC Pilots may be approved by the state after the initial application period if additional funds are available. DHCS will issue guidance to WPC Pilot Lead Entities in the form of guidance and policy letters to implement the Pilot program and structure, as needed.

115. **Whole Person Care Pilot Programs Target Population(s).** WPC Pilots shall identify high-risk, high-utilizing Medi-Cal beneficiaries in the geographic area that they serve and assess their unmet need. WPC Pilots must define their target populations and interventions to provide integrated services to high users of multiple systems. The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services often times across multiple systems. Target populations may include but are not limited to individuals:

a. with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
b. with two or more chronic conditions;
c. with mental health and/or substance use disorders;
d. who are currently experiencing homelessness; and/or
e. individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prisons, or other)

Individuals who are not Medi-Cal beneficiaries may participate in approved WPC Pilots, but funding in support of services provided to such individuals is not eligible for Federal financial participation. These individuals shall only be included in the Pilot at the discretion of the WPC Pilot and as approved during the application process. The non-Federal funds expended providing services to individuals who are not Medi-Cal beneficiaries may exceed the funding limits described in STCs 125 and 126.

116. **WPC Strategies.** WPC Pilots shall include specific strategies to:

a. Increase integration among county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term;
b. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
c. Reduce inappropriate emergency and inpatient utilization;
d. Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
e. Achieve targeted quality and administrative improvement benchmarks;
f. Increase access to housing and supportive services (optional); and
g. Improve health outcomes for the WPC population.

117. **Whole Person Care Pilot Payments**. Subject to the funding limits in STCs 125 and 126, DHCS shall review, approve, and make payments for WPC Pilots in accordance with the requirements in these WPC STCs. WPC Pilot payments shall be paid in accordance with STCs 125 and 126. WPC Pilot payments shall support 1) infrastructure to integrate services among local entities that serve the target population; 2) services not

otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing components; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

118. **Housing and Supportive Services**. WPC Pilots may target the focus of their Pilot on individuals at risk of or are experiencing homelessness who have a demonstrated medical need for housing or supportive services. In these instances, WPC Pilots would include local housing authorities, local Continuum of Care (CoCs) programs, community based organizations, and others serving the homeless population as entities collaborating and participating in the WPC Pilot. Housing interventions may include:

a. Tenancy-based care management services. Tenancy-based care management supports to assist the target population in locating and maintaining medically necessary housing. These services may include individual housing transition services, such as individual outreach and assessments; individual housing and tenancy sustaining services, such as tenant and landlord education and tenant coaching; and housing- related collaborative activities, such as services that support collaborative efforts across public agencies and the private sector that assist WPC entities in identifying and securing housing for the target population.

b. County Housing Pools. WPC Pilot entities may include contributions to a county-wide housing pool (Housing Pool) that will directly provide needed support for medically necessary housing services, with the goal of improving access to housing and reducing churn in the Medicaid population. The Housing Pool may be funded through WPC Pilot funds or direct contributions from community entities. These services may include those identified in the June 26, 2015 CMCS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities". State or local government and community entity contributions to the Housing Pool are separate from Federal financial participation funds, and may be allocated to fund support for long-term housing, including rental housing subsidies. The Housing Pool may leverage local resources to increase access to subsidized housing units. The Housing Pool may also incorporate a financing component to reallocate or reinvest a portion of the savings from the reduced utilization of health care services into the Housing Pool. As applicable to an approved WPC Pilot, WPC investments in housing units or housing subsidies including any payment for room and board are not eligible for Federal financial participation. Room and board would not include those housing –related activities or services recognized as reimbursable under CMS policy.

119. **Lead and Participating Entities.** DHCS will accept applications for WPC Pilots from a city, county, a city and county, a health or hospital authority, a consortium of any of the above entities serving a county or region consisting of more than one county, or federally recognized tribes and tribal health programs operated under a Public Law-638 contract with the federal Indian Health Services. Each WPC Pilot application shall designate a "Lead Entity" that will be either a city, county agency, designated public hospital as identified in Attachment D or district municipal public hospital as identified

in Attachment D that will coordinate the WPC Pilot and be the single point of contact for DHCS.

The WPC Pilot application shall identify other entities that shall participate in the WPC Pilot. Participating entities must include a minimum of one Medi-Cal managed care health plan (MCP) operating in the geographic area of the WPC Pilot to work in partnership with the Lead Entity when implementing the Pilot specific to Medi-Cal managed care beneficiaries. Participating entities shall also include both the health services and specialty mental health agencies or department, and at least one other public agency or departments, which may include county alcohol and substance use disorder programs, human services agencies, public health departments, criminal justice/probation entities, and housing authorities (regardless of how many of these fall under the same agency head within a county.) WPC Pilots must also include at least two other key community partners that have significant experience serving the target population within the participating county or counties geographic area such as physician groups, clinics, hospitals, and community-based organizations. If a Lead Entity cannot reach agreement with a required participant, it may request an exception to the requirement.

120. Whole Person Care Pilot Beneficiary Participation. Receipt of WPC Pilot services is voluntary and eligible beneficiaries must opt-in to the Pilot; they may also opt out at any time. Lead Entities may identify an enrollment cap for the Pilot during the application approval process. A Lead Entity must notify the State within 90 days prior to imposing an enrollment cap and obtain approval to do so. Lead Entities must develop wait lists when a cap is imposed.

121. WPC Pilot Application Process

a. Timing. Lead Entities shall submit WPC Pilot applications to DHCS by May 15, 2016, or 45 days after DHCS issues the WPC Pilot Request for Application (RFA), whichever is later. Additional funds for existing WPC Pilots or applications for new WPC Pilots may be accepted by the state after the initial application period if additional funds are available. The state shall establish a process to consider additional funding and applications in consultation with CMS. All initial applicant requirements separate from timelines would remain applicable.

b. Application Contents. WPC Pilot applications must include:
   i. Identification of the WPC Pilot Lead Entity;
   ii. Identification of participating entities including a description of each and the role in the WPC Pilot;
   iii. A background description of the geographic area in which the WPC Pilot will operate and the need for the WPC Pilot;
   iv. A general description of the WPC Pilot, its structure, and how it will address the needs of the target population;
   v. A collaboration plan that describes how communication amongst participating

entities and the Lead Entity will occur, how integration will be promoted and silos minimized, details about how decisions will be made in consultation with the WPC Pilot participating entities, and a schedule of regular meetings that will be convened;

vi. A description of the methodology used to identify the target population(s), including data analyses and a needs assessment of the target population;

vii. A description of services that will be available to beneficiaries under the WPC Pilot including medical, behavioral, social and non-medical services;

viii. A description of how care coordination will be implemented administratively including what each participating entity will be responsible for and how they will link to other participating entities, as appropriate, to provide wrap around care coordination to the beneficiary;

ix. Detail of the specific interventions, including how Plan-Do-Study-Act will be incorporated to modify and learn from the interventions during the WPC Pilot;

x. A description of how data sharing will occur between the entities including what data will be shared with which entity and how infrastructure and sharing will evolve over the life of the demonstration;

xi. A description of other strategies that will be implemented to achieve the goals of the WPC Pilot;

xii. Performance measures for each type of participating entity and the WPC Pilot itself, including short-term process measures and ongoing outcome measures; these measures should be grouped by Demonstration Year and include an annual target benchmark;

xiii. Transferring entity(ies) of the non-federal share for payments under the WPC Pilot;

xiv. A plan for the Lead Entity to conduct ongoing monitoring of the WPC Pilot participating entities and make subsequent adjustments should any issues be identified. This should include a process to provide technical assistance, impose corrective action, and termination from the Pilot, if poor performance is identified and continues;

xv. A plan for data collection, reporting, and analysis ongoing of the Pilot's interventions, strategies, and participant health outcomes letters of support from participating providers and other relevant stakeholders in the geographic area where the WPC Pilot will operate;

xvi. Letters of participation agreement from WPC participating entities

xvii. A financing structure including a description of WPC Pilot payments, how they will be distributed, and any financing or savings arrangements;

xviii. A funding diagram illustrating the flow of requested funds from DHCS to the Lead Entity and participating entities;

xix. A total requested annual dollar amount, which shall specify budgeted pre-set payment amounts for each element for which funding is proposed including: infrastructure, baseline data collection, interventions, and outcomes, such that a specific dollar amount is linked in each year to specific deliverables, e.g, the performance of specific activities, interventions, supports and services, and/or outcomes. Budgets should not include costs for services reimbursable with

Medi- Cal or other federal funding resources. Available funding in PYs 1 and 2 may be weighted more heavily towards infrastructure design, and baseline data collection, assessment and development activities;

xx. A description of any requirement exceptions requested;

xxi. An estimated number of beneficiaries to be served annually; and

xxii. A proposed enrollment cap, if applicable.

c. DHCS & CMS Review Process DHCS will review all WPC Pilot applications according to the following guidelines and timeline:

i. The selection criteria for WPC Pilot applications must be submitted for CMS approval before the state approves any applications. CMS shall approve or provide clarifying questions to DHCS in response to the submitted criteria within fifteen (15) business days of receipt.

ii. DHCS shall approve applications that meet the requirements of these WPC STCs and that further the goals of the WPC Pilot.

iii. By April 1, 2016, or within 90 days following CMS approval of WPC Pilot Requirements and Metrics Attachment MM, WPC Pilot Requirements and Application Process , Attachment HH, and WPC Reporting and Evaluation, Attachment GG, whichever is later, DHCS will publish via an RFA the application process, detailed timelines, and selection criteria. The criteria shall include sufficient detail to allow applicants to understand what makes a strong application.

iv. DHCS shall review each application to verify that it conforms to the relevant requirements as described in Attachment HH (WPC Pilot Requirements and Application Process) and meet the selection criteria in the RFA. Within 60 days after submission of the application, DHCS will complete its review of the application, and will respond to the WPC Pilot Lead Entity in writing with any questions, concerns or problems identified. The Lead Entity will respond to DHCS' questions and concerns in writing within 5 business days.

v. Within 30 days after submission of final responses to questions about the application, DHCS will take action on the application and promptly notify the applicant and CMS of that decision. No WPC Pilot shall be awarded more than 30 percent of the total funding available in a given year unless additional funds are available after all initial awards are made and approval is provided by DHCS through an application process.

vi. Within 10 days of DHCS' notification to CMS of DHCS approval of WPC Pilot applications, CMS shall notify DHCS of any concerns or questions regarding final approval.

122. **Lead Entity Agreement.** The WPC Pilot Lead Entity shall enter into an agreement with DHCS which specifies general requirements of the WPC Pilot including a data sharing agreement.

123. **Learning Collaboratives.** The WPC Pilot Lead Entity shall agree to help develop and participate in regular learning collaboratives to share best practices among Pilot entities.

The state will provide CMS its plan for holding learning collaboratives, and give CMS the opportunity to comment.

124. **Termination.** DHCS may suspend or terminate a WPC Pilot if corrective action has been imposed and persistent poor performance continues.

a. The state must develop a termination procedure protocol for CMS comment.
b. The state must also include in its protocol the requirements and process by which the WPC Pilot Lead Entity will notify affected beneficiaries in the event a WPC Pilot is suspended or terminated, including the content of said notices.

125. **Progress Reports**. The WPC Pilot shall submit mid-year and annual reports in a manner specified by DHCS. The WPC Pilot payments shall be contingent on timely submission of the mid-year and annual reports.

126. **Universal and Variant Metrics**. DHCS will categorize Pilots, as appropriate, and will create a list of category-specific performance metrics that the WPC Pilot entities in each category must report mid-year and annually, with reporting to start no later than one year following Pilot implementation after completion of any start-up period. Metrics may be reported partially during the initial implementation period due to data lags. These metrics will allow DHCS to measure progress consistently across Pilots, and allow flexibility for reflecting the variety of strategies. These will be sent to CMS for approval before Pilot applications are accepted. WPC Pilots will report on additional metrics which may vary between Pilots. These metrics will be approved through the application process and will be specific to the structure of the Pilot and target population. Metrics will be described in Attachment MM.

127. **Mid-Point and Final Evaluations.** Comprehensive mid-point and final evaluations will be conducted for WPC Pilot sites as described in Attachment GG. The mid-point evaluation will be due to DHCS one year prior to the expiration of the Demonstration, and the final evaluation will be due to DHCS no later than six months following the expiration of the Demonstration. The purpose of the evaluations will be to understand the extent to which the WPC Pilot interventions:

a. Improve coordination across participating entities including data and information sharing;
b. Improve beneficiary health outcomes;
c. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
d. Increase access to social services;
e. Improve care coordination across participating entities;
f. Improve housing stability, if applicable;

128. **WPC Pilot Protocols.**

a. Within 60 days of CMS approval of the terms and conditions for Medi-Cal 2020, CMS and the State will, through a collaborative process, develop and finalize WPC

Pilot Requirements and Metrics, WPC Pilot Requirements and Application Process, and WPC Reporting and Evaluation. These documents will be incorporated into the STCs as Attachments MM, HH, and, GG respectively).

b. After the state has received a Pilot application, but prior to the state's approval of any proposal, the state will submit to CMS its proposed list of Variant Metrics. CMS reserves the right to propose additional metrics. The Universal and Variant Metrics approved by CMS (including measure specifications) will be incorporated into a revised WPC Reporting and Evaluation (Attachment GG). The state may not approve any application prior to CMS approval of the revised Attachment GG.

129. **WPC Pilot Payment Structure** For purposes of the WPC Pilots, the WPC Pilot year shall begin on January 1 and end on December 31. Beginning in PY1 until the end of the Demonstration, up to $300 million in Federal financial participation shall be made available to fund the WPC Pilots as described in the WPC Pilot Special Terms and Conditions and Attachment HH.

130. **WPC Pilot Payments** Payments from the WPC Pool are available to approved Lead Entities. Funding from the WPC Pool (total computable) shall not exceed $3 billion in the aggregate over five years.

a. Each WPC Lead Entity or other entities as specified in the approved WPC Pilot application will provide the non-federal share of payment through an intergovernmental transfer (IGT). The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 C.F.R. part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. The state must have permissible sources for the non-federal share of WPC expenditures, which may include permissible IGTs from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

b. Funding for PY1 shall be made available to approved applications. Funding will support the initial identification of the target population, and other coordination and planning activities necessary to submit a successful application. Funding for PY1 shall be distributed and shall not exceed 300 million dollars in Federal funds.

c. Funding for PY2 through PY5 shall be made available based on the activities and interventions described in the approved WPC Pilot application. This amount may not exceed the total budget for each year as it appears in the approved application.

d. Notwithstanding the annual limits set forth in STCs 125 and 126, in the event that the number of approved WPC Pilots results in unallocated funding for a given Demonstration year, participating Lead Entities may submit applications to the state in a manner and timeline specified by DHCS proposing that the remaining funds be carried forward into the following PY, or to expand Pilot services or enrollment for which such unallocated funding will be made available. Additional applicants not approved during the initial application process may also submit an application for consideration.
e. If a selected applicant fails to substantially comply with any of the terms of the approved application, DHCS may terminate the contract and redirect remaining funds to other selected applicants or to other applicants whose programs were not previously selected for funding.
f. Payments for WPC Pilots are based on the approved WPC amounts and will be contingent upon specific deliverables, e.g., encounters or persons served, the performance of specific activities, interventions, supports and services, or achievement of Pilot outcomes, as described in the approved WPC application. WPC Pilot Lead Entities will be accountable to DHCS and CMS to demonstrate that WPC Pilot funds were received for the interventions and in the manner agreed upon. The annual progress reports must document how the Lead Entity satisfied the requirements for receiving funding for each component as described in the application. If the Lead Entity cannot demonstrate completion of a deliverable or outcome as described in the application DHCS shall withhold or recoup the WPC funds linked to that deliverable.
g. WPC Pilot Payments Are Not Direct Reimbursement for Expenditures or Payments for Services. Payments from the WPC Pool are intended to support WPC Pilots for infrastructure and non-Medicaid covered interventions that support increased integration among county agencies, health plans, and providers, and other entities within the participating county or counties, increased coordination and appropriate access to care for the most vulnerable, and improved data collection and sharing among local entities to support ongoing case management, monitoring, and strategic program improvements. The payments are not direct reimbursement for expenditures incurred by participating entities in implementing reforms. WPC Pilot payments are not for services otherwise reimbursable under the Medi-Cal program, and therefore providers may continue to bill Medi-Cal and/or the Medi-Cal managed care plan for all State Plan covered services. The WPC Pilot payments are not reimbursement for health care services that are recognized under these Special Terms and Conditions or under the State plan. WPC Pilot payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, disproportionate share hospital payments or administrative activities as defined under these Special Terms and Conditions and/or under the State plan. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs

X. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

131. Drug Medi-Cal Eligibility and Delivery System. The "Drug Medi-Cal Organized Delivery System (DMC-ODS)" is a Pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, increased local control and accountability, greater administrative oversight, creates utilization controls to improve care and efficient use of resources, evidence based practices in substance abuse treatment, and increased coordination with other systems of care. This approach is expected to provide the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery.

132. Drug Medi-Cal Definitions

a. Delivery System The DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. Any county that elects to opt into DMC-ODS services shall submit an implementation plan to the State for approval by DHCS and CMS pursuant to Attachment Z. Upon approval of the implementation plan, the State shall enter into an intergovernmental agreement with the County to provide or arrange for the provision of DMC-ODS services through a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR 438.2DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State will enter into an intergovernmental agreement with the county to provide DMC-ODS services. The county will, in turn, contract with DMC certified providers or offer county- operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design. Counties may act jointly in order to deliver these services.

b. Short-Term Resident Any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

c. Tribal and Indian Health Providers A description of how the Tribal operated and urban Indian health providers, as well as American Indians and Alaska Natives Medi-Cal beneficiaries, will participate in the program through a Tribal Delivery System will be outlined in Attachment BB following approval of this amendment. The provisions in Attachment BB will be consistent with the authorities in the Indian Health Care Improvement Act (including the statutory exemption from state or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act)

and will be developed in consultation with the California tribes, and Tribal and Urban Indian health programs located in the state, consistent with the Tribal Consultation SPA and the CMS Tribal Consultation Policy.

d. DMC-ODS Program Medical Criteria In order to receive services through the DMC-ODS, the beneficiary must be enrolled in Medi-Cal, reside in a participating county and meet the following medical necessity criteria:

   i. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance- Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).
   ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
   iii. If applicable, must meet the ASAM adolescent treatment criteria. As a point of clarification, beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

e. DMC-ODS Determination of Medicaid Eligibility Determination of who may receive the DMC-ODS benefit will be performed as follows:
   i. Medicaid eligibility must be verified by the county or county contracted provider. When the county contracted provider conducts the initial eligibility verification, it will be reviewed and approved by the county prior to payment for services, unless the individual is eligible to receive services from tribal health programs operating under the Indian Self Determination and Education Assistance Act (ISDEAA – Pub.L. 93-638, as amended) and urban Indian organizations operating under title V of the IHCIA. If so eligible, the determination will be conducted as set forth in the Tribal Delivery System - Attachment BB to these STCs.
   ii. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 3(a). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
   iii. Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate; except for NTP services which will require reauthorization annually.

f. Grievances and Appeals Each County shall have an internal grievance process that allows a beneficiary, or provider on behalf of the beneficiary, to challenge a denial of coverage of services or denial of payment for services by a participating County. The Department of Health Care Services will provide beneficiaries access to a state fair hearing process.
   i. The grievance and appeals process for the Tribal Delivery System will be outlined in Attachment BB.

133. DMC-ODS Benefit and Individual Treatment Plan (ITP) Standard DMC services approved through the State Plan Benefit will be available to all beneficiaries in all counties.

a. Beneficiaries that reside in a Pilot County will receive DMC-ODS benefits in addition to other state plan services. County eligibility will be based on the MEDs file.
b. In counties that do not opt into the Pilot, beneficiaries receive only those drug and substance use disorder treatment services outlined in the approved state plan (including EPSDT).
c. Beneficiaries receiving services in counties which do not opt into the Pilot will not have access to the services outlined in the DMC-ODS.
d. The benefits and ITP for the Tribal Delivery System will be discussed in Attachment BB.

Table ONE: State Plan and DMC-ODS Services Available to DMC-ODS Participants (with Expenditure Authority and Units of Service)

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Early Intervention (Note: SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers.)	x (preventive service; physician services)			Annual screen, up to 4 brief interventions
Outpatient Drug Free	x (rehab services)			

Intensive Outpatient	x (rehab services)			15 minute increments
Partial Hospitalization		X		Diagnosis-related Group (DRG)/Certified Public Expenditures (CPE)
Withdrawal management General Acute Care Hospital (VID, INVID) (non-IMD)	x inpatient services			DRG/CPE
CDRH/Free Standing Psych (IMD)			x	DRG/CPE
Residential (perinatal, non-IMD)	x (rehab services)			Per day/bed rate
(all pop., non-IMD)		X		Per day/bed rate
(IMD)			x	Per day/bed rate
NTP	x (rehab services)			Per day dosing; 10 minute increments

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Additional MAT (drug products)	x (pharmacy)			Drug cost
(physician services)	x (physician services; rehab)			Per visit or 15 minute increments
Recovery Services		x		Counseling: 15 min increments
Case Management	x (TCM)	x**		15 min increments
Physician Consultation				15 min increments

*Allowable 1905(a) services are all Medicaid services that can be covered upon CMS approval in a State Plan.

**TCM is not available state-wide as per 1915(g) and is not currently covered in all counties.

The following services (Tables TWO and THREE) must be provided, as outlined in Table FOUR, to all eligible DMC-ODS beneficiaries for the identified level of care as follows. DMC-ODS benefits include a continuum of care that ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses.

Table TWO: ASAM Criteria Continuum of Care Services and the DMC-ODS System

ASAM Level of Care	Title	Description	Provider
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Managed care or fee- for-service
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers, DHCS/ASAM Designated Chemical Dependency Recovery Hospitals, DHCS/ASAM Designated Free Standing Psychiatric hospitals

3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or	DHCS Licensed and DHCS/ASAM Designated Residential Providers, DHCS/ASAM Designated Chemical Dependency Recovery Hospitals, DHCS/ASAM Designated Free Standing Psychiatric hospitals

ASAM Level of Care	Title	Description	Provider
		other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM Designated Residential Providers, DHCS/ASAM Designated Chemical Dependency Recovery Hospitals, DHCS/ASAM Designated Free Standing Psychiatric hospitals
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber

Table THREE: ASAM Criteria Withdrawal Services
(Detoxification/Withdrawal Management) and the DMC-ODS System

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, licensed prescriber; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; licensed prescriber; or OTP.
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals; Physician, licensed prescriber; ability to promptly receive step-downs from acute level 4.

Level of Withdrawal Management	Level	Description	Provider
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Acute care hospital, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals; ability to promptly receive step- downs
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Acute care hospital, sometimes ICU, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals

Counties are required to provide the following services outlined in the chart below. Upon State approval, counties may implement a regional model with other counties or contract with providers in other counties in order to provide the required services.

TABLE FOUR: Required and Optional DMC-ODS Services

Service	Required	Optional
Early Intervention (SBIRT)	• (Provided and funded through FFS/managed care)	
Outpatient Services	• Outpatient (includes oral naltrexone) • Intensive Outpatient	**1.** Partial Hospitalization
Residential	• At least one ASAM level of service initially • All ASAM levels (3.1, 3.3, 3.5) within three years • Coordination with ASAM Levels 3.7 and 4.0 (provided and funded through FFS/managed care)	• Additional levels
NTP	• Required (includes buprenorphine, naloxone, disulfiram)	
Withdrawal Management	• At least one level of service	• Additional levels
Additional Medication Assisted Treatment		• Optional
Recovery Services	• Required	
Case Management	• Required	
Physician Consultation	• Required	

The continuum of care for SUD services outlined in Tables TWO and THREE are modeled after the levels identified in the ASAM Criteria. While counties will be responsible for the oversight and implementation of most of the levels in the continuum, a few of the levels (Early Intervention Services and Levels 3.7 and 4.0 for Residential and Withdrawal Management in acute care hospital settings) are overseen and funded by other sources not under the DMC-ODS. These services are contained in the DMC-ODS Pilot in order to show the entire continuum of care of SUD services available to California's MediCal population. Residential and withdrawal management services (Levels 3.7 and 4.0) can also be provided by counties and funded through the DMC-ODS waiver by utilizing Chemical Dependency Hospitals and/or Acute Free Standing Psychiatric Hospitals. Residential services within Levels 3.1-4.0 may include facilities that hold a current, valid license from another California State department.

134. **Early Intervention Services** (ASAM Level 0.5) Screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder.

a. SBIRT services are not paid for under the DMC-ODS system.
b. SBIRT services are paid for and provided by the managed care plans or by fee- for-service primary care providers.
c. SBIRT attempts to intervene early with non- addicted people, and to identify those who do have a substance use disorder and need linking to formal treatment.

Referrals by managed care providers or plans to treatment in the DMC-ODS will be governed by the Memorandum of Understanding (MOU) held between the participating counties and managed care plans. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties' implementation plan and waiver contracts.

d. The components of Early Intervention are:

    a. Screening: Primary Care physicians screen adults ages 18 years or older for alcohol misuse.
    b. Counseling: Persons engaged in risky or hazardous drinking receive brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary.
    c. Referral: Managed Care Plans and fee-for-service primary care providers will make referrals from SBIRT to the county for treatment through the DMC-ODS.

135. **Outpatient Services** (ASAM Level 1) Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

a. The Components of Outpatient Services are:
    i. Intake: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
    ii. Individual Counseling: Contacts between a beneficiary and a therapist or

counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

iii. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.

d. Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

e. Patient Education: Provide research based education on addiction, treatment, recovery and associated health risks.

f. Medication Services: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

g. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

h. Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.

i. Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan shall include:

    A. A statement of problems to be addressed,
    B. Goals to be reached which address each problem
    C. Action steps which will be taken by the provider and/or beneficiary to accomplish identified goals,
    D. Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof.
    E. Treatment plans have specific quantifiable goal/treatment

objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment.

F. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration.

G. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA.

j. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

136. **Intensive Outpatient Treatment** (ASAM Level 2.1) structured programming services are provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Lengths of treatment can be extended when determined to be medically necessary. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

a. The Components of Intensive Outpatient are (see Outpatient Services for definitions):

i. Intake
ii. Individual and/or Group Counseling
iii. Patient Education
iv. Family Therapy
v. Medication Services
vi. Collateral Services
vii. Crisis Intervention Service
viii. Treatment Planning
ix. Discharge Services

137. **Partial Hospitalization** (ASAM Level 2.5) services feature 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Providing this level of service is optional for participating counties.

138. **Residential Treatment** (ASAM Level 3) is a non-institutional, 24-hour non- medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed

Practitioner of the Healing Arts as medically necessary and in accordance with an individualized treatment plan. Residential services are provided to non-perinatal and perinatal beneficiaries. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

a. Residential services are provided in a DHCS, or for adolescents Department of Social Services, licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
b. Residential services can be provided in facilities of any size.
c. The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents; unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. The average length of stay for residential services is 30 days. Peri-natal clients may receive a longer length of stay based on medical necessity. Peri-natal clients may receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends.)
d. Residential Services for Adults- Residential services for adults may be authorized for up to 90 days in one continuous period. Reimbursement will be limited to two non-continuous regimens for adults in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period (365 days)
e. Residential Services for Adolescents Residential services for adolescents may be authorized for up 30 days in one continuous period. Reimbursement will be limited to two non-continuous 30-day regimens in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period (365 days).
f. One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1- 3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.
g. The components of Residential Treatment Services are (see Outpatient Services for definitions):

i. Intake
ii. Individual and Group Counseling
iii. Patient Education
iv. Family Therapy
v. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
vi. Collateral Services
vii. Crisis Intervention Services
viii. Treatment Planning
ix. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
x. Discharge Services

139. Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized client plan. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

a. Intake: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
b. Observation: The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.
c. Medication Services: The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
d. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

140. Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or

licensed prescriber and approved and authorized according to the State of California requirements. NTPs/OTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram.

a. A patient must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
b. The components of Opioid (Narcotic) Treatment Programs are (see Outpatient Treatment Services for definitions):
    i. Intake
    ii. Individual and Group Counseling
    iii. Patient Education
    iv. Medication Services
    v. Collateral Services
    vi. Crisis Intervention Services
    vii. Treatment Planning
    viii. Medical Psychotherapy: Type of counseling services consisting of a face- to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient.
    ix. Discharge Services

141. Additional Medication Assisted Treatment (ASAM OTP Level 1) includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

a. Opioid and alcohol dependence, in particular, have well- established medication options.
b. The current reimbursement mechanisms for medication assisted treatment (MAT) will remain the same except for the following changes for opt-in counties: buprenorphine, naloxone and disulfiram will be reimbursed for onsite administration and dispensing at NTP programs; additionally, physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment.
c. The components of Additional Medication Assisted Treatment are ordering, prescribing, administering, and monitoring of medication assisted treatment.
d. The goal of the DMC-ODS for MAT is to open up options for patients to receive MAT by requiring MAT services in all opt-in counties, educate counties on the various options pertaining to MAT and provide counties with technical assistance to implement any new services. These medications are available through the DMC- ODS and outside of Drug Medi-Cal programs. Further details explaining the financing and availability of MAT services in the Medi-Cal system are contained in Attachment CC.
e. Counties may also choose to utilize long-acting injectable naltrexone in allowable DMC facilities under this optional provision. Long-acting injectable naltrexone will be reimbursed for onsite administration and physicians and licensed prescribers in DMC-ODS programs will be reimbursed for the ordering,

prescribing, administering and monitoring.

f. Counties that choose to provide long-acting injectable naltrexone through this option must cover the non-federal share cost. While a treatment authorization request will not be required at the State level, under this option the county may choose to implement an approval process at the county level.

142. **Recovery Services**: Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

a. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse.

b. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

c. The components of Recovery Services are:

i. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

ii. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

iii. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

iv. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

v. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

vi. Support Groups: Linkages to self-help and support, spiritual and faith-based support;

vii. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

143. **Case Management:** Counties will coordinate case management services. Case management services can be provided at DMC provider sites, county locations, regional centers or as outlined by the county in the implementation plan; however, the county will be responsible for determining which entity monitors the case management activities. Services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.

a. Counties will be responsible for coordinating case management services for

the SUD client. Counties will also coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

b. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
c. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.
d. Case management services include:
    i. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
    ii. Transition to a higher or lower level SUD of care;
    iii. Development and periodic revision of a client plan that includes service activities;
    iv. Communication, coordination, referral and related activities;
    v. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
    vi. Monitoring the beneficiary's progress;
    vii. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services; and,
    viii. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

144. **Physician Consultation Services** include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries.

a. Physician consultation services are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
b. Counties may contract with one or more physicians or pharmacists in order to provide consultation services. Physician consultation services can only be billed by and reimbursed to DMC providers.

145. **Intersection with the Criminal Justice System:** Beneficiaries involved in the criminal justice system often are harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. Additional services for this population may include:

a. Eligibility: Counties recognize and educate staff and collaborative

partners that Parole and Probation status is not a barrier to expanded Medi-Cal substance use disorder treatment services if the parolees and probationers are eligible. Currently incarcerated inmates are not eligible to receive FFP for DMC-ODS services.

b. Lengths of Stay: Counties may provide extended lengths of stay for withdrawal and residential services for criminal justice offenders if assessed for need (e.g. up to 6 months residential; 3 months FFP with a one-time 30-day extension if found to be medically necessary and if longer lengths are needed, other county identified funds can be used).

c. Promising Practices: Counties utilize promising practices such as Drug Court services.

146. DMC-ODS Provider Specifications The following requirements will apply to DMC-ODS staff:

a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff.

c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.

d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

147. Responsibilities of Counties for DMC-ODS Benefits

The responsibilities of counties for the DMC-ODS benefit shall be consistent with each county's intergovernmental agreement with DHCS, and shall include that counties do the following.

a. Selective Provider Contracting Requirements for Counties: Counties may choose the DMC providers to participate in the DMC-ODS. DMC certified providers that do not receive a county contract cannot receive a direct contract with the State in counties which opt into the Pilot. If a county does not participate in the Pilot or is removed from participation in the Pilot by the State, the county will continue to cover state plan services.

b. Access: Each county must ensure that all required services covered under the DMC-ODS Pilot are available and accessible to enrollees of the DMC-ODS. NTP services are an important modality within the continuum of care. Counties are required to provide this service. Access to medically necessary NTP services

cannot be denied for DMC-ODS eligible beneficiaries. Eligible DMC-ODS beneficiaries will receive medically necessary services at a DMC certified NTP provider. All DMC-ODS services, including Medi-Cal NTP services, shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the county implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately. If the DMC-ODS network is unable to provide services, the county must adequately and timely cover these services out-of-network for as long as the county is unable to provide them.

c. All counties must ensure that beneficiaries who live in an opt-out county, but receive NTP services in an opt-in county do not experience a disruption of services. The opt-out county will claim state plan expenditures for the reimbursement made to the out-of-county NTP providers in accordance with the approved state plan methodology for services furnished to beneficiaries. No persons eligible for DMC-ODS services, including Medi-Cal funded NTP treatment services, will be placed on waiting lists for such services due to budgetary constraints.

d. The DMC-ODS Pilot program is administered locally by each demonstration county and each county provides for, or arranges for, substance use disorder treatment for Medi-Cal beneficiaries. Access cannot be limited in any way when counties select providers. Access to State Plan services must remain at the current level or expand upon implementation of the Pilot. The county shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors and that is sufficient to provide adequate access to all services covered under this Pilot. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, the county must consider the following:

    i. Require its providers to meet Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

    ii. The anticipated number of Medi-Cal eligible clients.

    iii. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries

    iv. The expected number and types of providers in terms of training and experience needed to meet expected utilization.

    v. The number of network providers who are not accepting new beneficiaries

    vi. The geographic location of providers and their accessibility to

beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disable beneficiaries.

e. Medication Assisted Treatment Services- Counties must describe in their implementation plan how they will guarantee access to medication assisted treatment services.

f. Counties currently with inadequate access to medication assisted treatment services must describe in their implementation plan how they will provide the service modality.

g. Counties are encouraged to increase medication assisted treatment services by exploring the use of the following interventions:
   i. Extend NTP/OTP programs to remote locations using mobile units and contracted pharmacies which may have onsite counseling and urinalysis.
   ii. Implement medication management protocols for alcohol dependence including naltrexone, disulfiram, and acamprosate. Alcohol maintenance medications may be dispensed onsite in NTPs/OTPs or prescribed by providers in outpatient programs.
   iii. Provide ambulatory alcohol detoxification services in settings such as outpatient programs, NTPs/OTPs, and contracted pharmacies.

h. Selection Criteria and Provider Contracting Requirements: In selecting providers to furnish services under this Pilot, counties must:
   i. Must have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this amendment and applicable federal laws and regulations.
   ii. Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.
   iii. Must not discriminate against persons who require high-risk or specialized services.
   iv. May contract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
   v. Select only providers that have a license and/or certification issued by the state that is in good standing.
   vi. Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a “high” categorical risk prior to furnishing services under this pilot, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider

(as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101),

that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e) If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider, shall be subject to suspension pursuant to Welfare and Institutions Code section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code section 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint-based background checks required under 42 CFR 455.434.

vii. Select only providers that have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

viii. Counties may contract individually with licensed LPHAs to provide services in the network.

ix. Must not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.

x. Must enter into contracts with providers that they have selected to furnish services under this pilot program. All contracts with providers must include the following provider requirements:

A. Services furnished to beneficiaries by the provider under this amendment are safe, effective, patient-centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine;
B. Possess the necessary license and/or certification;
C. Maintain a safe facility by adhering to the state licensing and certification regulations;
D. Maintain client records in a manner that meets state and federal standards;
E. Shall meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation, for residential services only, prior to providing Pilot services;
F. Be trained in the ASAM Criteria prior to providing services;
G. Meet quality assurance standards and any additional standards established by the county or other evaluation process; and
H. Provide for the appropriate supervision of staff.

xi. If a county elects to contract with a managed care plan to furnish services under this pilot, the contract must ensure that any provider furnishing services under this pilot on behalf of the managed care plan meets all of the requirements that apply to a provider (and any Medical Director) that is selected by a county under this section to furnish services under this Pilot.

148. Contract Denial: Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

a. County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.
   i. Counties shall have a protest procedure for providers that are not awarded a contract.
   ii. The protest procedure shall include requirements outlined in the State/County contract.
   iii. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the Department of Health Care Services (DHCS). If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.
b. DHCS Appeal Process: A provider may appeal to DHCS as outlined in Attachment Y.

149. Authorization: Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider. Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements

for the service. Counties shall have written policies and procedures for processing requests for initial and continuing authorization of services. Counties are to have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Counties are to meet the established timelines for decisions for service authorization. Counties are required to track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied. This prior authorization for residential services is compliant with the Medicaid- applicable parity requirements established by the Mental Health Parity and Addiction Equity Act. Non-residential services shall not require prior authorization.

a. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the template for the implementation plan, which is included here as Attachment Z. Counties cannot commence services without an implementation plan approved by the state and CMS. Counties must also have an executed State/County intergovernmental agreement (managed care contract per federal definition) with the county Board of Supervisors and approved by CMS. County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery.
b. One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1- 3.5) within three years of CMS approval of the county implementation plan and state- county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.
c. Upon CMS approval of the implementation plan and an executed contract, counties will be able to bill prospectively for services provided through this Pilot.
d. Below is a summary of the requirements that must be submitted with the county implementation plan:

Service descriptions
Care coordination strategy • MOU with managed care plan • DMC transitions, especially aftercare and recovery supports
• Withdrawal Management • Outpatient • Intensive Outpatient • NTP/OTP • Additional MAT • Residential

Provider network development plan • By service • With timeline pegged to specified timeliness standard • Network adequacy requirements (will vary by county)
Phase-in description for a one-year provisional period* • By service • With timeline and deliverables pegged to timeliness measure

*Only applies to counties unable to meet all mandatory requirements.

150. **Provisional Option:** For counties that are unable to comply fully with the mandatory requirements upon implementation of this Pilot, at the time of approval by DHCS and CMS, there exists the option for a one-year provisional period. A one year-provisional option will provide counties the opportunity to participate in the DMC-ODS Pilot while taking the necessary steps to build system capacity, provide training, ensure appropriate care coordination, and implement a full network of providers as described in the Pilot.

a. In order to apply for the one-year provisional option, a county must include with their implementation plan a strategy for coming into full compliance with the terms of this Pilot. Specifically, each county must describe the steps it will take to provide all required DMC-ODS services that it cannot provide upon initial DMC-ODS implementation. The county will assure that all DMC-ODS services will be available to beneficiaries (whether the services are provided in-network, out-of-network, or using telehealth) while meeting the timeliness requirement during the course of the one-year probation option.

b. At least sixty (60) days prior to the expiration of the one-year provisional period, counties must resubmit their revised implementation plans for renewal. The plans will describe how the county has implemented the requirements which they originally could not provide. DHCS and CMS will review the revised implementation plans, in conjunction with the state and county monitoring reports as described in Sections 5 and 6 of this amendment, to assess if the county is progressing towards complying fully with the terms of this Pilot. If a county originally awarded a one-year provisional option is able to fully comply with the terms of this Pilot upon renewal, they will be eligible to receive approval to participate in the remainder of the Pilot. If a county originally awarded a one- year provisional option is not able to fully comply with the terms of this Pilot, DHCS and CMS may approve a renewal pursuant to a Corrective Action Plan (CAP). The CAP will describe how the county will continue to implement its phase-in approach pursuant to its implementation plan, and will assure that all DMC-ODS services are available to beneficiaries in the interim (whether the services are provided are in-network, out-of-network, or using telehealth) within the timeliness requirement.

151. **State-County Intergovernmental Agreement (Managed Care Contract per federal definition):** DHCS will require a State-County intergovernmental agreement (managed care contract per federal definition) to be signed between the state and the county in opt- in counties, subject to CMS approval. The intergovernmental agreement will provide further detailed requirements including but not limited to access, monitoring, appeals and other provisions. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). CMS will review and approve the State-County intergovernmental agreement (managed care contract per federal definition) to ensure that the DMC-ODS program is operated in a manner that reduces the risk of fraud and abuse to the maximum extent feasible.

152. **Coordination with DMC-ODS Providers:** Counties will include the following provider requirements within their contracts with the providers.

a. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to- day operations. Translation services must be available for beneficiaries, as needed.
b. Medication Assisted Treatment: Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of clients who are prescribed these medications unless the client refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.
c. Evidenced Based Practices: Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP include:
    i. Motivational Interviewing: A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes.
    ii. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
    iii. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
    iv. Trauma-Informed Treatment: Services must take into account an

understanding of trauma, and place priority on trauma survivors' safety, choice and control.

v. Psycho-Education: Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self- awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

153. **Beneficiary Access Number**: All counties shall have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.

154. **Beneficiary Informing**: Upon first contact with a beneficiary or referral, counties shall inform beneficiaries about the amount, duration and scope of services under this waiver in sufficient detail to ensure that the beneficiaries understand the benefits to which they are entitled.

155. **Care Coordination:** Counties' implementation plans and state/county contracts (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition) how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

a. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate which beneficiaries receiving SUD services will receive care coordination.

b. The participating county shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties'

implementation plan. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s). Any MOU shall be consistent with the confidentiality provisions of 42 CFR Part 2.

c. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

   i. Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
   ii. Beneficiary engagement and participation in an integrated care program as needed;
   iii. Shared development of care plans by the beneficiary, caregivers and all providers;
   iv. Collaborative treatment planning with managed care;
   v. Delineation of case management responsibilities;
   vi. A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
   vii. Availability of clinical consultation, including consultation on medications;
   viii. Care coordination and effective communication among providers including procedures for exchanges of medical information;
   ix. Navigation support for patients and caregivers; and
   x. Facilitation and tracking of referrals between systems including bidirectional referral protocols.

156. Integration with Primary Care: DHCS is committed to participate in the Medicaid Innovation Accelerator Program initiative for substance use disorder, specifically in the Targeted Learning Opportunity topics on primary care and SUD integration.

DHCS is embarking on a strategy to integrate physical and behavioral health care services delivered to beneficiaries in order to improve health outcomes for beneficiaries with SUD and reduce costs in the Medi-Cal program. DHCS will explore options for identifying the best integration strategy upon approval of this waiver amendment and will commit to specifying an integration approach by April 1, 2016. DHCS will produce a concept design for an integrated care model by October 1, 2016, with the goal of implementing physical and behavioral health integration by April 1, 2017.

157. ASAM Designation for Residential Providers: In order to enroll in Medi-Cal and bill for

services under the auspices of this waiver, all residential providers must be designated to have met the ASAM requirements described in STC 134. DHCS will develop a designation program by July 1, 2015 to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM criteria. As part of this designation program, DHCS will use an existing tool or develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1- 3.5, develop standard program audit materials and protocols, and implement the ASAM designation program. The timeline for this designation program is outlined in an attachment and will be technically amended after the program has been developed.

158. Services for Adolescents and Youth: At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria. In addition, the state will identify recovery services geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin "Coverage for Behavioral Health Services for Youth with Substance Use Disorder".

159. DMC-ODS State Oversight, Monitoring, and Reporting.

a. Monitoring Plan: The State shall maintain a plan for oversight and monitoring of DMC-ODS providers and counties to ensure compliance and corrective action with standards, access, and delivery of quality care and services. The state/county intergovernmental agreement (managed care contracts per federal definition) will require counties to monitor providers at least once per year, and the state to monitor the counties at least once per year through the External Quality Review Organizations (EQRO). If significant deficiencies or significant evidence of noncompliance with the terms of this waiver, the county implementation plan or the state/county intergovernmental agreement are found in a county, DHCS will engage the county to determine if there challenges that can be addressed with facilitation and technical assistance. If the county remains noncompliant, the county must submit a corrective action plan (CAP) to DHCS. The CAP must detail how and when the county will remedy the issue(s). DHCS may remove the county from participating in the Pilot if the CAP is not promptly implemented.

b. Timely Access. The state must ensure that demonstration counties comply with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to Medi-Cal population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

c. Program Integrity. The State has taken action to ensure the integrity of oversight processes and will continue to closely monitor for any wrongdoing that impacts the DMC-ODS. The State will continue to direct investigative staff, including trained auditors, nurse evaluators and peace officers to continue to discover and eliminate complex scams aimed

at profiting from Medi-Cal. Efforts include extensive mining and analyzing of data to identify suspicious Drug Medi-Cal providers; designating DMC providers as "high" risk which requires additional onsite visits, fingerprinting and background checks (except for county providers); and regulations that strengthen DMC program integrity by clarifying the requirements and responsibilities of DMC providers, DMC Medical Directors, and other provider personnel. In conducting site visits of providers seeking to furnish services under this Pilot, the State shall conduct a site visit monitoring review of every site through which the provider furnishes such services. In addition, providers that have not billed DMC in the last 12 months have been and will continue to be decertified. Counties are required to select and contract with providers according to the requirements specified in section 4(iv) of this amendment

The State will ensure that the counties are providing the required services in the DMC-ODS, including but not limited to the proper application of the ASAM Criteria, through the initial approval in the county implementation plan and through the ongoing county monitoring. The State will conduct a state monitoring review for residential facilities to provide an ASAM designation prior to facilities providing Pilot services. This review will ensure that the facility meets the requirements to operate at the designated ASAM level (as explained in 4(k)).

d. Reporting of Activity: The State will report activity consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements. Such oversight, monitoring and reporting shall include all of the following:
   i. Enrollment information to include the number of DMC-ODS beneficiaries served in the DMC-ODS program.
   ii. Summary of operational, policy development, issues, complaints, grievances and appeals. The State will also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.
   iii. Number of days to first DMC-ODS service at appropriate level of care after referral
   iv. Existence of a 24/7 telephone access line with prevalent non-English language(s)
   v. Access to DMC-ODS services with translation services in the prevalent non-English language(s)
   vi. Number, percentage and time period of authorization requests approved or denied

e. Triennial Reviews: During the triennial reviews, the State will review the status of the Quality Improvement Plan and the county monitoring activities. This review will include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review. This triennial review will provide the State with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity. The counties will receive a final report summarizing the findings of the triennial review and if out of compliance, the

county must submit a plan of correction (POC) within 60 days of receipt of the final report. The State will follow-up with the POC to ensure compliance.

160. **DMC-ODS County Oversight, Monitoring and Reporting**. The intergovernmental agreement with the state and counties that opt into the waiver must require counties to have a Quality Improvement Plan that includes the county's plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services. For counties that have an integrated mental health and substance use disorders department, this Quality Improvement Plan may be combined with the Mental Health Plan (MHP) Quality Improvement Plan.

a. The county shall have a Quality Improvement committee to review the quality of substance use disorders services provided to the beneficiary. For counties with an integrated mental health and substance use disorders department, the county may use the same committee with SUD participation as required in the MHP contract.
b. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment
    ii. Timeliness of services of the first dose of NTP services
    iii. Access to after-hours care
    iv. Responsiveness of the beneficiary access line
    v. Strategies to reduce avoidable hospitalizations
    vi. Coordination of physical and mental health services with waiver services at the provider level
    vii. Assessment of the beneficiaries' experiences
    viii. Telephone access line and services in the prevalent non-English languages.

c. Each county's QI Committee should review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol.
    i. Number of days to first DMC-ODS service at appropriate level of care after referral
    ii. Existence of a 24/7 telephone access line with prevalent non-English language(s)
    iii. Access to DMC-ODS services with translation services in the prevalent non- English language(s)
    iv. Number, percentage of denied and time period of authorization requests approved or denied

d. Counties will have a Utilization Management (UM) Program assuring that beneficiaries

have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care. Counties shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

e. Counties will provide the necessary data and information required in order to comply with the evaluation required by the DMC-ODS.

161. **DMC-ODS Financing** For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC- ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide their county with financial data on an annual basis. This data is to be collected for the purpose of setting the rates after the expiration of the waiver. The DHCS Rates Setting Workgroup shall propose a recommended format for this annual financial data and the State will approve a final format. Counties shall provide this financial data to the DHCS Rates Setting Workgroup upon its request. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

a. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment AA) must explain the process the State will use to determine costs incurred by the counties under this demonstration.
b. Only state plan DMC services will be provided prior to the DHCS and CMS approval of the State/County intergovernmental agreement (managed care contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC- ODS services.
c. SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including

Drug Medi- Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.

d. Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure, including but not limited to, for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

162. DMC-ODS Evaluation Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care. Specifically, the data collection, reporting and analysis strategy for this waiver program will be designed to assess:

a. The impact of providing intensive outpatient SUD services in the community;
b. The effectiveness of drug based SUD treatments;
c. The impact of providing residential SUD services;
d. Whether the length of stay of residential SUD services affects the impact of such services; and
e. 5) Whether the residential treatment methods affect the impact of such services.

These impacts will be assessed in terms of beneficiary access, health care costs, outcomes and service utilization, and will utilize a comparison between comparable populations in opt-in counties and other counties. The measurement strategy will track readmission rates to the same level of SUD care or higher, emergency department utilization and inpatient hospital utilization. The measurement strategy will also evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD continuum as well as linkages with primary care upon discharge.

California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The design of the evaluation is contained in Attachment DD, UCLA Evaluation. The state will submit the complete design of the evaluation within 60 days of the approval of

the amendment.

One of the focuses of the first year of the evaluation will be that each opt-in county has an adequate number of contracts with NTP providers, access to NTP services has remained consistent or increased and that no disruption to NTP services has occurred as a result of the DMC-ODS.

163. Federal 42 CFR 438 and other Managed Care Requirements

a. Any entity that receives a prepayment from the state to provide services to beneficiaries will be considered by federal definition, a managed care plan and held to all federal 42 CFR 438 requirements and requirements in this section. Accordingly, counties participating in this DMC-ODS Pilot program will be considered managed care plans. CMS will waive the following 438 requirement(s):
    i. 438.310-370 (External Quality Review Organizations, or EQROs). Opt-in counties will include in their implementation plan a strategy and timeline for meeting EQR requirements. EQR requirements must be phased in within 12 months of having an approved implementation plan. EQRO monitoring visits will begin in March 2016 in Phase One counties and Phase Two counties will begin in September 2016. By January 2017, the EQRO will begin monitoring all Pilot counties phased into the DMC-ODS.
    ii. 438.52- Enrollment: of beneficiaries in a single DMC-ODS in each county. The DMC-ODS meets the criteria set forth in the preamble of the MMC Final Rule published on June 14, 2002 for approving waivers for the choice requirement for PIHPs.
    iii. 438.56 – Disenrollment: Requirements and Limitations: The DMC-ODS meets the criteria set forth in the preamble of the MMC Final Rule published on June 14, 2002 for approving waivers for the choice requirement for PIHPs. A waiver of choice requirement conversely implies that of disenrollment since both go hand in hand.
    iv. 438.10 (f)(3)-Information requirements: This section establishes specific requirements for the types, content and distribution of information describing the DMC-ODS program. Waiver of the distribution requirements of subsection (f)(3), allows DMC-ODS to provide informing materials and provider lists that meet the content requirements of Section 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (f)(3) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution.
    v. Implementation cannot begin prior to CMS review and approval of the State/County intergovernmental agreement (managed care plan contracts per federal definition).
    vi. At least sixty (60) days prior to CMS contract approval the state shall submit for each opt-in county the applicable network adequacy requirements as part of the county implementation plan. CMS concurrence with standards is required.

vii. At least sixty (60) days prior to CMS contract approval the state shall provide all deliverables necessary to indicate compliance with network adequacy requirements.

XI. Negative Balance

164. Repayment of Payment Management System (PMS) Negative Account Balances: As of November 20, 2015, the total of all Medicaid and CHIP negative subaccount balances through Federal Fiscal Year 2013 for the State of California is **$1,277,770,233**. In order to bring the accounts into balance, the State shall do the following:

a. Issue Resolution. CMS and State shall work collaboratively to resolve outstanding issues, including action on deferred plan amendments, other open deferrals, delayed CMS-64 certifications, delayed certified public expenditure reconciliations, positive PMS account balances through FY 2013, the False Claim Act reduction, and overpayment of third party liability collections. By June 30, 2017, CMS and State will:

   i. Identify and document outstanding issues;
   ii. Prioritize list; and
   iii. Create timeline for resolution of each issue by June 30, 2017.

b. Repayment Process.

   i. Negative Account Balances - For any negative account balances unresolved as of June 30, 2017, CMS will issue a demand letter to the state identifying the final negative account balance amount and the state's right to appeal. The state may request a repayment schedule in attachment PP that ensures repayment of any remaining amount of the negative account balances identified through Federal Fiscal Year 2013 through regular quarterly installments, plus interest, by the end of the waiver period (12/31/2020) or in three years or less from CMS' approval of the repayment schedule, whichever is longer. The repayment period will not be extended if the waiver is renewed or extended. Interest will begin on the date of the demand notice and end when the debt is paid in full. Additional repayment requirements are identified in section C through H below.

   ii. Deferred Claims - For any deferred claims 1) not paid by CMS by June 30, 2017, 2) for which the state has drawn federal financial participation (FFP) from its PMS account, and 3) for which the state has not returned all drawn FFP to its PMS account by June 30, 2017, CMS shall proceed by disallowance in accordance with 42 CFR 430 Subpart C. The state may request a repayment schedule in accordance with 42 CFR 430 Subpart C. This repayment is not subject to the provisions of subsection C through H below.

c. Repayment Period Interest. Interest will accrue on the final unresolved negative account balance amount; at the Current Value of Funds Rate (CVFR) published by the U.S. Department of Treasury, beginning on the date of the demand letter issued by CMS pursuant to STC 160(b)(i) until the entire principle amount is repaid in full. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance

until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

d. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

e. Source of Repayment Funds. The funding source of repayment cannot be derived from federal funds, including any Medicaid or CHIP funds available to the state in FY 2014 or later PMS accounts.

f. Mechanism of Repayment. The quarter payment amount due or payment in full may be sent via FedWire (preferred), Automated Clearing House (ACH), or check – specific instructions for FedWire or ACH may be obtained from your state's Division of Payment Management representative. The quarter payment amount due or in payment full via check should be made payable to: "The Department of Health and Human Services" and sent to the following address:

HHS Program Support Center P.
O. Box 530231
Atlanta, GA 30353-0231

Please include your PMS account number and a brief description explaining the nature of the return. Please include a copy of this STC along with your payment.

g. PMS Draws for Deferred FFP. When CMS issues a deferral of claims for FFP to the state in accordance with the timelines set forth in 42 CFR 430.40, the state must immediately return the deferred FFP to the applicable PMS subaccount while the deferral is being resolved. After CMS reviews the deferred claims, CMS will determine the allowability of the claims. If CMS determines that a deferred claims are allowable under federal requirements, CMS will release the deferred funds to the appropriate PMS subaccount and will notify California that the funds are available for draw.

h. Adjustments to Repayment Schedule. The state may request a recalculation of the repayment schedule from CMS if the state decides to make accelerated repayment installments. CMS will also adjust and reissue the repayment schedule to reflect any positive Medicaid grant awards issued that reduce the outstanding negative account balance amounts in any of the following PMS subaccounts:

i. FY 2009 and Prior MT
ii. XIX-MAP11
iii. XIX-ADM11
iv. HIT-ADM11

v. ARRA-EXT INC-FMAPEXTN
vi. XIX-MAP12
vii. XIX-ADM12
viii. HIT-IMP12
ix. HIT-IMP13

i. Cash Management Improvement Act (CMIA) Agreement. The Repayment of Payment Management System (PMS) Negative Account Balances section of these STCs does not preclude action by other federal agencies, including the United States Department of Treasury resulting from a violation of the CMIA agreement between the State of California and the United States Department of Treasury.

XII. Global Payment Program

165. Global Payment Program for Public Health Care Systems

a. California will operate a global payment program (GPP) to assist public health care systems (PHCS) that provide health care for the uninsured. The GPP is meant to focus on value, rather than volume, of care provided. The purpose is to support PHCS for their key role in providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Promoting more cost-effective and higher value care means that the payment structure will reward the provision of care in more appropriate venues, rather than through the emergency department or through inpatient hospital settings. The State will test a new approach to assist PHCS, and will evaluate the success of the GPP for potentially broader application.

b. Under the GPP, participating PHCS will receive GPP payments that will be 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 reinforce structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. The methodology for setting service values will incorporate measures of value for the patient in conjunction with the recognition of costs to the health care system. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness.

c. Payments will not exceed the limits in Attachment EE but may be less if the thresholds are not achieved. Services will be grouped into categories that reflect where care is being provided. Within each category services will be grouped into tiers of similar service intensity. This will assist in modifying relative values of services, so that their long term value is incorporated and no longer an externality. Service tiers across categories that aim to provide the same end result would have relative values of generally equivalent care. The intent of this framework is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that

is person-centered.

d. The total amount available for the GPP is a combination of portion the state's DSH allotment that would otherwise be allocated to the PHCS and the amount associated with the Safety Net Care Uncompensated Care Pool under the Bridge to Reform demonstration.

166. Entities Eligible to Receive Global Payments. Payments under the GPP are available for PHCS that are comprised of a designated public hospital (DPH) identified in Attachment C that agrees to participate in the GPP and the DPH's affiliated and contracted providers (collectively, for purposes of the GPP only, Public Health Care System or "PHCS"). For purposes of the GPP, multiple DPHs and their affiliated and contracted providers may comprise a single PHCS in accordance with criteria established and set forth in Attachment EE (GPP Funding and Mechanics Protocol). DHCS shall identify to CMS all PHCS that will participate in the GPP. A list of Public Health Care Systems is set forth in Attachment C.

167. General Overview of Global Payments

a. Global payments shall be available based on a GPP program year that aligns with the state fiscal year from July 1 through June 30 ("GPP PY"). The first GPP PY is for the period July 1, 2015 through June 30, 2016.

b. An annual GPP budget for each participating PHCS shall be established in accordance with the parameters set forth in Attachment EE (GPP Funding and Mechanics Protocol). The aggregate GPP budget among participating PHCS shall not exceed the total computable amount of GPP funds available in a given GPP PY, as established by the limits set forth in STC 167.

c. PHCS shall be required to provide a threshold amount of care, measured in points, to earn their entire annual GPP budget amount. Points for services will be assigned in a manner that incorporates measures of value for the patient and that achieves other programmatic goals, as set forth in Attachment FF Valuation of Services.

d. Each PHCS annual threshold point amount is determined through a baseline analysis, accounting for factors such as its historical and projected volume, cost and mix of services to the uninsured and estimated need, determined in accordance with Attachment FF. These thresholds will ensure that PHCS only receive full GPP payments if the PHCS provides levels of services to the uninsured population necessary to meet its threshold that has been set based on the level of services that would otherwise have been provided to the uninsured. For purposes of the GPP, care will be considered uninsured for individuals for whom there is no source of third party coverage for the specific service furnished by the PHCS. Furthermore, an individual will not be considered uninsured with regard to a non-traditional

service (as identified in Attachment FF, GPP Valuation Methodology Protocol) he or she receives from the PHCS if the individual has a source of third party coverage for the category of service for which the non-traditional service is being used as a substitute.

e. Interim GPP payments shall be made to PHCS on a quarterly basis, calculated as 25% of the PHCS's annual global budget. Within nine months following the end of each GPP PY, the State shall reconcile interim payments to the amount earned for services as established by the reports submitted in accordance with f. below.

f. Attachment EE (GPP Funding and Mechanics Protocol) sets forth a reporting schedule by which each PHCS will report its actual services provided under the GPP, the corresponding points valuation, and the payments due. The report shall at least include the GPP-related services furnished by the PHCS during the applicable year, reported by category, tier, and type, and shall serve as the basis for reconciling interim GPP payments with final amounts due. As payments for services under the GPP are based on point value, no cost reconciliation protocol will apply. PHCS shall not be subject to the reporting requirements of 42 C.F.R. Section 447.299.

g. The full amount of a PHCS global budget shall be payable to the PHCS if it meets or exceeds its designated threshold for a given GPP PY. In the event a PHCS does not achieve or exceed its threshold for a given GPP PY, the PHCS's GPP payment shall equal its global budget as reduced by the proportion by which it fell short of its threshold.

h. The State, in accordance with procedures set forth in Attachment EE (GPP Funding and Mechanics Protocol), shall redistribute unearned GPP funds that were available in a given GPP PY amongst other PHCS that have exceeded their respective threshold for that year.

i. The non-federal share of GPP payments will be provided by PHCS through intergovernmental transfers (IGT), subject to the requirements of STC 188 (Sources of Non-Federal Share) below. Upon receipt of the IGTs, DHCS will draw the federal funding and pay both the non-federal and federal shares of the applicable GPP payments in accordance with the requirements and schedules described herein and in Attachment EE (GPP Funding and Mechanics Protocol). In the event GPP payments are recouped upon reconciliation, DHCS will repay the corresponding federal share to CMS in accordance with federal regulations at 42 CFR 430.30, et seq.

j. GPP payments determined annually for each eligible PHCS, after accounting for

finalization of the applicable DSH allotment and subparagraphs g and h as applicable, represent the final amounts available for that GPP PY.

168. Valuation of Services.

a. Services under the GPP shall be valued in accordance with the methodology set forth in Attachment FF (GPP Valuation Methodology). The valuation methodology allows for the continuation of services provided by Public Health Care Systems that were reimbursed under the previous Demonstration's DSH and SNCP structure, while encouraging more cost-effective and innovative care where appropriate. Point values shall also be developed for those innovative or alternative services where there is currently little to no reimbursement. The valuation methodology reflects the following programmatic goals:
   i. Facilitate a shift away from the previous cost-based payment that was restricted to mostly hospital settings and subject to prolonged periods of cost reconciliation;
   ii. Broaden the settings in which Public Health Care Systems receive payment for services furnished to the uninsured, and encourages Public Health Care Systems to provide greater primary and preventive services, as well as to create access to alternative modalities such as telehealth, group visits and health coaching;
   iii. Emphasize coordinated care and alternative modalities by recognizing the higher value of access to primary care, ambulatory care, and other core components of care management, as compared to the higher cost of avoidable emergency room visits and acute care hospital stays;
   iv. Recognize the value of services that typically are not directly or separately reimbursed by Medicaid or other payors ("non-traditional" services), and that substitute or complement services for which payment is typically available upon provision of the service ("traditional" services).

b. All services eligible for points under the GPP are grouped into the four categories described below in STC 167:

   Services within the categories are further stratified into tiers based on similar service intensity, activity and/or effort. Relative point values are assigned to tiers for purposes of reporting and generating payments.

c. The valuation methodology incorporates a phased approach in which traditional services, over the course of the Demonstration term, reflect reduced point values. High intensity services will continue to be recognized for their value and importance, including recognition in the point system that emergency room visits and inpatient stays may be necessary and appropriate.

d. Relative values will be initially set based on cost and then adjusted to a limited degree based on other measures of value, in order to assist in maintaining accountability for the amount of services provided compared to the funding Public Health Care Systems receive. Higher relative value points may be assigned to services, including non-traditional services that help promote one or more of the objectives from the list below; however, the relative point value of services, except for those services for which cost information is not readily available, such as non- traditional services, may not vary from their initial cost-based amounts by more than 40 percent at any time during the GPP.

    i. Timeliness and convenience of service to patient;
    ii. Increased access to care;
    iii. Earlier intervention;
    iv. Appropriate resource use for a given outcome;
    v. Health and wellness services that result in improved patient; decisions and overall health status;
    vi. Potential to mitigate future costs;
    vii. Preventive services;
    viii. Likelihood of bringing a patient into an organized system of care;
    ix. Additional criteria, to be designed by the state;

e. In GPP PYs in which point revaluation has occurred, point revaluation must be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if its utilization and the mix of services provided remained the same as in the baseline period used to determine the designated threshold.

f. The exact methodology for assigning points to the services will be provided for CMS approval in Attachment FF. The methodology will require CMS approval before it can be implemented. If the state proposes to change point valuations or add new services, it must obtain CMS approval before they may be implemented in the program.

g. PHCS are not required to provide every service identified on Attachment FF (GPP Valuation Methodology), but are allowed the flexibility to provide services, through their global payments budgets and service-related point thresholds, to address local needs.

169. Global Payment Protocols. Within 60 days of CMS approval of the terms and conditions for Medi-Cal 2020, CMS and the State will, through a collaborative process, develop and finalize Global Payment Funding and Mechanic Protocols, and Global Payment Valuation Protocol. These documents will be incorporated into the STCs as Attachments EE and FF, respectively).

170. Funding and Annual Limits

a. Under this new approach, the state's existing Disproportionate Share Hospital (DSH) funding for participating PHCS and funding from the UC Pool will be combined to make payments to participating PHCS that incur costs for services to the remaining uninsured. During each GPP PY, FFP will be available for such GPP payment expenditures up to the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, adjusted as described in subparagraphs of this STC b and .c below ("Adjusted DSH"), combined with the additional Demonstration UC funding amounts as set forth in subparagraph d below. In order to align DSH amounts with each SFY, the state's DSH allotment for the federal fiscal year that commences in the SFY will be used.

b. A portion of California's DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP. The amount set aside shall be identified in Attachment NN DSH Coordination Methodology.

c. In any year to which reductions to California's DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to GPP in a given GPP PY shall be reduced consistent with CMS guidelines.

d. The total computable amount available for the UC component shall equal $472 million in GPP PY1. For GPP PYs two through five, the UC component was determined by CMS based upon the information contained in the Independent Report on Uncompensated Care. Such reductions were to be specified by CMS within 60 days of receipt of such report. As approved by CMS on July 14, 2016, the total computable amounts available for the UC component shall equal $472 million for each of GPP PYs two through five.

   Taken together, the total computable annual limits for GPP payments will not exceed the limits set forth below:

   GPP PY 1 (SFY 15-16) – Adjusted DSH + $472 million = approximately $2.9 billion

   GPP PY 2 (SFY 16-17) – Adjusted DSH + $472 million = approximately $2.9 billion

   GPP PY 3 (SFY 17-18) – Adjusted DSH + $472 million = approximately $2.9 billion

   GPP PY 4 (SFY 18-19) – Adjusted DSH + $472 million = approximately $2.9 billion

   GPP PY 5 (SFY 19-20) – Adjusted DSH + $472 million = approximately $2.9 billion

e. The non-federal share of payments under the GPP shall be funded by voluntary intergovernmental transfers made by PHCS, or governmental agencies affiliated

with PHCS. The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 C.F.R. part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. The State must have permissible sources for the non-federal share of GPP expenditures, which may include permissible Intergovernmental Transfers (IGTs) from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

f. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

171. **Categories.** Each service will be assigned into a category by the state that best reflects its characteristics of intensity and area delivered. These categories will assist in determining the point values of individual services. The categories listed below are intended to provide a broad overview of the categories and services. The full description of categories are included in Attachment FF

a. **Category 1**: Traditional Outpatient - This category includes traditional outpatient services provided by a public hospital system facility:
   - ii. Non-physician practitioner;
   - iii. Traditional, provider-based primary care or specialty care visit;
   - iv. Mental health visit;
   - v. Dental;
   - vi. Public health visit;
   - vii. Post-hospital discharge;
   - viii. Emergency room/Urgent Care;
   - ix. Outpatient procedures/surgery, provider performed diagnostic procedures;

b. **Category 2:** Non-Traditional Outpatient – This category includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings:
   - x. Community health worker encounters;
   - xi. Health coach encounters;

xii. Care navigation;
xiii. Health education & community wellness encounters;

c. **Category 3**: Technology-Based Outpatient – This category includes technology-based outpatient encounters that rely mainly on technology to provide care:
   xiv. Call line encounters;
   xv. Texting;
   xvi. Telephone and email consultations between provider and patient;
   xvii. Provider-to-provider eConsults for specialty care;
   xviii. Telemedicine;

d. **Category 4:** Inpatient and Facility Stays – This category includes traditional inpatient and facility stays by patients:
   xix. Recuperative/respite care days;
   xx. Sober center days;
   xxi. Sub-acute care days;
   xxii. Skilled nursing facility days;

172. **Service Threshold** The threshold amounts for each PHCS will initially be constructed using the volume and cost of services occurring in participating providers, and will use the most recent complete state fiscal year data (Base SFY). Point values for each service will be consistent across all providers. The threshold amounts shall be determined in accordance with the methodology set forth in Attachment EE (GPP Funding and Mechanics Protocol), which takes into account the following requirements and factors:

a. Historic point values for each service category on a per unit of service basis across all Public Health Care Systems, taking into account at a minimum varying methods for identifying units and categories of services, cost per unit, cost trends and service mix;
b. Base SFY utilization for each Public Health Care System; and
c. Adjustments to account for changes in uninsured service needs since Base SFY, including the coverage expansions resulting from ACA implementation.
d. This threshold will require approval by CMS before it can be finalized.
   i. Thresholds for GPP PY2-PY5 will decline in proportion to reductions in annual limits.

173. **Penalties for non-compliance** If the state does not timely submit the final report as required in STC 180 below, including all requested analyses and recommendations, the state's expenditure authority for uncompensated care pools will be reduced by $500,000. The state may seek, and CMS may grant, relief from this reduction, if needed.

174. **Global Payment Program Protocols** The GPP Funding and Mechanics Protocol (Attachment EE) and a GPP Valuation Methodology Protocol (Attachment FF) set forth in detail the parameters and procedures related to the operation of the GPP.

175. **Global Payment Program Value Methodology Protocol** includes the following:

a. The master list of services and activities for which points apply under the GPP and their associated point values, including the placement of services within the categories and tiers and how point values will change over the course of the Demonstration
b. Methodology for calculating and modifying the PHCS thresholds.

176. The Global Payment Program Funding and Mechanics Protocol specifies the following**:**

a. How PHCS may be defined, including criteria for when multiple DPHs may comprise a single Public Health Care System.
b. Methodology for establishing and modifying annual global budgets for each PHCS.
c. Technical guidance on how eligible services to the uninsured are defined, accounted for and reported.
d. Reporting schedule for PHCS to report services provided under the GPP.
e. Transfer of IGTs, interim payment and final payment reconciliation mechanics and schedules.
f. Methods for redistributing unused portions of annual global budgets among PHCS that exceeded their point threshold

177. Evaluations of provider expenditures and activities under the global payment program.

a. The state will conduct two evaluations of provider expenditures and activities under the global payment methodology. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of GPP PY 4.
b. As the Global Payment Program is testing a new approach to financing care to the remaining uninsured, the two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstration.
c. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by PHCS and patients' experience, with a focus on understanding the benefits and challenges of this innovative payment approach.
d. To ensure the GPP is achieving the goals of promoting value, not volume, the evaluations will address by each individual PHCS, at baseline and under the GPP methodology:
    i. The number of uninsured individuals served
    ii. The number and types of services provided,
    iii. Expenditures associated with the services provided,
    iv. Expenditures that the evaluators estimate were avoided or reduced due to the Global Payment Program. The ratio of the GPP funding to uninsured uncompensated care cost compared to the ratio in SFY 2014-2015 ratio of SNCP and DSH payments to uninsured uncompensated care cost including how and why the ratio of payment to uninsured uncompensated cost has evolved compared to the prior DSH and SNCP methodologies;
    v. An assessment of the effects of the GPP on care delivery and costs.

vi. In determining uncompensated care costs, the evaluations shall be conducted at both the 100 percent and 175 percent UCC levels to account for the recognition of cost levels specific to California in federal law set forth in section 4721(e) of the Balanced Budget Act of 1997 (P.L. 105-33) and in section 607 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113).

e. As part of the evaluation of the overall success of the GPP, in addition to the items above, for the second evaluation only, the evaluation will also examine factors to evaluate the objectives of the GPP program, including the extent to which the GPP encouraged or improved:
   i. Care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time.
   ii. Changes in resource allocation
   iii. Improvements in workforce involvement and care team transformation under the demonstration
f. Both evaluations will include narrative hospital self-assessments of the successes and challenges of the GPP.

g. The evaluations are not intended to be the basis of funding changes to the Uncompensated Care Pool during the term of the demonstration.

178. Coordination with DSH

a. To maintain budget neutrality, the state will not make DSH payments and uncompensated care payments to hospitals participating in the GPP that are authorized under the state plan.
b. Hospitals that meet DSH eligibility criteria and which are not participating within a PHCS may receive DSH payments under the applicable provisions of Attachment 4.19-A of the state plan, as modified pursuant to Attachment NN (DSH Coordination Methodology).

179. Discontinuation of GPP

DHCS may, in consultation with the participating PHCS, discontinue the GPP in any subsequent state fiscal year(s) for the remainder of the Demonstration and revert to financing uncompensated care costs for Medicaid and uninsured patients under the DSH program pursuant to the state plan. DHCS shall notify CMS no later than 30 days prior to the start of the initial state fiscal year for which the GPP will be discontinued. DHCS will follow the appropriate processes as is necessary to facilitate DSH payments to affected PHCS under the State plan.

180. DSH Payments and FFY

The state is not authorized to make a DSH payment under the Medicaid state plan for any hospital for any federal fiscal year (FFY) in which the hospital is eligible for a GPP

payment for the corresponding GPP Program Year (PY). Each PY corresponds with the FFY that begins during the PY, except that GPP PY 1 corresponds with FFY 2016. A DSH payment is considered to be made for a FFY if the payment would count against the DSH allotment for that FFY. In the event that the GPP is not authorized for a full PY, the state is prohibited from making duplicate GPP and DSH payments to GPP-eligible hospitals and must submit, subject to CMS approval, a method for allocating GPP and DSH payments to avoid duplication during the affected period.

XIII. Uncompensated Care Reporting

181. Independent Report on Uncompensated Care.

The following describe the requirements for two independent reports on uncompensated care.

a. Description. The state must commission two reports from an independent entity on uncompensated care in the state.
   i. The first report, due May 15, 2016, will focus on Designated Public Hospitals. The objective of this report will be to support a determination of the appropriate level of Uncompensated Care Pool funding at those providers in years two through five of the demonstration. CMS will provide a formal determination of the funding levels for demonstration years two through five within 60 days of receipt of the complete report.
   ii. The second report, due June 1, 2017, will focus on uncompensated care, provider payments and financing across hospital providers that serve Medicaid beneficiaries and the uninsured under the current demonstration. The report will include information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California's Medicaid beneficiaries and for the uninsured.

182. The state must assure that $1,000,000 is available to complete the reports. Funding made available for the reports from non-state entities, such as foundations, would satisfy this requirement even if such funds did not flow through the state.

183. Contents of the Reports. The analysis will be completed in two separate reports.

a. **The First Report.** The first report must review the impact of the uncompensated care pool on those providers who participate in the UC pool with respect to:
   i. Uncompensated care provided: The cost of uncompensated care provided to uninsured individuals, distinguishing between costs associated with charity care from those associated with bad debt, and the extent that historical pool payments have addressed these costs.
   ii. Medicaid provider payment rates;
   iii. Medicaid beneficiary access; and
   iv. Role of managed care plans in managing care.

b. **The Second Report**. The second report will include the elements in subsection (a) of this STC with respect to all Medicaid hospital providers in the state, including data from the first report, and will also include a comparable examination of provider financing for those providers who serve the Medicaid population and the low-income uninsured. In addition, the second report will include:
    i. The role of the PRIME program for designated public hospital systems.
    ii. A detailed description and analysis of the current Medicaid hospital payment and financing system, with a major focus on services currently supported with pool funds;
    iii. The financing of overall uncompensated care in the state and the financing of providers that play a significant role in serving the Medicaid population and the low income uninsured, and the extent to which pool funds are needed to cover uncompensated care;
    iv. Reporting of how uncompensated care has changed since implementation of the ACA expansion.
    v. Information to support the goal for public health care systems to become self-sustaining entities that are not reliant on pool funds beyond 2020;
    vi. Information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California's Medicaid beneficiaries and for the uninsured.
c. **Both Reports.** Both reports should provide the following information for the hospital providers covered in the respective reports:
    i. Total hospital system revenue from all payors
    ii. Total Medicaid revenue (including patient care revenue and all other Medicaid revenue such as demonstration revenue and incentive payments)
    iii. Total Medicaid patient care revenue
    iv. Total safety net care pool revenue

All data presented in each report must be submitted to CMS in unlocked Excel worksheets to assist in review of the analysis

180. Monitoring and Potential Reductions

a. Monthly monitoring calls with the state will include an update of progress on the report as noted in monitoring section of the STCs.
b. If the state does not timely submit a final report, including all requested analyses and recommendations, the state's expenditure authority for uncompensated care pools will be reduced by $500,000. The state may seek, and CMS may grant, relief from this reduction, if needed.

XIV. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

181. **Quarterly Reports.** The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the California's Medi-Cal 2020 demonstration under section 1115 authority which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI (Monitoring Budget Neutrality).

182. **Reporting Expenditures under the Demonstration.** In order to track expenditures under this demonstration, California will report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM).

a. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate CMS-64.9 Waiver and/or 64.9P Waiver forms, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term "expenditures subject to the budget neutrality cap," is defined in STC 183**.**

b. For each demonstration year, thirty-three (33) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following demonstration expenditures. The eligibility groups (EGs) and Demonstration Programs that are used for calculation of the budget neutrality limit described in STC 197 and the specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver are described below**.**

Eligibility Group (EG) or Demonstration Program (DP)	**Demonstration Expenditures**	**CMS 64 Waiver Form**
Urban Family – TPM/GMC	Family & Children – Pre-2013 TPM/GMC counties, excludes those in CCI counties Includes low income pregnant women	A-FamilyU TPM/GMC

Eligibility Group (EG) or Demonstration Program (DP)	Demonstration Expenditures	CMS 64 Waiver Form
Rural Family – TPM/GMC	Family & Children – 2013 managed care expansion non-COHS counties (including San Benito and Imperial counties) Includes low income pregnant women	A-FamilyR TPM/GMC
SPD – TPM/GMC	Seniors & People with Disabilities –Includes partial dual eligibles without Medicare Part A or B; Excludes those in CCI counties.	A-SPD TPM/GMC
Duals - TPM/GMC	Beneficiaries with Medicare Part A and B–excludes those enrolled in CCI counties	A-Duals TPM/GMC
Urban Family – COHS	Family & Children – Pre-2013 expansion COHS counties, excludes those in CCI counties Includes low income pregnant women	A-FamilyU COHS
Rural Family - COHS	Family & Children – 2013 managed care expansion COHS counties Includes low income pregnant women	A-FamilyR COHS
SPD – COHS	Seniors & People with Disabilities –Includes partial dual eligibles without Medicare Part A or B) Excludes those enrolled in CCI counties	A-SPD COHS
Duals - COHS	Beneficiaries with Medicare Part A and B–excludes those enrolled in CCI counties	A-Duals COHS

Eligibility Group (EG) or Demonstration Program (DP)	Demonstration Expenditures	CMS 64 Waiver Form
MLTSS Family – TPM/GMC	Family & Children in TPM/GMC CCI counties Includes low income pregnant women	A-Family TPM/GMC CCI
MLTSS SPDs – TPM/GMC	Seniors & People with Disabilities in TPM/GMC CCI counties	A-SPD TPM/GMC CCI
MLTSS Duals - TPM/GMC	Beneficiaries with Medicare Part A and B in TPM/GMC CCI counties not enrolled in Medi-Connect	A-Duals TPM/GMC CCI
Cal-Medi-Connect - TPM/GMC	Beneficiaries with Medicare Part A and B enrolled in Cal-Medi-Connect in TPM/GMC CCI counties	A-Cal-Medi TPM/GMC CCI
MLTSS Family – COHS	Family & Children receiving MLTSS in COHS CCI counties Includes low income pregnant women	A-Family COHS CCI
MLTSS SPDs - COHS	Seniors & People with Disabilities in COHS CCI counties	A-SPD COHS CCI
MLTSS Duals - COHS	Beneficiaries with Medicare Part A and B in COHS CCI counties not enrolled in Cal-Medi-Connect	A-Duals COHS CCI
Cal-Medi-Connect - COHS	Beneficiaries with Medicare Part A and B enrolled in Cal-Medi-Connect in COHS CCI counties	A-Cal-Medi COHS CCI
CBAS*	Community Based Adult Services	CBAS
New Adult Group*	New adult group (section 1902(a)(10)(A)(i)(VIII) of the Act)	New Adult Group
Global Payment Program for the Remaining Uninsured	Global Payment expenditures	Global

Eligibility Group (EG) or Demonstration Program (DP)	Demonstration Expenditures	CMS 64 Waiver Form
Disproportionate Share Hospital Payments	Continuing DSH not included in Global. Each reported DSH payment must be associated with the appropriate FFY DSH allotment, and with the DY that includes the start date of the FFY for the DSH allotment.	DSH
Public Hospital Redesign and Incentives in Medi-Cal	Payment for Submission/Approval of 5-Year PRIME Plan	PRIME-5 Year Plan
	Domain 1: Outpatient Delivery System Transformation and Prevention	PRIME-Domain 1
	Domain 2: Targeted High-Risk or High-Cost Populations	PRIME-Domain 2
	Domain 3: Resource Utilization Efficiency	PRIME-Domain 3
IHS Uncompensated Care	Uncompensated care payments to IHS and 638 Facilities (IHS)	UC - IHS
Designated State Health Programs	California Children Services - Designated State Health Program	CCS - DSHP
	Genetically Handicapped Persons Program - Designated State Health Program	GHPP – DSHP
	Medically Indigent Adult Long Term Care - Designated State Health Program	MIALTC – DSHP
	Breast & Cervical Cancer Treatment Program - Designated State Health Program	BCCTP – DSHP

	AIDS Drug Assistance Program - Designated State Health Program	ADAP- DSHP
	Workforce Development Programs - Designated State Health Program	Work – DSHP
	Department of Developmental Services - Designated State Health Program	DDS – DSHP
	Prostate Cancer Treatment Program - Designated State Health Program	PCTP-DSHP
DMC-ODS*	Drug Medi-Cal Organized Delivery System	DMC-ODS
Dental Transformation Incentive Program	Dental Transformation Incentive Program expenditures	Dental Trans
Whole Person Care Pilots	Whole Person Care Pilots expenditures	Whole Person
Out-of-State Former Foster Care Youth	Out-of-State Former Foster Care Youth expenditures	FFCY

* Note: These expenditures are excluded from the demonstration's budget neutrality cap, as described below.

c. Pharmacy Rebates and FQHC Wrap Payments. Pharmacy rebates and wrap payments to federally qualified health centers (FQHC) are excluded from the determination of budget neutrality, and therefore should be reported on the CMS-64.9 Base and/or 64.9P Base forms.

d. The following table indicates how expenditures will be reported by DY for programs in which the program year may not coincide with a DY. Expenditures for all EGs listed in the table in (b) above that do not appear in the table below must be reported by DY according to the date in which services were rendered or for which capitation payments were made, except that expenditures with service dates between July 1 and December 31, 2015 should be reported for DY 11.

Report for This DY	Payments by Program Year (PY)	Payments Subject to FFY DSH Allotment	PRIME Payments by DY	WPC Payments by PY	DTI Payments by PY	DSHP Spending by SFY
DY 11	PY 1	2016	DY 11	PY 1	PY 1	2016

DY 12	PY 2	2017	DY 12	PY 2	PY 2	2017
DY 13	PY 3	2018	DY 13	PY 3	PY 3	2018
DY 14	PY 4	2019	DY 14	PY 4	PY 4	2019
DY 15	PY 5	2020	DY 15	PY 5	PY 5	2020

e. For each Demonstration year, a separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver must be completed to report expenditures for the following demonstration expenditures. The specific waiver names to be used to identify these separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver appear in brackets below:

   i. MCHIP: The CMS 64.21-Waiver form must be completed to report expenditures for the Medicaid expansion demonstration population. [MCHIP].

f. Reporting member months. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

   i. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the Quarterly Report required under paragraph 25, the actual number of eligible member months for each of the EGs described (b) above. The state must submit a statement accompanying the Quarterly Report, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.

   ii. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

   iii. Eligible member months for July through December 2015 will apply to DY 11 under Medi-Cal 2020, and not DY 10 or Bridge to Reform.

183. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all expenditures, identified in STC 195, except for those designated for exclusion (*). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver, and CMS 64.21 Waiver and/or 64.21P Waiver.

184. **Administrative Costs**. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration on Forms 64.10 Waiver and/or 64.10P Waiver.

185. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2 year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

186. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. California must estimate matchable Medicaid expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each Federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the appropriate Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

187. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding and in accordance with paragraphs 30 entitled Certified Public Expenditures CMS will provide FFP at the applicable Federal reimbursement rate as outlined below, subject to the limits described in Section XI:

a. Administrative costs, including those associated with the administration of the California's Medi-Cal 2020 Demonstration.

b. Net medical assistance payments/expenditures and prior period adjustments paid in accordance with the approved State Plan.

c. Expenditures associated with expenditure authorities granted for the demonstration.

188. **Sources of Non-Federal Share.** The state certifies that state and local monies are used as matching funds for the demonstration. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by law. All sources of the non-federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations, i.e., are not derived from impermissible provider taxes or donations or federal funds (unless the other federal funding source by law allows use of federal funds for matching purposes). Further, these sources and distribution of monies involving

federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies, any sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. For non- federal share funding using intergovernmental transfers, the funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 Subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non- bona fide provider-related donations. The state must have permissible sources for the non- federal share of demonstration expenditures, which may include CPEs or permissible Intergovernmental Transfers (IGTs) from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid.

189. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

190. **Cost-Claiming.** All costs will be claimed in accordance with OMB Circular A-87 as defined within Attachment F, and any other cost claiming methodologies or protocols approved by CMS under this Demonstration.

XV. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

191. **Quarterly Expenditure Reports.** The State must report State Plan and Demonstration expenditures using the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following the routine CMS MBES system instructions. The State shall report on separate forms, CMS-64.21U Waiver and/or CMS-64.21UP Waiver, for Title XXI Demonstration expenditures for Medicaid Expansion children eligible for title XXI funding. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration expenditures that do not exceed the State's available title XXI funding.

192. **Reporting Expenditures Under the Demonstration.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, following routine CMS MBES system instructions. The State will report Title XXI Demonstration expenditures on separate Forms CMS-64.21U Waiver and CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension,

which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State must identify the program code and coverage.

a. The State must submit all claims for expenditures related to the Demonstration (including any cost settlements) within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, the State must submit all claims for services during the Demonstration period (including cost settlements) within 2 years after the conclusion or termination of the Demonstration. During the 2-year period, the State must continue to identify separately, on the Form CMS-64, 21, net expenditures related to dates of service during the operation of the Demonstration.

b. The State will use standard MCHIP funding process during the Demonstration. The State must estimate matchable MCHIP expenditures on the quarterly Form CMS-37. On a separate CMS-37, the State shall provide updated estimates of expenditures for the Medicaid Expansion Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-64.21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

193. Limitations on Title XXI Funding. The State will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI separate child health program or Demonstration until the next allotment becomes available.

a. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this Demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

b. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

Premium contributions under the Demonstration shall be reported to CMS on Form CMS-21 Waiver, Line 29, in order to assure that the Demonstration is properly credited with premium collections.

If the state exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State must continue to provide coverage to the approved title XXI State plan separate child health program population and the demonstration population with State funds.

XVI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

194. Budget Neutrality Effective Date. All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2016. Notwithstanding this effective date, expenditures made by California for Safety Net Care Uncompensated Care Pool payments during the temporary extension period of November 1, 2015 through December 31, 2015, and Medicaid service expenditures for managed care populations and DSHP expenditures from July 1 to December 31, 2015, must be applied against Demonstration Year 11 (DY 11) expenditures.

195. Limit on Title XIX Funding. California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of three parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California and disproportionate share hospital (DSH) allotments. Spending under the budget neutrality limit is authorized for (1) managed care population expenditures for the following groups – family and children, dual eligibles, and SPD, (2) all spending related to approved expenditure authorities. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the demonstration extension (January 2016 through June 2020). Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for General Financial Requirements Under Title XIX. The data supplied by the State to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

196. **Risk.** California will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

197. **Budget Neutrality Annual Expenditure Limit.** For each DY, three annual limits are calculated.

a. Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each eligibility group (EG) described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State for that EG under the section entitled General Reporting Requirements, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below.

ii. Actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS services (whether provided through managed care or fee-for-service) to the SPD Medicaid-only population and to dual eligible.

iii. Actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the DMC-ODS benefit to the eligible population;

iv. Actual expenditures for the HHP benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the HHP benefit to the HHP-eligible populations;

v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)[1]	Trend Rate	DY 11 PMPM	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM[3]
State Plan Groups						
Urban Family – TPM/GMC	4.00%	$196.82	$204.69	$212.88	$221.40	$230.26
Rural Family – TPM/GMC	4.00%	$172.17	$179.06	$186.22	$193.67	$201.42

SPD – TPM/GMC	4.00%	$899.54	$935.52	$972.94	$1,011.86	$1,052.33
Duals - TPM/GMC	3.28%	$121.84	$125.84	$129.97	$134.23	$138.63
Urban Family – COHS	4.00%	$224.03	$232.99	$242.31	$252.00	$262.08
Rural Family - COHS	4.00%	$183.36	$190.69	$198.32	$206.25	$214.50
SPD – COHS	4.00%	$1,719.62	$1,788.40	$1,859.94	$1,934.34	$2,011.71
Duals – COHS	2.47%	$450.10	$461.22	$472.61	$484.28	$496.24
MLTSS Family – TPM/GMC	4.00%	$195.32	$203.13	$211.26	$219.71	$228.50
MLTSS SPDs – TPM/GMC	4.00%	$1,093.06	$1,136.78	$1,182.25	$1,229.54	$1,278.72
MLTSS Duals - TPM/GMC	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70
Cal-Medi-	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70

Eligibility Group (EG)[1]	Trend Rate	DY 11 PMPM	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM[3]
Connect - TPM/GMC						
MLTSS Family – COHS	4.00%	$222.30	$231.19	$240.44	$250.06	$260.06
MLTSS SPDs - COHS	4.00%	$2,114.13	$2,198.70	$2,286.65	$2,378.12	$2,473.24
MLTSS Duals - COHS	1.61%	$663.28	$673.96	$684.81	$695.84	$707.04
Cal-Medi-Connect - COHS	1.61%	$663.28	$673.96	$684.81	$695.84	$707.04
Hypothetical Populations						
CBAS	3.16%	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30

DMC-ODS	n/a	n/a	$2,942.29	$3,418.10	$2,913.42	$2,912.74
Out-of-State Former Foster Care Youth	5.2%	N/A	N/A	$204.33	$214.96	$226.14
HHP				$65.00	$65.00	$65.00

Key: TPM = Two Plan Model counties, GMC = Geographic Managed Care counties

[1] The applicable reporting forms for expenditures in each eligibility group are described in STC 182.

[2] These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit. As described in paragraph (a)(ii) and (a)(iii) above, the actual expenditures for these hypothetical populations are included in the budget neutrality limit.

b. Limit B. The amount of the designated public hospital spending as determined in the chart below. The state is prohibited from changing the reimbursement methodology or amounts of supplemental payments approved in the Medicaid state plan on January 1, 2016 that result in higher overall reimbursement without recalculating the Upper Payment Limit (UPL) for the period of the new or modified payments and adjusting the UPL diversion if necessary.

Total Computable IP Unspent Public Hospital Amounts	
DY 11	$863,054,068
DY 12	$863,054,068
DY 13	$863,054,068
DY 14	$863,054,068
DY 15	$863,054,068
5 Year Total	**$4,315,270,340**

c. Limit C. Annual DSH allotments for California, as determined under section 1923(f) of the Act and 42 CFR 447 Subpart E. For each DY, Limit C will be the total computable equivalent of the DSH allotment for the federal fiscal year (FFY) that begins during the DY, calculated using the FMAP in effect for the largest portion of the FFY to which the DSH allotment pertains. For DY 11, Limit C will be the total computable equivalent of the DSH allotment for the FFY 2016.

d. The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limits A, B, and C. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that California can receive for expenditures on behalf of demonstration populations as well as demonstration expenditure authorities under the demonstration programs (GPP, WPC, PRIME, DSHP, IHS, and DTI) described in

these STCs.

e. California must present to CMS for approval MCO contract modifications to include an increase in PMPM amounts due to adjustments associated with the inpatient hospital provider tax. The with waiver and without waiver budget neutrality PMPM limits will be adjusted for each EG with an affected rate due to requirements in the Affordable Care Act based on the increases in contracts, if necessary.

f. Savings Phase-out: Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medicaid population based EGs. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages for each EG and DY are determined based how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations. The EGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an EG in a DY is negative, the applicable percentage is 100 percent.

EG	DY 11	DY 12	DY 13	DY 14	DY 15
Urban Family – TPM/GMC	23%	23%	23%	23%	23%
Rural Family – TPM/GMC	100%	100%	100%	90%	80%
SPD – TPM/GMC	100%	90%	80%	70%	60%
Duals - TPM/GMC	23%	23%	23%	23%	23%

EG	DY 11	DY 12	DY 13	DY 14	DY 15
Urban Family – COHS	23%	23%	23%	23%	23%
Rural Family - COHS	100%	100%	100%	90%	80%
SPD – COHS	23%	23%	23%	23%	23%
Duals – COHS	23%	23%	23%	23%	23%
MLTSS Family – TPM/GMC	23%	23%	23%	23%	23%
MLTSS SPDs – TPM/GMC	100%	100%	100%	90%	80%
MLTSS Duals - TPM/GMC	100%	100%	100%	100%	90%
Cal-Medi-Connect - TPM/GMC	100%	100%	100%	100%	90%
MLTSS Family – COHS	23%	23%	23%	23%	23%
MLTSS SPDs - COHS	100%	100%	100%	90%	80%
MLTSS Duals - COHS	100%	100%	100%	100%	90%
Cal-Medi-Connect - COHS	100%	100%	100%	100%	90%

198. 1115A Duals Demo Savings. When California's section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the duals demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the

methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration are equal to the savings percentage specified in the 1115A duals demonstration MOU multiplied by the 1115A demonstration capitation rate and the number of 1115A duals demonstration beneficiaries enrolled in the 1115(a) demonstration. 1115A Demonstration capitation rate is reviewed by CMS's Medicare and Medicaid Coordination Office (MPLAN), MPLAN's contracted actuaries and CMS' Office of the Actuary (OACT), and was certified by the state's actuaries. Per the 1115A duals demonstration MOU, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A demonstration is equivalent to the state's 1115A Medicaid capitation rate minus an established savings percentage (as outlined in the chart below). The state must track the number of member months for every Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A demonstration.

The table below provides an illustrative example of how the savings attributable to populations and services provided under the 1115(a) demonstration is calculated

A. 1115A Demonstration Year	**B. Medicaid Capitation Rate (hypothetical)**	**C. Medicaid Savings Percentage Applied Per MOU (average)**	**D. Savings Per Month (B*C)**	**E. Member Months of MMEs who participated in 1115A and 1115(a) Demos (estimated)**	**F. Amount subtracted from 1115(a) BN savings/ margin (D*E)**
DY 1	$1,000 PMPM	1%	$10 PMPM	1,000	1,000* $10 PMPM = $10,000
DY 2	$1,000 PMPM	2%	$20 PMPM	1,000	1,000 * $20 PMPM = $20,000
DY 3	$1,000 PMPM	4%	$40 PMPM	1,000	1,000 * 40 PMPM = $40,000

In each quarterly report, the state must provide the information in the above-named chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the state must show the "amount subtracted from the 1115(a) BN savings" in the updated budget neutrality Excel worksheets that are submitted in each quarterly report.

Finally, in each quarterly CMS-64 submission and in each quarterly report, the state must indicate in the notes section: "For purposes of 1115(a) demonstration budget neutrality reporting purposes,

the state reports the following information:

a. Number of Medicare-Medicaid enrollees served under the 1115 duals demonstration = *[Insert number]*
b. Number of member months = *[Insert number]*
c. PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = *[Insert number]*

The State must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A demonstration. This must include any Medicaid payment triggered by the risk corridor, IGTs, or other retroactive adjustments. The State must add additional columns to the chart above in subsequent quarterly reporting to reflect those adjustments.

By December 31, 2016, California must submit to CMS a completed version of the table above, covering the period from the implementation of the 1115A duals demonstration through October 31, 2015, to support OACT estimation and certification of actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration attributable to the 1115A duals demonstration.

199. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 182(f). The trend rates and per capita cost estimates for the new adult group are listed in the table below.

MEG	TREND	DY 11 PMPM	DY 12	DY 13	DY 14	DY 15
New Adult - COHS	3.2%	$664.73	$686.00	$707.95	$730.61	$753.99
New Adult – TPM/ GMC	3.2%	$521.37	$538.05	$555.27	$573.04	$591.38

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the State has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than 11 months into the demonstration year for which the adjustment would take effect. Additional adjustments to the PMPM limit may be made pursuant to the process outlined in (d) below.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member

months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from this population. Excess spending for the new adult group does not count against the budget neutrality limit defined in STC 197.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state will submit plan to CMS for further modifying the PMPM limit as appropriate to ensure it is consistent with actual PMPM expenditures for the new adult group. The plan must identify the cause of the discrepancy between the state's initial estimates and actual costs and must describe a timeline for revising the state's projections.

200. **Composite Federal Share Ratios.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share Ratio. The Composite Federal Share Ratio is the ratio calculated by dividing the sum total of FFP received by California on actual Demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable Demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms.

201. **Budget Neutrality Monitoring Tool.** The state and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly budget neutrality status updates and other in situations when an analysis of budget neutrality is required. The tool will incorporate the C Report for monitoring actual expenditures subject to budget neutrality. A working version of the monitoring tool will be available for the state's first Quarterly Progress Report in 2016.

202. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration extension, which will be from November 1, 2015 through December 31, 2020. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period of November 1, 2010 through December 31, 2015 (but not from any earlier approval period). To incorporate savings from the November 1, 2010 through December 31, 2015 approval period, California must provide CMS a certified and audited final assessment of budget neutrality for that period in which demonstration expenditures totals are consistent with the amounts reported by the state on the CMS-64 report (as summarized in the C Report). Historical information about the budget neutrality test for California's 1115 demonstration appears in Attachment LL.

203. Exceeding Budget Neutrality. If the budget neutrality expenditure limit defined in STC 197 has been exceeded at the end of the demonstration extension period (including Savings Phase-Out), the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XVII. EVALUATION OF THE DEMONSTRATION

211. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 180 days of the approval date of the Medi-Cal 2020 demonstration and applicable attachments, a draft evaluation design for all elements of the demonstration discussed below, excluding PRIME. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures, as applicable. The updated design should be described in sufficient detail to determine that it is scientifically rigorous including a thoroughly documented data strategy.

212. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate, to the greatest extent possible, fully with CMS or the evaluator selected by HHS; in addition, the state shall submit the required data to HHS or its contractor. Requests from HHS for information and data shall be made in a timely manner and provide the state with an adequate timeframe to provide the information as agreed to by CMS and the state.

213. Evaluation Design.

a. The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

b. The state and CMS agree that a robust evaluation is desired in order to, to the greatest extent possible, determine the causal impacts of the Demonstration. The state and CMS will work to identify available data sources in order to allow for this type of evaluation, including data sources that would provide the ability to use control and comparison groups, where available, as well as before-and-after studies. The design will include a description of the quantitative and qualitative study design including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of

sensitivity analyses as appropriate shall be considered. The evaluation design must include descriptive statistics that reflect the socioeconomic status and demographic composition of those served by the demonstration, and will consider the impact of the demonstration on socioeconomic and demographic subgroups. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention-specific stratifications, for further depth and to glean potential non- equivalent effects on different sub-groups.

c. The state shall seek comment from the public on the development of its evaluation design. The submitted design must describe the state's process for seeking comment from the public on the evaluation approach and questions to be addressed.

d. The updated design must describe the state's process to contract with an independent entity, ensuring no conflict of interest.

e. The design, including the budget and adequacy of approach, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above.

f. Measures - The draft evaluation design must discuss, for each hypothesis, as applicable, the quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the demonstration in terms of cost of services and total costs of care, improved health outcomes and system transformation including better care, better quality, and enhanced value, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements under managed care. Measures will be clearly stated and described, with the numerator and dominator clearly defined, including:
    i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
    ii. The measure steward;
    iii. The baseline value for each measure;
    iv. The sampling methodology for assessing these outcomes; and

g. Sources of Measures - CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), and Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)).

h. Data Sources - The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys, when applicable. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate

program level, as appropriate, and include population stratifications to the extent feasible.

i. Domains of Focus – The state must at a minimum address the domains and evaluation questions listed below.

   i. SPD Managed Care: State shall include an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report.
      1. Access to care
      2. Quality of care
      3. Cost of coverage

   ii. Global Payment for the Remaining Uninsured
      1. All evaluation questions listed in STC 173 entitled, "Evaluations of provider expenditures and activities under the global payment program," in the section on Global Payment Program for the Remaining Uninsured.

   iii. Whole Person Care Pilots
      1. What did the pilots do to achieve the desired outcomes listed in the paragraph entitled, "Mid-Point and Final Evaluations"? What were the critical differences in the approaches they took?
      2. Were the pilots able to show improvement on any of the identified dimensions?
      3. What promising practices were identified by the pilots?
      4. How will counties ensure that improvements achieved by the pilots are sustained after pilot funding is exhausted?

   iv. CCS Pilots
      1. What is the impact of the pilots on providers' satisfaction with the delivery of and the reimbursement of services?
      2. What is the impact of the pilots on amounts expended on CCS services, and the total cost of care?
      3. What is the impact of the pilots on children's access to CCS services?
      4. What is the impact of the pilots on the quality of care?
      5. What is the impact of the pilots on care coordination?
      6. What is the impact of the pilots on clients' satisfaction?

   v. Dental Transformation Incentive Program
      1. How do the benefits of the Dental Transformation Incentive Program compare to the cost of the incentives? Do some portions of the Dental Transformation Incentive Program exhibit a more favorable benefit to cost ratio than others?
      2. What promising practices were identified in the county Caries

Risk Assessment and Management pilots?

214. What measures can be taken to ensure that the improvements achieved by the Dental Transformation Incentive Program can be sustained after 1115 program funding is exhausted?**Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design, and describe progress relating to the evaluation design in each of the quarterly and annual progress reports.

215. Interim Evaluation Report. Consistent with 42 CFR 431.424(d), the state must submit to CMS an interim evaluation report in conjunction with its request to extend the demonstration, or any portion thereof.

216. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report by December 31, 2021. The final report must include the following:

a. An executive summary;
b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
f. Successes, challenges, and lessons learned.

Attachment A
(Reserved)

http://www.medicare.gov/publications/pubs/pdf/11376.pdf

Attachment C
Global Payment Program Participating Public Health Care Systems

Public Health Care Systems participating in the GPP consist of the following designated public hospitals (DPHs), including any successor or differently named hospital as applicable, and their affiliated and contracted providers. The DPHs are operated by a county, a city and county, University of California, or special hospital authority described in Section 101850 or 101852, *et seq*., of the California Health & Safety Code.

1. Los Angeles County (LA Co.) health system
    a. LA Co. Harbor/UCLA Medical Center
    b. LA Co. Olive View Medical Center
    c. LA Co. Rancho Los Amigos National Rehabilitation Center
    d. LA Co. University of Southern California Medical Center
2. Alameda Health System
    a. Highland Hospital (including the Fairmont and John George Psychiatric facilities)
    b. Alameda Hospital
    c. San Leandro Hospital
3. Arrowhead Regional Medical Center
4. Contra Costa Regional Medical Center
5. Kern Medical Center
6. Natividad Medical Center
7. Riverside University Health System -- Medical Center
8. San Francisco General Hospital
9. San Joaquin General Hospital
10. San Mateo County General Hospital
11. Santa Clara Valley Medical Center
12. Ventura County Medical Center

Attachment D
Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME Entities

The following governmental health systems participate in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pool.

I. Designated Public Hospital (DPH) systems

DPH systems include the following designated public hospitals and their affiliated governmental providers and contracted governmental and non-governmental providers, including any successor or differently named hospital as applicable. The DPHs are operated by a county, a city and county, University of California, or special hospital authority described in Section 101850 or 101852, *et seq*., of the California Health & Safety Code.

State Government-operated University of California (UC) Hospitals

1. UC Davis Medical Center
2. UC Irvine Medical Center
3. UC San Diego Medical Center
4. UC San Francisco Medical Center
5. UC Los Angeles Medical Center
6. Santa Monica UCLA Medical Center (aka – Santa Monica UCLA Medical Center & Orthopedic Hospital)

Non-State Government-operated

7. Los Angeles County (LA Co.) health system
    a. LA Co. Harbor/UCLA Medical Center
    b. LA Co. Olive View Medical Center
    c. LA Co. Rancho Los Amigos National Rehabilitation Center
    d. LA Co. University of Southern California Medical Center
8. Alameda Health System
    a. Highland Hospital (including the Fairmont and John George Psychiatric facilities)
    b. Alameda Hospital
    c. San Leandro Hospital
9. Arrowhead Regional Medical Center
10. Contra Costa Regional Medical Center
11. Kern Medical Center
12. Natividad Medical Center
13. Riverside University Health System -- Medical Center
14. San Francisco General Hospital
15. San Joaquin General Hospital
16. San Mateo Medical Center
17. Santa Clara Valley Medical Center
18. Ventura County Medical Center

II. District and Municipal Public Hospitals (DMPH)

DMPHs include the following district and municipals public hospitals, including any successor or differently named hospital as applicable. The DMPHs operate in California pursuant to Cal. Health & Safety Code §32000, et seq.

1. Antelope Valley Hospital, Lancaster
2. Bear Valley Community Hospital, Big Bear Lake
3. Coalinga Regional Medical Center, Coalinga
4. Eastern Plumas Health Care, Portol
5. El Camino Hospital, Mountain View
6. El Centro Regional Medical Center, El Centro
7. Hazel Hawkins Memorial Hospital, Hollister
8. Healdsburg District Hospital, Healdsburg
9. Jerold Phelps Community Hospital, Garberville
10. John C. Fremont Healthcare District, Mariposa
11. Kaweah Delta Health Care District, Visalia
12. Kern Valley Healthcare District, Lake Isabella
13. Lompoc Valley Medical Center, Lompoc
14. Mammoth Hospital, Mammoth Lakes
15. Marin General Hospital, Greenbrae
16. Mayers Memorial Hospital District, Fall River Mills
17. Mendocino Coast District Hospital, Fort Bragg
18. Modoc Medical Center, Alturas
19. Northern Inyo Hospital, Bishop
20. Oak Valley Hospital District, Oakdale
21. Palo Verde Hospital, Blythe
22. Palomar Medical Center, Escondido
    - Pomerado Hospital, Poway
23. Pioneers Memorial Healthcare District, Brawley
24. Plumas District Hospital, Quincy
25. Salinas Valley Memorial Healthcare System, Salinas
26. San Bernardino Mountains Community Hospital, Lake Arrowhead
27. San Gorgonio Memorial Hospital, Banning
28. Seneca Healthcare District, Chester
29. Sierra View District Hospital, Porterville
30. Sonoma Valley Hospital, Sonoma
31. Sonoma West Medical Center, Sebastopol
32. Southern Inyo Hospital, Lone Pine
33. Tahoe Forest Hospital District, Truckee
34. Tehachapi Valley Healthcare District, Tehachapi
35. Tri-City Medical Center, Oceanside
36. Trinity Hospital, Weaverville
37. Tulare Regional Medical Center, Tulare
38. Washington Hospital Healthcare System, Fremon

Attachment E
(Reserved)

I. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR CCS, GHPP, MIA/LTC, BCCTP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS

A. General Provisions

Program costs, for each program described above, mean the total expenditures incurred in the State Fiscal Year (SFY) ended June 30 from all the funding sources. Allowable DSHP expenditures will be applied against each Demonstration Year using the date of service information from each paid claim.

Net program costs are program costs for health care services only.

DSHP costs, for each program described above, are net program costs funded by the State and/or local funds.

Allowable DSHP costs are DSHP costs for health care services which are allowable under section 1905(a) of the Social Security Act, rendered to the uninsured population.

For the purpose of interim claiming, the estimated program costs for each SFY are the budget amount of Fund Appropriation for the applicable fiscal period that the State and other funding authorities commit to each SOMP. The estimated program cost for each fiscal period is reduced by funding for administrative activities to arrive at estimated net program cost. Estimated net program cost is reduced by budgeted funding from non-State, non-local sources to arrive at estimated DSHP cost. Estimated DSHP cost is multiplied by an interim allocation percentage to arrive at the estimated allowable SNCP cost for the fiscal period.

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. 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 State will implement this requirement for the following DSHPs:

- CCS, GHPP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS– A 13.95 percent reduction factor is applied to the total certified SNCP expenditures before costs are claimed.

- MIA/LTC and BCCTP - No reduction factor is applied to the total certified SNCP expenditures before costs are claimed. There are no unqualified aliens receiving services under the MIA/LTC program. Expenditures related to non-emergency services for unqualified aliens under the BCCTP will be identified and excluded

by aid codes.

B. Program Description

California Children Services (CCS)
CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age.

Genetically Handicapped Persons Program (GHPP)
GHPP provides comprehensive health care coverage for persons over 21 years of age with specified genetic disease, including cystic fibrosis, hemophilia, sickle cell diseases and thalassemia, and chronic degenerative neurological diseases.

Medically Indigent Adult Long-Term Care (MIA/LTC)
MIA/LTC provides the medically necessary services required as part of the patient's day-to-day plan of care in the long-term care facility, including pharmacy, support surface and therapies.

Breast and Cervical Cancer Treatment Program (BCCTP)
BCCTP provides cancer treatments for eligible low-income California (CA) residents who are screened by Cancer Detection Program and Family Planning, Access, Care and Treatment (Family PACT).

* Eligibility

CCS: A child under 21 years old with family income of $40,000 or less is a resident of CA and has out-of-pocket medical expenses expected to be more than 20% of family adjusted gross income.

GHPP: California residents ages 21 years or older have genetic conditions specified in the CA Code of Regulations, Title 17, Section 2932.

MIA/LTC: Individuals age 21 or older and under 65 year of age who do not have linkage to another program and who are US citizens or legal residents and are residing in a Nursing Facility Level A or B.

BCCTP: A CA resident, who is male of any age or any immigration status, a female under 65 years of age with non-citizen or unsatisfactory immigration status, or a female 65 years of age or older, has been screened and found in need of treatment for breast and/or cervical cancer, follow-up care for cancer or precancerous cervical lesions/conditions.

* Funding Sources/Flow

CCS, GHPP, MIA/LTC, and BCCTP are State-Only funded programs and funded by the State General Funds. The State fiscal intermediary pays the program claims.

* DSHP Costs
CCS, GHPP, MIA/LTC and BCCTP services are Medicaid-like services. The total program costs for each program funded by the State General Fund for the uninsured population will be used to determine allowable DSHP costs for SNCP reimbursement.

* Report Format
CCS, GHPP, MIA/LTC, and BCCTP program costs will be compiled from the State fiscal intermediary Paid Claims Data using the specific Aid Codes to identify eligibility and the specific Billing Provider Type to identify the services types by date of services.

AIDS Drug Assistance Program (ADAP)
ADAP, established in 1987, provides prescription drug coverage for the HIV positive uninsured and under-insured individuals who are HIV positive, to ensure that they have access to medication. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 established the ADAP nationally and provides the federal fund (CARE Act Fund) for this program.

* Eligibility
HIV-infected individuals who are California residents and 18 years of age or older who:

- Have a Federal Adjusted Gross Income (FAGI) that does not exceed $50,000;
- Have a valid prescription from a licensed California physician; and
- Have limited or no prescription drug benefits from another source.

Federal and State laws require that ADAP funds be used as the payer of last resort and ensure that ADAP is used only after all other potential payer options are exhausted. ADAP participants with limited prescription drug benefits will be eligible for financial assistance in meeting their out-of-pocket costs or premiums payment assistance. ADAP also pays the Share of Cost for individuals who are Medi-Cal beneficiaries.

* Funding Sources/Flow
ADAP is funded by the State General Fund, the Federal fund (CARE Act Fund), and the Special Fund (drug rebate). CDPH is the State's grantee for the federal CARE Act Fund. CDPH is required to meet the annual federal maintenance of effort (MOE) requirements for the grant. Federal CARE Act and Special Funds are deposited into the State General Fund to pay claims. The State pays the program claims.

* DSHP Costs
ADAP services are Medicaid-like services except for payments of share of cost for a

limited number of ADAP participants. ADAP program costs funded by the State

General Fund and Special Fund that are not used for the CARE Act MOE and matching requirements, net of costs incurred for Medi-Cal share of cost payments or costs incurred for individuals who are otherwise insured, will be used to determine allowable DSHP cost for SNCP reimbursement.
* Report Format
ADAP program costs will be compiled from ADAP Paid Claims Data by funding sources and the eligible population. Claims data is compiled from CDPH paid claims database.

Every Woman Counts (EWC)
EWC is a cancer detection programs that provides CA low income, uninsured and medically underserved women access to screening, and diagnostic services for breast and cervical cancer. EWC offers multi-faceted, early detection and diagnosis services for breast and cervical cancer, coupled with continuous monitoring to reduce missed or delayed cancer diagnoses. EWC provides the direct services including: (1) screening and diagnostic mammography; (2) clinical breast exams; (3) pelvic exams; (4) case management, including follow–up and referrals for abnormal screens; and (5) cervical cancer screening.

* Eligibility
CA female residents with household income at or below 200 percent of the Federal poverty level have no medical insurance coverage for these services or have a high insurance deductible or co-payment and are not getting these services through Medi-Cal or another government-sponsored program. To receive free breast cancer screening services, the individuals must be at least 40 years of ages; to receive free cervical cancer prevention services, the individuals must be at least 25 years of age.

* Funding Sources/Flow
EWC is mainly funded by a federal grant from Disease Control and Prevention (CDC), the tobacco tax revenue, including the Breast Cancer Control Account (BCCA) fund and Proposition 99 fund, and State General Fund. At least 60% of EWC's federal CDC grant must be spent on direct services. After meeting this 60 percent obligation, remaining federal grant funds can be spent for program administration. The CDC grant requires MOE in addition to a three to one matching requirement. The program delivers these direct services through a statewide network of medical providers who enroll women into the program and submit claims to EWC to be reimbursed for delivering the clinical services.

* DSHP Costs
EWC services are Medicaid-like services. EWC total program costs, which are reduced by any program costs for services provided to individuals with high insurance deductible or co-payment and funded by State General Fund, BCCA fund, and Proposition 99 fund that are not used for CDC MOE and matching requirements, will be used to determine

allowable DSHP costs for SNCP reimbursement.

* Report Format
EWC program costs will be compiled from EWC Paid Claim Data by the eligible population. Claims data is compile from CDPH paid claims database.

Prostate Cancer Treatment Program (PCTP)
PCTP provides prostate cancer early detection, diagnosis, and comprehensive treatment services to low-income and uninsured men to prevent and reduce the devastating effects of prostate cancer. The direct treatment services include brachytherapy, chemotherapy, hormone therapy, orchiectomy, radical retropubic prostatectomy, radiation therapy, transurethral resection of the prostate and active surveillance. In addition to the direct treatment services, PCTP also offers support services, such as psychosocial therapy, nutrition counseling, patient education, incontinence supplies and transportation assistance. PCTP is administered through a contract with the University of California, Los Angeles (UCLA).

* Eligibility
CA male residents, who are 18 years old or older with household income at or below 200 percent of the Federal poverty level, have no medical insurance coverage for these services and do not qualify for Medicare or Medi-Cal.

* Funding Sources/Flow
PCTP is funded by State General Fund. Eighty seven percent of the total contract funding shall be used for direct patient care. No less than seventy percent of the total contract funding shall be expended on direct patient care treatment, which is defined as funding for fee-for-service providers for Medi-Cal eligible services at established Medi-Cal rate.

* DSHP Costs
PCTP services for direct patient care treatment are Medicaid-like services. PCTP is the payer of last resort for men who are not eligible for Medi-Cal or Medicare and have no access to local or county resources. PCTP total program costs incurred for direct patient care treatment will be used to determine allowable DSPH costs for SNCP reimbursement.

* Report Format
PCTP program costs will be compiled from PCTP Paid Claim Data by treatment category and by the eligible population.

Department of Developmental Services (DDS)
DDS is responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that more than 246,000 people with developmental

disabilities receive the services and supports needed to live independent and productive lives. These disabilities include mental retardation, cerebral palsy, epilepsy, autism and related conditions. Services are delivered directly through four state-operated developmental centers and one community facility (Developmental Center Services), and under contract with a statewide network of 21 private, nonprofit regional centers (Community Based Services).

The Lanterman Act establishes an entitlement to services and supports for persons with developmental disabilities and their families that are determined through an individualized planning process that occurs after a series of discussions or interactions among a team of people including the person with a developmental disability, their family (when appropriate), regional center representative(s) and others. The Individual Program Plan (IPP) may include a wide array of services such as: residential, day program and employment, independent and supported living, transportation, behavioral, respite and other family supports, and case management/service coordination. Regional centers are payers of last resort, requiring consumers to access generic resources when available to meet their individual needs.

*Eligibility

- A person with a developmental disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, as defined in California Welfare and Institutions Code (W&I Code) Section 4512. A developmental disability includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. It does not include conditions that are solely physical in nature.
- Infants and toddlers (age 0 to 36 months) who have a developmental delay (defined in Section 95014 of CA Government Code) also receive services from DDS.

*Funding Sources/Flows
DDS Community-Based Services are funded by the following funding sources:
State Funds:

- State General Fund
- Mental Health Services Fund
- California Children and Family Trust Fund (Proposition 10 funding to create a comprehensive and integrated system of information and services to promote early childhood development (from prenatal to age 5) and school readiness, including community health care, quality child care, and education programs for young children)

Federal Funds:

- Medicaid (e.g. Home and Community Based Services Waiver (HCBS), Medicaid Administration, Targeted Case Management, 1915(i) State Plan Amendment, and Money Follows the Person Grant)
- Title XX Block Grant (no State match or MOE is required)
- Early Start Program Grant for infants and toddlers age 0 to 36 months
- Foster Grandparents Program (administrative funding supports the volunteer program that establishes person-to-person relationship between low income senior, age 55 years or older, and children with intellectual disabilities)
- Homeland Security Grant (funding to regional centers for equipment, training, and exercise to prevent, respond to, and recover from acts of terrorism and other catastrophic events)

Others:

- Program Development Fund (fees assessed to parents of children under the age of 18 who receive 24-hour out-of-home services purchased with State funds through a regional center)
- Vocational Rehabilitation (funding by HCBS and GF for transportation expenditures)
- Developmental Disabilities Services Account (application fees paid by housing developers to reimburse DDS' costs for review and approval of the housing proposals)

The above represents all funding received by DDS for community-based services.

The federal funds are deposited into the State General Fund as reimbursement for appropriate claims initially paid from the General Fund.

*DSHP Costs
DDS services to individuals not eligible for Medi-Cal are Medicaid-like services in that they are the same services as State plan approved services and services provided under approved HCBS waivers for Medi-Cal beneficiaries. DDS services applicable to this claiming protocol include uninsured Medicaid-like services provided under Community Based Services to individuals age 3 years and older, including assessment, evaluation and diagnostic services.

Allowable DSHP costs will be the community-based Purchase of Services (POS) expenditures, which exclude administrative expenditures, adjusted for the following exclusions:

DDS community-based POS costs that are not related to Medicaid-like healthcare services, including:

- POS contract costs

- Expenditures for Community Placement Plan (funds paid to regional centers for permanent housing placement)
- Expenditures for Medical Facilities (payments to Intermediate Care Facilities and Developmentally Disabled Continuous Nursing Care for services not eligible for Medi-Cal).
- Proposition 10/California & Family Trust Fund expenditures (funds paid to regional centers for development of comprehensive and integrated system of information and services to promote early childhood development and school readiness).

DDS community-based POS costs related to Medicaid-like healthcare services funded by other payers, including:

- Expenditures for Early Start program (including federal funds and State matching/MOE funds)
- Expenditures for services to Medi-Cal beneficiaries(including federal funds, State matching funds, and Vocational Rehabilitation funds)
- Expenditures related to services eligible for Federal Title XX funds
- Program Development Fund

*Report Format
DDS program costs will be compiled from DDS POS Claims Data file using Eligibility Codes to identify the uninsured population, Budget Codes to identify the funding sources, and Service Codes to identify the eligible services.

C. DSHP Interim Claiming
The purpose of DSHP interim claiming is to provide an interim payment that will approximate the allowable costs for Medicaid-like services in SOMPs that are eligible for FFP through the CPE process.

For each demonstration year, the process of determining the allowable costs eligible for FFP begins with the use of most recently completed Paid Claims Data reports for CCS, GHPP, MIA/LTC, BCCTP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS. The fiscal year covered by the most recently completed Paid Claims Data reports will serve as the prior period.

The net program costs, for each program described above, will be determined by using the most recently completed Paid Claims Data report provided by its governing agency.

The costs from the Paid Claims Data report represent net program costs incurred by the governing agency for medical services and are net of any self-payment or copayments made by or on behalf of the patients.

Net program costs are reduced by other funding and subsidies made by a federal government, MOE and other matching requirements, or other third party to the program costs to arrive at the computed DSHP costs.

DSHP costs are further reduced by any program costs incurred for payments made for non-Medicaid-equivalent services or payments for services furnished to any individuals who are otherwise insured. The result is the allowable DSHP costs.

An interim allocation percentage is computed by dividing the allowable SNCP costs for each fiscal year by the total DSHP costs from Step 3 computed above.

SFYs 2010-2011 to 2015-2016 DSHP costs will be computed pursuant to the step 3, except for interim claiming purposes, the DSHP costs will be based on budgeted appropriations and funding amounts rather than actual paid claims reports.
Interim certified public expenditures of the DSHPs will be equal to the amounts of

SFYs 2010-11 to 2015-2016 DSHP costs in Step 6 multiplied by the interim allocation percentage for the applicable fiscal period computed in step 5 and reduced by 13.95 percent as described in subsection A to account for non-emergency care furnished to non-qualified aliens.

SNCP interim claiming for the federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.

D. Final Reconciliation of DSHP Interim Claiming
The DSHP interim certified public expenditures will be reconciled based on the actual Paid Claims Data for the applicable fiscal periods as finalized by its governing agencies for each program.

Allowable SNCP costs for each SFY will be computed pursuant to the steps described in subsection C.1 through C.5 above, using actual paid claims reports and actual funding and expenditure amounts for each SFY.

The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified DSHP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR CMHS

A. Cost Finding Methodology

California counties, which receive federal and state funds for providing public mental health services, are required to submit a fiscal year-end (July to June) Mental Health Cost Report with the Department of Mental Health (DMH) by December 31 following the close of each fiscal year. The cost report forms, cost determination, and allocation methodologies are approved by the State and in compliance with the Federal Medicaid regulations.

County total mental health costs are reported in four primary groups of service categories:
Administrative Costs.
Research & Evaluation Costs.
Utilization Review Costs.
Direct Service Costs.

The eligible SNCP costs are direct service costs funded by the State Realignment Funds and Mental Health Services Act (MHSA) Fund incurred by each county for the furnishing of mental health services allowable under Section 1905(a) of the Social Security Act to uninsured individuals.

The allowable SNCP costs, computed under this Supplement, are limited to the eligible SNCP costs incurred for months of DYs. Allowable SNCP costs claimable under this Supplement should not include any uninsured mental health costs incurred by counties which operate Designated Public Hospitals (DPHs); such uninsured costs are separately addressed in Attachment F - Supplement 4.

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. A 13.95 percent reduction factor is applied to the total certified SNCP expenditures before costs are claimed.

B. Summary of Mental Health Cost Report
The Mental Health Cost Report includes:

Detail Cost Report: Detail forms for each legal entity, including county and contract providers.

Summary Cost Report: Aggregate county mental health costs for the Fiscal Year.

Legal entity means each county mental health department or agency and each private provider furnishing public mental health services under contract with the county department or agency.

Direct service costs are reported by Modes of Service (MS) and Service Functions (SF). MS describes a classification of service types. SF identifies the specific type of service received under a MS.

Allowable SNCP costs are captured by the following MS and SF (which represent specialty mental health services that would be covered by Medi-Cal if furnished to Medi-Cal recipients):

05 (Hospital Inpatient and other 24 Hour Services)
SF 10-18: Local Hospital Inpatient
SF 19: Hospital Administrative Days
SF 20-29: Psychiatric Health Facility
SF 40-49: Adult Crisis Residential
SF 65-79: Adult Residential
10 (Less than 24 Hour Day Treatment Program Services)
SF 20-29: Crisis Stabilization
SF 81-89: Day Treatment Intensive
SF 91-99: Day Rehabilitation
15 (Outpatient Services) All SFs.

The above MS and SF do not include any service that is subject to the Institutions for Mental Diseases (IMDs) exclusion per Section 1905(a) of the Social Security Act.

MH 1901 Schedule B (Worksheet for Units of Service and Revenue by Mode & Service Function
The individual legal entity's worksheet for units of service by MS and SF codes under the following categories
Medi-Cal Units:
Regular Medi-Cal
Medicare/Medi-Cal Crossover
Enhanced Medi-Cal (Children and Refugees)
Healthy Families
Non Medi-Cal Units

MH 1901 Schedule C (Allocated costs to Mode of Service & Service Function)
The individual legal entity's supporting documentation to distribute the direct service costs to MS and SF.

MH 1960 (Calculation of Program Costs)
The individual legal entity's worksheet to identify the allowable costs for allocation applicable to the four major service categories.

The individual legal entity's worksheet to compute the cost per unit and the allocation costs to SFs. The units of service are derived from MH 1901 Schedule B; the total allocated costs are derived from MH 1901 Schedule C.

MH 1992 (Funding Sources)
The individual legal entity's total mental health costs by funding sources and service categories.

MH 1992 SUM (Summary Funding Sources)
The county total mental health costs (from all reporting legal entities) by funding sources and service categories.

C. DSHP Interim Claiming
The process of determining the allowable SNCP costs eligible for FFP begins with the use of most recently filed Mental Health Cost Report. The period covered by this most recently filed cost report will serve as the base period for interim payment computation.

Cost per unit for each SF will be computed by using the total direct service costs from MH 1901 Schedule C divided by the total units of service from MH 1901 Schedule B.

Non Medi-Cal units of service form MH 1901 Schedule B will be reduced, using additional auditable county and provider records, to determine the uninsured units of service.

Cost per unit will be multiplied by the number of uninsured units of service computed above for each eligible SF to determine the total uninsured costs. If a legal entity has a contract with the county limiting its cost per unit and the contracted cost per unit is lower than the cost per unit computed in the cost report, the lower contracted cost per unit will be used to determine the total uninsured costs for the legal entity.

The total uninsured costs computed above can be trended to current year based on Consumer Price Index (CPI) for U.S City Average by commodity for Hospital and related services.

In order to identify the total uninsured costs funded by the State Realignment Funds and the MHSA Fund, the State will compute the allocation percentage based on funding sources for each direct service MS. By using the Summary Cost Report, MH 1992 SUM, the Realignment Funds and MHSA Funds for each direct service MS will be adjusted to exclude the matching funds used for Short-Doyle/Medi-Cal and Healthy Families FFP.

The allocation percentage for each direct service MS is the ratio of direct service costs funded by the net State Realignment Funds and MHSA Funds computed above to the total direct service costs from all funding sources.

The eligible SNCP costs will be the total trended uninsured costs for each MS computed in step 3 multiplied by the applicable allocation percentage.

Uninsured mental health costs claimable under this Supplement do not include uninsured mental health costs incurred by counties which operate DPHs; those costs are addressed in Attachment F - Supplement 4. Furthermore, any county uninsured mental health costs incurred for other SNCP claiming, such as the Medicaid Coverage Expansion and the Health Care Coverage Initiative, will be offset against the computed eligible SNCP costs.

The net eligible SNCP costs will be multiplied by the following ratio to determine the allowable SNCP costs:

SFY 2010-11:	67.67% (8 months over 12 months)
SFYs 2011-12 to 2014-15:	100%
SFY 2015-16:	33.33% (4 months over 12 months)

Interim certified public expenditures for CMHS are the allowable SNCP costs computed above reduced by 13.95 percent to account for non-emergency care furnished to non-qualified aliens.

DSHP interim claiming for federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.

D. Interim and Final Reconciliations of DSHP Interim Claiming

The interim certified public expenditures for CMHS will be first reconciled based on the Mental Health Cost Reports for the applicable fiscal years accepted by DMH.

The interim certified public expenditures for CMHS will also be subsequently reconciled based on Mental Health Cost Reports for the applicable fiscal years as settled and audited by DMH.

Allowable SNCP costs for each SFY will be computed pursuant to the steps described in subsection C, except that the cost report for the applicable SFYs will be used to determine actual expenditures incurred. For DY 10, allowable SNCP costs for the partial period of July 1, 2015 through October 31, 2015 will be computed pursuant to the steps described in subsection C, except that the cost report for the SFY 2015-2016 will be used to determine actual expenditures incurred.

If legal entities costs are not fully reimbursed by the county, such as the application of legal entity contract limits, thereby reducing actual expenditures incurred by the county below legal entity costs, such reduction must be proportionately applied to the allowable SNCP costs. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified SNCP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

Any prospective revision to the Medi-Cal mental health cost reports, as approved by CMS, must be incorporated into the mental health cost reporting methodology used in this CPE protocol.

Attachment F – Supplement 1
Funding and Reimbursement Protocol for
Determination of Allowable Costs to Workforce Development Programs in Designated State Health Programs

The Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration, approved by the federal Centers for Medicare and Medicaid Services (CMS) on November 2, 2010, allow the State to use allowable costs in Designated State Health Programs (DSHPs) incurred from November 1, 2015 through December 31, 2020 for federal claiming against the Safety Net Care Pool (SNCP).

DSHPs, as described under this Supplement, have two components, State Only Medical Programs (SOMPs) and Workforce Development Programs (WDPs). WDPs are integral to the successful transition to the era of health care reform. They improve access to healthcare in underserved areas of CA by providing scholarship, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas. WDPs also provide educational opportunities in health professional training through established state educational institutions and state department programs. WDPs include the following state/local funded programs:

- Office of Statewide Health Planning & Development (OSHPD)
    - Song-Brown Healthcare Workforce Training Program (Song-Brown)
    - Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)
    - Mental Health Loan Assumption Program (MHLAP)

The allowable costs incurred in the WDPs for claiming against the SNCP are the State program expenditures incurred in the months of Demonstration Year (DY) per the STCs.

To determine allowable SNCP costs and the associated SNCP reimbursement when such costs are incurred by the State as certified public expenditures (CPEs), the following steps must be taken to ensure federal financial participation (FFP):

I. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

A. General Provision

Program costs, for each OSHPD program described above, mean the total expenditures incurred in the State Fiscal Year (SFY) ended June 30 from all the funding sources. Program costs are the expenditures necessary to maintain and support WDPs, including State operation expenditures, loan repayment, and award payments.

Net program costs are program costs for award or loan repayments funded by the State or local only.

Allowable SNCP costs, for each OSHPD program described above, are limited to the net program costs paid in the months of Demonstration Year (DY) per the STCs.

For the purpose of interim claiming, the estimated program costs for each SFY are the total budget amount of Fund Appropriation for the applicable fiscal period that the State commits to each OSHPD program. The estimated program cost for each fiscal period is reduced by budgeted funding for State operation costs and from non-State, non-local sources to arrive at the estimated net program cost. The estimated net program cost is multiplied by an interim allocation percentage to arrive at the estimated allowable SNCP cost for the fiscal period.

B. Program Description

Song-Brown Healthcare Workforce Training Program

The Song-Brown Health Care Workforce Training Act (Song-Brown Program), established in 1973, provides financial support to various healthcare education programs with an emphasis on primary care and encourages primary care health professionals to provide healthcare in medically underserved areas.

*Eligibility

The Song-Brown Program provides award funding to institutions (not individual students) that provide clinical training for Family Practice Residents, Family Nurse Practitioners, Physician Assistants, and Registered Nurses in rural and urban undeserved areas. The awards are utilized by the residence programs to develop curriculum, clinical training sites and other necessary expenses to increase the number of health professional training slots in established medical schools. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas, and provides financial support to family practice residency, nurse practitioner, physician assistant, and registered nurse education programs through CA. It does not help cover resident tuition.

*Funding Source

The Song-Brown Program is currently funded by the California Health Data and Planning Fund (CHDPF), a special fee charged to CA licensed health facilities, and the State General Fund (GF). The State pays the program claims.

*Report Format

Song-Brown Program costs will be compiled from the State CalSTARS system, which uses Object of Expenditure Codes, Program Cost Account (PCA), and Category to identify the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)

The purpose of STLRP is to encourage physicians to practice in medically underserved areas of California by authorizing a plan for repayment of their educational loans. STLRP repays up to $105,000 in outstanding government or commercial educational

loans for expenses incurred for undergraduate education and graduate medical education.

*Eligibility
Loan repayment awards are available to physicians who hold a full and unrestricted license to practice medicine in CA. Physicians awarded under this program must complete a three years service obligation to practice as a full-time physician in a medically underserved area of CA providing direct patient care.

*Funding Source
STLRP is funded through $25 surcharge for renewal of allopathic physician licenses in CA and through the Managed Care Administrative Fines and Penalties Fund.

*Report Format
STLRP program cost will be compiled from the State CalSTARS system, which uses Object of Expenditure Codes, Program Cost Account (PCA), and Category to identify the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

Mental Health Loan Assumption Program (MHLAP)
The MHLAP, created by the Mental Health Services Act, encourages mental health providers to practice in underserved locations in CA by authorizing a plan for repayment of some or all of their educational loans in exchange for their services in a designated hard-to-fill/retain position in the Public Mental Health System. Each eligible participant may receive up to $10,000 award. In no event shall the amount of the award exceed the amount of the participant's outstanding educational debt.

*Eligibility
Loan repayment awards are available to mental health provides who have a current, full, permanent, unencumbered, unrestricted health provider license, registration, or waiver and work or volunteer in the Public Mental Health System. Award recipients are required to complete a minimum 12 months consecutive or equivalent paid or unpaid service obligation and work or volunteer either full-time or part-time.

*Funding Source
The MHLAP is funded through the Mental Health Services Act, which receives the funding from special tax revenue to expand mental health services. The annual MHLAP funding is used to administer the programs, including awards, marketing, program operations, and staff.

*Report Format
MHLAP program cost will be compiled from the State CalSTARS system, which uses

the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

C. DSHP Interim Claiming

The purpose of DSHP interim claiming is to provide an interim payment that will approximate the allowable costs in OSHPD programs that are eligible for FFP through the CPE process.

1. The process of determining the allowable costs eligible for FFP begins with the use of annual budget amount of Funding Appropriation for each OSHPD program described above.
2. The estimated program costs are reduced by program operation costs and other funding and subsidies made by a federal government or other third party to arrive at the net program costs. For the OSHPD Workforce Development Programs, there is no funding other than State funding. Therefore, program operation costs are the only funding reduction needed to arrive at net program costs.
3. The net program costs for each SFY will be multiplied by the following interim allocation percentage to determine the allowable SNCP costs:
   SFY 2010-11: 67.67% (8 months over 12 months)
   SFYs 2011-12 to 2014-15: 100%
   SFY 2015-16: 33.33% (4 months over 12 months)
4. DSHP Interim certified public expenditures for OSHPD programs are the allowable SNCP costs as computed above.
5. SNCP interim claiming for the federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.

D. Final Reconciliation of DSHP Interim Claiming

The DSHP interim certified public expenditures will be reconciled based on the actual expenditures data for the applicable fiscal periods as finalized by its governing agencies for each program.

Allowable SNCP costs are the net program costs paid in the months of each DY, using actual expenditures reports for each SFY.

The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified DSHP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

Funding and Reimbursement Protocol for Claiming IHS and 638 Facilities Uncompensated Care Payment Methodology

The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from November 1, 2015 through December 31, 2020 as required by STC **Error! Reference source not found.**.b.iii. Using the methodology escribed below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and December 31, 2014 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal. Costs for optional dental and psychology, that were eliminated through SPA 09-001, but have been added back in through State Plan Amendments are not available for reimbursement through these supplemental payments.

A. <u>Provider Claiming Methodology for services provided Novemeber 1, 2015 through December 31, 2020</u>

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
    b. Whether the service was provided to an IHS eligible individual; and
    e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a

Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility,

broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility for uncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

.

Funding and Reimbursement Protocol for Claiming IHS and 638 Facilities Uncompensated Care Payment Methodology

Exhibit 1.B: Aggregate Encounter Report for January 1, 2014 through October 31, 2015

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
	X
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____

Signature (officer of the governmental entity) Date

_____

Title

Attachment G
(Reserved)

Attachment H
Accounting Procedures

The following Accounting Procedures have been developed to ensure that no over claiming of expenditures occur and to provide for accurate reporting of mandated reports as required by CMS for the Demonstration. The Safety Net Financing Division's (SNFD) Hospital Contracts Unit (HCU), within the Inpatient Contract and Monitoring Section (ICMS), is responsible for preparing quarterly and annual reconciliation of program expenditures.

I. STATE-ONLY PROGRAMS - Reserved for State submission of accounting procedures for DY 6-10 DSHPs per paragraph 22.

II. CERTIFIED PUBLIC EXPENDITURES

CPEs are expenditures certified by counties, university teaching hospitals, or other governmental entities within a state, as having been spent on the provision of covered services to Medi-Cal beneficiaries and uninsured individuals. CPEs are eligible for reimbursement at the federal medical assistance percentage in effect on the date the service is provided.

Cost Submission

At least annually, designated public hospitals (DPHs) send to SNFD an estimate of their CPEs for the project (current) year, accompanied by an attestation of the costs. The CPEs are derived from the Medi-Cal 2552-96 cost report, a Workbook developed by SNFD, and other documentation to support the estimated CPEs. These CPEs are used to establish an interim per diem rate of reimbursement for the costs of providing inpatient care to Medi-Cal beneficiaries, and to determine DSH payments, and payments from the SNCP. In addition, the data is used as the basis of a tentative settlement made for inpatient services rendered to Medi-Cal beneficiaries.

1. Review Process
   SNFD reviews all data submitted for accuracy and compliance with established procedures, and performs tests for reasonableness. If discrepancies or inconsistencies are identified, SNFD works directly with the DPH staff to resolve issues and correct data.

2. Interim Payment Process

   Establish Inpatient Interim Rates
   SNFD establishes the inpatient interim rate for each DPH based on the most current filed Medi-Cal 2552-96 and Workbook. SNFD instructs Provider Enrollment Division (PED) to update the Provider Master File (PMF) to reflect the new interim rates. The new interim rates are not retroactive and are applied to all claims for services rendered effective with the update.

Determine Interim Payment
SNFD reviews the most current filed Medi-Cal 2552-96 cost report and Workbook filed by each DPH for the purpose of determining a tentative settlement. The tentative settlement is made to settle on an interim basis all claims paid to date to reflect the difference between the interim rate paid and actual costs. The actual claims paid are based on the most current Medi-Cal claims payment data generated by California's fiscal intermediary. Based on the review and application of the current payment data, SNFD generates a notice of tentative settlement to each DPH that includes schedules supporting the calculation and a copy of the payment data. A copy of the notice is forwarded to A&I for preparation of an action notice authorizing California's fiscal intermediary to pay or recover the tentative settlement amount. California's fiscal intermediary will prepare a Statement of Account Status which will inform the hospital of the date of payment or instructions for repayment.

3. Final Reconciliation Process
The final audit report of the Medi-Cal 2552-96 cost report generated by A&I will be used as the basis for final determination and settlement of the CPEs. SNFD will instruct A&I to prepare an action notice informing California's fiscal intermediary of the final settlement. California's fiscal intermediary will issue a Statement of Account Status which will incorporate the previous tentative settlement and inform the DPH of any further payment or recovery.

III. INTERGOVERNMENTAL TRANSFERS (IGTs)

IGTs are transfers of public funds between governmental entities, such as from a county to the State. One source of the funding used for the transfer is local tax dollars. SNFD reviews the source of funding for each IGT that is proposed by a governmental entity to ensure that it meets state and federal requirements for permissible transfers.

Pre-Transfer

For IGTs used as the non-federal share of DSH payments, DHCS and the State Treasurer's Office (STO) are notified by the county or governmental entity, prior to the transfer of funds to ensure all arrangements are complete.

For IGTs used as the non-federal share of the supplemental payments under the provisions of section 14166.12 of the California Welfare and Institutions (W&I) Code, DHCS, the California Medical Assistance Commission (CMAC), and STO are notified by the county, or governmental entity, prior to the transfer of funds to assure that all arrangements are complete.

Transfer

1. IGTs used as the non-federal share of DSH payments.

The amounts of the IGTs are determined by the data submitted to DHCS by the DPHs. Staff of the DSH Payment Unit will coordinate the amount and timing of transfers from the DPHs to STO.

2. IGTs used as the non-federal share of the supplemental payments.
   CMAC coordinates with HCU on the amount and timing of IGTs to the STO under the provisions of section 14166.12 of the W&I Code.

Post-Transfer

For all IGTs, the county, or governmental entity, notifies DHCS after the transfer is complete. The transfer is verified and documented, and DHCS deposits the transferred amount into the appropriate funds for payments.

IV. SAFETY NET CARE POOL PAYMENTS

DPHs receive SNCP payments for hospital and clinic costs associated with health care services provided to uninsured individuals.

Payment Processes

The SNFD Program payment computation includes automated verification that the federal SNCP allotment, quarterly interim payments and the total SNCP funding level are not exceeded.
The payment process includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation occurs based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

V. DISPROPORTIONATE SHARE HOSPITAL PROGRAM

DHCS disburses $1.0325 billion of the federal DSH allotment to eligible DPHs and non-designated public hospitals (NDPHs) annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines DPHs and NDPHs, specifies the funding level, and describes the distribution methodology.

The non-federal share of DSH payments to DPHs is comprised of CPEs and IGTs. DPHs use CPEs to claim DSH funding for up to 100 percent of their uncompensated care costs, and use IGTs to claim DSH funding for up to 175 percent of their uncompensated care costs, as permitted by the Omnibus Budget Reconciliation Act of 1993. By contract, the nonfederal share of DSH payments to NDPHs is the State General Fund.

Annually, the DSH Share Hospital Eligibility Unit submits a DSH Program audit report to CMS as required by the Social Security Act. The DSH Share Hospital Payment Unit (DSHPU) performs a final reconciliation of total DSH hospital-specific payments to ensure that funding provided during and after the project year does not exceed appropriate funding levels established by actual hospital uncompensated care costs, as required by the State Plan.

The DSH Program payment computations include automated verification that the federal DSH allotment, appropriate IGT funds invoiced for DSH payments, and the total DSH Program funding level are not exceeded.

The DSHPU protocol and procedures include quality audits to ensure that correct data is used appropriately and that correct amounts are disbursed to the appropriate

hospitals.

A. DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source.

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. For payments using IGTs as the non-federal share of the payments, the PAN provides Accounting with authorization to use the federal DSH allotment and IGT funds from the Medicaid Inpatient Adjustment Fund. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for DPHs includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation is based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

EDS prepares the check write computer file for submission to SCO.

B. NON-DESIGNATED PUBLIC HOSPITALS

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal DSH allotment).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the General Fund and federal DSH allotment. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for NDPHs includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information.

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover any overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

C. PRIVATE HOSPITALS

DHCS disburses approximately $465 million of DSH replacement funding to eligible private hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the State Plan, are eligible to receive DSH replacement funding. The State Plan defines private hospitals, specifies the funding level, and describes the funding distribution methodology. In addition to the DSH replacement funding, DSH-eligible private hospitals receive their pro rata share of payments from a

defined pool within the annual DSH allotment.

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal Medicaid funding).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the State General Fund and federal Medicaid funds. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for private hospitals includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

VI. PRIVATE HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi-Cal patients. Eligible private hospitals receive supplemental payments funded with

State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Private Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VII. NON-DESIGNATED PUBLIC HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the SPCP to provide acute inpatient hospital care to Medi-Cal patients. Eligible NDPHs receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Non-designated Public Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief

requesting authorization for payment.

(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VIII. DISTRESSED HOSPITAL FUND PAYMENTS

CMAC negotiates contract amendments with participating SPCP hospitals that meet criteria for distressed hospitals. These hospitals must serve a substantial volume of Medi-Cal patients, be a critical component of the Medi-Cal program's health care delivery system, and be facing a significant financial hardship that may impair ability to continue their range of services for the Medi-Cal program.

The non-federal share of distressed hospital fund payments is funded by State Treasury funds that are 20% of the July 2005 balance of the prior supplemental funds (PFSs), accrued interest on the PFSs, and any additional amounts appropriated by the Legislature.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for payments from the Distressed Hospital Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.

(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request, and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

IX. CONSTRUCTION/RENOVATION REIMBURSEMENT PROGRAM (SB 1732)

In 1989, Senate Bill (SB) 1732 was enacted to establish the Construction/Renovation Reimbursement Program (also known as the SB 1732 program) (Welfare and Institutions Code 14085.5). Under this program, reimbursement is provided to eligible hospitals for the debt service costs incurred on revenue bonds used to finance eligible hospital construction project(s).

Invoice Submission

Invoices are submitted by participating hospitals to HCU no more than twice each year. The invoices consist of the following:

(i) A cover letter from the hospital's Chief Financial Officer, or other appropriate representative.
(ii) A reimbursement request that includes bond debt service payment (principal and/or interest).
(iii) Support documents verifying payment by the hospital to the debt holder.

Review Process

HCU verifies inclusion and accuracy of all required documents in the invoice package.

Payment Process

HCU calculates reimbursement amounts on a spreadsheet by:

(i) Determining the amount of debt service paid.
(ii) Deducting interest earned in the hospital's SB 1732 account.
(iii) Calculating the reimbursable amount based on the eligible portion of the construction project and the Medi-Cal Utilization Rate percentage.

HCU prepares a reimbursement payment package, which is reviewed and approved by the ICMS Chief, and submits it to California's fiscal intermediary.

HCU sends a notification letter to each eligible hospital and a copy of the notification letter is forwarded to CMAC.

California's fiscal intermediary forwards payment requests to SCO and sends copies of the payment requests to HCU.

SCO mails the payment to the hospital.

X. SELECTIVE PROVIDER CONTRACTING PROGRAM

The SPCP was established in 1982 and operated under a two-year section 1915(b) waiver until August 31, 2005. On September 1, 2005, CMS approved the continuation of a restructured SPCP under California's new five-year section 1115 Medi-Cal Hospital/Uninsured Care Demonstration. The SPCP allows DHCS to selectively contract with acute care hospitals to provide inpatient hospital care to Medi-Cal beneficiaries. Under the SPCP, CMAC negotiates contract terms and conditions and per diem rates with participating hospitals on behalf of DHCS. This program has resulted in millions of dollars of savings each year which offset expenditures in this Demonstration to assist in achieving budget neutrality.

The non-federal share of SPCP payments is funded by amounts from the State General Fund.

Contract Process

CMAC forwards proposed contract(s)/amendment(s) to HCU for review. After review, final proposed contracts/amendments are presented at a CMAC meeting for approval by the Commissioners. The approved contracts/amendments are signed by authorized hospital representatives and submitted by CMAC to HCU for processing. The HCU analyst prepares contract/amendment packages for processing and obtains the signature of DHCS's delegated Contract Officer (SNFD Chief) to fully execute the contracts/amendments.

Notification Process

HCU notifies PED of new per diem rates and/or new Current Procedural Terminology codes, revenue codes, and Health Care Procedure Coding System codes, to update the Provider Master File with the hospital- specific information. This file is used by California's fiscal intermediary to process and pay claims submitted by all Medi-Cal providers, including those participating in the SPCP.

Distribution Process

HCU distributes fully executed contracts/amendments to the following:

(i) Contracted hospital
(ii) CMAC Executive Director
(iii) Medi-Cal Field Office
(iv) A&I

i. CMS-64 QUARTERLY EXPENSE REPORT

After the end of every quarter, Accounting summarizes all payments and claims made relating to the Demonstration during the quarter and sends the summary to SNFD to verify the payment period, amount and funding source. After the confirmation, Accounting prepares and submits the CMS-64 Quarterly Expense Report to CMS.

Attachment I
Quarterly Report Guidelines

In accordance with Section, paragraph 20, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of California Bridge to Health Reform Demonstration 11-W-00193/9)

Title Line Two - Section 1115 Quarterly Report
Demonstration Reporting Period:
Example:
Demonstration Year: 6 (9/1/10 - 12/31/10)

Introduction:
Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:
Please complete the following table that outlines current enrollment in each HCCI program under the Demonstration. The State should indicate "N/A" where appropriate.
Note:
Monthly enrollment data during the quarter and Demonstration Year to Date by:

i. County of participation the number of persons in the Medicaid Coverage Expansion Program ([MCE]) who are new recipients and existing recipients by FPL;
ii. County of participation the number of persons in the HCCI program ([SNCP – HCCI]) who are new recipients and existing recipients by FPL;
iii. County of participation the number of persons enrolled in the SPD program ([Existing SPD] or [Mandatory SPD]);
iv. County of participation the number of persons enrolled in the California Children Services Program based on Medi-Cal eligibility ([CCS – State Plan]) and DSHP ([CCS – DSHP]); and
v. County of participation the number of persons participating in DSHP receiving FFP.
vi. Monthly eligible member-month totals for [LIHP], [Existing SPD], [Mandatory

SPD], [CCS – State Plan], and [Families],

Member-Months: To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
2.					

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

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.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment J – Reserved

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

BUDGET NEUTRALITY				MEDI-CAL 2020 WAIVER					
			FY 14-15	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
WOW (Non-Family)	MEGS	Trend Rate	Baseline	DY11	DY12	DY13	DY14	DY15	5 Year Total
PMPM									
TPM/GMC									
	Urban Family	4.00%	$189.25	$196.82	$204.69	$212.88	$221.40	$230.26	
	Rural Family	4.00%	$165.55	$172.17	$179.06	$186.22	$193.67	$201.42	
	SPDs	4.00%	$864.94	$899.54	$935.52	$972.94	$1,011.86	$1,052.33	
	Duals	3.28%	$117.97	$121.84	$125.84	$129.97	$134.23	$138.63	
COHS									
	Urban Family	4.00%	$215.41	$224.03	$232.99	$242.31	$252.00	$262.08	
	Rural Family	4.00%	$176.30	$183.36	$190.69	$198.32	$206.25	$214.50	
	SPDs	4.00%	$1,653.48	$1,719.62	$1,788.40	$1,859.94	$1,934.34	$2,011.71	
	Duals	2.47%	$439.25	$450.10	$461.22	$472.61	$484.28	$496.24	
CCI TPM/GMC									
	Family	4.00%	$187.81	$195.32	$203.13	$211.26	$219.71	$228.50	
	SPDs	4.00%	$1,051.02	$1,093.06	$1,136.78	$1,182.25	$1,229.54	$1,278.72	
	Duals	3.40%	$749.35	$774.83	$801.17	$828.41	$856.58	$885.70	
	Cal MediConnect	3.40%	$749.35	$774.83	$801.17	$828.41	$856.58	$885.70	
CCI COHS									
	Family	4.00%	$213.75	$222.30	$231.19	$240.44	$250.06	$260.06	
	SPDs	4.00%	$2,032.81	$2,114.13	$2,198.70	$2,286.65	$2,378.12	$2,473.24	
	Duals	1.61%	$652.77	$663.28	$673.96	$684.81	$695.84	$707.04	
	Cal MediConnect	1.61%	$652.77	$663.28	$673.96	$684.81	$695.84	$707.04	
CBAS		3.16%	$1,130.95	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30	
HHP					$0.00	$65.00	$65.00	$65.00	
DMC ODS					$2,942.29	$3,418.10	$2,913.42	$2,912.74	
Member Months									
TPM/GMC									
	Urban Family	1.00%	15,949,730	16,109,227	16,270,320	16,433,023	16,597,353	16,763,327	
	Rural Family	1.00%	2,619,811	2,646,009	2,672,469	2,699,194	2,726,186	2,753,448	
	SPDs	1.00%	2,155,214	2,176,766	2,198,534	2,220,519	2,242,724	2,265,152	
	Duals	1.00%	864,855	873,504	882,239	891,061	899,972	908,971	
COHS									
	Urban Family	1.00%	7,428,534	7,502,819	7,577,848	7,653,626	7,730,162	7,807,464	
	Rural Family	1.00%	870,990	879,700	888,497	897,382	906,356	915,419	
	SPDs	1.00%	905,774	914,832	923,980	933,220	942,552	951,978	
	Duals	1.00%	1,599,092	1,615,083	1,631,234	1,647,546	1,664,022	1,680,662	
CCI TPM/GMC									
	Family	1.00%	33,001,616	33,331,632	33,664,948	34,001,598	34,341,614	34,685,030	
	SPDs	1.00%	4,301,367	4,344,381	4,387,824	4,431,703	4,476,020	4,520,780	
	Duals	1.00%	3,519,767	3,554,965	3,590,515	3,626,420	3,662,684	3,699,311	
	Cal MediConnect	1.00%	1,372,072	1,385,792	1,399,650	1,413,647	1,427,783	1,442,061	

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

CCI COHS									
	Family	1.00%	4,810,033	4,858,133	4,906,715	4,955,782	5,005,340	5,055,393	
	SPDs	1.00%	549,931	555,430	560,985	566,594	572,260	577,983	
	Duals	1.00%	1,119,648	1,130,844	1,142,152	1,153,574	1,165,110	1,176,761	
	Cal MediConnect	1.00%	115,147	116,299	117,462	118,637	119,823	121,021	
CBAS		6.87%	369,651	395,046	422,185	451,190	482,186	515,312	
HHP						236,259	1,925,061	2,804,640	
DMC ODS					14,446	267,033	528,914	547,964	
WOW Expenditures									
TPM/GMC									
	Urban Family			$3,170,618,117	$3,330,371,713	$3,498,261,887	$3,674,653,953	$3,859,923,566	**$17,533,829,237**
	Rural Family			$455,563,388	$478,532,335	$502,643,887	$527,980,410	$554,599,434	**$2,519,319,454**
	SPDs			$1,958,088,214	$2,056,772,342	$2,160,431,892	$2,269,323,041	$2,383,686,956	**$10,828,302,444**
	Duals			$106,427,673	$111,020,904	$115,811,194	$120,803,185	$126,010,691	**$580,073,647**
COHS									
	Urban Family			$1,680,856,617	$1,765,562,697	$1,854,550,118	$1,948,000,892	$2,046,180,137	**$9,295,150,460**
	Rural Family			$161,301,774	$169,427,474	$177,968,772	$186,935,860	$196,357,428	**$891,991,308**
	SPDs			$1,573,162,957	$1,652,445,935	$1,735,732,943	$1,823,216,145	$1,915,102,812	**$8,699,660,791**
	Duals			$726,948,822	$752,357,630	$778,646,756	$805,852,355	$834,011,593	**$3,897,817,156**
CCI TPM/GMC									
	Family			$6,510,334,393	$6,838,360,985	$7,183,177,586	$7,545,196,000	$7,925,529,375	**$36,002,598,340**
	SPDs			$4,748,668,735	$4,987,991,109	$5,239,380,542	$5,503,445,322	$5,780,811,733	**$26,260,297,441**
	Duals			$2,754,493,532	$2,876,612,623	$3,004,162,425	$3,137,381,857	$3,276,479,607	**$15,049,130,043**
	Cal MediConnect			$1,073,753,517	$1,121,357,841	$1,171,079,159	$1,223,010,605	$1,277,233,531	**$5,866,434,653**
CCI COHS									
	Family			$1,079,963,039	$1,134,383,363	$1,191,568,178	$1,251,635,227	$1,314,705,510	**$5,972,255,318**
	SPDs			$1,174,251,881	$1,233,436,869	$1,295,603,220	$1,360,903,912	$1,429,490,694	**$6,493,686,576**
	Duals			$750,066,227	$769,765,078	$789,979,006	$810,729,957	$832,016,978	**$3,952,557,245**
	Cal MediConnect			$77,138,749	$79,164,630	$81,243,482	$83,377,564	$85,566,776	**$406,491,200**
CBAS				$460,895,170	$508,123,522	$560,191,407	$617,594,735	$680,880,236	**$2,827,685,070**
HHP				$0	$0	$15,356,835	$125,128,965	$182,301,600	**$322,787,400**
DMC ODS				$0	$42,505,318	$912,745,040	$1,540,949,661	$1,596,078,071	**$4,092,278,090**
DSH (estimate will be based on actual)				$ 2,423,161,227	$ 2,471,624,452	$ 2,125,503,107	$ 1,977,980,939	$ 1,831,576,406	**$10,829,846,131**
IP UPL PH		0.00%	$3,504,932,961	$ 3,504,932,961	$ 3,504,932,961	$ 3,504,932,961	$ 3,504,932,961	$ 3,504,932,961	**$17,524,664,805**

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

WW								
PMPM								
TPM/GMC								
	Family	4.25%	$133.75	$139.44	$145.37	$151.54	$157.98	$164.70
	Rural Family	4.25%	$141.73	$147.75	$154.03	$160.58	$167.40	$174.52
	SPDs	4.25%	$704.57	$734.52	$765.73	$798.28	$832.20	$867.57
	Duals	4.25%	$172.32	$179.65	$187.28	$195.24	$203.54	$212.19
COHS								
	Family	4.25%	$183.23	$191.02	$199.14	$207.60	$216.43	$225.62
	Rural Family	4.25%	$174.66	$182.09	$189.83	$197.89	$206.31	$215.07
	SPDs	4.25%	$1,040.95	$1,085.19	$1,131.31	$1,179.39	$1,229.52	$1,281.77
	Duals	4.25%	$347.14	$361.90	$377.28	$393.31	$410.03	$427.45
CCI TPM/GMC								
	Family	4.25%	$149.41	$155.76	$162.37	$169.28	$176.47	$183.97
	SPDs	4.25%	$901.76	$940.08	$980.04	$1,021.69	$1,065.11	$1,110.38
	Duals	4.25%	$743.18	$774.77	$807.69	$842.02	$877.81	$915.11
	Cal MediConnect	4.25%	$743.18	$774.77	$807.69	$842.02	$877.81	$915.11
CCI COHS								
	Family	4.25%	$185.12	$192.99	$201.19	$209.74	$218.65	$227.95
	SPDs	4.25%	$1,225.74	$1,277.83	$1,332.14	$1,388.75	$1,447.77	$1,509.31
	Duals	4.25%	$649.77	$677.38	$706.17	$736.19	$767.47	$800.09
	Cal MediConnect	4.25%	$649.77	$677.38	$706.17	$736.19	$767.47	$800.09
CBAS		3.16%	$1,130.95	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30
HHP					$0.00	$65.00	$65.00	$65.00
DMC ODS					$2,942.29	$3,418.10	$2,913.42	$2,912.74
Member Months								
TPM/GMC								
	Family	1.00%	15,949,730	16,109,227	16,270,320	16,433,023	16,597,353	16,763,327
	Rural Family	1.00%	2,619,811	2,646,009	2,672,469	2,699,194	2,726,186	2,753,448
	SPDs	1.00%	2,155,214	2,176,766	2,198,534	2,220,519	2,242,724	2,265,152
	Duals	1.00%	864,855	873,504	882,239	891,061	899,972	908,971
COHS								
	Family	1.00%	7,428,534	7,502,819	7,577,848	7,653,626	7,730,162	7,807,464
	Rural Family	1.00%	870,990	879,700	888,497	897,382	906,356	915,419
	SPDs	1.00%	905,774	914,832	923,980	933,220	942,552	951,978
	Duals	1.00%	1,599,092	1,615,083	1,631,234	1,647,546	1,664,022	1,680,662
CCI TPM/GMC								
	Family	1.00%	33,001,616	33,331,632	33,664,948	34,001,598	34,341,614	34,685,030
	SPDs	1.00%	4,301,367	4,344,381	4,387,824	4,431,703	4,476,020	4,520,780
	Duals	1.00%	3,519,767	3,554,965	3,590,515	3,626,420	3,662,684	3,699,311
	Cal MediConnect	1.00%	1,372,072	1,385,792	1,399,650	1,413,647	1,427,783	1,442,061

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

CCI COHS									
	Family	1.00%	4,810,033	4,858,133	4,906,715	4,955,782	5,005,340	5,055,393	
	SPDs	1.00%	549,931	555,430	560,985	566,594	572,260	577,983	
	Duals	1.00%	1,119,648	1,130,844	1,142,152	1,153,574	1,165,110	1,176,761	
	Cal MediConnect	1.00%	115,147	116,299	117,462	118,637	119,823	121,021	
CBAS		6.87%	369,651	395,046	422,185	451,190	482,186	515,312	
HHP						236,259	1,925,061	2,804,640	
DMC ODS					14,446	267,033	528,914	547,964	
WW Expenditures									
TPM/GMC									
	Family			$2,246,252,987	$2,365,135,927	$2,490,310,746	$2,622,110,442	$2,760,885,637	**$12,484,695,739**
	Rural Family			$390,951,032	$411,642,116	$433,428,274	$456,367,466	$480,520,714	**$2,172,909,602**
	SPDs			$1,598,870,026	$1,683,490,222	$1,772,588,942	$1,866,403,212	$1,965,182,602	**$8,886,535,004**
	Duals			$156,920,682	$165,225,709	$173,970,280	$183,177,657	$192,872,334	**$872,166,662**
COHS									
	Family			$1,433,198,883	$1,509,050,934	$1,588,917,455	$1,673,010,911	$1,761,555,014	**$7,965,733,198**
	Rural Family			$160,182,961	$168,660,645	$177,587,009	$186,985,802	$196,882,025	**$890,298,442**
	SPDs			$992,769,280	$1,045,311,594	$1,100,634,711	$1,158,885,803	$1,220,219,834	**$5,517,821,221**
	Duals			$584,491,692	$615,425,915	$647,997,332	$682,292,591	$718,402,926	**$3,248,610,456**
CCI TPM/GMC									
	Family			$5,191,578,359	$5,466,342,644	$5,755,648,828	$6,060,266,542	$6,381,006,149	**$28,854,842,521**
	SPDs			$4,084,077,716	$4,300,227,529	$4,527,817,071	$4,767,451,790	$5,019,769,176	**$22,699,343,281**
	Duals			$2,754,262,992	$2,900,032,361	$3,053,516,574	$3,215,123,939	$3,385,284,373	**$15,308,220,239**
	Cal MediConnect			$1,073,663,648	$1,130,487,297	$1,190,318,337	$1,253,315,935	$1,319,647,681	**$5,967,432,897**
CCI COHS									
	Family			$937,555,680	$987,175,815	$1,039,422,095	$1,094,433,509	$1,152,356,403	**$5,210,943,502**
	SPDs			$709,745,051	$747,308,308	$786,859,600	$828,504,144	$872,352,726	**$3,944,769,828**
	Duals			$766,015,615	$806,556,991	$849,244,020	$894,190,260	$941,515,279	**$4,257,522,165**
	Cal MediConnect			$78,779,025	$82,948,405	$87,338,449	$91,960,837	$96,827,864	**$437,854,580**
CBAS				$460,895,170	$508,123,522	$560,191,407	$617,594,735	$680,880,236	**$2,827,685,070**
HHP				$0	$0	$15,356,835	$125,128,965	$182,301,600	**$322,787,400**
DMC ODS				$0	$42,505,318	$912,745,040	$1,540,949,661	$1,596,078,071	**$4,092,278,090**
HOSPITAL EXPENDITURES									
Public Hospital Payments		0.00%	$2,637,061,900	$2,637,061,900	$2,637,061,900	$2,637,061,900	$2,637,061,900	$2,637,061,900	**$13,185,309,500**
Mental Health Supplements		0.00%	$4,816,992	$4,816,992	$4,816,992	$4,816,992	$4,816,992	$4,816,992	**$24,084,962**
TOTAL HOSPITAL EXPENDITURES				**$2,641,878,893**	**$2,641,878,893**	**$2,641,878,893**	**$2,641,878,893**	**$2,641,878,893**	**$13,209,394,463**

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

MEGS SAVINGS CALCULATION (WITHOUT WAIVER MINUS WITH WAIVER AND APPLICATION OF SAVINGS PERCENTAGE)									
TPM/GMC		**Transition Complete**							
	Urban Family			$924,365,130	$965,235,787	$1,007,951,141	$1,052,543,512	$1,099,037,929	**$5,049,133,498**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			$212,603,980	$222,004,231	$231,828,763	$242,085,008	$252,778,724	**$1,161,300,705**
	Rural Family	2013-14		$64,612,356	$66,890,220	$69,215,612	$71,612,944	$74,078,720	**$346,409,852**
	Shared Savings %			100%	100%	100%	90%	80%	
	Savings Value for BN			$64,612,356	$66,890,220	$69,215,612	$64,451,650	$59,262,976	**$324,432,814**
	SPDs	2011-12		$359,218,188	$373,282,120	$387,842,949	$402,919,830	$418,504,354	**$1,941,767,441**
	Shared Savings %			100%	90%	80%	70%	60%	
	Savings Value for BN			$359,218,188	$335,953,908	$310,274,360	$282,043,881	$251,102,613	**$1,538,592,948**
	Duals	Voluntary		-$50,493,009	-$54,204,806	-$58,159,085	-$62,374,471	-$66,861,643	**-$292,093,015**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			-$50,493,009	-$54,204,806	-$58,159,085	-$62,374,471	-$66,861,643	**-$292,093,015**
COHS									
	Urban Family			$247,657,733	$256,511,763	$265,632,663	$274,989,980	$284,625,123	**$1,329,417,262**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			$56,961,279	$58,997,705	$61,095,513	$63,247,696	$65,463,778	**$305,765,970**
	Rural Family	2013-14		$1,118,812	$766,829	$381,763	-$49,941	-$524,598	**$1,692,865**
	Shared Savings %			100%	100%	100%	90%	80%	
	Savings Value for BN			$1,118,812	$766,829	$381,763	-$49,941	-$524,598	**$1,692,865**
	SPDs	Pre-2010		$580,393,676	$607,134,340	$635,098,232	$664,330,342	$694,882,978	**$3,181,839,569**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			$133,490,546	$139,640,898	$146,072,593	$152,795,979	$159,823,085	**$731,823,101**
	Duals	Pre-2010		$142,457,130	$136,931,714	$130,649,424	$123,559,764	$115,608,667	**$649,206,700**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			$32,765,140	$31,494,294	$30,049,368	$28,418,746	$26,589,993	**$149,317,541**
CCI TPM/GMC									
	Family			$1,318,756,035	$1,372,018,342	$1,427,528,758	$1,484,929,458	$1,544,523,226	**$7,147,755,818**
	Shared Savings %			23%	23%	23%	23%	23%	
	Savings Value for BN			$303,313,888	$315,564,219	$328,331,614	$341,533,775	$355,240,342	**$1,643,983,838**
	SPDs	2013-14		$664,591,019	$687,763,579	$711,563,471	$735,993,532	$761,042,557	**$3,560,954,159**
	Shared Savings %			100%	100%	100%	90%	80%	
	Savings Value for BN			$664,591,019	$687,763,579	$711,563,471	$662,394,179	$608,834,046	**$3,335,146,295**
	Duals	2014-15		$230,539	-$23,419,738	-$49,354,149	-$77,742,082	-$108,804,766	**-$259,090,196**
	Shared Savings %			100%	100%	100%	100%	90%	
	Savings Value for BN			$230,539	-$23,419,738	-$49,354,149	-$77,742,082	-$108,804,766	**-$259,090,196**
	Cal MediConnect	2014-15		$89,869	-$9,129,456	-$19,239,178	-$30,305,329	-$42,414,149	**-$100,998,244**
	Shared Savings %			100%	100%	100%	100%	90%	
	Savings Value for BN			$89,869	-$9,129,456	-$19,239,178	-$30,305,329	-$42,414,149	**-$100,998,244**

Attachment K
Budget Neutrality Projections and Allotment Neutrality Requirements

CCI COHS								
	Family		$142,407,359	$147,207,548	$152,146,084	$157,201,718	$162,349,107	**$761,311,816**
	Shared Savings %		23%	23%	23%	23%	23%	
	Savings Value for BN		$32,753,693	$33,857,736	$34,993,599	$36,156,395	$37,340,295	**$175,101,718**
	SPDs	2013-14	$464,506,830	$486,128,561	$508,743,620	$532,399,767	$557,137,968	**$2,548,916,748**
	Shared Savings %		100%	100%	100%	90%	80%	
	Savings Value for BN		$464,506,830	$486,128,561	$508,743,620	$479,159,791	$445,710,375	**$2,384,249,177**
	Duals	2014-15	-$15,949,388	-$36,791,914	-$59,265,014	-$83,460,303	-$109,498,302	**-$304,964,920**
	Shared Savings %		100%	100%	100%	100%	90%	
	Savings Value for BN		-$15,949,388	-$36,791,914	-$59,265,014	-$83,460,303	-$109,498,302	**-$304,964,920**
	Cal MediConnect	2014-15	-$1,640,276	-$3,783,775	-$6,094,967	-$8,583,273	-$11,261,088	**-$31,363,380**
	Shared Savings %		100%	100%	100%	100%	90%	
	Savings Value for BN		-$1,640,276	-$3,783,775	-$6,094,967	-$8,583,273	-$11,261,088	**-$31,363,380**
CBAS			$0	$0	$0	$0	$0	**$0**
HHP			$0	$0	$0	$0	$0	**$0**
DMC ODS			$0	$0	$0	$0	$0	**$0**
Total Net Other Population Savings Margin			$2,258,173,465	$2,251,732,493	$2,240,437,883	$2,089,771,698	$1,922,781,679	**$10,762,897,218**
INTIAL BUDGET NEUTRALITY MARGIN								
Population Savings Margin			$2,258,173,465	$2,251,732,493	$2,240,437,883	$2,089,771,698	$1,922,781,679	**$10,762,897,218**
Hospital UPL Margin			$863,054,068	$863,054,068	$863,054,068	$863,054,068	$863,054,068	**$4,315,270,342**
DSH			$2,423,161,227	$2,471,624,452	$2,125,503,107	$1,977,980,939	$1,831,576,406	**$10,829,846,131**
Initial Annual Budget Neutrality Margin, Pre-Waiver Expenditures			**$5,544,388,761**	**$5,586,411,013**	**$5,228,995,058**	**$4,930,806,706**	**$4,617,412,154**	**$25,908,013,691**
WAIVER EXPENDITURES								
Global Budget for the Uninsured			$2,895,161,227	$2,943,624,452	$2,515,503,107	$2,337,980,939	$2,151,576,406	**$12,843,846,131**
DSH Component (estimate - will be based on actual)			$2,423,161,227	$2,471,624,452	$2,125,503,107	$1,977,980,939	$1,831,576,406	$10,829,846,131
SNCP Component			$472,000,000	$472,000,000	$390,000,000	$360,000,000	$320,000,000	$2,014,000,000
Dental Incentives			$150,000,000	$150,000,000	$150,000,000	$150,000,000	$150,000,000	**$750,000,000**
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)			$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,440,000,000	$1,224,000,000	**$7,464,000,000**
Whole Person Care Pilots			$600,000,000	$600,000,000	$600,000,000	$600,000,000	$600,000,000	**$3,000,000,000**
Designated State Health Programs			$150,000,000	$150,000,000	$150,000,000	$150,000,000	$150,000,000	**$750,000,000**
IHS Uncompensated Care			$1,550,000	$1,550,000	$1,550,000	$1,550,000	$1,550,000	**$7,750,000**
TOTAL WAIVER EXPENDITURES			**$5,396,711,227**	**$5,445,174,452**	**$5,017,053,107**	**$4,679,530,939**	**$4,277,126,406**	**$24,815,596,131**
DSH State Plan Expenditures (estimate - will be based on actual)								
Annual Budget Neutrality Margin			**$147,677,533**	**$141,236,561**	**$211,941,951**	**$251,275,767**	**$340,285,748**	**$1,092,417,560**
Cumulative Budget Neutrality Margin			**$147,677,533**	**$288,914,094**	**$500,856,045**	**$752,131,812**	**$1,092,417,560**	**$1,092,417,560**

Attachment L
Managed Care Enrollment Requirements

		Included State Plan Populations								
Prior authority/ 1115 transition group	**County Included**	Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP [a]	BCCPT * Program	Children with accelerated eligibility
HIO Waiver 1915(b)	**Santa Cruz**	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Monterey	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Merced	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Orange	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Solano	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Napa	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Sonoma	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Yolo	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
HPSM 1915(b)	**San Mateo**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
SBSLORHA 1915(b)	**Santa Barbara**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
	San Luis Obispo	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
Two-Plan/GMC Waiver 1915(b)	**Alameda**	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Contra Costa	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Fresno	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kern	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kings	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Los Angeles	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Madera	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Riverside	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Sacramento	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Bernardino	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Diego	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Francisco	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Joaquin	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Santa Clara	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Stanislaus	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Tulare	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
2011 Managed Care Expansions	**Marin**	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Mendocino	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Ventura	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
2013 Managed Care Expansion County Organized Health System (COHS) Health Insuring	**Del Norte**	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Humboldt	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lake	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lassen	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Modoc	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Shasta	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Siskiyou	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Trinity	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]

Attachment L
Managed Care Enrollment Requirements

		Included State Plan Populations								
Prior authority/ 1115 transition group	**County Included**	Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP [a]	BCCPT * Program	Children with accelerated eligibility
Organization (HIO)±										
2013 managed care expansion Regional[z]	**Alpine**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Amador	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Butte	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Calaveras	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Colusa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	El Dorado	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Glenn	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Inyo	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mariposa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mono	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Nevada	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Placer	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Plumas	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sierra	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sutter	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tehama	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tuolumne	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Yuba	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion Imperial[z]	**Imperial**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion San Benito[z]	**San Benito**	Vol					Vol	Vol	Vol	Vol[b]

Notes:
Vol=Voluntary
Req=Required

[a] Required CHIP enrollment is subject to the transition requirements of STC **Error! Reference source ot found.** and all other requirements in section VIII. E of the demonstration's STCs.
[b] New eligible children after January 1, 2013 that meet CHIP and enrollment requirements as set forth by above designation [a]

* BCCPT - Breast and Cervical Cancer Prevention Treatment Program

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013
[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment L
Managed Care Enrollment Requirements

		Populations that may be excluded from enrollment in managed care									
Prior authority / 1115 transition group	**County Included**	Dual Eligibles	Preg. Women	Other Insurance	Nursing Facility or ICF/MR Resident	Enrolled in Another Managed Care Program	Less than 3 Months Eligibility	HCBS Waiver-Enrolled	Special Needs Children (State Defined)	CHIP Title XXI	Retro Eligibility
HIO Waiver 1915(b)	**Santa Cruz**					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM 1915(b)	**San Mateo**					X				X[h]	
SBSLOR HA 1915(b)	**Santa Barbara**					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver 1915(b)	**Alameda**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
2011 Managed Care Expansion	**Marin**					X				X[h]	
	Mendocino					X				X[h]	
	Ventura					X				X[h]	
2013 Managed Care Expansion	**Del Norte**					X				X[h]	
	Humboldt					X				X[h]	
	Lake					X				X[h]	
	Lassen					X				X[h]	
	Modoc					X				X[h]	

County Organized Health System (COHS) Health Insuring Organization (HIO)±	**Shasta**					X				X[h]	
	Siskiyou					X				X[h]	
	Trinity					X				X[h]	
2013 Managed Care Expansion Regional[z]	**Alpine**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Amador	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Butte	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Calaveras	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Colusa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	El Dorado	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Glenn	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Inyo	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mariposa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mono	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Nevada	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Placer	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Plumas	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sierra	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sutter	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tehama	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tuolumne	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Yuba	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion Imperial,[z]	**Imperial**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion San Benito[z]	**San Benito**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	

Notes:

[c] State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;

[d] Beneficiaries with incomes above 138 percent up to and including 213percent of FPL receive pregnancy- related services only, and are therefore excluded from mandatory managed care;

[e] State excludes individuals that have a share of cost or are ineligible for full-scope services;

[f] State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;

[g] Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program

[h] State only Healthy Families;

[i] Except for non-Healthy Families children in the Percent of Poverty program.

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013

[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment L
Managed Care Enrollment Requirements

		Populations that may be excluded from enrollment in managed care									
Prior authority / 1115 transition group	**County Included**	Dual Eligibles	Preg. Women	Other Insurance	Nursing Facility or ICF/MR Resident	Enrolled in Another Managed Care Program	Less than 3 Months Eligibility	HCBS aiver-nrolled	Special Needs Children (State Defined)	CHIP Title XXI	Retro Eligibility
HIO Waiver 1915(b)	**Santa Cruz**					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM 1915(b)	**San Mateo**					X				X[h]	
SBSLOR HA 1915(b)	**Santa Barbara**					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver 1915(b)	**Alameda**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
2011 Managed Care Expansion	**Marin**					X				X[h]	
	Mendocino					X				X[h]	
	Ventura					X				X[h]	
2013 Managed Care Expansion	**Del Norte**					X				X[h]	
	Humboldt					X				X[h]	
	Lake					X				X[h]	
	Lassen					X				X[h]	
	Modoc					X				X[h]	

County Organized Health System (COHS) Health Insuring Organization (HIO)±	**Shasta**					X				X[h]	
	Siskiyou					X				X[h]	
	Trinity					X				X[h]	
2013 Managed Care Expansion Regional[z]	**Alpine**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Amador	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Butte	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Calaveras	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Colusa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	El Dorado	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Glenn	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Inyo	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mariposa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mono	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Nevada	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Placer	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Plumas	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sierra	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sutter	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tehama	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tuolumne	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Yuba	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion Imperial,[z]	**Imperial**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion San Benito[z]	**San Benito**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	

Notes:

[c] State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;

[d] These beneficiaries receive pregnancy related services only;

[e] State excludes individuals that have a share of cost or are ineligible for full-scope services;

[f] State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;

[g] Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program

[h] State only Healthy Families;

[i] Except for non-Healthy Families children in the Percent of Poverty program.

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013

[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment M
Geographic Distribution and Delivery System Model

Prior authority / 1115 transition group	Counties Included	Delivery System Model	Managed Care Organizations Participating
HIO Waiver 1915(b)	**Santa Cruz**	MCO/HIO	Central Coast Alliance
	Monterey	MCO/HIO	Central Coast Alliance
	Merced	MCO/HIO	Central Coast Alliance
	Orange	MCO/HIO	CalOPTIMA
	Solano	MCO/HIO	Partnership HealthPlan of California
	Napa	MCO/HIO	Partnership HealthPlan of California
	Sonoma	MCO/HIO	Partnership HealthPlan of California
	Yolo	MCO/HIO	Partnership HealthPlan of California
HPSM 1915(b)	**San Mateo**	MCO	Health Plan of San Mateo
SBSLORHA 1915(b)	**Santa Barbara**	MCO/HIO	CenCal
	San Luis Obispo	MCO/HIO	CenCal
Two-Plan/ GMC Waiver 1915(b)	**Alameda**	MCO	Alameda Alliance for Health , Anthem Blue Cross Partnership Plan
	Contra Costa	MCO	Contra Costa Health Plan, Anthem Blue Cross Partnership Plan
	Fresno	MCO	Health Net Community Solutions, Anthem Blue Cross Partnership Plan
	Kern	MCO	Kern Family Health, Health Net Community Solutions
	Kings**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Los Angeles *	MCO	L.A. Care Health Plan, Health Net Community Solutions
	Madera**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Riverside *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	Sacramento	MCO; medical PAHP; dental	Anthem Blue Cross, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Bernardino *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	San Diego	MCO	Care First, Community Health Group, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Francisco	MCO	San Francisco Health Plan, Anthem Blue Cross Partnership Plan
	San Joaquin	MCO	Health Plan of San Joaquin, Health Net
	Santa Clara	MCO	Santa Clara Family Health Plan, Anthem Blue Cross Partnership Plan
	Stanislaus	MCO	Health Plan of San Joaquin, , Health Net Community Solutions
	Tulare	MCO	Anthem Blue Cross Partnership Plan, Health Net Community Solutions
2011 Managed Care Expansions	**Kings**	MCO	Anthem Blue Cross, CalViva
	Madera	MCO	Anthem Blue Cross, CalViva
	Marin	MCO/HIO	Partnership HealthPlan of California
	Mendocino	MCO/HIO	Partnership HealthPlan of California
	Ventura	MCO/HIO	Gold Coast Health Plan
2013 Managed Care Expansion	**Del Norte**	MCO/HIO	Partnership HealthPlan of California
	Humboldt	MCO/HIO	Partnership HealthPlan of California
	Lake	MCO/HIO	Partnership HealthPlan of California
	Lassen	MCO/HIO	Partnership HealthPlan of California

County Organized Health System (COHS) Health Insuring Organization (HIO)±	**Modoc**	MCO/HIO	Partnership HealthPlan of California
	Shasta	MCO/HIO	Partnership HealthPlan of California
	Siskiyou	MCO/HIO	Partnership HealthPlan of California
	Trinity	MCO/HIO	Partnership Health Plan of California
2013 Managed Care Expansion Regional±	**Alpine**	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Amador	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Butte	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Calaveras	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Colusa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	El Dorado	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Glenn	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Inyo	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mariposa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mono	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Nevada	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Placer	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Plumas	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sierra	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sutter	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tehama	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tuolumne	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Yuba	MCO	Anthem Blue Cross, California Health and Wellness Plan
2013 Managed Care Expansion Imperial±	**Imperial**	MCO	California Health and Wellness Plan, Molina Healthcare
2013 Managed Care Expansion San Benito±	**San Benito**	MCO	Anthem Blue Cross (Note: beneficiaries in this county will also have a choice of FFS because only one plan is available)

Note: * These counties allow beneficiaries in certain zip codes to enroll on a voluntary basis

Planned Expansions:

- **In March 2011, Kings and Madera County, Two Plan Expansion - authority as approved by the Tri-Country 1915b approval
- ***In July, 2011, Marin, Mendocino and Ventura counties plan to begin operation using an HIO model

± Part of the 2013 Managed Care Regional Expansion effective September 1, 2013 for COHS counties and November 1, 2013 for non-COHS counties.

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan..	X[10]	X[10]	X[10]	X[10]	X[10]	X[10]
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X	X	X	X
California Children Services (CCS)	Service is not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			X[6]			
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provide services within the scope of their practice.	X	X	X	X	X	X

Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Child Health and Disability Prevention (CHDP) Program		A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X[4]	X	X	X
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)		A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.						
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The “cleaned” blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 95.	X	X	X			
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X	X	X	X
Dental Services (Covered under Denti-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.						
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.						

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X	X	X	X
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X	X	X	X
Erectile Dysfunction Drugs		FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.						
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.						
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]

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Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).	X	X	X	X	X	X
Health Home Program Services	Health Home Program Services	The community based care management entity assigns care managers, such as nurses or other trained professionals, to help members who have chronic conditions find the right health care or other services in their communities. Health Home Program services: Comprehensive Care Management; Care Coordination; Health Promotion; Comprehensive Transitional Care; Individual and Family Supports; and Referral to Community/Social Supports; are defined in the CMS- approved Health Home Program SPAs, and include any subsequent amendments to the CMS-approved Health Home Program SPAs.	X[11]	X[11]	X[11]	X[11]	X[11]	X[11]
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X	X	X	X

Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.						
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X	X	X	X
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X	X	X	X
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X	X	X	X
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			X[7]			

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.			X			
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services	.	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X[5]	X[5]	X	X[5]	X[5]	X[5]

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/ID-N) are covered subject to prior authorization by the Department for the ICF/ ID-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/ID-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X	X	X	X

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.						

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Long Term Care (LTC)		Care in a facility for longer than the month of admission plus one month. Medically necessary care in a facility covered under managed care health plan contracts	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	X	X	X	X	X	X
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.	X	X	X	X	X	X
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.	X[9]	X[9]	X[9]			
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X	X	X	X
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management	X[2]	X[2]	X[2]	X[2]	X[2]	X[2]

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.						
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.						
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5]	X[5]	X	X[5]	X[5]	X[5]

Attachment N
Capitated Benefits Provided in Managed Care
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.	X[9]	X[9]	X[9]			
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	X	X	X	X	X	X
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	X	X	X	X	X
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Prosthetic and Orthotic Appliances	Prosthetic and Orthodic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X	X	X	X
Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X[1,2*]	X[1,2]	X[1,2*]	X[1,2]	X[1,2]	X[1,2]
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			X[8]			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X	X	X	X
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.						

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.						
Skilled Nursing Facility Services,	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X	X	X	X
Specialty Mental health services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.						
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[5]	X[5]	X	X[5]	X[5]	X[5]
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X	X	X	X

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.						
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.						

Attachment N
Capitated Benefits Provided in Managed Care
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	X	X	X	X	X
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.						

[1] Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.
[2] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[3] Fabrication of optical lenses only covered by CenCal Health.

[4] Not covered by CenCal

[5] Only covered for the month of admission and the following month

[6] Not covered by Gold Coast Health Plan.
Covered by CenCal Health, Central California Alliance for Health, and Health Plan of San Mateo (effective July 1, 2018).
Covered by Partnership HealthPlan of California and CalOptima (effective January 1, 2019).
[7] Only covered in Health Plan of San Mateo and CalOptima

[8] Only covered in Health Plan of San Mateo

[9] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Alameda, Los Angeles, Orange, San Bernadino, San Diego, San Mateo, Santa Clara, and Riverside
[10] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT program.
[11] Health Home Program (HHP) service coverage is limited to only those beneficiaries specified in the HHP State Plan Amendments (SPAs), including any subsequent amendments to the CMS-approved HHP SPAs. HHP services will be provided only through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Individuals receiving benefits through the fee-for-service (FFS) delivery system who meet HHP eligibility criteria, and who wish to receive HHP services, must instead enroll in an MCP to receive all services, including HHP services. HHP services will not be provided through a FFS delivery system. The HHP-specific provisions of the Medi-Cal 2020 demonstration freedom of choice waiver, and managed care delivery system implementation Medicaid authority, are in effect for any CMS-approved HHP SPAs - including SPA requirements specific to eligible populations, geographic limitation approved providers, and any other SPA requirements, including any subsequent amendments to the CMS- approved HHP SPAs - for the duration of the Medi-Cal 2020 demonstration.

Attachment O
County Listing for SPD Enrollment

County Name	Plan Model						Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	Regional	Imperial	San Benito	
Alameda	X						X
Alpine				X			X
Amador				X			X
Butte				X			X
Calaveras				X			X
Colusa				X			X
Contra Costa	X						X
Del Norte			X				
El Dorado				X			X
Fresno	X						X
Glenn				X			X
Humboldt			X				
Imperial					X		X
Inyo				X			X
Kern	X						X
Kings	X						X
Lake			X				
Lassen			X				
Los Angeles	X						X
Madera	X						X
Marin			X				
Mariposa				X			X
Mendocino			X				
Merced			X				
Modoc			X				
Mono				X			X
Monterey			X				
Napa			X				
Nevada				X			X
Orange			X				
Placer				X			X
Plumas				X			X
Riverside	X						X
Sacramento		X					X
San Benito							
San Bernardino	X						X

San Diego		X					X
San Francisco	X						X
San Joaquin	X						X
San Luis Obispo			X				
San Mateo			X				
Santa Barbara			X				
Santa Clara	X						X
Santa Cruz			X				
Shasta			X				
Sierra				X			X
Siskiyou			X				
Solano			X				
Sonoma			X				
Stanislaus	X						X
Sutter				X			X
Tehama				X			X
Trinity			X				
Tulare	X						X
Tuolumne				X			X
Ventura			X				
Yolo			X				
Yuba				X			X

Medi-Cal 2020: Demonstration and Program Years

Demonstration Year (DY)	Dates
DY 11	January 1, 2016 – June 30, 2016
DY 12	July 1, 2016 – June 30, 2017
DY 13	July 1, 2017 – June 30, 2018
DY 14	July 1, 2018 – June 30, 2019
DY 15	July 1, 2019 – June 30, 2020
DY 16	July 1, 2020 – December 31, 2020

Global Payment Program	
Program Year (PY)	**Dates**
PY 1	July 1, 2015 – June 30, 2016
PY 2	July 1, 2016 – June 30, 2017
PY 3	July 1, 2017 – June 30, 2018
PY 4	July 1, 2018 – June 30, 2019
PY 5	July 1, 2019 – June 30, 2020

Public Hospital Redesign and Incentives in Medi Cal (PRIME)	
Demonstration Year (DY)	**Dates**
DY 11	January 1, 2016 – June 30, 2016
DY 12	July 1, 2016 – June 30, 2017
DY 13	July 1, 2017 – June 30, 2018
DY 14	July 1, 2018 – June 30, 2019
DY 15	July 1, 2019 – June 30, 2020

Whole Person Care Pilots	
Program Year (PY)	**Dates**
PY 1	January 1, 2016 – December 31, 2016
PY 2	January 1, 2017 – December 31, 2017
PY 3	January 1, 2018 – December 31, 2018
PY 4	January 1, 2019 – December 31, 2019
PY 5	January 1, 2020 – December 31, 2020

Dental Transformation Initiative

Attachment P Demonstration and Program Years

Program Year (DY)	Dates
PY 1	January 1, 2016 – December 31, 2016
PY 2	January 1, 2017 – December 31, 2017
PY 3	January 1, 2018 – December 31, 2018
PY 4	January 1, 2019 – December 31, 2019
PY 5	January 1, 2020 – December 31, 2020

Attachment Q
PRIME Projects and Metrics

I. Table of Contents

II. Preface 267
A. Public Hospital Redesign and Incentives in Medi-Cal 267
B. PRIME Protocols 267
III. Background 268
A. Overview of the PRIME Program & Participating Entities 268
B. Development Summary 268
IV. Projects 269
A. Domains 269
Table 1: High-Level Summary of Projects by Domain 269
B. Project Selection Exclusions 270
V. Metrics 270
A. Reporting of PRIME Project Metrics 270
B. Metric Types 271
Table 2: Summary of Metric Progression from P4R to P4P 271
C. Metrics Governance 271
D. Innovative Metric Testing 271
E. Metrics Summary 275
Table 2: High-Level Summary of Metrics 276
F. Measurement Period 280
Table 3: Measurement Periods 280
G. DMPH Infrastructure Building 280
H. Establishing Baseline Performance During PRIME 281
I. Target Setting for Pay-for-Performance Metrics 281
J. Minimum Number of Cases 281
K. Sampling 282
1. Indication for Use of Sampling 282
L. Defining the Denominator 282
VI. Project Toolkit 283

A. Domain 1: Outpatient Delivery System Transformation and Prevention 284
1. Project 1.1 Integration of Behavioral Health and Primary Care 284
2. Project 1.2 Ambulatory Care Redesign: Primary Care 288
3. Project 1.3 Ambulatory Care Redesign: Specialty Care 292
4. Project 1.4 Patient Safety in the Ambulatory Setting 295
5. Project 1.5 Million Hearts Initiative 297
6. Project 1.6 Cancer Screening and Follow-up 299
7. Project 1.7 Obesity Prevention and Healthier Foods Initiative 301
B. Domain 2: Targeted High-Risk or High-Cost Populations 303
1. Project 2.1 Improvements in Perinatal Care 303
2. Project 2.2 Care Transitions: Integration of Post-Acute Care 305
3. Project 2.3 Complex Care Management for High Risk Medical Populations 308
4. Project 2.4 Integrated Health Home for Foster Children 311
5. Project 2.5 Transition to Integrated Care: Post Incarceration 314
6. Project 2.6 Chronic Non-Malignant Pain Management 317
7. Project 2.7 Comprehensive Advanced Illness Planning and Care 320
C. Domain 3: Resource Utilization Efficiency 323
1. Project 3.1 Antibiotic Stewardship 323
2. Project 3.2 Resource Stewardship: High-Cost Imaging 326
3. Project 3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals 328
4. Project 3.4 Resource Stewardship: Blood Products 330

II. Preface

A. Public Hospital Redesign and Incentives in Medi-Cal

On December 30, 2015 , the Centers for Medicare and Medicaid Services (CMS) approved California's request for a renewal to California's section 1115(a) Medicaid demonstration (hereinafter "demonstration") authorizing the creation of a Public Hospital Redesign and Incentives in Medi-Cal (hereinafter "PRIME"). .

B. PRIME Protocols

The PRIME requirements specified in the STCs are supplemented by the following attachments to the STCs:

Attachment D. Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME entities

Attachment Q. PRIME Projects and Metrics (this document): This Attachment details the specific delivery system improvement activities ("projects"), including requirements regarding project metrics, that are eligible for PRIME funding; for each project, Attachment Q specifies the details of the projects, projects' metrics, and metrics' targets that will be the basis for earning PRIME incentive payments. Attachment Q also specifies the key elements of and the review and approval process for participating PRIME entities' 5-year PRIME Project Plans. Participating PRIME entities will utilize this document for purposes of selecting projects (each of which specifies required metrics) to include in their 5-year PRIME Project Plans.

Attachment R. Alternative Payment Methodologies: Attachment R will outline additional payment methodologies that will qualify as APM outside of the capitation payment methodologies.

Attachment S. PRIME Evaluation and Monitoring: Attachment S will describe the state's plan for meeting PRIME monitoring requirements as well as will include the final evaluation plan.

Attachment II. PRIME Funding and Mechanics: Attachment II describes the general requirements for receiving incentive payments under PRIME, including the allocation, payment mechanisms and disbursement of pool funds; reporting requirements; and reinvestment of unallocated funds.

III. Background

A. Overview of the PRIME Program & Participating Entities

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pool will build 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 Pool are designed to accelerate efforts by participating PRIME entities (as defined in Attachment D) to change care delivery to maximize health care value and 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 is intentionally designed to be ambitious in scope and time-limited. 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. Participating PRIME entities will consist of two types of entities: Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPH) (described further in Attachment II).

DPHs participating in PRIME, will be required to contract with at least one Medi-Cal Managed Care Provider (MCP) in the MCP service area that they operate using APM methodologies as part of their PRIME Project Plan by January 1, 2018. If a DPH is unable to meet this requirement and can demonstrate that it has made a good faith effort to contract with an MCP in the service area that it operates in and a gap in contract period occurs, DHCS has discretion to waive this requirement as specified in Attachment R.

Each project in PRIME has a required set of projects and metrics in which payment will be tied to performance. Domains, projects and metrics are described below in more detail.

B. Development Summary

PRIME projects have been identified and designed through a rigorous, lengthy, thoughtful and consultative process. Every project and each metric has gone through a thorough, iterative process based on detailed criteria over the past year and a half that included in-depth review by and input from:

- Over 100 clinical and quality experts with on-the-ground experience caring for California's Medi-Cal beneficiaries and most vulnerable populations,
- Experts on reporting/IT technical capabilities of the public hospital safety net that have a deep working knowledge of Medi-Cal data and state reporting,
- Public hospital leadership across the state,
- Quality improvement professionals in partnership with DHCS, and
- Public stakeholder representing statewide health care, consumer and advocacy organizations

Each project is measured by a core required set of metrics so that all participating PRIME entities are working toward industry best practices and the same desired results; as such, the program will yield comparable data across entities and throughout the Demonstration. The data to be reported through the PRIME will be meaningful and provide useful information in order to continue to drive improvement.

IV. Projects

A. Domains

Projects are organized into 3 domains. Participating DPH systems will implement at least 9 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.
The projects by domain are summarized in Table 1 below.

Table 1: High-Level Summary of Projects by Domain

Domain Name	Required Projects by Domain for DPHs	Project(s)	Required for DPHs
Domain 1: Outpatient Delivery System Transformation and Prevention	3 required projects + 1 additional	Project 1.1 Integration of Physical and Behavioral Health	Y
		Project 1.2 Ambulatory Care Redesign: Primary Care (includes reduction in disparities in health and health outcomes)	Y
		Project 1.3 Ambulatory Care Redesign: Specialty Care	Y
		Project 1.4 Patient Safety in the Ambulatory Setting	N
		Project 1.5 Million Hearts Initiative	N
		Project 1.6 Cancer Screening and Follow-up	N
		Project 1.7 Obesity Prevention and Healthier Foods Initiative	N
Domain 2: Targeted High Risk or High Cost Populations	3 required projects + 1 additional	Project 2.1 Improved Perinatal Care	Y

Domain Name	Required Projects by Domain for DPHs	Project(s)	Required for DPHs
		Project 2.2 Care Transitions: Integration of Post-Acute Care	Y
		Project 2.3 Complex Care Management for High Risk Medical Populations	Y
		Project 2.4 Integrated Health Home for Foster Children	N
		Project 2.5 Transition to Integrated Care: Post Incarceration	N
		Project 2.6 Chronic Non-Malignant Pain Management	N
		Project 2.7 Comprehensive Advanced Illness Planning and Care	N
Domain 3: Resource Utilization Efficiency	1 minimum	Project 3.1 Antibiotic Stewardship	N
		Project 3.2 Resource Stewardship: High Cost Imaging	N
		Project 3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals	N
		Project 3.4 Resource Stewardship: Blood Products	N

Descriptions of each project can be found below in Section VI.

B. Project Selection Exclusions

Participating PRIME entities may only select projects for which the target population is sufficient to accurately measure success, as defined as having greater than or equal to 30 individuals meeting the project target population definition. Participating PRIME entities also may not select optional projects for which they have achieved top performance of the metric benchmark for > 50% of the number of a project's metrics. If a DPH is unable to select a particular optional project for the above reason, the DPH must choose another optional project from the same domain as necessary to fulfill program minimum project requirements. If a DPH is unable to select a particular required project for either of the above reasons, the DPH must choose another project from the same domain as necessary to fulfill program minimum project requirements.

V. Metrics

A. Reporting of PRIME Project Metrics

Reporting of metrics will be completed per the Program Funding and Mechanics Protocol (Attachment II, Section VII). Participating PRIME entities will report on all metrics required for each project, unless as described by Section IV.B. All PRIME metric reporting will conform to technical measure specifications as required by DHCS. Each participating PRIME entity will receive PRIME incentive payments based on the participating PRIME entity's performance on the project metrics, per Attachment II.

Each project has a required set of metrics. Section V.E lists the specific metrics that will be used to assess performance. All metrics are reported at the DPH or DMPH level.

B. Metric Types

1. Metrics are primarily clinical metrics.
2. Metrics were chosen from State, Medi-Cal, or CMS quality metrics if available.
3. Metrics were preferentially chosen from state or national metrics which have been vetted by Measure Stewards, which are defined as recognized, authoritative entities able to assess clinical relevance, feasibility and appropriateness of a metric. Examples of Measure Stewards include the NCQA, AMA, and CMS. These vetted measures have been included in PRIME as "standard metrics" where possible. Innovative metrics, representing around 20% of all metrics, are used to measure performance for PRIME projects only in instances in which a project's current set of standard metrics does not adequately assess successful transformation. Innovative metrics are defined as metrics that, at the beginning of PRIME, have not yet undergone a vetting and testing process by a Measure Steward. Measure Stewards have been identified for every innovative metric. Innovative metrics enable participating PRIME entities to demonstrate the transformation of health care towards coordinated, team-based, patient-centered care, in a manner not afforded by many of the standard metrics. Innovative metrics will go through an established metric testing process, as described in the DHCS PRIME Metrics and Specification Manual.
4. Pay for Reporting and Pay for Performance: Following the submission of baseline data for all metrics in DY 11, the majority of standard metrics will convert to pay-for-performance in DY 12. A smaller proportion of standard metrics, those which are both new to participating PRIME entities and are much more complex to report on, will convert to pay-for-performance in DY 13. The innovative metrics will convert to pay-for-performance in later years once each has completed a rigorous testing process as described in the Innovative Metric Testing summary found in D. Table 2 provides a breakdown of the transition of PRIME metrics from pay-for-reporting to pay-for-performance for each DY.

Table 2: Summary of Metric Progression from P4R to P4P

	DY 11	DY 12	DY 13	DY 14	DY 15
% of P4R Metrics	100%	40%	21%	2%	2%
% of P4P Metrics	0%	60%	79%	98%	98%

C. Metrics Governance

The measurement specifications for a PRIME metric will stay current with those of the Measure Steward and/or endorsing body. DHCS will monitor any changes to NQF-endorsed and non-NQF endorsed measures that are used in PRIME projects. If a measure is dropped or significantly changed by the measure steward, any changes will be effective at the start of the next annual PRIME Demonstration Year. Per Metric Modification Process (Attachment II, VI, C), DHCS retains authority to modify metric specifications for the program.

D. Innovative Metric Testing

Innovative metrics, are defined as metrics that at the start of PRIME have not yet undergone a vetting a testing process by a Measure Steward. All PRIME innovative metrics have a confirmed Measure Steward and will go through a formal and rigorous testing process by a DHCS PRIME Metric Technical Advisory Committee (MTAC). The Committee will test the metric against criteria including, but not limited to, importance, scientific feasibility, and usefulness as supported by evidence gathered by the Measure Steward. During the testing process, innovative metrics are pay-for-reporting until which time they have been sufficiently vetted to be pay-for performance metrics as determined by DHCS and the above referenced metric testing process.

1. **Principles Of The Process**

a. An innovative metric is a metric that currently has no state or national metric steward or entity that has already defined and vetted the metric.

b. An innovative metric is included only when a project's current metric set does not adequately assess successful transformation.

c. Each PRIME innovative metric will have either DHCS or a PHS volunteering to serve as the measure steward for the duration of PRIME.

    i. The measure steward is responsible for defining the specifications and providing evidence for its use.

    ii. The measure steward will also recommend a reasonable high performance level based on research of evidence.

d. A in collaboration with DHCS a MTAC will govern the innovative metric testing process by which the measure will be tested against criteria including, but not limited to, importance, scientific feasibility, and usefulness as supported by evidence gathered by the measure steward.

    i. The metric will be removed from PRIME if it fails to meet test criteria.

e. Testing, refinement, and baseline setting will occur over the first three years of PRIME during which the measure maintains Pay for Reporting (P4R) status.

f. MTAC will also review the reported data to test the measure for room for improvement and stability.

g. Once MTAC has vetted the metric, MTAC will recommend to DHCS to convert the status of the metric from P4R to Pay for Performance (P4P) for the last two years of PRIME.

    i. For metrics that convert from P4R to P4P, DHCS will work with MTAC to establish improvement metrics for the final two years of the demonstration.

    ii. On an exception basis, MTAC may recommend to maintain a metric's status as P4R status beyond the first three years based on the progress of testing.

2. **Purpose**

This PRIME Innovative Metrics Testing Process is how "innovative" measures will be defined and tested for appropriate inclusion in PRIME. An innovative measure (formerly referred to as "novel") is a measure that currently has no state or national measure steward or entity that has already defined and vetted the measure. Innovative measures will be initially included in PRIME as P4R measures and may evolve to P4P through 5 years of the program depending on the outcomes of the Metric Testing Process.

1. **Role Of The Measure Steward**

    a. Draft the measure specifications, including:

        i. The "narrative" version of the specifications

1. Here is an example of measure specs that include both the "narrative" version and the electronic specs (aka eCQM – electronic Clinical Quality Metric). While we might not need all the rationale and background that is in that document, we certainly need all the specifics.

ii. Measurement period

iii. Numerator/Denominator

iv. Exclusions & exceptions

v. Methodologies for any needed calculations

vi. Data criteria, including data sources and codes needed for reporting (i.e., when your IT/Data/Business Intelligence Dept asks you for details so they can develop the query and reports)

b. Gathering evidence supporting the measure's fulfillment of the evaluation criteria as described below.

c. In conjunction with the MTAC, determine if and when the metric is "stable" enough with sufficient data to move from testing (P4R) to financial accountability (P4P.)

d. Serve as the content expert resource body for the measure in conjunction with the Metric Technical Advisory Committee (MTAC) for technical expertise

i. Answer any questions that will come back from PHS using the metric

ii. Revise the measure specifications as issues arise

2. **Role Of MTAC**

a. Composed of clinical, operational, and reporting/technical experts, MTAC will govern the testing process

b. Test the metric specifications and ask for additional clarification from measure steward

i. Is this information adequate for reporting at my system?

ii. What additional information needs to be provided to ensure standardized reporting?

iii. Other questions as they see fit

c. Evaluate the measure (via the Worksheet completed by the Measure Steward) against test criteria:

i. Importance – clinical impact to PRIME project target population

ii. Scientific acceptability – measure is evidence-based, reliable, valid, and precise

iii. Feasibility – data for the measure can be collected without undue burden;, data is auditable

iv. Usefulness – results in useful information to stakeholders; applicability to a significant population, robust results for public reporting

v. Room for improvement – based on available evidence, Measure Steward determines what would reasonably be considered high performance for this measure. MTAC, in conjunction with the Measure Steward will assess data, obtained during the testing period, against the high performance benchmark identified by the Measure Steward to determine room for improvement across the PHS.

d. Serve as the technical resource body for the measure along with the Measure Steward.

3. **Process Steps**

Responsible Entity	**Step**	**Timeframe**
Measure Steward	Completes the PRIME Innovation Metric Worksheet with measure specifications and supporting evidence.	Q1 2016
MTAC	Reviews the worksheet and conceptually tests the measure according to test criteria.	Q2 2016
Measure Steward	Refines measure specifications based on MTAC input.	Q2 2016
PHS	Mock reports on the measure, identifying reporting issues and questions.	Q3 2016
MTAC, Measure Steward	Provide additional guidance and revises measure specifications accordingly.	Q3 2016
PHS	Collect baseline data and reports to MTAC.	Q3-Q4 2016
MTAC, Measure Steward	Test the collected data for room for improvement against the high performance level as identified by the Measure Steward. If there is no room for improvement, then the measure is dropped.	Q3 2016

Responsible Entity	Step	Timeframe
PHS	Relay any issues or concerns about each innovative metric to MTAC.	Throughout DY 12 (7/16-6/17)
MTAC, MS	Revise measure specification or provide additional guidance as needed based on ongoing feedback.	Throughout DY 12
MTAC	Review PHS-reported data and feedback for each innovative measure to decide whether the P4R P4P status conversion should deviate from the original timetable (see below).	After DY 12 Annual report
PHS	Collect and report on measure, relaying issues or concerns that arise.	DY 13*
MTAC	Reviews PHS-reported data and feedback for each innovative measure. Revises if needed. Determines high performance level and performance target methodology.	After DY 13 Annual report
MTAC	Approves final measure specifications and recommends DHCS submit to CMS for approval of conversion to P4P.	After DY 13 Annual Report
DHCS	DHCS submits to CMS for approval of measure as P4P.	Q3 2017
CMS	Approve measure for P4P.	Q4 2017
PHS	Report on measure, relaying technical issues and questions to MTAC as needed.	DY 14 and 15

* PHS get paid for reporting on the measure at the time of the Annual Report even if the measure hasn't completed the entire testing process yet and achieved stability.

4. P4R/P4P Timeline

In general, an innovative measure will be P4R in Year 1, 2, and 3; P4P in Year 4, and 5 as the metric is defined as stable and testing is complete.

E. Metrics Summary

The metrics by project are summarized in Table 2 below.

Table 2: High-Level Summary of Metrics

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Abnormal Results Follow-Up	1.4	*Alameda Health System (AHS)	N/A
Adherence to Medications	3.3	*AHS, Santa Clara Valley Health System	
Adolescent Well-Care Visit	2.4	NCQA	N/A
Advance Care Plan	2.7	NCQA	0326
Alcohol and Drug Misuse (SBIRT)	1.1, 1.2, 2.5, 2.6	Oregon CCO	N/A
Ambulatory Palliative Care Team Established	2.7[1]	*UC San Francisco (UCSF)	N/A
Annual Monitoring for Patients on Persistent Medications	1.4	NCQA	2371
Assessment and Management of Chronic Pain: Patients with chronic pain prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen	2.6	AHRQ	N/A
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	3.1	NCQA	0058
Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures	3.1	*University of California Davis (UCD), UC Irvine (UCI), UC San Diego (UCSD)	N/A
Baby Friendly Hospital designation	2.1	Baby-Friendly USA/DHCS	N/A
BIRADS to Biopsy	1.6	*LA County Dept of Health Services (LAC DHS), San Francisco Health Network (SFHN)	N/A
BMI Screening and Follow-up	1.7	CMS	0421
Breast Cancer Screening	1.6	NCQA	2372
Care Coordinator Assignment	1.1, 2.3	University of Washington/ Coordinated Care Initiative	N/A
Cervical Cancer Screening	1.6	NCQA	0032
CG-CAHPS: Provider Rating	1.2	AHRQ	0005
Closing the referral loop: receipt of specialist report (CMS50v3)	1.3	CMS	N/A
Colorectal Cancer Screening	1.2, 1.6	NCQA	0034

[1] The "Ambulatory Palliative Care Team Established" metric will start in DY11 and sunset once the PRIME Entity can attest to the establishment of their Ambulatory Palliative Care Team. This metric works in tandem with the metric "Palliative Care Service Offered at Time of Diagnosis of Advanced Illness".

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	1.1, 1.2	NCQA	0059
Controlling Blood Pressure	1.2, 1.5, 2.5	NCQA	0018
Depression Remission at 12 Months (CMS159v4)	1.1	Minnesota Community Measurement	0710
Developmental Screening in the First Three Years of Life	2.4	NCQA	1448
DHCS All-Cause Readmissions	1.3, 2.2	CDHCS	N/A
Documentation of Current Medications in the Medical Record	3.3	CMS	0419
Documentation of Current Medications in the Medical Record (0-18 yo)	2.4	CMS	Variation on 0419
Documented REAL and/or SO/GI disparity reduction plan	1.2[2]	DHCS	N/A
ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-02 Pre-op Hemoglobin Level, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-04 Initial Transfusion Threshold	3.4	AABB/TJC (approval pending)	N/A
ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
Exclusive Breast Milk Feeding (PC-05)	2.1	JNC	0480
H-CAHPS: Care Transition Metrics (3)	2.2	AHRQ	0166
High-Cost Pharmaceuticals Ordering Protocols	3.3	*AHS	N/A
Imaging for Routine Headaches (Choosing Wisely)	3.2	*Washington Health Alliance	N/A
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	3.2	ACEP	0667

[2] The "Documented REAL and/or SO/GI disparity reduction plan" metric will only be active for DY 12.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Influenza Immunization	1.3	NCQA	0041
INR Monitoring for Individuals on Warfarin	1.4	CMS	0555
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	1.2, 1.5	NCQA	0068
Medication Reconciliation – 30 days	2.2, 2.3	NCQA	0097
MWM #8: Treatment Preferences (documentation) Inpatient	2.7	UNC Chapel Hill	1641
MWM #8: Treatment Preferences (documentation) Outpatient	2.7	*UCSF	N/A
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	3.1	CDC	2720
OB Hemorrhage: Massive Transfusion	2.1	CMQCC	N/A
OB Hemorrhage: Total Products Transfused	2.1	CMQCC	N/A
Palliative Care Service Offered at Time of Diagnosis of Advanced Illness	2.7[3]	*University of California, San Francisco (UCSF)	N/A
Partnership for a Healthier America's Hospital Health Food Initiative external food service verification	1.7	DHCS	N/A
Patients with chronic pain on long term opioid therapy checked in PDMPs	2.6	*AHRQ/SFHN, AHS, UCSD	N/A
PC-02 Cesarean Section	2.1	JNC	0471
Post Procedure ED Visits	1.3	*SFHN	N/A
PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	1.5	CMS	N/A
Prenatal and Postpartum Care	2.1	NCQA	1517
Prevention Quality Overall Composite #90	1.2, 2.3, 2.5	AHRQ	N/A

[3] The "Palliative Care Service Offered at Time of Diagnosis of Advanced Illness" metric will be reported as P4R the same Demonstration Year that the PRIME Entity can attest to the establishment of their Ambulatory Palliative Care Team. For the remaining Demonstration Years the "Palliative Care Service Offered…" will be P4P.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Primary Care Redesign metrics stratified by REAL categories and SO/GI	1.2	*DHCS	N/A
Prophylactic antibiotics discontinued at time of surgical closure	3.1	CMS	N/A
Proportion Admitted to Hospice for Less Than 3 Days	2.7	ASCO	0216
REAL and/or SO/GI disparity reduction	1.2[4]	*DHCS	N/A
REAL data completeness	1.2[5]	CMS	N/A
Receipt of appropriate follow-up for abnormal CRC screening	1.6	*SFHN	N/A
Reconciled Medication List Received by Discharged Patients	2.2	AMA-PCPI	0646
Reduction in Hospital Acquired Clostridium Difficile Infections	3.1	NHSN	N/A
Referral Reply Turnaround Rate	1.3	*LAC DHS, SFHN	N/A
Screening for Clinical Depression and follow-up	1.1, 1.2, 2.4, 2.5, 2.6	CMS	0418
Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage	2.1	CMQCC	N/A
SO/GI data completeness	1.2[6]	CMS	N/A
Specialty Care Touches: Specialty Expertise Requests Managed Via Non-Face to Face Specialty Encounters	1.3	*LAC DHS, UCD	N/A
Timely Transmission of Transition Record	2.2, 2.3	AMA-PCPI	0648
Tobacco Assessment and Counseling	1.1, 1.2, 1.3, 1.5, 2.5	AMA-PCPI	0028
Tobacco Assessment and Counseling (13 yo and older)	2.4	AMA-PCPI	Variation on 0028
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	2.6	*SFHN, AHS, UCSD	N/A
Unexpected Newborn Complications (UNC)	2.1	California Maternal Quality Care Collaborative (CMQCC)	0716

[4] The "REAL and/or SO/GI disparity reduction" metric will be active DY 13-15, and will be P4P throughout those years.
[5] The "REAL data completeness" metric will be P4R in DY 11 and P4P in DY 12-15. Although this metric is active for all 5 years, it's status is included here for the sake of clarity.
[6] The "SO/GI data completeness" metric will become active starting in DY 12 as P4R and will be P4P in DY 13-15.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Use of Imaging Studies for Low Back Pain	3.2	NCQA	0052
Use of Imaging Studies for Low Back Pain (red flags, no time limit)	3.2	*LAC Department of Health Services	Variation on NQF 0052
Well Child Visits - First 15 months of life	2.4	NCQA	1392
Well Child Visits - Third, Fourth, Fifth, and Sixth Years of life	2.4	NCQA	1516
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	1.7	NCQA	0024

Below are further details for metric measurement.

F. Measurement Period

Measurement periods are summarized in Table 3 below.

Table 3: Measurement Periods

Demonstration Year (DY)	Mid-Year Report Measurement Period	Mid-Year Report Due	Year-End Report Measurement Period	Year-End Report Due
DY 11	Not applicable	Not applicable	July 1, 2015 – June 30, 2016	September 30, 2016
DY12	January 1, 2016 – December 31, 2016	March 31, 2017	July 1, 2016 – June 30, 2017	September 30, 2017
DY13	January 1, 2017 – December 31, 2017	March 31, 2018	July 1, 2017 – June 30, 2018	September 30, 2018
DY14	January 1, 2018 – December 31, 2018	March 31, 2019	July 1, 2018 – June 30, 2019	September 30, 2019
DY15	January 1, 2019 – December 31, 2019	March 31, 2020	July 1, 2019 – June 30, 2020	September 30, 2020

G. DMPH Infrastructure Building

Subject to the funding limits in PRIME Funding and Mechanics (Attachment II), DHCS shall review, approve, and make payments for DMPHs in accordance with the requirements in PRIME Funding and Mechanics (Attachment II). DMPH infrastructure building payments shall be paid in accordance with PRIME Funding and Mechanics (Attachment II). DMPH infrastructure building payments shall support 1) infrastructure activities to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target

population; and 3) other strategies including data and related quality improvement systems, to advance integration, reduce unnecessary utilization of health care services, and improve health outcomes. Infrastructure building metrics must be reported mid-year and annually, with reporting of process pay for performance (P4P) metrics beginning no later than one year following the start of the demonstration. These metrics will allow DMPHs to establish the essential infrastructure necessary to drive healthcare system transformation. DMPHs will be able to develop a set of infrastructure building metrics that are linked to their selected project metric(s) set outlined in sections V.A-C below (Domains 1-3). The infrastructure building metrics will be included as part of DMPHs five-year PRIME Pool Plans and approved of by DHCS and CMS.

H. Establishing Baseline Performance During PRIME

To fulfill metric reporting for all PRIME projects for DY 11, Participating PRIME entities will submit reports on metric baseline performance, per the PRIME Program and Funding Mechanics Attachment II. The DY11 report will include baseline data for all relevant project metrics and will identify data sources, consolidating data from multiple inpatient and ambulatory systems, and including data reported from health plans.

I. Target Setting for Pay-for-Performance Metrics

By DY12, the majority of standard metrics will convert to P4P status. All metrics classified as P4P will have annual P4P targets for each of the DYs. At the beginning of each Demonstration Year, participating PRIME entities will know the annual performance target to be achieved by the end of that Demonstration Year. The method for determining the annual performance target will remain the same throughout the PRIME years for that metric. The participating PRIME entity will earn incentive payments on P4P measures proportional to the achievement value, per Program Funding and Mechanics Protocol (Attachment II).
Below are target setting methodologies for PRIME:

1. **10% Gap Closure:** This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. The gap is defined as the difference between the end of demonstration year performance and the 90th percentile benchmark. The target setting methodology will be a 10% gap closure year over year. This is the preferred methodology because top performance is defined relative to state or national top performance and targets are relative to individual performance. This methodology has been widely adopted in pay-for-performance programs across the nation.
2. **Improvement Over Self:** For those metrics without a state or national Medicaid benchmark available, including innovative metrics using pay-for-performance, DHCS will set a standard percent improvement (e.g. 10%) relative to individual current annual performance. On a metric by metric basis, DHCS will determine the percent improvement based on available evidence of what is a reasonable expectation for magnitude of clinical change. This standard relative improvement will be used by every participating PRIME entity reporting on that metric.

DHCS will set a high performance level and a minimum performance level for pay-for-performance measures. These levels will be used as guidelines to set targets. Each subsequent year, the annual target will be reset based on performance at the end of the prior year. Over the course of the PRIME, DHCS will update the high and minimum performance levels, i.e., the benchmark performance levels, as they may be revised by Metric Stewards. Any change will be effective at the start of the next annual reporting period.

J. Minimum Number of Cases

A participating PRIME entity must have a minimum of 30 individuals or cases in a metric denominator in order to be eligible to report on that metric, as determined by DHCS. If a participating PRIME entity meets this minimum, then the participating PRIME entity must report the metric. If a participating PRIME entity has fewer than 30 cases, then the participating PRIME entity is not eligible to report on the metric for the reporting period.

K. Sampling

1. Indication for Use of Sampling

For each measure, the participating PRIME entity has the option to either report on the entire measure population or on a sample, adhering closely to sampling criteria published and maintained in the CMS Hospital Outpatient Quality Reporting Program Specifications Manual. For each measure, participating PRIME entities are required to indicate if sampling was used when reporting performance data.

Participating PRIME entities are encouraged to submit as many cases as possible up to the entire population of cases if reasonably feasible. If the raw data can be easily extracted from an existing electronic database or the abstraction burden is manageable, the participating PRIME entity should submit the entire population of cases that meet the initial selection criteria. Otherwise, a statistically valid sample can be selected.

If the participating PRIME entity is not sampling, the entity should use all medical records identified in the population. If the participating PRIME entity is sampling, the entity should use the medical records from the cases in the identified sample.

When a measure population size is less than the minimum number of cases for the sample size, sampling cannot be used, as determined by DHCS.

L. Defining the Denominator

The denominator for each metric is determined uniformly through a standardized process (outlined below). When reporting the baseline data for the metric, the participating PRIME entity must report to DHCS the methodology for determining the denominator in order to demonstrate uniformity with other participating PRIME entities also reporting that metric for that project. For each subsequent report on that metric, the same methodology, as approved by DHCS, must be applied for determining the population to include in the metric denominator.

Step 1) For DPHs: Determine the PRIME Defined Population composed of (a) all Medi-Cal Managed Care primary care lives assigned to the participating PRIME[7] entity as listed by DHCS at the end of each measurement period; and (b) all individuals with at least two encounters by the participating PRIME entity for an eligible primary care service[8] during the measurement period. This Defined Population serves as the starting point for all metric denominators, and then for each project is refined in Step 2 below.

For DMPHs: Determine the PRIME Defined Population composed of all individuals with at least two encounters by the participating PRIME entity among Medi-Cal beneficiaries. This Defined Population serves as the starting point for all metric denominators, and then for each project is refined in Step 2 below.

Step 2) Determine the Project Population. The Project Population for each project is further refined based on the focus of the project, which includes narrowing or expanding the Program Population to best align with the goals of the project.

Step 3) Determine the Metric Denominator by only including those individuals or visits from the Project Population that meet the metric measurement specifications.

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[7] Assigned lives must have been continuously enrolled with the participating PRIME entity during the preceding 12 months, have no gaps in enrollment greater than 45 days, and be enrolled with the participating PRIME entity on the last day of the measurement period.

[8] Eligible Primary Care Services include both traditional face-to-face encounters with a provider, as well as any Complementary Service Encounter defined through the Global Payment Program for the Remaining Uninsured under this same 1115 Medicaid Waiver. See Global Payment Program Attachment EE for details.

VI. Project Toolkit

Each project description includes the:

- Rationale for the proposed project (evidence base and reasoning behind project idea),
- Goals and objectives of the project (project-specific Triple Aim goals and expected project outcomes),
- Core components, or key activities to guide project development and implementation, and
- Metrics required for the project, including clinical event outcomes, potentially preventable events, and patient experience measures.

The Core Components for projects are not required. However, most will be necessary to achieve the required results. The core components provide a guide for participating PRIME entities as they develop and implement the projects. In this way, the core components promote standardization across the program, while allowing participating PRIME entities to tailor program activities to meet local needs.

A. Domain 1: Outpatient Delivery System Transformation and Prevention

Projects 1.1-1.3 Required for DPHs

Projects included in Domain 1 are designed to ensure that patients experience timely access to high-quality and efficient patient-centered care. Participating PRIME entities will improve physical and behavioral health outcomes, care delivery efficiency and patient experience, by establishing or expanding fully integrated care, culturally and linguistically appropriate teams—delivering coordinated comprehensive care for the whole patient.
Primary and specialty care will be integrated and designed to work collaboratively with patients and care providers. Patients will receive appropriate preventive services, early diagnosis and treatment, and will be supported in improving their ability to care for themselves through access to other needed services including those that support social and well-being needs. Particular attention will be focused on optimizing care experience and outcomes, and improving patient safety in the outpatient setting where an increasing volume of care is being provided.
Multi-disciplinary care teams will provide coordinated care that meets the patient's needs and preferences, and results in improved capacity for patient self-management and a reduction in avoidable acute care and interventions, thereby improving quality of life and health outcomes. Several projects in this Domain will also identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations (cardiovascular disease; breast, cervical and colorectal cancer; and obesity).

1. Project 1.1 Integration of Behavioral Health and Primary Care

Required Project for DPHs

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.1 Integration of Behavioral Health and Primary Care
Rationale	
According to the DHCS Mental Health Prevalence Estimates, 15.9% of Californian adults suffer from Mental Health Disorder (MHD). This translates to 4.4 million Californians that are in need of mental health treatment. Nearly 2 million Californians are suffering from a serious mental illness (SMI); 4.3% and 7.4% of adults and children, respectively. A common co-occurring condition with Mental Health Disorder (MHD) is substance use disorder (SUD), which plagues 8.8% of Californians. A fragmented health care system is ill equipped to treat people with chronic medical and behavioral issues. In order to combat the gap in treatment of MHD and SUD, as of January 2014, Medi-Cal covers new services for members with mild to moderate mental health conditions, and has implemented an Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit for adults in primary care settings. The prevalence of MHDs varies greatly by economic status. Adult members of households below 200% of the federal poverty level are 150% more likely to have a MHD than their more affluent counterparts. Among the SMI population, the disparity is even greater. Adult members of households below 200% of the federal poverty level are almost two times more likely to have a MHD than their more affluent counterparts. The prevalence of MHDs also varies greatly by race/ethnicity. Native Americans and Hispanics are the most likely to have MHDs (20%), followed by African Americans (19%), Whites (14%), and Asians (10%), who are the least likely to have MHDs.[9] Within distinct cultures and communities of color, stigma and cultural attitudes about behavioral health have a large impact on whether individuals seek care, and adherence to care plans and will need to be a factor in designing care teams and treatment plans.	

[9] California Mental Health Prevalence Estimates, Task Team: HSRI, TAC and Expert Consultation From Charles Holzer. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.1 Integration of Behavioral Health and Primary Care

MHDs and SUDs reduce a person's life expectancy by 10 to 25 years, which is equivalent to the reduced life expectancy that is the result of heavy smoking.[10] People with a MHD and/or SUD die from the same causes as does the general population, such as: heart disease, diabetes, and cancer. However, these diseases are more prevalent among people who suffer from a MHD or SUD, and lead to earlier death.[11] For the entire population, the greatest indicators for such diseases are: smoking, obesity, hypertension, poor diet, and low levels of physical activity. Such health risks have an increased prevalence among those with a MHD and/or SUD, and have an earlier onset.

Because of the low rate of preventive and treatment services offered to people with a MHD and/or SUD, these individuals experience serious health burdens and are at risk of premature death.[12] The Substance Abuse and Mental Health Services Administration and Health Resources Services Administration's jointly funded Center for Integrated Health Solutions (SAMHSA-HRSA CIHS) advocates that the solution to providing better care to those with co-occurring conditions, whether medical or behavioral, is to *integrate* care. When behavioral health (BH) conditions are detected early and treated appropriately, those individuals experience a greater quality of life, better self-care, improved adherence to medical and mental health treatments, and better overall health outcomes.[13] The implementation of regular, validated screening tools along with brief intervention techniques serve as strategies for early detection of SMIs and SUDs, resulting in reduced alcohol misuse and earlier intervention and treatment opportunities. When preventive efforts are combined with coordinated care efforts (e.g. psych-consultation, team-care approach, peer providers, enhanced linkages to community and BH settings), the result is a significant improvement in health outcomes. One example of such success is the IMPACT model, which led to two times better clinical outcomes than general care.[14] Programs such as the IMPACT model not only improve care at the individual and population levels, but lead to lower overall health care costs.[15]

Goals/Objectives

To improve physical and behavioral health outcomes, care delivery efficiency and patient experience by establishing or expanding fully integrated care, culturally and linguistically appropriate teams—with expertise in primary care, substance use disorder conditions and mental health conditions delivering coordinated comprehensive care for the whole patient. To integrate mental health and substance abuse with primary care and ensure coordination of care for all services in order to: 1) identify behavioral health diagnoses early, allowing rapid treatment; 2) ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects; 3) improve medical and behavioral health outcomes for those patients with chronic medical disorders, and for those with co-occurring physical and behavioral health conditions.

Specific objectives include:

- Increase use of screening tools (e.g. PHQ-9, GAD-7, AUDIT, DAST)
- Improve patient adherence to their treatment regimen

[10] University of Oxford, "Many mental illnesses reduce life expectancy more than heavy smoking." ScienceDaily. ScienceDaily, 23 May 2014. www.sciencedaily.com/releases/2014/05/140523082934.htm.

[11] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599–604.

[12] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011; 49(6):599–604.

[13] SAMHSA-HRSA Center for Integrated health Solutions. http://www.integration.samhsa.gov/

[14] IMPACT. Evidence-based depression care. http://impact-uw.org/

[15] Jurgen Unützer, Jeffrey Lieberman. Collaborative Care: An Integral Part of Psychiatry's Future. Psychiatry Online, Psychiatric News Article, November 12, 2013.

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.1 Integration of Behavioral Health and Primary Care

- Improve health indicators for patients with both physical and behavioral chronic conditions
- Increase access to mental health and substance use disorder services
- Reduce preventable acute care utilization
- Reduce ED visits for patients with behavioral health conditions
- Improve communication between PCP and behavioral health providers
- Reduce admissions for patients with behavioral health problems through earlier recognition and intervention
- Reduce admissions for physical problems by better managing co-morbid behavioral health conditions
- Improve patient experience
- Reduce disparities in health and health care

Core Components

Systems undertaking this project may complete the following components:

1. Implement a behavioral health integration assessment tool (baseline and annual progress measurement)[16,17]
2. Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other IBH resources from SAMHSA).
3. Integrate appropriate screening tools and decision support into the emergency department to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to PCPs, MH and SUD specialists and behavioral health and other community services through the discharge process
4. Physical-behavioral health integration may be an implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations, (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
5. PCHM and behavioral health providers will:
   a. Collaborate on evidence based standards of care including medication management and care engagement process.
   b. Implement case conferences/consults on patients with complex needs
6. Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
7. Ensure systems are in place to support patient linkage to appropriate specialty physical, mental and SUD services. Preventive care screenings including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including provision of brief interventions (e.g., MI techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

[16] *e.g.,* AIMS Center Behavioral Integration Checklist, McHAF Site Self-Assessment)

[17] Level of Integration Measure (LIM): http://integrationacademy.ahrq.gov/measures/C6%20Level%20of%20Integration%20Measure
Purpose: To rate the degree to which behavioral health providers or behavioral health care is integrated into primary care settings from the perspective of staff and/or providers. Developer: Antioch University

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.1 Integration of Behavioral Health and Primary Care

8. Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
9. Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater compliance with treatment for co-morbid medical and mental health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment includes maintenance treatment with methadone and buprenorphine.
10. Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptoms management groups.
11. Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline workers to the care team to assist with care navigation, treatment plan development and adherence.
12. Ensure that the Treatment Plan:
    a. Is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning.
    b. Outcomes are evaluated and monitored for quality and safety for each patient.
13. Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
14. Demonstrate engagement of patients in the design and implementation of the project
15. Increase team engagement by:
    a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials
    b. Providing ongoing staff training on care model.
16. Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Care coordinator assignment	N/A	*University of Washington/ Coordinated Care Initiative
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	0059	NCQA
Depression Remission at 12 Months CMS159v4	0710	MN Community Measurement
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

2. Project 1.2 Ambulatory Care Redesign: Primary Care

Required Project for DPHs

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.2 Ambulatory Care Redesign: Primary Care
Rationale	

Under the Affordable Care Act primary care providers are seeing an unprecedented increase in the demand for services, with 2.3 million new Californians receiving coverage during the first year of implementation.[18] Demand will continue to grow over the next five years, yet the supply of primary care providers remains relatively static, with fewer than 20% of medical school students choosing a career in primary care.[19] By 2020, the demand for care is expected to outpace the supply of primary care providers.[20]

In order to meet the growing demand for services, participating PRIME entities must become more efficient, better-coordinated systems of care. Patient-centered medical homes (PCMH) show promise for improving the efficiency and effectiveness of primary care by leveraging the skills of non-physicians and sharing responsibilities among a care team. Nurse practitioners and physicians assistants, for example, are entering the field at a greater rate than primary care providers[3] and can offer increased capacity and quality to the primary care team. By sharing responsibilities among members of the care team, the medical home can relieve the burden on primary care providers and allow all staff to maximize their skills, resulting in enhanced collaborative care with patients.

In addition to redesigning care to support the medical home model, participating PRIME entities can leverage new technologies to expand primary care access and improve quality of care. Reaching patients through alternate modes, such as patient portals, is both convenient for patients and shown to improve clinical quality measures.[21] Disease registries and electronic reminders can increase screening rates for chronic illness and keep vulnerable patients from "falling through the cracks." Under the PCMH model, the care team uses data to drive decision-making, becoming more efficient and effective providers of care.

This delivery system transformation will require re-thinking traditional provider roles and engaging all levels of staff to work together in coordinated teams. It will require processes for improved provider-provider and provider-patient communication, both in-person and remote. Transformation will also require building the data capacity to support alternate modes of care delivery, build robust disease registries, and make data available to care teams in real time, so they can work collaboratively with patients to make the best decisions for optimum health outcomes.

Furthermore, in addition to transforming care for all patients, participating PRIME entities must reduce disparities in health and healthcare between patient populations. The PRIME Primary Care Redesign

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[18] Medicaid Marketplace Overview. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html. Accessed Jan 21, 2015.

[19] Harris, Scott. Primary Care in Medical Education: The Problems, The Solutions. Association of American Medical Colleges. https://www.aamc.org/newsroom/reporter/march10/45548/primary_care_in_medical_education.html. Accessed Jan 21, 2015.

[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

[21] Yi Yvonne Zhou, Michael H. Kanter, Jian J. Wang and Terhilda Garrido. Improved Quality At Kaiser Permanente Through E-Mail Between Physicians And Patients. Health Affairs, 29, no.7 (2010):1370-1375.

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.2 Ambulatory Care Redesign: Primary Care

project will require participating PRIME entities deliver targeted interventions that address the specific needs of underrepresented populations and communities of color, and target resources to improve health equity. The approach to incorporate disparities reduction into quality improvement initiatives aligns with direction from the Institute of Medicine, which includes equity as a cross-cutting dimension of all quality care.[22]

Goals/Objectives

Patients will experience timely access to high quality, efficient, and equitable primary care, designed to work collaboratively with patients and other care providers in achieving and maintaining optimum patient health, and avoiding unplanned interventions.

Specific objectives include:

- Increase the number of primary care practices undergoing Patient Centered Medical Home transformation, most notably implementing team based care and better utilization of front line workers
- Increase provision of recommended preventive health services
- Improve health indicators for patients with chronic condition(s) (including mental health and substance use disorder conditions)
- Increase patient access to care
- Decrease preventable acute care utilization
- Improve patient experience of care
- Increase staff engagement
- Improve the completeness, accuracy, and specificity of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data
- Reduce disparities in health and health care

Core Components

Systems undertaking this project may complete the following components:

1. Gap analysis of practice sites within the DPH/DMPH system.
2. Primary Care practices will demonstrate advancement of their PCMH transformation through the use of a nationally recognized PCMH methodology[23]
3. Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
4. Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
    a. Implementation of Electronic Health Record (EHR) technology that meets meaningful use standards (MU)
5. Ongoing identification of all patients for population management (including assigned managed care lives):

[22] Ulmer C, Bruno M, Burke S, eds. Future Directions for the National Healthcare Quality and Disparities Reports. Washington, D.C.: National Academies Press; 2010.

[23] For example: NCQA Patient-Centered Medical Home Recognition, http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx, accessed 12/5/14; Safety Net Medical Home Initiative, http://www.safetynetmedicalhome.org/ , accessed 12/4/2014; AAFP's TransforMed, http://www.transformed.com/, accessed 12/4/2014

   a. Manage panel size, assignments, and continuity to internal targets;
   b. Develop interventions for targeted patients by condition, risk, and self-management status.
   c. Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
6. Enable prompt access to care by:
   a. Implementing open or advanced access scheduling
   b. Creating alternatives to face-to-face provider/patient visits
   c. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
7. Coordinate care across settings
   a. Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers)
      i. Establish onsite Care/Case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients
   b. Implement processes for timely bi-directional communication and referral to specialty care, (including mental health and substance use disorder services), acute care, social services and community based services
8. Demonstrate evidence-based preventive and chronic disease management
9. Improve staff engagement by:
   a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
   b. Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
10. Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
11. Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:
    a. Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data
    b. Developing capacity to track and report REAL/SO/GI data, and data field completeness
    c. Implementing and/or refining processes for ongoing validation of REAL/SO/GI data
    d. Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions
    e. Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders
    f. Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
12. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention	
Project Title	1.2 Ambulatory Care Redesign: Primary Care	
Required Project Metrics		
Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
CG-CAHPS: Provider Rating	0005	AHRQ
Colorectal Cancer Screening	0034	NCQA
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	0059	NCQA
Controlling Blood Pressure	0018	NCQA
Documented REAL and/or SO/GI disparity reduction	N/A	*DHCS
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0068	NCQA
Prevention Quality Overall Composite #90	N/A	AHRQ
Primary Care Redesign project metrics stratified by REAL and SO/GI categories	N/A	*DHCS
REAL and/or SO/GI disparity reduction	N/A	*DHCS
REAL[24]data completeness	N/A	CMS
Screening for Clinical Depression and follow-up	0418	CMS
SO/GI [25]data completeness	N/A	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

[24] As per the 2015 Final Rule on Certified EHR Technology, record each one of a patient's races and ethnicities in accordance with, at a minimum, the "Race & Ethnicity – CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS), Release 3.3.918 and use the Internet Engineering Task Force (IETF) Request for Comments (RFC) 564619 standard for preferred language

[25] Refer to 2015 Final Rule on Certified EHR Technology, pages 56-57 for recommended SO/GI "best practice" questions, and pages 495-497 for SO/GI SNODMED and HL7 codes sets.

3. Project 1.3 Ambulatory Care Redesign: Specialty Care

Required Project for DPHs

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.3 Ambulatory Care Redesign: Specialty Care
Rationale	

While a strong primary care service is an essential component of an effective health system, efficient linkage to specialty care, including mental health and substance use services, is also critical. The rapid increase in patients eligible for health care and other drivers necessitate system redesign that enables patients to access specialists in more efficient ways since the demand for such care is increasing while the supply is static. Increased "supply" is achievable through expansion of the specialty care team, improved efficiency in the provision of care (both in person and virtual), improved coordination and collaboration with referring providers, and enhanced engagement of patients and families.

Timely access to specialty care continues to be a challenge for patients of DPHs, the largest provider of specialty care in California's safety net, and DMPHs.[26] Delays can lead to adverse medical outcomes,[27] increased ED utilization,[28] and higher health care costs.[29] Many patients experience fragmented care, with multiple care plans and little communication between providers. To improve timely access to specialty care, DPHs/DMPHs are redesigning processes that link patients and providers to specialists, particularly by leveraging new technology for remote communication.

Participating PRIME entities transformation into patient-centered medical homes involves improving the collaborative partnership between specialists and the primary care team. The proposed PRIME project provides a structure and goals to guide this transformation. Primary care providers and specialists develop a co-management plan, which clearly defines their roles and responsibilities in caring for a patient, and outlines the protocol for care coordination. Increasingly, this coordination involves the use of telehealth technology, such as electronic referrals and consults, and real time patient/provider virtual visits. Telehealth is a promising strategy for improving coordination between all parties. Electronic referrals and consultations allow bi-directional primary care-specialist communications, coordination and co-management to minimize the number of visits a patient will need and optimize required visits thus reducing historically long wait-times for new and follow-up appointments[30]. In addition to increasing coordination, technology can also improve the quality of care.

Redesigning specialty care will involve more than new technology — it will require a shift in the relationship between primary care providers (PCPs) and specialists. Under the patient-centered medical home model, PCPs and specialists work together as part of a single care team, organized around the needs of the patient. The project involves enhancing the engagement of patients and families, expanding the roles of non-providers on the specialty care team, leveraging technology to increase timely access to specialty care expertise, integrating specialists into the system care team through improved communication and coordination between providers, and implementing data systems and workflows to support more efficient care delivery.

Goals/Objectives

[26] Specialty Care in the Safety Net: Efforts to Expand Timely Access. California HealthCare Foundation and Kaiser Permanente Community Benefit Programs. May 2009.
[27] Prentice, J. C. and Pizer, S. D. (2007), Delayed Access to Health Care and Mortality. Health Services Research, 42: 644–662. doi: 10.1111/j.1475-6773.2006.00626.x
[28] AskCHIS, California Health Interview Survey, 2011-2012.
[29] Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options. The Commonwealth Fund. June 2013.
[30] Chen, A, Murphy, E.J., and Yee, H.F. (2013) eReferral — A New Model for Integrated Care. New England Journal of Medicine, N Engl J Med 2013; 368:2450-2453June 27, 2013DOI: 10.1056/NEJMp1215594

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.3 Ambulatory Care Redesign: Specialty Care

Patients will experience timely access to high quality, effective specialty care, including care for mental health and substance use services, designed to work collaboratively with patients and their PCPs, in achieving and maintaining optimum patient health, and avoiding unplanned interventions. Redesign of specialty care system processes will include improvements to be patient centric, expand the use of non-physician care team members, implement alternatives to face-to-face, patient-provider encounters, including the use of telehealth solutions, and engage in population health management strategies.

Specific objectives include:

- Partner with Patient Centered Medical Home (PCMH) to improve health outcomes in acute and chronic disease
  - Increase patient and provider access to specialty expertise– delivered in the most effective means to meet the need.
  - Provide resources to PCPs to increase their capacity to care for complex patients
- Decrease avoidable acute care utilization
- Improve Patient Experience
- Increase specialty care staff engagement
- Right size number of specialists for target population
- Reduce disparities in health and health care

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Develop a specialty care program that is broadly applied to the entire population of service.
2. Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the *current* and *ideal state* capacity to meet that need. Benchmark to other CA Public Health Care systems.
   a. For *ideal state* analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters. (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or Medication Assisted Treatment (MAT)).
3. Engage primary care providers and local public health departments in development and implementation of specialty care model
   a. Implement processes for primary care: specialty care co-management of patient care
   b. Establish processes to enable timely follow up for specialty expertise requests
   c. Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
4. Clinical teams engage in team- and evidence-based care
5. Increase staff engagement by:
   a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
   b. Providing ongoing staff training on care model
6. Develop and implement standardized workflows for diversified care delivery strategies (e.g. shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency
7. Adopt and follow treatment protocols mutually agreed upon across the delivery system
8. Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Timely, relevant and actionable data is used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous QI activities.

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.3 Ambulatory Care Redesign: Specialty Care

a. Implement EHR technology that meets meaningful use standards (MU)

9. Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit
10. Improve medication adherence
11. Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs
12. Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral)
13. Demonstrate engagement of patients in the design and implementation of the project
14. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
15. Test use of novel performance metrics for redesigned specialty care models

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Closing the referral loop: receipt of specialist report (CMS50v3)	N/A	CMS
DHCS All-Cause Readmissions	N/A	DHCS
Influenza Immunization	0041	NCQA
Post procedure ED visits	N/A	*San Francisco Health Network (SFHN)
Referral Reply Turnaround Rate	N/A	*Los Angeles County Department of Health Services (LAC DHS), SFHN
Specialty Care Touches: Specialty expertise requests managed via non-face to face specialty encounters	N/A	*LAC DHS, UC Davis
Tobacco Assessment and Counseling	0028	AMA-PCPI

4. Project 1.4 Patient Safety in the Ambulatory Setting

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.4 Patient Safety in the Ambulatory Setting

Rationale

Despite the fact that the vast majority of health care takes place in the ambulatory care setting, efforts to improve safety have mostly focused on the inpatient setting. The ambulatory environment is prone to problems and errors that include missed/delayed diagnoses, delay of proper treatment or preventive services, medication errors/adverse drug events, and ineffective communication and information flow. However, compared with the hospital environment, there has been considerably less research, metric development, and interventions implemented to address these identified patient safety concerns[31]. Because it is self-evident that outpatient patient safety issues can lead to preventable morbidity and mortality, improving quality in this domain remains a critical target even though some approaches will need to be developmental and innovative in the absence of consensus national measures and guidelines.

Participating PRIME entities will focus their improvement efforts on the most common tests ordered in the outpatient setting for which prompt follow-up is typically required of clinically significant and either critical or sub-critical abnormal results. The focus on annual monitoring of patients on persistent medications and abnormal but subcritical results is impactful because no standard or workflow governs management of such results, in contrast to critical-range abnormal results, and these tests are a known vulnerability.[32]

Goals/Objectives

To implement standardized monitoring, alert notification and response workflows to ensure the health and safety of individuals for whom diagnostic testing has been performed and for those on medications for chronic conditions.

Specific objectives include:

- Ensure that abnormal test results are conveyed to the ordering clinician and that appropriate follow-up is implemented.
- Ensure annual monitoring being done for patients on persistent medications

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
2. Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
3. Develop a standardized workflow so that:
    - Documentation in the medical record that the targeted test results were reviewed by the ordering clinician;

[31] Gandhi and Lee. (2010) Patient Safety Beyond the Hospital. *New England Journal of Medicine* 363:1000-1003

[32] Casalino, LP et al. "Frequency of failure to inform patients of clinically significant outpatient test results.", Arch Intern Med. 2009 Jun 22;169(12):1123-9. http://www.ncbi.nlm.nih.gov/pubmed/19546413, Accessed 11/16/2015.

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.4 Patient Safety in the Ambulatory Setting

- Use the American College of Radiology's Actionable Findings Workgroup[33] for guidance on mammography results notification.
  - Evidence that every abnormal result had appropriate and timely follow-up; and
  - Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.

4. In support of the standard protocols referenced in #2:
   - Create and disseminate guidelines for critical abnormal result levels
   - Creation of protocol for provider notification, then patient notification
   - Script notification to assure patient returns for follow up
   - Create follow-up protocols for difficult to reach patients
5. Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Abnormal Results Follow-Up	N/A	*Alameda Health System (AHS)
Annual Monitoring for Patients on Persistent Medications	2371	NCQA
INR Monitoring for Individuals on Warfarin	0555	CMS

[33] Actionable Findings and the Role of IT Support: Report of the ACR Actionable Reporting Work Group. Larson, Paul A. et al. Journal of the American College of Radiology , Volume 11 , Issue 6 , 552 – 558. ***http://www.jacr.org/article/S1546-1440(13)00840-5/fulltext#sec4.3***, Accessed 11/16/15.

5. Project 1.5 Million Hearts Initiative

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.5 Million Hearts® Initiative

Rationale

According to the California Department of Public Health, heart disease and stroke were the first and third leading causes of death among Californians, respectively, accounting for 24.6 percent and 5.8 percent of deaths in 2010.[34] Risk factors for heart disease, such as tobacco use and hypertension, need to be reduced in order to improve cardiovascular health. The California Health Interview Survey and Behavioral Risk Factor Surveillance System indicate that 20 percent of Medi-Cal members use tobacco, compared to the State average of 12 percent.[35,36] In addition, 37 percent of adult Medi-Cal members have been diagnosed with hypertension at some point in their lives.[37]

In 2011, the US Department of Health and Human Services launched the Million Hearts® initiative to prevent 1 million heart attacks and strokes by 2017 through public and private commitments to:

- Improve care for people who need treatment by encouraging health systems and health professionals to focus on the "ABCS"—Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation—which address the major risk factors for cardiovascular disease and can help to prevent heart attacks and stroke.
- Empower Americans to make healthy choices, such as preventing tobacco use and reducing sodium and trans fat consumption. These efforts can reduce the number of people who need medical treatment, including blood pressure or cholesterol medications, to prevent heart attacks and stroke.[38]

DHCS is participating in the Centers for Medicare and Medicaid Services' Prevention Learning Network to advance the Million Hearts® initiative in California. As a result, Medi-Cal Managed Care Plans are participating in QI learning collaboratives to improve hypertension control and reduce tobacco use prevalence. In addition, the Department is collaborating with the California Department of Public Health and Right Care Initiative to advance Million Hearts®. The Department also supports the efforts of the $10 million, 5-year Medi-Cal Incentives to Quit Smoking Project to significantly reduce tobacco use. These activities and partnerships make the designated public hospitals well positioned to meet the clinical goals of Million Hearts®.

Goals/Objectives (Project-specific prevention goals and expected project outcomes)

Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across multiple participating PRIME entities. Collaborate among participating PRIME entities on approaches to meet clinical targets that support the Million Hearts® initiative, starting with tobacco cessation, hypertension control, and appropriate low-dose aspirin use.

Specific objectives include:

- Identify cost effective, evidence-based approaches to:
  - Support the Million Hearts® initiative clinical targets, starting with tobacco cessation, hypertension control, and appropriate aspirin use
- Reduce disparities in receipt of targeted prevention services

[34] California Department of Public Health. Thirteen leading causes of death by race/ethnic group and sex, California, 2010. http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0508.pdf Web site. Published October 3, 2012.
[35] California Health Interview Survey, 2009.
[36] Behavioral Risk Factor Surveillance System, 2011.
[37] AskCHIS, California Health Interview Survey, 2011-2012.
[38] Million Hearts Initiative. http://millionhearts.hhs.gov/index.html

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.5 Million Hearts® Initiative

- Reduce variation and improve performance on Million Hearts® initiative goals across multiple DPHs/DMPHs

Core Components

Systems undertaking these projects may complete the following components:

- Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need. See figures 1 and 2 for related data among the Medi-Cal population.
- Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
- Improve access to quality care and decrease disparities in the delivery of preventive services.
- Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
- Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
- Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
- Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership
    - Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
- Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Controlling Blood Pressure	0018	NCQA
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0068	NCQA
PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	N/A	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

6. Project 1.6 Cancer Screening and Follow-up

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.6 Cancer Screening and Follow-up

Rationale (Evidence base and reasoning for project idea)

Cancer is the second leading cause of mortality in California, accounting for nearly 1 out of every 4 deaths. The risk of developing cancer varies considerably by race/ethnicity. For example, African American men have the highest overall cancer rate, followed by non-Hispanic white men. Among women, non-Hispanic white women are most likely to be diagnosed with cancer, but African American women are more likely to die of the disease. The reasons for racial/ethnic differences in cancer risk and developing cancer is likely the result of a complex combination of dietary, lifestyle, environmental, occupational, and genetic factors. Higher mortality rates among some populations are due in part to poverty, which may increase the risk of developing certain cancers and limit access to and utilization of preventive measures and screening.[39]

Regular screening tests offer the ability for secondary prevention by detecting cancer early, before symptoms appear. Screening tests that allow the early detection and removal of precancerous growth are known to reduce mortality of cancers of the cervix, colon, and rectum. Early diagnosis can also save lives by identifying cancers when they require less expensive treatment and have better outcomes. Five-year relative survival rates for common cancers, such as those of the breast, colon and rectum, and cervix, are 93 percent to 100 percent if they are discovered before having spread beyond the organ where the cancer began.[40]

Goals/Objectives

Implement collaboratively-identified, standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across multiple participating PRIME entities. Develop consensus across participating PRIME entities on approaches to a select group of cancer screening and follow-up services with high clinical impact, and variation in resource utilization and performance. Increase receipt of these services by participating PRIME entity patients while reducing associated participating PRIME entity variation in approach, performance and disparities of receipt of services across the population.

Specific objectives include:

- Identify cost-effective standard approaches to Breast, Cervical and Colorectal Cancer screening and completion of follow-up on abnormal screening tests
- Increase rates of screening and completion of follow-up across targeted prevention services
- Reduce disparities in receipt of targeted prevention services
- Reduce variation in performance of targeted prevention services across multiple participating PRIME entities

Core Components

Systems undertaking this project may complete the following components:

- Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to:
  - Standard approach to screening and follow-up within each DPH/DMPH
  - Screening:
    - Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool)

[39] American Cancer Society and the California Cancer Registry of the California Department of Public Health, California Cancer Facts & Figures, 2014. http://www.ccrcal.org/pdf/Reports/ACS_2014.pdf

[40] *Ibid*. p. 3

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.6 Cancer Screening and Follow-up

- Follow-up for abnormal screening exams:
  - Clinical risk-stratified screening process (e.g., family history, red flags)
  - Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam)
- Demonstrate patient engagement in the design and implementation of programs.
- Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
- Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
- Improve access to quality care and decrease disparities in the delivery of preventive services.
- Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
- Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
- Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
- Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
BIRADS to Biopsy	N/A	*Los Angeles County Department of Health Care Services, San Francisco Health Network
Breast Cancer Screening	2372	NCQA
Cervical Cancer Screening	0032	NCQA
Colorectal Cancer Screening	0034	NCQA
Receipt of appropriate follow-up for abnormal CRC screening[41]	N/A	*San Francisco Health Network

[41] Proposed measure is a variation on the San Francisco Health Plan's Performance Improvement Plan measure entitled "Population Management for Colorectal Cancer Screening" http://www.sfhp.org/files/providers/incentive_programs/2015_PIP_Guide_CPG.pdf, page 22; and the measure "Patients with positive FOBT who underwent an appropriate evaluation" as discussed in AHRQ Cancer Care Quality Measures: Diagnosis and Treatment of Colorectal Cancer, pages 31-32, E-5 Accessed 10/6/14

7. Project 1.7 Obesity Prevention and Healthier Foods Initiative

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.7 Obesity Prevention and Healthier Foods Initiative

Rationale

Approximately two-thirds of adults and one-third of children and adolescents are overweight or obese, and the prevalence is higher among low-income populations. Evidence suggests that as weight increases to reach the levels referred to as "overweight" and "obese," the risk of several serious conditions, such as heart disease and hypertension, also increases.[42] According to the US Preventive Services Task Force, all adults and children, ages 6 and older, should be screened for obesity and referred to behavioral interventions, as appropriate.[43] In the broader clinical environment, the Centers for Disease Control and Prevention and Harvard School of Public Health recommend increasing the availability and affordability of healthful food and beverages in hospitals and other public venues as one key strategy to prevent obesity in the United States.[44,45] Hundreds of hospitals have successfully implemented the Partnership for a Healthier America's Hospital Healthier Foods Initiative guidelines, including well-known teaching hospitals, such as the Cleveland Clinic Foundation and the Henry Ford Health System.

There is a wide variety of obesity prevention and management efforts occurring throughout the state of California. The California Department of Health Care Services partners with the California Department of Social Services to reduce overweight and obesity among Medi-Cal members. This project serves as a natural complement to obesity prevention and management activities happening throughout California.

Goals/Objectives

Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across participating PRIME entities. Collaborate among participating PRIME entities on approaches to meet obesity screening and referral to treatment targets, and the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Specific objectives include:

- Identify cost-effective, evidence-based approaches to:
  - Implement obesity screening and referral to treatment for pediatric and adult populations
- Reduce disparities in receipt of targeted prevention services
- Reduce variation and improve performance on obesity screening and referral to treatment across multiple participating PRIME entities
- Support the provision of healthful foods in clinical facilities by implementing the Partnership for a Healthier America's Hospital Healthier Food Initiative

Core Components

Systems undertaking these projects may complete the following components:

- Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
- Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.

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[42] U.S. Department of Health and Human Services, Overweight and Obesity Statistics. http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf Updated October, 2012. Accessed October 29, 2014.

[43] U.S. Preventive Services Task Force, A and B Recommendations. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

[44] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf Published July 24, 2009.

[45] Harvard School of Public Health, Obesity Prevention Source. http://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/food-environment/healthy-food-environment-recommendations-for-obesity-prevention-complete-list/

Project Domain	Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title	1.7 Obesity Prevention and Healthier Foods Initiative

- Improve access to quality care and decrease disparities in the delivery of preventive services.
- Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
- Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
- Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
- Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.
    - Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
- Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
- Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
BMI Screening and Follow-up	0421	CMS
Partnership for a Healthier America's Hospital Health Food Initiative external food service verification	N/A	DHCS
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	0024	NCQA

B. Domain 2: Targeted High-Risk or High-Cost Populations

Projects 2.1-2.3 Required for DPHs

The projects in this domain focus on specific populations that would benefit most significantly from care integration and coordination: individuals with chronic non-malignant pain and those with advanced. The projects on Improved Perinatal Care, Care Transitions: Integration of Post-Acute Care and Complex Care Management for High-Risk Medical Populations will be required of all participating DPH systems.

1. Project 2.1 Improvements in Perinatal Care

Required Project for DPHs

Project Domain	Domain 2: Targeted High Risk Or High Cost Populations
Project Title	2.1 Improvements in Perinatal Care
Rationale (Evidence base and reasoning behind project idea)	

Approximately 500,000 babies are born each year in California[46], and ensuring a healthy pregnancy, delivery, and beginning of life are crucial to fostering a healthy population. Unfortunately, rates of maternal mortality and severe maternal morbidity in both the United States and California doubled in the 10 years between 1999 and 2008 in California[47]. Medical procedures during childbirth have markedly increased, including primary and repeat cesareans, labor inductions and early elective deliveries often when they are not be medically indicated; practices that result in higher costs and higher rate of complications for both women and babies. Furthermore, there are notable racial differences for key pregnancy outcomes. California data indicate that non-Hispanic black women are more likely to have cesareans, and have 3-4 times higher rates of maternal death and morbidity. Overall, cesarean deliveries in California rose from 22 to 33 percent between 1998 and 2008, and now total more than 165,000 per year[48]. While the statewide cesarean delivery rate was 33 percent in 2012, there was exceptionally large variation among hospitals with some outlier hospitals had rates as high as 80.9 percent[49]. On the other hand, 36 percent of California hospitals were already meeting the national Healthy People 2020 target of 23.9 percent for low-risk first-birth hospitals. This finding indicates that significant reduction is not only possible but already achieved by one-third of our hospitals. Participating PRIME entities also have significant variation among all of these measures suggesting significant opportunities for improvement.

Several multi-disciplinary and multi-stakeholder statewide initiatives are currently in place to address perinatal care quality and safety. These programs have the goal to improve the health of women and children and to ensure these health services are delivered safely, efficiently, and equitably.

These statewide initiatives include:

- The California Maternal Quality Care Collaborative (CMQCC). CMQCC has engaged a wide range of stakeholders across the State to improve health outcomes of mothers and newborns through best practices. The CMQCC's California Maternal Data Center (CMDC) supports QI activities by generating perinatal performance metrics.

[46] State of California, Department of Finance, Demographic Research Unit. Historical and Projected State and County Births, 1970-2021, with Actual and Projected Fertility Rates by Mother's Age and Race/Ethnicity, 2000-2021, 2012. http://www.dof.ca.gov/research/demographic/reports/projections/births/.

[47] State of California, Department of Public Health, Maternal Child and Adolescent Health. Maternal Mortality Rates for U.S. and CA, 1999-2013. https://www.cdph.ca.gov/data/statistics/Documents/2013MaternalMortalityRates-CA%20and%20US.pdf

[48] Main, Elliott et al. Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality, 2011

[49] Personal Communication with Elliot Main. The California Maternal Data Center (CMDC) slide deck, California Maternal Quality Care Collaborative, July 24, 2013

Project Domain	Domain 2: Targeted High Risk Or High Cost Populations
Project Title	2.1 Improvements in Perinatal Care

- The Patient Safety First (PSF) initiative funded by Anthem Blue Cross has been working with over 100 California hospitals since 2009 in several patient safety areas, including obstetrics.
- The recent formation of the Hospital Quality Institute (HQI) by the California Hospital Association (CHA) is committed to improving maternity care.

The first three of these organizations are working closely together in a unified program to support hospital-based maternity QI to reduce maternal mortality, morbidity and unneeded obstetric procedures. These initiatives are now national in scope, all being part of the National Partnership for Maternal Safety supported by ACOG, AWHONN, AHA , TJC, CMS/CMMI, and many other women's health organizations.

Goals/Objectives

- Support breastfeeding initiation, continuation, and baby-friendly practices.
- Ensure and support best practices to prevent morbidity and mortality associated with obstetrical hemorrhage.
- Decrease statewide cesarean section rate, and decrease variability in cesarean section rates in hospitals throughout California.
- Improve maternal morbidity and mortality statewide.
- Ensure women receive comprehensive, evidenced-based, and timely prenatal and postpartum care.
- Postpartum care should effectively address and support breastfeeding initiation and continuation, contraception, and ensure follow-up and treatment of medical co-morbidities.

Core Components

Systems undertaking this project may complete the following components:

- DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
- Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
- Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
- Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Baby Friendly Hospital designation	N/A	Baby-Friendly USA
Exclusive Breast Milk Feeding (PC-05)	0480	JNC
OB Hemorrhage: Massive Transfusion	N/A	CMQCC
OB Hemorrhage: Total Products Transfused	N/A	CMQCC
PC-02 Cesarean Section	0471	JNC
Prenatal and Postpartum Care (PPC)	1517	NCQA
Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage	N/A	CMQCC
Unexpected Newborn Complications (UNC)	0716	CMQCC

2. Project 2.2 Care Transitions: Integration of Post-Acute Care

Required Project for DPHs

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.2 Care Transitions: Integration of Post-Acute Care

Rationale

The transition from inpatient to outpatient settings is a critical point in the care continuum, when providers can link patients to appropriate, ongoing care. All too often, patients are discharged from the hospital without an adequate transition plan and return within the month. According to the Center for Medicare and Medicaid Services, nearly one in five Medicare patients discharged from a hospital are readmitted within 30 days, at a cost of $26 billion each year in Medicare spending.[50] While some readmissions are appropriate, many are due to preventable events that could have been avoided.[51]

Across the country public hospitals readmissions rates rise above the national average.[52] This may be in part because public hospitals serve a large volume of patients with risk factors associated with increased 30-day readmissions, such as co-morbid conditions, low-income status, and mental illness.[53] Safety net patients being discharged from inpatient care may not have a stable environment to return to or lack access to reliable care. Given the complex needs of their patients, participating PRIME entities must continue to develop robust care transitions programs that equip patients with a clear discharge plan, empanel them in patient-centered medical homes in collaboration with health plans, and link them to behavioral health and community services. Continued investment in care transitions programs through the PRIME will allow participating PRIME entities to improve coordination between inpatient and outpatient settings and reduce avoidable readmissions across the state.

Goals/Objectives

To ensure the coordination and continuity of health care as high-risk patients, with chronic health conditions, behavioral health conditions and/or housing instability, move from the hospital to the ambulatory care setting. To improve patients' ability to care for themselves, effectively hand off health care responsibility to the appropriate ambulatory care provider, optimize patients' course of chronic illness and ultimately reduce avoidable acute utilization.

Specific objectives include:

- Improve communication and coordination between inpatient and outpatient care teams
- Increase patients capacity for self-management
- Improve patient experience
- Reduce avoidable acute care utilization
- Reduce disparities in health and health care

Core Components

Systems undertaking this project may complete the following components:

1. Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology[54].

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[50] Center for Medicare and Medicaid Services. Community Based Care Transitions Program. http://innovation.cms.gov/initiatives/CCTP/. Accessed Jan 28, 2015.

[51] S. Jencks, M. Williams, and E. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," New England Journal of Medicine, April 2009 360(14):1418–28.

[52] Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions. The Commonwealth Fund. December 2012.

[53] Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care. American Hospital Association. September 2011.

[54] E.g., CMS Discharge Planning Hospital Conditions of Participation, AHRQ Hospital Guide to Reducing Medicaid Readmissions, Coleman Care Transitions Intervention-CTI, Project BOOST, STAAR, Project RED

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.2 Care Transitions: Integration of Post-Acute Care

2. Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes /risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
3. Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
4. Develop standardized workflows for inpatient discharge care:
   a. Optimize hospital discharge planning and medication management for all hospitalized patients.
   b. Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
   c. Develop and use standardized process for transitioning patients to sub-acute and long term care facilities
   d. Provide tiered multi-disciplinary interventions according to level of risk
      i. Involve mental health, substance use, pharmacy and palliative care when possible
      ii. Involve trained, enhanced IHSS workers when possible
      iii. Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
5. Inpatient and Outpatient teams will collaboratively develop standardized transition workflows:
   a. Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation
   b. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
6. Develop standardized workflows for post-discharge (outpatient) care:
   a. Deliver timely access to primary and/or specialty care following a hospitalization
   b. Standardize post-hospital visits and include outpatient medication reconciliation.
7. Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing:
   a. Engagement of patients in the care planning process
   b. Pre-discharge patient and caregiver education and coaching
   c. Written transition care plan for patient and caregiver
   d. Timely communication and coordination with receiving practitioner
   e. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
8. Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported, identification of and follow-up engagement with PCP is established, covered services including DME will be readily available; and a payment strategy for the transition of care services is in place.
9. Demonstrate engagement of patients in the design and implementation of the project.
10. Increase multidisciplinary team engagement by:
    a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials
    b. Providing ongoing staff training on care model.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations	
Project Title	2.2 Care Transitions: Integration of Post-Acute Care	
11. Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.		
Required Project Metrics		
Measure name	NQF#	Measure Steward (*Innovative metrics)
DHCS All-Cause Readmissions	N/A	DHCS
H-CAHPS: Care Transition Metrics	0166	AHRQ
Medication Reconciliation: 30 days	0097	NCQA
Reconciled Medication List Received by Discharged Patients	0646	AMA-PCPI
Timely Transmission of Transition Record	0648	AMA-PCPI

3. Project 2.3 Complex Care Management for High Risk Medical Populations

Required Project for DPHs

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.3 Complex Care Management for High-Risk Medical Populations

Rationale

A disproportionate share of Medicaid spending in the United States is used to provide care for a relatively small number of patients, with 1% of beneficiaries accounting for the top quartile of total Medicaid expenditures.[55] Among high-cost beneficiaries, nearly two-thirds have co-morbid conditions and one third have co-occurring physical and mental health conditions.[56] These patients incur frequent emergency department (ED) visits and hospitalizations that might have been prevented with less expensive preventive and primary care.[57] Increasingly, payers and providers are investing in complex care management programs that target super-utilizers with coordinated outpatient care to keep them healthy and out of the hospital. Complex care management programs address patients' physical conditions as well as the co-occurring behavioral health and socioeconomic challenges that increase their likelihood of hospitalization. Successful complex care management programs can improve quality of life for complex patients while dramatically reducing costly ED and hospital stays.

A growing body of literature provides evidence for effective strategies in complex care management. Dr. Clemens Hong, a leader in complex care management research, identifies seven strategies that are commonly used in successful programs: adopt a patient-centered, customized approach to care; use qualitative and quantitative methods to identify high-utilizing patients; prioritize care coordination; build trust between patients and primary care providers; form care teams that meet the patient's needs; and use technology to enhance care management activities.[58] The proposed PRIME project incorporates these evidence-based best practices and provides a structure for participating PRIME entities to target super-utilizers in their systems. Participating PRIME entities will build on existing care management infrastructure to develop intensive, integrated programs for their most vulnerable patients, with the goal of improving lives and reducing excessive spending.

Goals/Objectives

To implement, and/or improve upon, a complex care management model for targeted high-risk patient populations, that facilitates the appropriate coordinated delivery of health care services, is better able to meet the patient's needs and preferences and results in improvement of the patients' health outcomes.

Specific objectives include:

- Improve patients' functional status
- Increase patients' capacity to self-manage their condition
- Improve medication management and reconciliation
- Improve health indicators for chronically ill patients including those with mental health and substance abuse disorders

[55] Mann C. Medicaid and CHIP: On the Road to Reform. Presentation to the Alliance for Health Reform/Kaiser Family Foundation. March 2011. Based on FY 2008 MSIS claims data.

[56] Where the Money Goes: Understanding Medi-Cal's High-Cost Beneficiaries. The California HealthCare Foundation. 2010http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/W/PDF%20WhereTheMoneyGoesMediCalHighCostSnapshot.pdf, Accessed 1/29/30.

[57] Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality. Center for Medicare and Medicaid Services Informational Bulletin. July 2013.

[58] C. S. Hong, A. L. Siegel, and T. G. Ferris, ***Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?*** The Commonwealth Fund, August 2014.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.3 Complex Care Management for High-Risk Medical Populations

- Reduce avoidable acute care utilization (readmissions, admissions & ED visits)
- Improve patient experience

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
2. Utilize at least one nationally recognized complex care management program methodology.[59]
3. Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
4. Conduct a qualitative assessment of high-risk, high-utilizing patients.
5. Establish data analytics systems using clinical (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
6. Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
7. Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
8. Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening/etc.) as well as to ensure appropriate management of chronic diseases:
   a. Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources[60])
   b. Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
9. Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
10. Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
11. Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)

[59] see The Commonwealth Fund, California Quality Collaborative, Camden Coalition, IHI and The Center for Health Care Strategies Super Utilizer Summit and Policy Brief

[60] e.g., PHQ-9, HARMS-8, Patient Activation Measure, AHRQ Whole Person Care Assessment Tool

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations	
Project Title	2.3 Complex Care Management for High-Risk Medical Populations	
Care Coordinator Assignment	N/A	*University of Washington/Coordinated Care Initiative
Medication Reconciliation – 30 days	0097	NCQA
Prevention Quality Overall Composite PQI #90	N/A	AHRQ
Timely Transmission of Transition Record	0648	AMA-PCPI

4. Project 2.4 Integrated Health Home for Foster Children

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.4 Integrated Health Home for Foster Children

Rationale

Many of the 55,000 foster children in California are at risk of caretaker, food, housing, and health provider insecurity, or some combination thereof.[61] These challenges lead to an increase in their medical, behavior and social needs. Over half of foster children demonstrate behavioral issues calling for mental health treatment, and 35% to 60% show signs of acute or chronic health condition.[62] Provisions at the federal level in the ACA adopted in California are recent efforts to support this vulnerable population.

To provide the best care to foster children, an integrated health home offers important stability, improved primary care outcomes and timely specialty care. Under the health home model, DPH/DMPH would serve as a central entity to facilitate connections between the patient and the medical, behavioral, social and legal entities operating in a foster child's life would increase case continuity and remove system inefficiencies**.**

An integrated health home, including medication management and integrated behavioral health, would also be a tool used to reduce the inappropriate use of psychotropic medications for foster children, which have been found to be prescribed without accompanying mental health treatment, in high doses, and to very young children**.**[63] Foster children are found to receive psychotropic medication in 16% to 23% of cases, compared to 5% to 6% of children on Medicaid.[64]

PRIME investments in an integrated health home of the foster child population would provide opportunities for early identification of risk factors, improved medication management and treatment plan continuity and engagement with caretakers that will best improve this population's quality of care.

Goals/Objectives

To implement integrated health homes for children in the Department of Children Youth and Families foster system. Provide foster children with a "one-stop-shop" for fully integrated health services including physical and behavioral health, as well as needed substance abuse and social services. Improve the overall quality of care for foster children within the development and implementation of a patient centered medical home.

Specific objectives include:

- Improve care coordination for foster youth and their families
- Improve patient adherence to their treatment regimen
- Improved communication and documentation of communication and coordination with child welfare services
- Reduce avoidable acute care utilization (ER, admissions)

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[61] California Child Welfare Indicators Project. http://cssr.berkeley.edu/ucb_childwelfare/

[62] Stoltzfus E, Baumrucker E, Fernandes-Alcanra A, Ferdandez B. (2014). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues (CRS Report No. R42378). Retrieved from Congressional Research Service website: http://www.fas.org/sgp/crs/misc/R42378.pdf

[63] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.

[64] Ibid.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.4 Integrated Health Home for Foster Children

- Improve patient experience

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Develop or expand a multi-therapeutic support model whereby PCPs working in Public Healthcare Systems receive support in the ongoing management and treatment of foster children:
   a. Demonstrate engagement of patients and families in the design and implementation of this project.
2. Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).
3. Multi-therapeutic care team will:
   a. Identify patient risk factors using a combination of qualitative and quantitative information. Complete a patient needs assessment using a standardized questionnaire
   b. Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process.
   c. Implement multi-disciplinary case conferences/consults on patients with complex needs.
   d. Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs:
      i. Use of individual and group peer support.
   e. Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home.
   f. Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning.
   g. Assess and provide care for all routine pediatric issues with a specific focus on:
      i. Mental health/toxic stress
      ii. Obesity
      iii. Chronic disease management
      iv. Medication/care plan adherence which are vulnerable when kids transition care givers frequently
      v. Substance abuse issues
      vi. Developmental assessment, identification and treatment.
4. Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.
5. Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.
6. Develop liaisons/linkage with school systems.
7. Provide timely access to eligibility and enrollment services as part of the health home services.
8. Evidence-based practice guidelines will be implemented to address risk factor reduction. (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., Asthma, Diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
9. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement, that includes patients, front line staff, and senior leadership.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations	
Project Title	2.4 Integrated Health Home for Foster Children	
Required Project Metrics		
Measure name	NQF#	Measure Steward (*Innovative metrics)
Adolescent Well-Care Visit	N/A	NCQA
Developmental Screening in the First Three Years of Life	1448	NCQA
Documentation of Current Medications in the Medical Record (0-18 yo)	Variation on 0419	CMS
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling (13 yo and older)	Variation on 0028	AMA-PCPI
Well Child Visits - First 15 months of life	1392	NCQA
Well Child Visits - Third, Fourth, Fifth, and Sixth Years of life	1516	NCQA

5. Project 2.5 Transition to Integrated Care: Post Incarceration

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.5 Transition to Integrated Care: Post Incarceration

Rationale

Incarcerated populations have much higher prevalence of serious medical and behavioral health conditions than the non-incarcerated population. In light of the significant health needs of formerly incarcerated Californians, this project is designed to ensure a well-planned transition into the public health care system for former inmates. Release from incarceration represents a significant public health opportunity to continue treatment of critical conditions, increase engagement of former inmates and drive down avoidable health care costs.[65]

For the 130,000 individuals leaving a California prison each year, transitioning into society from incarceration presents an opportunity to promote health care enrollment, interaction with medical providers, and coordination of other social services. A community health worker-led care management program reduced ED utilization through increasing primary care engagement with individuals transitioning from prison.[66] The San Francisco-based Transitions Clinic, a community health center focused on transitional health care services, has shown increased patient engagement through medical care and coordinated support with services such as assistance with housing, jobs, legal aid, substance abuse counseling, health care system navigation, and chronic disease self-management support.[67]
By incorporating these evidence-based approaches, proposed PRIME initiatives would utilize community health workers and leverage partnerships with prisons, jails, social services and housing to create seamless transitions and improved care for these recently released populations.

Goals/Objectives

To improve the transition of care for the recently incarcerated, from the criminal justice system to the public health care system. Increase rates of enrollment into coverage, successfully establish care with, and coordination between, primary care, and appropriate behavioral health, substance use and social services, reduce avoidable acute care utilization, and improve the immediate and long-term health of the patients.

Specific objectives include:

- Increase enrollment into health coverage
- Improve establishment of, and engagement with, primary care, the local public health department, and coordination with behavioral health care and necessary social services
- Improve health indicators for patients with chronic condition(s)
- Decrease preventable acute care utilization
- Link patients to necessary social services for housing, employment and other services to reduce risk of recidivism

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.

[65] Gorenstein, D. "In prison you get health care. When you're released ... " 30 December 2013. *Marketplace.org* http://www.marketplace.org/topics/health-care/prison-you-get-health-care-when-youre-released
[66] Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. "Engaging individuals recently released from prison into primary care: a randomized trial." American Journal of Public Health. 2012 Sep;102(9):e22-9. Epub 2012 Jul 19.
[67] Wang A, Hong C, Samuels L, Shavit S, Sanders R, Kushel M. 2010. "Transitions Clinic: Creating a Community-Based Model of Health Care for Recently Released California Prisoners." Public Health Report. 2010 Mar-Apr; 125(2): 171–177.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.5 Transition to Integrated Care: Post Incarceration

2. Develop processes for seamless transfer of patient care upon release from correctional facilities, including:
   a. Identification of high-risk individuals (e.g, medical, behavioral health, recidivism risk) prior to time of release
   b. Ongoing coordination between health care and correctional entities (e.g, parole/probation departments)
   c. Linkage to primary care medical home at time of release
   d. Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care
   e. Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release
   f. Establishing a clear point of contact within the health system for prison discharges.
3. Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.
4. Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.
5. Identify specific patient risk factors which contribute to high medical utilization
   a. Develop risk factor-specific interventions to reduce avoidable acute care utilization.
6. Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.
7. Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.
8. Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., Asthma, Cardiovascular Disease, COPD, Diabetes).
9. Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.
10. Engage health plan partners to pro-actively coordinate Long Term Care services prior to release for timely placement according to need.
11. Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.
12. Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.
13. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.
14. Improve staff engagement by:

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.5 Transition to Integrated Care: Post Incarceration

a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials
b. Providing ongoing staff training on care model
c. Involving staff in the design and implementation of this project.

15. Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
16. Participate in the testing of novel metrics for this population.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Controlling Blood Pressure	0018	NCQA
Prevention Quality Overall Composite #90	N/A	AHRQ
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

6. Project 2.6 Chronic Non-Malignant Pain Management

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.6 Chronic Non-Malignant Pain Management

Rationale

Thirty-four million Americans suffer from chronic non-malignant pain (CNMP), defined as pain lasting six months or more unrelated to cancer that does not respond to conventional medical treatment. The high prevalence of CNMP results in annual total costs of $85 to $90 billion in the United States, including medical costs and loss in productivity.[68] For patients, risks include pain from failure to get treatment, possible addiction to prescribed medication and a high risk of depression and/or suicide from untreated pain.

Over the last decade deaths involving opioid analgesics has more than tripled, with the majority of those deaths due to prescription drugs[69]. Opiates were the most commonly involved medication although often these were used in combination with other drugs. Drug-related deaths in the U.S. each year now exceed those due to motor vehicle accidents. However, it is equally clear that a significant number of individuals have severe, non-malignant, chronic pain that may even be disabling. Thus, there is a pressing need in the health care system to address the needs of these chronic pain patients using interventions recognize current or potential substance abuse disorders and can maximize benefit while minimizing risk and potential side effects.

Research on effective pain management supports a multi-modal approach, incorporating physical and occupational therapy and other complementary disciplines.[70] Participating PRIME entities can best provide high-quality care to these patients through the adoption of evidence-based protocols and guidelines employing non-pharmacologic treatment. Additionally, training on these new processes should be provided to educate and engage clinicians and non-clinical staff. The proposed PRIME project incorporates these modified protocols and guidelines as system re-design to better manage patients' pain.

Goals/Objectives

To improve primary care providers' and care teams' ability to identify, and manage chronic non-malignant pain using a function-based, multimodal approach, and to improve outcomes by distinguishing between, and implementing appropriate care plans, for patients who will benefit from opioids and patients who are likely to be harmed by them.

Specific objectives include:

- Improve the function and/or health related quality of life of patients age 18 years and older with chronic pain.
- Improve the assessment and reassessment of patients age 18 years and older with chronic pain diagnosis utilizing the biopsychosocial model.
- Improve the use of multi-modal pain management strategies, including but not limited to physical and occupational therapy, group or individual psychotherapy/counseling, and other complementary and alternative therapies for patients age 18 years and older with chronic pain.

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[68] Carter C, Goldfarb NI, Hartmann CW, Roumm AR, Vallow SM, Durkin M. Chronic pain management in managed care organizations: a national survey of medical directors. Pharmacol Ther. 2003;28(3):179–215.

[69] Margaret Warner, PhD, Holly Hedegaard, MD, MSPH, and Li-Hui Chen, MS, PhD, Trends in Drug-poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999–2012. NCHS Health E-Stat. Hyattsville, MD: National Center for Health Statistics, December 2014, p. 1.
http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning.htm

[70] Ibid.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.6 Chronic Non-Malignant Pain Management

- Develop safe and effective prescribing practices for providers caring for patients age 18 years and older with chronic pain.
- Improve the effective use of non-opioid medications in the management of patients age 18 years and older with chronic pain.
- Improve the rate of identification and treatment of prescription opioid use disorders in primary care patients age 18 and older with a diagnosis of chronic pain.
- Decrease the rate of opioid prescriptions for adults 18 years and older who have ongoing substance abuse and/or diagnoses that do not warrant opioids (e.g., fibromyalgia, neuropathy, headache, sore throat, uncomplicated neck and back pain, uncomplicated musculoskeletal pain, non-traumatic tooth pain).
- Decrease the rate of ED visits/acute care utilization related to opioid overdose of patients age 18 years and older with chronic pain.
- Increase access to naloxone for patients with chronic opioid prescriptions.

Core Components (key elements)

Participating PRIME entities undertaking this project may complete the following components:

1. Develop an enterprise-wide Chronic Non-Malignant Pain management strategy.
2. Demonstrate engagement of patients in the design and implementation of the project.
3. Implement or adapt a state or nationally recognized methodology[71] for the assessment and management of chronic pain.
4. Implement protocols for primary care management of patients with chronic pain including:
   a. A standard standardized Pain Care Agreement
   b. Standard work and policies to support safe prescribing practices
   c. Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols
   d. Guidelines regarding maximum acceptable dosing.
5. Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
6. Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
7. Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
8. Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
9. Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
10. Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.

[71] Institute for Clinical Systems Improvement, Medical Board of California September 2014 (DRAFT) Guidelines for Prescribing Controlled Substances for Pain, The American Pain Society, or The American Society of Anesthesiologists

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.6 Chronic Non-Malignant Pain Management

11. Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
12. Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
13. Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
14. Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
15. Identify standardized multidimensional pain assessment, functional assessment, psychological assessment[72], and opioid assessment tools[73] that meet the needs of the care clinicians and are appropriate for the patient populations.
16. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Assessment and Management of Chronic Pain: Patients with chronic pain prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen	N/A	AHRQ
Patients with chronic pain on long term opioid therapy checked in PDMPs	N/A	*AHRQ/SFHN, AHS, UCSD
Screening for Clinical Depression and follow-up	0418	CMS
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	N/A	*SFHN, AHS, UCSD

[72] Examples of pain assessment, functional assessment, and psychological assessment tools are, but are not limited to: Brief Pain Inventory (BPI), Physical Functional Ability Questionnaire (FAQ5), Oswestry Low Back Disability Index, PHQ-9, GAD 7

[73] Examples of opioid and substance abuse assessment tools are, but are not limited to:CAGE and CAGE-AID, Webster's Opioid Risk Tool (ORT), DIRE Tool, Screener and Opioid Assessment for Patients in Pain (SOAPP®), Current Opioid Misuse Measure (COMMTM), Prescription Drug Use Questionnaire (PDUQ), Screening Tool for Addiction Risk (STAR), Screening Instrument for Substance Abuse Potential (SISAP), Pain Medicine Questionnaire (PMQ), Audit-C, Screening, Brief Intervention, Referral to Treatment (SBIRT)

7. Project 2.7 Comprehensive Advanced Illness Planning and Care

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.7 Comprehensive Advanced Illness Planning and Care

Rationale

Palliative care and end of life planning have the potential to increase quality of life for those most in need of sensitive, cohesive care. Only 20 percent of potentially appropriate patients have access to community-based palliative care services, according to an estimate by the Berkeley Forum[74]. Crucial to improving quality of life for patients with chronic or terminal illnesses is ensuring smooth transitions of care, and excellent care in every setting, including hospitals, skilled nursing facilities, and home-based environments.

Several concurrent statewide end of life care programs and initiatives exist with the goal to increase quality of end of life care. PRIME hospitals should participate in these statewide initiatives as they address patient needs at the most sensitive time of life.

These statewide programs and initiatives include:

- Senate Bill 1004 (Hernandez): This legislation, enacted in September 2014 and effective January 1, 2015, directs DHCS to establish standards, impart quality metrics, and provide technical assistance to Medi-Cal managed care plans to ensure delivery of palliative care services, including hospice benefits.
- Health Homes for Complex Patients Initiative: This effort, in part, aims to identify patients in hospitals, long-term care facilities, or the community, who may benefit from and have a desire for palliative care services, and offer them comprehensive palliative care by people who are trained in this area.
- Statewide Physician Orders for Life-Sustaining Treatment (POLST) registry: The California Healthcare Foundation is coordinating an effort to establish a statewide POLST registry, and is currently planning a pilot project to test the registry. Several states have had initial success creating and maintaining a successful registry.
- Let's Get Healthy California (LGHC): There are several end of life care measures selected for LGHC, including: Terminal hospital stays that include intensive care unit days, percent of California hospitals providing in-patient palliative care, hospice enrollment rate, and advance care planning.

Goals/Objectives

To ensure access to comprehensive care in alignment with patient preferences in hospital and community settings for all patients facing advanced illness.

Specific objectives include:

- Increase timely access to ambulatory and inpatient palliative care services
- Introduction of Primary and/or Specialty Palliative Care services at time of diagnosis of advanced illness
- Relieve pain and other distressing symptoms
- Improve quality of life for both the patient and the family
- Improve concordance between patient/family preference and provision of care

[74] University of California, Berkeley, School of Public Health. (2014). Honoring Patient's Wishes: Expanding Palliative Care in California. http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForum_PalliativeBrief_nov18.pdf. Accessed July 2015.

Project Domain	Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title	2.7 Comprehensive Advanced Illness Planning and Care

- Reduce avoidable acute care utilization

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Establish or expand both ambulatory and inpatient palliative care programs that provide:
    a. Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery
    b. Support for the family
    c. Interdisciplinary teamwork
    d. Effective communication (culturally and linguistically appropriate)
    e. Effective coordination
    f. Attention to quality of life and reduction of symptom burden
    g. Engagement of patients and families in the design and implementation of the program.
2. Develop criteria for program inclusion based on quantitative and qualitative data:
    a. Establish data analytics systems to capture program inclusion criteria data elements.
3. Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including Advanced Care Planning, as well as supervision from specialty PC clinicians.
    a. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management
4. Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
5. Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
6. Improve completion of POLST with eligible patients and participate in the state-wide POLST registry.
7. Provide access to clinical psychologist on the Palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
8. Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
9. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
10. For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
11. Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
12. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Advance Care Plan	0326	NCQA

Measure name	NQF#	Measure Steward (*Innovative metrics)
Ambulatory Palliative Care Team Established	N/A	*University of California, San Francisco (UCSF)
MWM#8 - Treatment Preferences (Inpatient)	1641	UNC Chapel Hill
MWM#8 - Treatment Preferences (Outpatient)	N/A	*University of California, San Francisco (UCSF)
Palliative Care Service Offered at Time of Diagnosis of Advanced Illness	N/A	*University of California, San Francisco (UCSF)
Proportion Admitted to Hospice for Less than 3 Days	0216	ASCO

C. Domain 3: Resource Utilization Efficiency

Minimum of One Project Required for DPHs

Projects in Domain 3 will reduce unwarranted variation in the use of evidence-based, diagnostics and treatments (antibiotics, blood or blood products, and high cost imaging studies and pharmaceutical therapies) targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. Participating DPH systems must select at least one project in this domain.

1. Project 3.1 Antibiotic Stewardship

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.1 Antibiotic Stewardship
Rationale	
Proper use of antibiotics has become a pressing healthcare quality concern as antimicrobial resistance has been documented across several pathogens in increasing numbers throughout the United States. [75] Infections resistant to antibiotic treatment put patient health at risk and also add to healthcare costs through extended patient treatment. The CDC has identified antibiotic stewardship as a key strategy to combat pathogen resistance through incorporating best clinical practices based on antibiotic dosing, duration and route. For participating PRIME entities, a stewardship program can be implemented through policies and procedures, training, and a reporting system. In addition to reducing resistance, promoting antimicrobial stewardship has proven to lower costs, minimize medication-based adverse events and improve patient quality of care.[76] California continues to be the sole state with legislation passed targeting antimicrobial stewardship. Participating PRIME entities can participate in learning forums such as the Antimicrobial Stewardship Program Collaborative facilitated by the California Department of Public Health, to continue the cross-pollination of best practices.	
Goals/Objectives	
To improve the appropriate use of antimicrobials by reducing overall antibiotic use for non-bacterial diseases, and optimizing antibiotic use for bacterial infections, with a special emphasis on agents with broad spectrum activity, in order to improve patient outcomes and eliminate unnecessary patient care costs. Specific objectives include: • Reduce broad-spectrum antibiotic use • Decrease inappropriate use of antibiotics across hospital and health care system • Reduce hospital associated Clostridium difficile infections	
Core Components	
Systems undertaking this project may complete the following components:	

[75] Infection Control and Hospital Epidemiology, Vol. 33, No. 4, Special Topic Issue: Antimicrobial Stewardship (April 2012), pp. 322-327

[76] "Promoting Antimicrobial Stewardship in Human Medicine." Infectious Diseases Society of America : Antimicrobial Stewardship. Web. 23 Jan. 2015.

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.1 Antibiotic Stewardship

1. Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package"[77]
    a. Demonstrate engagement of patients in the design and implementation of the project.
2. Develop antimicrobial stewardship policies and procedures.
3. Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[78]
4. Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
5. Develop a method for informing clinicians about unnecessary combinations of antibiotics.
6. Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5 day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
7. Develop evidence-based CPOE algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
8. Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
9. Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as:
    a. Procalcitonin as an antibiotic decision aid
    b. Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections
    c. Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
10. Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.
11. Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for URIs.
12. Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
13. Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)

[77] The Change Package notes: "We do not recommend that any facility attempt to implement all of the interventions at once. There are a large number of interventions outlined in the Change Package, and attempting to implement too many at one time will likely create huge challenges. Rather, the Change Package is meant to serve as a menu of options from which facilities can select specific interventions to improve antibiotic use." (p. 1, Introduction).

[78] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes: http://www.cdph.ca.gov/programs/hai/Pages/AntimicrobialStewardshipProgramInitiative.aspx.

Project Domain	Domain 3: Resource Utilization Efficiency	
Project Title	3.1 Antibiotic Stewardship	
Avoidance of antibiotic treatment in adults with acute bronchitis	0058	NCQA
Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures	N/A	*UC Davis, UC Irvine, UC San Diego
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	2720	CDC
Prophylactic antibiotics discontinued at time of surgical closure	N/A	CMS
Reduction in Hospital Acquired Clostridium Difficile Infections	N/A	NHSN

2. Project 3.2 Resource Stewardship: High-Cost Imaging

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.2 Resource Stewardship: High-Cost Imaging

Rationale

Over-ordering diagnostic tests increases healthcare costs, inefficiency for patients, and produces no valuable clinical information. Imaging studies represent a very high percentage of these tests.[79] The Choosing Wisely initiative, a joint effort between the American Board of Internal Medicine Foundation and *Consumer Reports*, produced a series of evidence-based recommendations for certain tests identified as overused.

Participating PRIME entities will incorporate learnings from the Choosing Wisely program, as well as other resources like the American College of Radiology's Appropriateness Criteria, in creating their own imaging management program meant to combat imaging overuse and misuse. Elements of the program will include established standards of care, data capacity improvements and the incorporation of cost information into the decision making process.

Goals/Objectives

To implement evidence based and population resource stewardship approaches to the use of high-cost imaging services, in order to reduce inappropriate utilization of imaging, and increase the amount of cost-effective and evidence based imaging performed in the system of care.
"The right study for the right patient at the right time"

Specific objectives include:

- Reduce the number of unnecessary/inappropriate studies
- Improve the use of evidence-based, lower cost imaging modalities when imaging is warranted

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
2. Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:
   a. Frequency and cost of inappropriate/unnecessary imaging
      i. Appropriate Use: Beginning with state or nationally recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness
      ii. Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system
   b. Unwarranted practice variation within the participating DPHs/DMPHs
   c. Data completeness and ability to report the extent of a-c, building data capacity where needed
   d. Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
3. Establish standards of care regarding use of imaging, including:
   a. Costs are high and evidence for clinical effectiveness is highly variable or low.
   b. The imaging service is overused compared to evidence-based appropriateness criteria.

[79] Rao VM, Levin DC. The Overuse of Diagnostic Imaging and the Choosing Wisely Initiative. Annals of Internal Medicine. 2012;157:574-576.

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.2 Resource Stewardship: High-Cost Imaging

c. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.

4. Incorporate cost information into decision making processes:
   a. Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan.
   b. Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action
5. Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
6. Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Imaging for Routine Headaches (Choosing Wisely)	N/A	*Washington Health Alliance
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	0667	ACEP
Use of Imaging Studies for Low Back Pain	0052	NCQA
Use of Imaging Studies for Low Back Pain (red flags, no time limit)	N/A	*LAC Department of Health Services (variation on NQF 0052)

3. Project 3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals

Rationale

Expanded coverage under the Affordable Care Act has dramatically increased demand for prescription drugs in recent years. Nationwide, spending on prescription drugs reached $329.2 billion in 2013, up 3.2% from 2012.[80] The recent surge in high-cost specialty drugs – popularly debated with the release an effective hepatitis C treatment costing $84,000 -- is expected to further increase drug spending by 6.6% per year between 2015 and 2021.[81] In response to rapid spending increases, payers and providers are gaining interest in resource stewardship programs that can curb unnecessary costs. These programs employ evidence-based strategies, such as utilization management, drug formularies, and prior authorization protocols.

Under the proposed PRIME project, participating PRIME entities will develop robust resource stewardship programs. The project will establish multidisciplinary teams of experts with committed time to monitor and contain drug costs. By investing in resource stewardship, the project has the potential to yield significant savings, transforming participating PRIME entities into more efficient, cost-effective providers of care.

Goals/Objectives

To implement evidence-based and population resource stewardship approaches to the use of high-cost pharmaceuticals. To guide clinician use of targeted therapies involving high-cost medications, develop decision analyses that include the impact of such treatments on the participating PRIME entity population in terms of health outcomes and the efficient use of available resources. Increase the use of decision support mechanisms for provider ordering of high-cost pharmaceuticals.

Specific objectives include:

- Increase appropriate use of high-cost pharmaceutical therapies
- Decrease inappropriate use of high-cost pharmaceutical therapies
- Improve use of shared decision making with patients
- Drive down health-care costs through improved use of targeted medications and prescribing behaviors
- Optimize 340b if eligible

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Implement or expand a high-cost pharmaceuticals management program.
2. Implement a multidisciplinary pharmaceuticals stewardship team.
3. Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications.
   a. Using purchase price data, Identify the Top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes,

[80] National Conference of State Legislatures. Pharmaceuticals: Facts, Policies, and NCSL Resources. http://www.ncsl.org/research/health/pharmaceuticals-facts-policies-and-ncsl-resources.aspx. Accessed Jan 29, 2015.
[81] National Health Expenditure Projections: 2011-2021. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis

i. Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects)

4. Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations:
   a. Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
5. Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including:
   a. Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards
   b. Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible
   c. Promote standards for generic prescribing
   d. Promote standards for utilizing therapeutic interchange.
6. Improve the process for proper billing of medications, through clinician education and decision support processes.
7. Develop formulary alignment with local health plans.
8. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.
9. Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
10. Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards:
    a. Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
11. Maximize access to 340b pricing:
    a. Share templates for contracting with external pharmacies
    b. To improve program integrity, share tools for monitoring of 340b contract compliance.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Adherence to Medications	Variation on NQF 2467	*Alameda Health Systems (AHS)
Documentation of Current Medications in the Medical Record	0419	CMS
High-cost pharmaceuticals ordering protocols	N/A	*AHS

4. Project 3.4 Resource Stewardship: Blood Products

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.4 Resource Stewardship: Blood Products

Rationale

Blood transfusions are one of the most common procedures performed in hospitals in the United States, but are also associated with significant risk for the patients.[82] With over 15 million units of red blood cells transfused annually, quality organizations have focused on appropriate blood management as an area of massive opportunity to improve clinical outcomes through evidence-based standardization.

Through the implementation of a blood management program, participating PRIME entities will develop and streamline clinical processes, closely track clinical outcomes on dashboards and better manage blood products. Existing patient blood management methodologies, like those created by the Joint Commission, will be adopted locally, as will an interdisciplinary Transfusion Committee to drive change.

Goals/Objectives

To implement evidence-based approaches to the use of blood products. Increase use of decision support mechanisms for provider ordering of blood products to improve the safety and appropriateness of their use, with resultant improvements in health quality and resource utilization.

Specific objectives include:

- Promote reduced wastage of blood products that have been dispensed to the patient care area
- Promote reduced wastage of blood products that are in the hospital inventory but never get dispensed
- To identify, develop and promote the implementation of patient blood management (PBM) to improve appropriate use of blood and blood products by health providers.
- To improve clinical outcomes of transfusion and reduce adverse events from transfusion

Core Components

Participating PRIME entities undertaking this project may complete the following components:

1. Implement or expand a patient blood products management (PBM) program.
2. Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
3. Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission[83], AABB)
4. Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget. impact. Develop a data analytics process to track these and other program metrics.
5. Establish standards of care regarding use of blood products, including:
   a. Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.
6. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

[82] Blood transfusion. (n.d.). In Wikipedia. Retrieved January 28, 2015, from http://en.wikipedia.org/wiki/Blood_transfusion

[83] The Joint Commission. Implementation Guide for The Joint Commission Patient Blood Management Performance Measures 2011. http://www.jointcommission.org/assets/1/6/pbm_implementation_guide_20110624.pdf.

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	3.4 Resource Stewardship: Blood Products

7. Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
8. Participate in the testing of novel metrics for PBM programs

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients	N/A	AABB/TJC (approval pending)
ePBM-02 Pre-op Hemoglobin Level, Selected Elective Surgical Patients	N/A	AABB/TJC
ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients	N/A	AABB/TJC
ePBM-04 Initial Transfusion Threshold	N/A	AABB/TJC
ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	N/A	AABB/TJC

Attachment R
Alternative Payment Methodologies
Value Based Payment Models that Qualify as APMs Overview

In addition to the already defined value-based payment (VBP) models that qualify as Alternative Payment Models (APMs) under California's PRIME program, below are additional types of arrangements that would qualify. These APMs will be used to calculate the program's stated goals of assigned managed care plan (MCP) enrollees in Designated Public Hospital Systems (DPHs) to receive care under an APM (50% beginning in January 2018, 55% beginning in January 2019, and 60% beginning in January 2020). The APMs used in the PRIME Framework align closely with the Health Care Payment Learning and Action Network (HCP LAN) Framework. Payments must also be tied to quality performance, using one of the methods defined below. While the state expects many DPHs will leverage their existing capitated arrangements to pursue Level 4 APMs, any method listed below will qualify as an APM.

Relationship between Payment and Quality

Payments for all APMs are affected wholly or in part by quality performance against a benchmark (e.g. vs. prior performance, vs. peers, vs. national/regional/state standard). Quality performance impact could be in the form of:

- Bonus payments for meeting or exceeding quality benchmarks
- Withholds or clawbacks of FFS or capitated rates for failing to meet quality benchmarks
- A lower/higher percentage of shared savings/losses being paid for meeting/exceeding/failing to meet quality benchmarks
- No shared savings being paid for failing to meet quality benchmarks
- Quality pool payments for highest performing practices funded by a quality withhold

APM Descriptions

Introductory APMs (LAN Categories 2C and 2D)

Fee-for-service payments tied to quality performance: A purchasing strategy in which providers or provider organizations are financially rewarded or penalized for meeting certain pre-defined performance benchmarks for quality and/or cost.

This introductory level of APM will only be allowed for the first year of the APM requirement which is calendar year 2018.

APMs (LAN Category 3A)

Bundled payments with shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a pre-defined set of services. Under this strategy, providers continue to receive payments for the individual services included in the bundle based on the rates under the existing claims-based system. At the end of the predetermined time period, all of the paid claims for the set of services provided to an individual are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 20% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not

at risk for that amount. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Episode-based payments with shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a clinically defined episode of care. Under this strategy, providers continue to receive payments for the individual services included in the episode, based on the rates under the existing claims-based system. At the conclusion of the episode, all of the paid claims for the episode are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 20% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not at risk for that amount. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance. An example of an episode is the management of pregnancy, delivery, and post-partum care.

Shared savings tied to cost of care (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across a defined set of services delivered to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to a defined set of the services that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 20% of savings achieved. If actual spending exceeds the benchmark amount, participating providers will not be responsible for the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Total cost of care shared savings (upside only): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across all services provided to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to all of the services (total cost of care) that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 20% of savings achieved. If actual spending exceeds the benchmark amount, participating providers will not be responsible for the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Advanced APMs (LAN Category 3B)

Bundled payments with shared savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a pre-defined set of services. Under this strategy, providers continue to receive payments for the individual services included in the bundle, based on the

rates under the existing claims-based system. At the end of the predetermined time period, all of the paid claims for the defined bundle of services provided to an individual are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 30% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is financially responsible for up to 10% of the difference. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Episode-based payments with shared savings savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care for a clinically defined episode of care. Under this strategy, providers continue to receive payments for the individual services included in the episode, based on the rates under the existing claims-based system. At the conclusion of the episode, all of the paid claims for the episode are aggregated and compared to a predetermined cost benchmark. If the actual spending falls within an agreed upon range below the benchmark amount, the provider or provider organization receives a payment of at least 30% of the savings achieved. If actual spending exceeds the benchmark, the provider or provider organization is not at risk for that amount. If actual spending exceeds the benchmark, the provider or provider organization is financially responsible for up to 10% of the difference. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance. An example of an episode is the management of pregnancy, delivery, and post-partum care.

Shared savings/risk tied to cost of care (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across a defined set of services delivered to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to a defined set of the services that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 30% of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to 10% of the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Total cost of care shared savings/risk (upside/downside): A purchasing strategy that provides an incentive for providers or provider organizations to efficiently manage health care spending and coordinate care across all services provided to a defined population of patients by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between an expected cost benchmark and actual cost in a given measurement time period, for example. Shared savings programs can be based on a fee-for-service payment system. Shared savings are applied to all of the services (total cost of care) that are expected to be used by a patient population and vary based on provider performance. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least 30% of savings achieved. If actual spending exceeds the target amount, participating providers or

provider organizations will be responsible for up to 10% of the losses incurred. Providers and MCOs are free to negotiate a higher percentage threshold of savings for providers, if they so choose. Payment adjustments must be made based on measured quality performance.

Prospective payments (LAN Category 4A)

Bundled payments with full risk: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover a bundle of services for each enrollee assigned to them, rather than payment for individual services actually provided. The payment is delivered upfront, or prospective to the delivery of services, once a pre-defined trigger event occurs (a specific service(s) is provided). The payment is inclusive of a pre-defined set of services and represents the full payment that will be provided by the payer to the provider or provider organization). If actual spending exceeds the payment, the provider or provider organization is fully financially responsible for any portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance.

Episode-based payments with full risk: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover the expected costs of clinically defined episodes of care. The payment is delivered upfront, or prospective to the delivery of services, once a pre-defined trigger event occurs. Episodes may involve predefined range of provider types, different settings of care and is inclusive of predefined set of services and procedures over a defined time period. If actual spending exceeds the payment, the provider or provider organization is fully financially responsible for the portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance. An example is payment to obstetricians for ongoing management of pregnancy, delivery, and post-partum care.

Condition-specific capitated payments: A purchasing strategy in which providers or provider organizations receive an upfront payment designed to cover the expected costs for clinically defined health conditions. The payment is delivered upfront, or prospective to the delivery of services. Condition-specific capitated payments may involve predefined range of provider types, different settings of care and is inclusive of predefined set of services related to specified health conditions, over a defined time period. If actual spending exceeds the payment, the provider or provider organization is financially responsible for the portion of expenses not covered by the payment. If actual spending is less than the payment, the provider or provider organization retains the full portion of reimbursement not used to cover expenditures. Payment adjustments must be made based on measured quality performance. An example is payment to pediatricians for delivering services related to the care of asthmatic children.

Table 1: Proposed Medi-Cal VBP Requirements

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
APMs LAN Category 3A				
Bundled payments with shared savings (upside only)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
Episode-based payments with shared savings(upside only)	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Shared savings tied to cost of care (upside only)	• Population(s) included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
Total cost of care shared savings (upside only)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 20%, based on quality performance	N/A
APMs LAN Category 3B				
Bundled payments with shared savings (upside/downside)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Episode-based payments with shared savings (upside/downside)	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance
Shared savings tied to cost of care (upside/downside)	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance
Total cost of care shared savings (upside only)	• Population(s) included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5% of payment at risk for failure to meet quality performance benchmarks	At least 30%, based on quality performance	Up to 10%, based on quality performance

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Prospective Payments (LAN Category 4)				
Bundled payments with full risk	• Population(s) included • Services included • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%
Episode-based payments with full risk	• Population(s) included • Clinical definitions of episodes of care • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

VBP Model	Required Model Components	Payment at risk based on quality	Minimum Provider Savings Rate[1]	Minimum Provider Loss Rate[1]
Condition-specific capitated payments	• Population(s) included • Clinical definitions of covered conditions • Trigger event • Services included in the payment • Providers eligible to participate • Quality measures and performance benchmarks • Payment methodology • Link between quality and payment	5%	100%	100%

[1] Minimum Savings/Loss Rate establishes benchmark for % of savings/losses. If actual spending falls within an agreed upon range below the benchmark amount, participating providers can earn at least stated % of savings achieved. If actual spending exceeds the target amount, participating providers or provider organizations will be responsible for up to stated % of the losses incurred. These are the benchmarks for APM inclusion in meeting the targeted amounts.

Attachment S
Evaluation Design for the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program

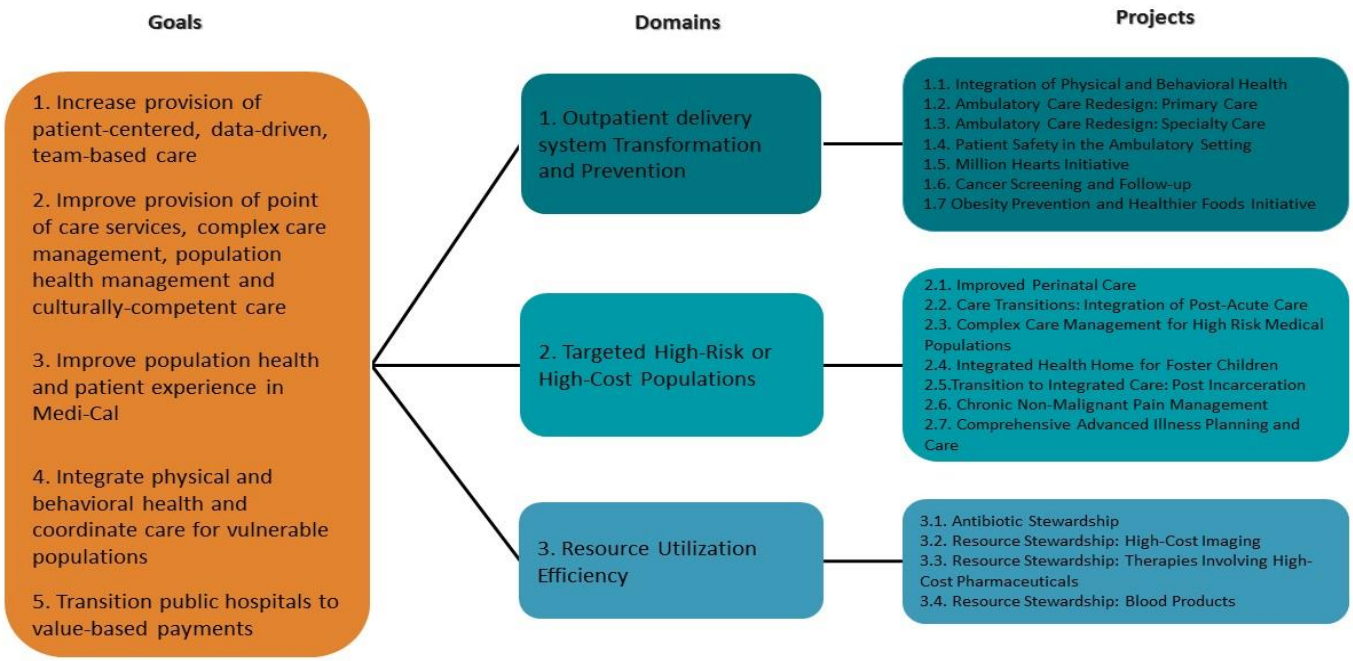
The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program is part of California's Medi-Cal 2020 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. PRIME aims to expand access and improve health outcomes in California's designated public hospitals (DPHs) and municipal public hospitals (DMPHs) (referred to as PRIME entities) while managing utilization and cost. PRIME is designed to establish or improve infrastructure to manage high-cost populations through a range of interventions, expand capacity through enhanced efficiency and reductions in unnecessary utilization, and build capabilities to support the transition to value-based purchasing. The California Department of Health Care Services (DHCS) will monitor performance, distribute PRIME funds, and provide support and technical assistance to PRIME entities.
Under the Special Terms and Conditions (STC) of this waiver, CMS requires an evaluation of the PRIME demonstration to determine whether this initiative has achieved the program's intended goals.

Overview of PRIME Demonstration

Building on the experience and outcomes of the Delivery System Reform Incentive Payment (DSRIP) program, PRIME provides approximately $3.7 billion in federal incentive payments to PRIME entities for demonstrating improved outcomes. PRIME goals and Projects that are designed to achieve these goals are displayed in Exhibit 1.

The protocol for PRIME Projects and metrics was developed and vetted through a consultative process involving clinical and quality experts, public hospital leadership, DHCS leadership, technical experts, and public stakeholders over the course of 18 months. Extensive documentation of rationale, goals and objectives, key activities that guide project development and implementation, and specific metrics (clinical event outcomes, potentially preventable events, and patient experience measures) are provided in Attachment Q.[i]

Exhibit 1. PRIME Program Goals and Projects



To receive payment, PRIME entities must comply with pay-for-reporting requirements and achieve specific targets for the pay-for-performance metrics associated with their Projects over the course of the demonstration. Details of funding mechanism and funding protocols are described in Attachment II.[1] Across the five-year program, DPHs collectively may qualify for up to $1.4 billion annually of combined state and federal funding, while DMPHs collectively may qualify for up to $200 million annually.

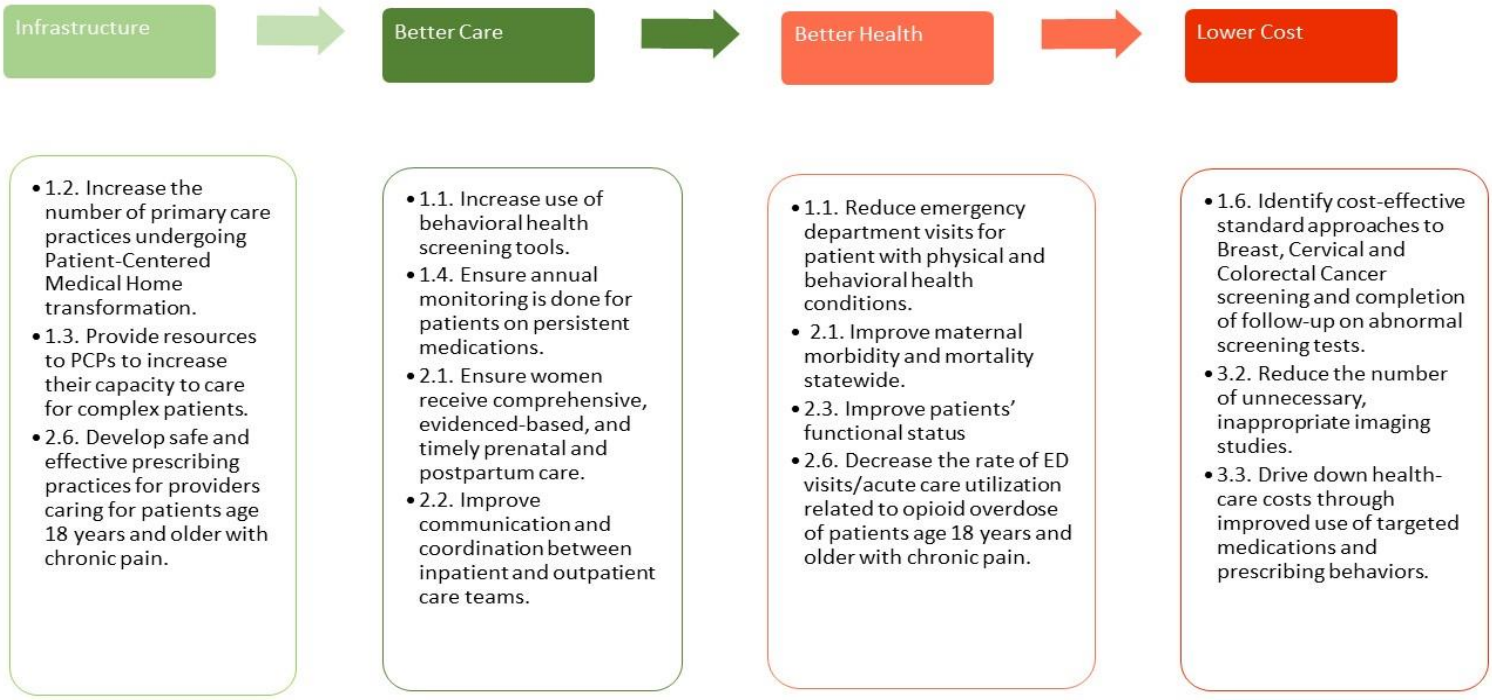
Participating DPHs were required to implement at least nine PRIME required and optional Projects from each Domain. DMPHs, in contrast, were required to implement at least one Project across three Domains: Outpatient Delivery System Transformation and Prevention; Targeted High-Risk or High-Cost Populations; and Resource Utilization Efficiency. PRIME entities submitted five-year plans to DHCS in April 2016. In June 2016, DHCS approved plans from 54 PRIME entities (17 DPHs and 37 DMPHs). Appendix A.1 provides the number of PRIME entities (both DPHs and DMPHs) that selected various Projects for the five-year demonstration. The first payments to PRIME entities were awarded based on the submission and approval of hospital five-year plans. Payments associated with performance began on September 2016 and are contingent upon meeting reporting requirements. The demonstration will run until June 30, 2020.

PRIME Evaluation Conceptual Framework

PRIME is designed to achieve the Triple Aim of better care, better health, and lower costs. The three PRIME Domains target specific aspects of care delivery within PRIME entities that are most likely to achieve the Triple Aim. Domain 1 Projects are designed to develop/enhance the infrastructure and change the process of care delivery overall as well as reduce the prevalence of specific chronic conditions. Domain 2 Projects are designed to target specific high-risk or high-cost populations that require change in care delivery that is focused on their needs. Domain 3 Projects are designed to target inappropriate use of

specific services. PRIME Projects generally include objectives that can be classified as process or outcome indicators. Process objectives indicate achievement of changes in processes demonstrating successful implementation of Project objectives. Outcome objectives demonstrate (1) improvements in patient health that have implications for efficiency and cost reduction and (2) improvements in efficiencies and cost reduction directly. The conceptual framework for PRIME evaluation is displayed in Exhibit 2 and includes examples of Project objectives and how achieving these objectives is likely to lead to the Triple Aim of better care, better health, and lower costs. For example, Project 1.1 in Domain 1 is designed to increase use of behavioral health screening tools (better care). Early identification and intervention of behavioral health problems is expected to reduce emergency department visits (better health). Reduction of emergency department visits is expected to reduce costs. Exhibit 2 also displays the expected impact of each objective under PRIME. The improvements in the Triple Aim will ultimately lead to PRIME entities that are efficient safety net providers that can operate under alternative payment methods such as those employed by managed care organizations. Improved efficiencies are essential in the ability of Medi-Cal to maintain high levels of eligibility and coverage given potential budget shortfalls.

Exhibit 2. PRIME Evaluation Conceptual Framework



Methods

Qualitative and Quantitative Data Collection

The data for PRIME evaluation will include qualitative and quantitative data. The qualitative data will include available data from DPH and DMPH annual reports, which include self-reported data on performance of PRIME required metrics, challenges faced and successful strategies employed in achievement of Project objectives. These data will be supplemented with detailed and structured surveys of DPHs and DMPHs and semi-structured interviews with key PRIME personnel of a representative sample of these hospitals. The structured surveys will gather further information on Projects implemented by each hospital, using the Consolidated Framework for Implementation Research (CFIR)[ii] domains as appropriate. DPHs and DMPHs had flexibility to choose different approaches to implement each Project leading to difficulty in attributing the outcomes achieved by each hospital to specific types of interventions. As such, this information will be most useful in interpreting the quantitative findings and how they were achieved. Additional data will be gathered on other concurrent projects with goals similar to PRIME Projects, key lessons learned, and sustainability of PRIME Projects.

DHCS will ensure that the evaluator has access to quantitative data sources including individual level data from confidential discharge data from the California Office of Statewide Health Planning and Development (OSHPD) and Medi-Cal fee-for-service (FFS) claims and managed care encounter data when available. The evaluator will be required to use two years of data prior to implementation of PRIME to control for baseline trends, and all the years available during PRIME implementation. Medi-Cal data will allow for assessment of the impact of PRIME on Medi-Cal enrollees' inpatient and outpatient service use and expenditures. OSHPD data will allow for assessment of impact of PRIME on all California inpatient discharges. The evaluator will use all available and appropriate data to conduct the evaluation and will

refine the evaluation hypotheses and research questions accordingly.

The quantitative data submitted by DPHs and DMPHs for use by the external evaluator will adhere to the PRIME Metric Specification Manual based on metrics outlined in Attachment Q. Following biannual data submission by each entity, DHCS conducts a comprehensive clinical review of the data to determine whether on-site audits or for-cause audits of specific entities are necessary.
Based on data that have undergone the above processes for assuring data quality, the evaluator will use an existing and validated methodology to identify the appropriate numerators and denominators for the quantitative outcomes used in PRIME evaluation. Many of the quantitative outcomes will be based on metrics endorsed by organizations such as National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA), and/or CMS, and have detailed measure specifications.

Additionally, DHCS requires all participating PRIME entities to adhere to a PRIME Data Integrity Policy. This policy outlines hospital responsibilities, standards and the State's expectations around collecting, validating, sharing and maintaining data. The Data Integrity Policy also outlines the reserved right for internal and external review and audits of data reported and its supporting documentation. Additionally, DHCS will ensure, to the extent possible, that the evaluator use the most reliable data source for each particular analysis including, but not limited to, Medi-Cal FFS claims data and managed care encounter data, mandated PRIME entity reported data, Medi-Cal-specific CMS core set metrics, EHR incentive program data, and OSHPD data. Under guidance from the DHCS Chief Medical Information Officer, Medi-Cal data routinely undergo data quality checks prior to mandated, regular data submissions to CMS.

Evaluation Questions and Related Hypothesis

Exhibit 3 shows the objectives of each PRIME Domain and Project to be used for the PRIME evaluation, how the objectives are hypothesized to achieve the desired outcomes, and the qualitative and quantitative research questions that will be used to test the proposed hypotheses.

Exhibit 4 includes the evaluation metrics per Project including those specified in Attachment Q[1] and additional metrics that could be used to assess the impact of specific Project or the overall impact of PRIME. For example, the Attachment Q metrics for Project 1.1 (integration of physical and behavioral health) include measures of screening for alcohol and drug misuse, care coordinator assignment, comprehensive diabetes care, depression remissions at 12 months, screening for clinical depression and follow-up, and tobacco assessment and counseling. Additional quantitative measures for assessing the impact of this Project are mental health and substance use service rates, emergency department visit and hospitalization rates with mental health and substance use diagnosis. A number of additional measures assessing the broad impact of PRIME are also included in Exhibit 4, such as rates of all-cause emergency department visits and hospitalizations overall and by race/ethnicity or preferred language.

This exhibit also includes the number of PRIME entities that are implementing a given Project as a proxy for the likely impact of the Project statewide and the likelihood of detecting an impact. In other words, projects that are implemented for many PRIME entities are likely to be analyzable given the larger sample sizes and their impact is more likely to be detectable. The likely source of data for each metric and whether it can be used to assess impact on costs is also indicated. For example, the evaluator will determine the success of PRIME entities in assessing alcohol and drug misuse under Project 1.1 from PRIME entity reports submitted to DHCS. The evaluator will use the qualitative data to assess the implementation

process of PRIME entities for this Project. The inclusion of additional metrics, testing of the proposed hypothesis, and answering the research questions are dependent on availability and quality of data. The evaluator will examine the data available in Medicaid Claims and OSHPD and determine if the numerator and denominators for each proposed measure can be constructed. The evaluator will report on data limitations in quarterly reports to DHCS and CMS. In the absence of data that allow the creation of a metric in the claims data, the evaluator will rely on self-reported metrics provided by PRIME Entities and will discuss data limitations in the interim and final reports.

The evaluation will include analyses of four other measures that are not expected to change as a result of PRIME, including severe sepsis mortality, central line blood stream infections, hospital acquired pressure ulcers, and venous thromboembolisms. These measures are selected because they are not targeted and are unlikely to be impacted by any of the PRIME projects. Furthermore, the evaluator has developed a detailed and valid methodology to assess these measures using OSHPD data.

Analyses Methods

The evaluator will use a quasi-experimental pre-post, intervention-comparison group analytic design and difference-in-difference (DD) methodology for analyses of quantitative data, when possible. This method is most likely possible for measures that are available in state-level Medi-Cal and OSHPD data. In the absence of these state-level data, the evaluator will employ the DD methodology to analyze entity-level data reported by PRIME entities in biannual reports to compare DPH and DMPH performance in Projects that were selected by both entities during PRIME. These analyses are useful when measures cannot be created in state-level administrative data and since state-level administrative data are not based on detailed information available in electronic health records and patient charts. Furthermore, to support entity-level data analyses methods, DPH and DMPH-reported metrics were designed and identified through a rigorous 18-month consultative process involving more than 100 clinical and quality experts, information technology and reporting experts, public hospital leaders, and statewide public stakeholders. The metrics were drawn, as much as possible, from nationally recognized measures that were carefully chosen and vetted by recognized, authoritative entities able to assess clinical relevance, feasibility and appropriateness of a metric. These vetting organizations are referred to as Measure Stewards and include NCQA, American Medical Association (AMA), and CMS. The PRIME Metric Specification Manual clearly defines each measure, spells out the denominator and numerator definitions, names the specification source, specifies the target population, lists the associated encounter codes, and provides explicit reporting instructions. For PRIME Projects where the current set of standard metrics does not adequately assess successful transformation innovative metrics have been identified (approximately 20% of all metrics). Innovative metrics are those that have not yet undergone a vetting and testing process by a Measure Steward. Innovative metrics will enable PRIME entities to demonstrate progress toward coordinated, team-based, patient-centered care, in a manner not afforded by many of the standard metrics.

The selection of comparison hospitals will follow a similar process as that employed in the DSRIP evaluation by UCLA. Comparison hospitals will be identified using hospital and patient characteristics available in OSHPD financial and patient discharge data. A mix of exact and distance matching methods will be used to identify hospitals that are most similar to the 17 DPHs and 37 DMPHs. Two-sided t-tests will be used to assess the differences in matching characteristics between PRIME entities and comparison hospitals. The DD analyses will be based on multivariate regression model to control for variations in patient demographic, case mix, and other relevant characteristics. Multi-level random effects models will be used to adjust for repeated measures and the nesting of patients within hospitals. Using regression

models, the evaluator will be able to compare the performance of PRIME entities with the most similar private hospitals, DPHs vs. DMPHs, participating vs. non-participating DPHs and DMPHs, and highest performing and lowest performing individual DPHs and DMPHs for quantitative measures.

The regression models will account for the multilevel nature of the data. The data will include all services used per patient over time. Thus, time is nested in individuals and individuals are nested in hospitals. The evaluator will use linear mixed model or generalized linear random effect models as appropriate for the outcome variables using three level models available in Stata 14. The random effect models allow for a clearer disentangling of program effect from individual effects and ranking of hospitals based on the outcome measures. The regression models will include the quantitative variables listed in Exhibit 4, time (pre and post), individual level controls (e.g., age, gender, race/ethnicity, comorbid conditions), and hospital level variables (e.g., number of beds, hospital type). These models will address the inter-correlation due to repeated measures overtime. The evaluator will also assess the utility of using interrupted time series models, which are a variation of the models described above. In these models, a binary indicator of time indicates PRIME implementation period versus baseline and the interaction term of the binary time variable with the continuous time variable to allow for the shift in trends between baseline and implementation periods. The evaluator will assess whether the impact of PRIME on race/ethnicity and preferred language required stratified models by assessing the adjusted rates (using the margins command in STATA) of outcomes such as ED visits by race/ethnicity or preferred language in a single model vs. stratified models by race/ethnicity or preferred language. The need for stratified models by DPH or DMPH indicators will be assessed.

Qualitative analyses methods will include thematic analyses of challenges and successful approaches to deal with challenges in PRIME entity annual reports. The approved Five-Year PRIME Plans, which include information from all PRIME entities around Project selection, system background, and planned improvements for meeting PRIME objectives will also be used to develop the context for PRIME implementation. The structured surveys with a key informant at all PRIME entities and semi-structured interviews with a representative sample of key informants will also be analyzed thematically to assess the variations in implementation process employed by PRIME entities. This information will be used to contextualize the quantitative findings and identify the potential sources of success or barriers to achieving targeted performance levels. These analyses allow for identifying more than a single successful approach to achieving improvements in specific Projects.

Qualitative analyses will also assess sustainability of PRIME Projects, by assessing the synergies between PRIME Project objectives with PRIME entities' strategic mission, incorporation of these Projects into the daily routine operations, non-PRIME concurrent activities and projects, and self-reported intentions to continue to gather Project metrics and use them in quality improvement activities after the conclusion of PRIME.

Using both qualitative and quantitative findings, the evaluation will address overarching questions such as aspects of PRIME Projects that could be implemented in other state Medicaid programs.

In addition to the above analyses, the evaluation will compare the self-reported metrics by PRIME entities and metrics calculated based on claims and encounter data with existing national benchmarks. National benchmarks are likely to be available for broadly used metrics such as those developed by NCQA, AHRQ, and CMS. The evaluator will identify such benchmarks, assess comparability with PRIME metrics, and compare PRIME metrics with these benchmarks in the evaluation.

Evaluation Limitations

Further analyses specific to national data will not be included in this evaluation due to limitations of poor comparability to participating PRIME entities and a significant time lag of available datasets.

In addition, the evaluation will not include analyses of EHR data from PRIME Entities for several reasons. PRIME entities have multiple electronic record systems with different features and capabilities, variations in data collection and storage methods, and different abilities to extract and submit files for external evaluation. In addition to level of effort required to obtain the data (developing and obtaining Data Use Agreements, assessing data limitations and usability, working with each organization to identify the correct information, assisting organizations with limited IT to extract data from their EHRs, setting up secure data transfer protocols, extensive discussion and repeated data extraction to address errors), the extent of the analyses possible with such data depend on the availability of data in an analyzable format. For example, different entities may store the same information in their EHRs in searchable fields, notes, or attached PDF files. These variations reduce the analyzability of the data.

Selection of Independent Evaluator, Evaluation Budget, and Timeline

The State will select an external evaluator that has the expertise, experience, and impartiality to conduct a sophisticated program evaluation that meets all requirements specified in the Terms and Conditions including specified intervention timeframes. Desired qualifications and experience include: multi-disciplinary, health services research training and experience; an understanding of and experience with the Medicaid and Medi-Cal programs; familiarity with California state programs and populations; and experience conducting complex, multi-faceted evaluations of large, multi-site health and/or social services programs. Potential evaluation entities will be assessed on their relevant work experience, staffing levels and expertise, data analytic capacity, proposed resource levels and availability, and the overall quality of their proposal.

In the process of identifying, selecting, and contracting with an independent evaluator, the State will take appropriate measures to prevent a conflict of interest. Specifically, individuals in PRIME entities providing clinical care or managing PRIME Projects will not be part of the external evaluation staff.

The total budget for the evaluation activities is estimated at a total of $2.2M. This estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, etc., as well as all costs related to quantitative and qualitative data collection and analysis, and report development. More detail and justification for proposed costs can be seen in the attached Exhibits A, A2, and B.

The State will select and enter into a contract with an independent entity to conduct the evaluation of the PRIME program to meet the timeframes and deliverables. Once approved, the evaluation design will become Attachment S to the Special Terms and Conditions.

The evaluator will receive the semi-annual data reports on metrics submitted by PRIME participants. These data reports are due after the mid-year report measurement periods (January to December each demonstration year) and after the final year-end report measurement periods (July to June of each demonstration year). The evaluator will conduct ongoing analyses of these data to inform both the interim

and summative evaluation reports.

An interim evaluation report including the same core elements as the final evaluation report will be prepared at the completion of DY14. The State will submit draft of this report to CMS by the end of the 1st quarter of DY15. The final interim evaluation report will be submitted within 60 days after receiving CMS' comments on the draft report.

A summative evaluation report that includes analysis of data from DY15 will be prepared by the evaluator. First, a preliminary summative evaluation report will be submitted to CMS within 180 days following the completion of the final demonstration year. This preliminary summative evaluation report will include documentation of outstanding assessments due to data lags. Then, within 360 days of the end of the demonstration, the State will submit the final summative evaluation report for CMS review. Finally, the State will respond to CMS' comments on the final summative evaluation report within 60 days.

The final summative evaluation report will include, at a minimum: an executive summary, a description of the demonstration's programmatic goals and strategies, a description of the study design, a discussion of the findings, conclusions, policy implications, and a discussion of this demonstration within an overall Medicaid context. Exhibit 5 shows the timeline for the major evaluation activities and deliverables.

Exhibit 5. PRIME Evaluation Timeline

	DY12 (2016 17)				DY13 (2017 18)				DY14 (2018 19)				DY15 (2019 20)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Evaluation Timeline																
Draft Evaluation design submitted to CMS	x															
Final Evaluation design submitted to CMS			x													
Contract with independent evaluator		x														
Semi-Annual Data Reports on Metrics from PRIME Entities																
DY11 final year-end report measurement period	x															
DY12 mid-year report measurement period			x													
DY12 final year-end report measurement period					x											
DY13 mid-year report measurement period							x									
DY13 final year-end report measurement period									x							
DY14 mid-year report measurement period											x					
DY14 final year-end report measurement period													x			
DY15 mid-year report measurement period																x
DY15 final year-end report measurement period																
Evaluation Data Collection and Reporting																
Quarterly reports from evaluator on evaluation activities for State reporting to CMS						x	x	x	x	x	x	x	x	x	x	x
Qualitative Data Collection							x x x									x x x
Quantitative Data Collection						x	x	x	x	x	x	x	x	x	x	x x x
Interim Evaluation Report with Same Core Elements as Final Evaluation													x			
Final Summative Evaluation Report to CMS																

References

Attachment T
2013 Managed Care
Expansion Monitoring
Elements

The following health plan measures will be used after implementation to ensure plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Office of the Ombudsman Calls
Monthly Health Plan Call Center Reports – tracks the types of calls received from Medi-Cal beneficiaries and trends within each plan

Monthly Grievance Reports – tracks what kind of grievances were submitted by Medi-Cal members, how the plan resolved them, and in what timeframe.
Quarterly Provider Network Reports – submitted to both DHCS and DMHC, lists all current providers and track additions and deletions from the last quarterly report.

Health Plans

DHCS currently has an established monitoring and reporting system for its health plans. These monitoring activities are completed regularly to ensure that plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law.

Health Plan Provider Assignments – plans will assign new enrollees within the contractual timeframes and allow member choice of Primary Care Providers.

Continuity of Care requests and outcomes – will be reported to DHCS on a monthly basis and will be used to monitor each plan's ability to continue to provide services without disruption of care.

Time and distance requirements for primary care providers (Geo Access) – used as a component of each plan's continued provider network adequacy review. Plans that show issues with meeting their time and distance standards for the transition must work closely with both the State to show provider access and/or alternative access as part of the monitoring

Health Plan Grievances/Appeals related to access to care – shall include grievances made to the State and shall be evaluated, including evaluating trends, s once the transition begins.

Office of the Ombudsman – health plan members that are experiencing difficulties are able to call the Ombudsman's office to report these issues, as well as receive help and guidance. DHCS tracks each call that comes in and is able to run reports on what issues are being reported and by which members of the Medi-Cal population.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
ENROLLMENT PROVISIONS: To be collected and reported for 6 months after transition				
Objective 1: Transitioning beneficiaries to Medi-Cal managed care will maintain access to health care coverage				
Enrollment status	Number/percent of beneficiaries enrolled in Medi-Cal Managed Care Identify choosers vs. those defaulted (non COHS only) Identify those who were defaulted who were linked (non COHS only)	Monthly[a]	MEDS data	Accurate count of the number of beneficiaries enrolled by health plan and county

MERs(non COHS only)	Number submitted Number approved/denied Number pending/ Number pending for greater than 60 days	Monthly[a]	DHCS tracking system	Number of MERs submitted will trend downward after the transition begins

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
ACCESS TO HEALTH CARE SERVICES: To be collected and reported for 6 months after transition				
Objective 2: Transitioning beneficiaries will maintain access to medical care through Medi-Cal managed care plans.				
Beneficiaries assigned to a primary care provider (PCP)	Number/percent of beneficiaries assigned to a PCP	Monthly[a]	Continuity of Care (COC) Report from Managed Care Health Plans	100 percent of beneficiaries are assigned to a PCP within 30 days of enrollment.
PCP changes by plan	Number of beneficiaries who change PCP within plan	Monthly[a]		Expect less than 10% after the first quarter of transition
Beneficiaries changing health plan, due to access to care or continuity of care concerns for counties that have two plans	Number/percent of beneficiaries enrolling in a different plan after month 1 and reason for change Compare beneficiaries who were auto-enrolled vs. those who their chose health plan, where applicable	Monthly[a]	Enrollment reports/MEDS data	No more than 10 percent of beneficiaries auto-assigned to a Medi-Cal health plan, change their current health plan due to access to care or continuity of care concerns.
Provider network changes	Additions/deletions of participating providers by plan	Quarterly[b]	Managed Care Health Plans submit quarterly reports	The overall provider network of the plan remains consistent with the network assessed during readiness.

Continuity of Care	Number of continuity of care requests and	Monthly[a]	Managed Care Health Plans	Plans will report all cases of transitioning beneficiaries receiving or requesting continuity

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
	outcomes for beneficiaries, by plan			of care.
Consumer satisfaction with health plan	Health Plan call center reports for beneficiaries by type of inquiry	Monthly[a]	Managed Care Health Plan Call Center reports submitted	The number of calls and types of calls related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition.
Grievance reporting	Grievance reports for beneficiaries, by type, resolution and timeframes to resolution	Monthly[a]	Managed Care Health Plans quarterly reports submitted	The number of grievances related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition. The plans are able to resolve grievances related to access under required timeframes.

	Office of Ombudsman calls from beneficiaries (including new enrollees), by type and by outcome	Monthly[a]	Call Center Reports	Tracking of calls with reports specific to identified issues and trends, by member category, health plan, and service area Calls related to the 2013 managed care transition will show minimal access to care issues.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
PROVIDER CREDENTIALING SCREENING: To be collected and reported for at least 6 months after each transition				
Objective 3: Plans shall follow administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse				
All cases of suspected fraud and/or abuse	Number of cases of suspected fraud and/or abuse, including 1) Source of complaint, 2) Type of provider, 3) Nature of complaint, 4) Approximate dollars involved, and 5) Legal and administrative disposition of the case.	Monthly[a]	Fraud and Abuse Reporting by Plans	All allegations of suspected fraud should be tracked and triaged by the state.

[a]Due 15 days from end of the calendar month. Upon completion of the transition and effective March 1, 2014, these items are due 20 days after the end of the reported calendar month.
[b]Due 21 days after close of the quarter

Attachment U
CCI Enrollment Timeline by Population and County

The following dates reflect the earliest date that Coordinated Care Initiative (CCI) enrollment may take effect in each CCI county. CMS and the state can mutually agree at any time to modify this timeline and structure as necessary.

In general, Cal MediConnect enrollment begins no earlier than April 2014 with passive enrollment in San Mateo; and "opt-in" in Riverside, San Bernardino, San Diego and Los Angeles counties. CCI will begin no earlier than April 2014 in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo and no earlier than January 2015 in Santa Clara counties. Orange County is on hold, until DHCS has completed an audit of CalOptima's Medicaid Plan Orange County. At that time, CMS and the state will update this attachment to establish an appropriate timeline for enrollment in Orange County. Alameda County is also on hold and CMS and the state will update this attachment in the future to establish an appropriate timeline for enrollment in Alameda County.

	Cal MediConnect (Passive enrollment)				**MLTSS (Mandatory enrollment)**								
	Full Duals Only				**Full Duals in Medi-Cal FFS**			**Full Duals in Medi-Cal Managed**			**MSSP**	**Partial Duals/ Medi-Cal**	
Start Date	Full Duals in Medicare FFS enrolled already in Medi-Cal Managed Care plan **(enrolled in one month)**	Full Duals in Medicare FFS and Medi-Cal FFS **(enrolled by birth month)**	MSSP Benes eligible for Cal Medi-Connect **(enrolled in one month)**	Full duals in a MA plan / Part D LIS **(enrolled in one month)**	Opt out of CMC and in Medi-Cal FFS **(enrolled by birth month)**	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal FFS **(enrolled by birth month)**	Full Duals in MA plans or LIS reasignees in Midi-Call FFS **(enrolled in one month)**	Full Duals in Medi-Cal managed care plan **(benefit added in one month)**[1]	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal Managed care **(benefit added in one month)**[1]	MA benes or LIS asignees in Medi-Cal managed care plan **(benefit added in one month)**[1]	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS **(enrolled in one month)**	Partial Dual/SPD already in Medi- Cal managed care **(benefi added in one month)**[1]	Partial Dual/SPD in Medi-Cal FFS **(enrolled by birth month)**
4/1/14	San Mateo		San Mateo					Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	San Mateo (Full Duals in MA plan or excluded CMC)		

5/1/14	Riverside, San Bernardino, and San Diego	Riverside, San Bernardino, and San Diego[2]			Riverside, San Bernardino, and San Diego								

Attachment U
CCI Enrollment Timeline by Population and County

	Cal MediConnect (Passive enrollment)				MLTSS (Mandatory enrollment)								
	Full Duals Only				Full Duals in Medi-Cal FFS			Full Duals in Medi-Cal Managed			MSSP	Partial Duals/ Medi-Cal	
Start Date	Full Duals in Medicare FFS enrolled already in Medi-Cal Managed Care plan **(enrolled in one month)**	Full Duals in Medicare FFS and Medi-Cal FFS **(enrolled by birth month)**	MSSP Benes eligible for Cal Medi-Connect **(enrolled in one month)**	Full duals in a MA plan / Part D LIS **(enrolled in one month)**	Opt out of CMC and in Medi-Cal FFS **(enrolled by birth month)**	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal FFS **(enrolled by birth month)**	Full Duals in MA plans or LIS reasignees in Midi-Call FFS **(enrolled in one month)**	Full Duals in Medi-Cal managed care plan **(benefit added in one month)**[1]	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal Managed care **(benefit added in one month)**[1]	MA benes or LIS asignees in Medi-Cal managed care plan **(benefit added in one month)**[1]	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS **(enrolled in one month)**	Partial Dual/SPD already in Medi- Cal managed care **(benefi added in one month)**[1]	Partial Dual/SPD in Medi-Cal FFS **(enrolled by birth month)**
7/1/14	Los Angeles	Los Angeles			Los Angeles			Santa Clara	Santa Clara	Santa Clara	San Mateo (Partials and Medi-Cal Only)	Los Angeles, Riverside, San Bernardino, San Diego,	
8/1/14			Los Angeles, Riverside, San Bernardino, & San Diego			Los Angeles, Riverside, San Bernardino, San Diego' and Santa Clara							Los Angeles, Riverside, San Bernardino, San Diego' and Santa Clara
1/1/15	Santa Clara	Santa Clara	and Santa Clara	, Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	Santa Clara		Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara						

1. Enrollees already in a Medi-Cal managed Care plan will receive one notice prior to the change in benefit.
2. There are no FFS Medi-Cal Enrollees in Orange and San Mateo counties.

3. Enrollees with April and May birthdays will be enrolled in May 2014. Then follow enrollment schedule by birth month.

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Enrollment Status	The plan selection and mandatory enrollment numbers and percentages for beneficiaries eligible for Managed Long Term Services and Supports (MLTSS) will be tracked in each MLTSS county.	Monthly	MEDS Data	100 percent of beneficiaries eligible for MLTSS will either make a plan selection, or be passively enrolled in each MLTSS county.
Plan Changes	The number of beneficiaries that changed health plans in Geographic Managed Care and wo-Plan model counties.	Monthly	MEDS Data	The number of plan changes by plan and county will be monitored. No more than 10% auto-assigned to a health plan will change plans due to access to care or continuity of care concerns.
Primary Care Provider Assignment	Number of MLTSS beneficiaries assigned to a Primary Care Provider.	Monthly	Monitoring Report from Health Plans	100% of Medi-Cal only and Partial Duals without Medicare Part B beneficiaries that are mandatorily enrolled or make a plan choice will be assigned a primary care provider within 30 days.

Attachment V
MLTSS Monitoring Items

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Criteria	Metric	Frequency	Data Source	Expected Outcome
Benefit Package	DHCS will ensure, through ongoing surveys and readiness and implementation monitoring, that Health Plans provide for enrollees long-term services and supports in care settings appropriate to their needs.	Quarterly	DHCS	The State will assure compliance with the characteristics of home and community based settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates published in the Federal Register.

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MLTSS Monitoring Items

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Criteria	Metric	Frequency	Data Source	Expected Outcome
Plan Readiness – Initial and Ongoing	The State shall submit to CMS its plan for ongoing monitoring of Health Plans.	Quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter	DHCS	Network adequacy will be verified on a quarterly basis for the first year. Plan readiness will be conducted in similar manner to HF and Geographic Expansion. Readiness assessments will be aligned with the Cal MediConnect reporting where possible. The State will complete a network certification for each county. The State will assess and monitor health plan capacity for the MLTSS population.

Participant Rights and Safeguards – Information – Network Adequacy Requirements	In addition to the network adequacy requirements set forth at 42 CFR 438, the state must: i. Require plan to refer everyone eligible for IHSS to the county social services agency and support member transition. ii. Require plan to refer all	This information is due to CMS prior to implementation and every 6 months afterward for the term of the demonstration.	DHCS	DHCS will ensure health plans maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support member transition. DHCS will ensure adequate MOUs are in place to ensure access to care between plan, county and MSSP Sites.

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome

	IHSS recipients to the Public Authorities network of IHSS workers/providers who will be providing services while the recipient waits for a county IHSS worker or the normal IHSS worker cannot provide services. iii. Have plans submit MOUs between the plan, the counties and MSSP Sites. v. Require plan to offer a care coordinator to everyone on a MSSP waitlist when the MLTSS member is waiting for a MSSP slot with a contracted MSSP Sitevi. Require plan to refer IHSS recipients who are awaiting a caregiver to other HCBS benefits (CBAS, MSSP) or work with community based organizations and resources to help bridge the gap to meet their needs. vii. Require state to identify all nursing facilities that house			DHCS will ensure health plans refer all persons eligible for the Multipurpose Senior Services Program (MSSP) to all contracted MSSP Sites. Ensure the availability of plan care coordinators for members waiting for Multipurpose Senior Services Program (MSSP) slot. Ensure health plans refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS, MSSP) to help meet / bridge their needs. Ensure health plans will work with community based organizations and resources to help IHSS recipients bridge the gap to meet their needs until they begin to receive IHSS. DHCS will monitor the nursing facilities that house MLTSS members and show the percent that have been contracted by each plan. Health plans will track and

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	MLTSS members. viii. Plans should demonstrate adequate capacity in their contracted nursing homes.			monitor all facilities that house MLTSS members including the number and percent of facilities contracted per plan to ensure adequate capacity in contracted nursing homes.

Quality Oversight and Monitoring – Measurement Activities	The state shall develop mandatory health plan reports related to the critical elements of MLTSS, including areas such as network adequacy; timeliness of assessments, MLTSS authorizations, service plans and service plan revisions; plan changes; utilization data; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; complaint and appeal actions. These reporting requirements must be specified in the health plan contract. DHCS must provide reports to CMS to demonstrate their	Annually	DHCS	DHCS will ensure ongoing monitoring of individual wellbeing and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts DHCS will analyze health plan reports as part of its quality oversight and based on the results, take corrective action as needed to ensure compliance. DHCS will obtain, monitor, evaluate, and make information on key experience and life indicator information including actions taken available to advisory groups for discussion, and publicly post results.

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome

	oversight of the key elements of the MLTSS program. The state shall measure key experience and quality of life indicators for MLTSS participants. The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g., phone or in-person as opposed to mail). Results of the surveys must be maintained by the state and report to CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results for the state. The state must analyze the results, make them available to its stakeholder advisory groups for discussion, publicly post the results on its website, and provide the results in print			DHCS will use performance measures Quality Strategy/reports to develop health plan report cards that are public, transparent, easily-understandable and useful to participants in choosing a health plan.

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	upon request for individuals without access to a computer.			
Complaints/Appeals	Number/percent of appeals or complaints	Monthly	Managed Care Health Plans	Complaints and grievances will be consistent with what was experienced by MLTSS members prior to transition. The plans must resolve grievances within required timeframes.
Provider Network Changes	Additions/deletions of participating providers by plan	Quarterly	Managed Care Health Plans submit quarterly reports to DHCS	The overall provider network of the plan will remain consistent with the network assessed during readiness.

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Continuity of Care	Number of Continuity of Care requests and outcomes for MLTSS members	Monthly	Managed Care Health Plans	Health plans will report all cases of transitioning MLTSS members receiving or requesting continuity of care.
Consumer Satisfaction with Health Plan	Health Plans Call Center Report for MLTSS members by type of inquiry	Quarterly	Managed Care Health Plans submit quarterly reports to DHCS	Health plans will ensure the number of complaints and types of complaints related to access to care and continuity of care with consideration to the transition taken into account. The expectation is that there will be a decrease each month following the transition.

Support and Retention of Community Placement	Members that are referred to the Home and Community-Based Services (HCBS) waivers are assessed for the HCBS waiver Members that are referred to IHSS are assessed by the county social services agency for IHSS	Quarterly	Health Plans	Health Plans will refer members to appropriate services that support retention of community placement. Health Plans will track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers

Attachment V
MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	Members newly admitted to nursing facilities without a discharge plan in place were first afforded supports and services in the community Number and proportion of beneficiaries who transitioned to the community from an institution and did not return to the institution, excluding post hospital rehabilitation, within a year. Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.			Health Plans will track and monitor the number of IHSS referrals made to the county social services agency and the number of completed assessments performed by the county social services agency. Health Plans will track and monitor the number of referrals made to HCBS programs for newly admitted NF residents without discharge plans in place. If the evaluation indicates an increase in NF placement rather than community replacement, the rates will be adjusted to create an incentive to keep beneficiaries in community placement.

Attachment W
Community-Based Adult Services (CBAS)
Provider Standards of Participation

A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

1. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
2. Adhere to these waiver Standards of Participation (SOPs);
3. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
4. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
5. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
6. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*****The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. Future reference in these SOPs will specify CDA.

B. CBAS Center Services

A CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of at least four hours of CBAS to each participant at the center.

1. Core services: each CBAS participant shall receive ALL of these services on each day of attendance at the center:
   a. Professional nursing.
   b. Therapeutic activities.
   c. Social services and/or personal care services.
   d. One meal offered per day.

2. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
   a. Physical therapy.
   b. Occupational therapy.
   c. Speech therapy.
   d. Mental health services
   e. Registered dietitian services.

3. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

C. Legal Authority and Requirements.

1. CBAS providers shall:
   a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s).
   b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; and as set forth in these SOPs.
   c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
   d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.

2. If there is a change in adopted laws or regulations governing the licensing of ADHC centers and/or the certification of CBAS providers, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

D. Physical Plant and Health and Safety Requirements.

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
   a. Comply with state and local building requirements and codes.

b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
c. Have a working, listed telephone number.
d. Have a working FAX number.
e. Have a working email address.
f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
g. Have a working heating and cooling system.
h. Have adequate lighting.
i. Have appropriate water supply and plumbing.

2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
   a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
   b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
   c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
   d. Appropriate office area(s).

3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.

4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.

5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.

6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.
2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months as specified in the STCs, and must continue to be supported by the participant's IPC.

3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.

2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.

3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.

4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.

5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA) from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.
   a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.

2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the

first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.

a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.

3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.

4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants
   a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
   b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).

5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.

6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times

   a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
   b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.

2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.

3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.

4. Financial and accounting records that fully disclose the disposition of all funds.

5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.

6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
   a. Discharge plan at time of disenrollment from the CBAS center:
      i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
   b. Incident reports:
      i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.

7. Written policies and procedures for center operations and the provision of services to CBAS participants.

8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
   a. Use of the local 911 system.
   b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
   c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.

9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.

10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).

11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).

12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs.

    Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.

    A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.

    b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).

13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
    a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).

    b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.

    c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

A primary goal underlying the ASAM Criteria is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions. The ASAM Criteria structures multidimensional assessment around six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.

The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

There are several ASAM training opportunities available for providers and counties. The ASAM eTraining series educates clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. One-on-one consultation is also available to review individual or group cases with the Chief Editor of the ASAM Criteria. Additionally, there is a two-day training which provides participants with opportunities for skill practice at every stage of the treatment process: assessment, engagement, treatment planning, continuing care and discharge or transfer. There are also a variety of webinars available.

At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care. A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the State, counties will facilitate ASAM provider trainings.

All residential providers must be designated to have met the ASAM requirements and receive a DHCS issued ASAM designation. DHCS will develop a designation program to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM Criteria. As part of this designation program, DHCS will develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1-3.5, develop standard program monitoring materials and protocols, and implement the ASAM designation program. After developing the protocol and monitoring tool, DHCS will designate all current residential providers which will require initial paperwork and a DHCS designation. DHCS will then fold the ASAM designation process into the initial licensing process so all new residential providers will have an ASAM designation.

Attachment Y
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Department of Health Care Services (DHCS) Appeals Process

1. Following a county's contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.
2. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet beneficiary need and the provider can demonstrate it is capable of providing high quality services under current rates, and:
    A. It can demonstrate arbitrary or inappropriate county fiscal limitations; or
    B. It can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.
3. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county's decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
4. A provider shall have 30 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.
5. The provider shall include the following documentation to DHCS for consideration of an appeal:
    a) County's solicitation document;
    b) County's response to the county's solicitation document;
    c) County's written decision not to contract
    d) Documentation submitted for purposes of the county protest;
    e) Decision from county protest; and
    f) Evidence supporting the basis of appeal.
6. The county shall have 10 working days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation: 1) the qualification and selection procedures set forth in its solicitation documents; 2) the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of beneficiaries served in the county, including any anticipated change in need and the rationale for the change; and 3) the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County's solicitation procedures. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.

7. Within 10 calendar days of receiving the county's written response to the provider's appeal, DHCS will set a date for the parties to discuss the respective positions set forth in the appeal documentation. A representative from DHCS with subject matter knowledge will be present to facilitate the discussion.
8. Following the facilitated discussion, DHCS will review the evidence provided and will make a determination.
9. Following DHCS' determination that the county must take further action pursuant to Paragraph 8 above, the county must submit a Corrective Action Plan (CAP) to DHCS within 30 days. The CAP must detail how and when the county will follow its solicitation procedure to remedy the issues identified by DHCS. DHCS may remove the county from participating in the Waiver if the CAP is not promptly implemented. If the county is removed from participating in the Waiver, the county will revert to providing State Plan approved services.
10. The decision issued by DHCS shall be final and not appealable.

Attachment Z
Drug Medi-Cal Organized Delivery System (DMC-ODS) County Implementation Plan

The county implementation plan will be used by the Department of Health Care Services (DHCS) and the Center for Medicaid and Medicare Services (CMS) to assess the county's readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The implementation plan will also demonstrate how the county will have the capacity, access and network adequacy required for DMC-ODS implementation. The questions contained in this plan draw upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS and CMS will review and render an approval or denial of the county's participation in the Waiver based upon the initial and follow-up information provided by the counties.

Table of Contents

Part I **Plan Questions**
This part is a series of questions regarding the county's DMC-ODS program.

Part II **Plan Description: Narrative Description of the County's Plan**
In this part, the county describes its DMC-ODS program based on guidelines provided by the Department of Health Care Services.

PART I
PLAN QUESTIONS

This part is a series of questions that summarize the county's DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.

   ☐County Behavioral Health Agency
   ☐County Substance Use Disorder Agency
   ☐Providers of drug/alcohol treatment services in the community
   ☐Representatives of drug/alcohol treatment associations in the community
   ☐Physical Health Care Providers
   ☐Medi-Cal Managed Care Plans
   ☐Federally Qualified Health Centers (FQHCs)
   ☐Clients/Client Advocate Groups
   ☐County Executive Office
   ☐County Public Health
   ☐County Social Services
   ☐Foster Care Agencies
   ☐Law Enforcement
   ☐Court
   ☐Probation Department
   ☐Education
   ☐Recovery support service providers (including recovery residences)
   ☐Health Information technology stakeholders
   ☐Other (specify) _____

2. How was community input collected?

   ☐Community meetings
   ☐County advisory groups
   ☐Focus groups
   ☐Other method(s) (explain briefly)

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

   ☐ Monthly
   ☐ Bi-monthly
   ☐ Quarterly
   ☐ Other: _____

   Review Note: One box must be checked.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

   ☐ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

   ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

   ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

   ☐ There were no regular meetings previously, but they will occur during implementation.

   ☐ There were no regular meetings previously, and none are anticipated.

5. What services will be available to DMC-ODS clients upon year one implementation under this county plan?

REQUIRED

☐Withdrawal Management (minimum one level)
☐Residential Services (minimum one level)
☐Intensive Outpatient
☐Outpatient
☐Opioid (Narcotic) Treatment Programs
☐Recovery Services
☐Case Management
☐Physician Consultation

How will these required services be provided?

☐All County operated
☐Some County and some contracted
☐All contracted.

OPTIONAL

☐ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☐ Recovery Residences
☐ Other (specify) _____

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?

☐ Yes (required)
☐ No. Plan to establish by:_____.

Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

   ☐ Yes (required)
   ☐ No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.

   ☐ Yes (required)
   ☐ No

9. Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:
   - Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment
   - Existence of a 24/7 telephone access line with prevalent non-English language(s)
   - Access to DMC-ODS services with translation services in the prevalent non-English language(s)
   - Number, percentage of denied and time period of authorization requests approved or denied

   ☐ Yes (required)
   ☐ No

PART II
PLAN DESCRIPTION (Narrative)

In this part of the plan, the county must describe DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS and CMS review the plan description, the county may need to make revisions. When making changes to the implementation plan, use track changes mode so reviewers can see what has been added or deleted.
- Counties must submit a revised implementation plan to DHCS when the county requests to add a new level of service.

Narrative Description

1. Collaborative Process. Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

Review Note: Stakeholder engagement is required in development of the implementation plan.

2. Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.

Review Note: A flow chart may be included.

3. Beneficiary Notification and Access Line. For the beneficiary toll free access number, what data will be collected (i.e.: measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Review Note: Please note that all written information must be available in the prevalent non-English languages identified by the state in a particular service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes for the Short Doyle 2 system.

5. Coordination with Mental Health. How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

6. Coordination with Physical Health. Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

7. Coordination Assistance. The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- Comprehensive substance use, physical, and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;

- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;

- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

8. Availability of Services. Pursuant to 42 CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:

- The anticipated number of Medi-Cal clients.
- The expected utilization of services by service type.
- The numbers and types of providers required to furnish the contracted Medi-Cal services.
- A demonstration of how the current network of providers compares to the expected utilization by service type.
- Hours of operation of providers.
- Language capability for the county threshold languages.
- Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
- The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities
- How will the county address service gaps, including access to MAT services?
- As an appendix document, please include a list of network providers indicating, if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (i.e., adolescent, adult, perinatal).

9. Access to Services. In accordance with 42 CFR 438.206, describe how the County will assure the following:

- Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.
- Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.
- Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- Establish mechanisms to ensure that network providers comply with the timely access requirements.

- Monitor network providers regularly to determine compliance with timely access requirements.
- Take corrective action if there is a failure to comply with timely access requirements.

Attachment Z
Drug Medi-Cal Organized Delivery System (DMC-ODS) County Implementation Plan

10. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Review Note: Include the frequency of training and whether it is required or optional.

11. Technical Assistance. What technical assistance will the county need from DHCS?

12. Quality Assurance. Describe the County's Quality Management and Quality Improvement programs. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

- Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences, including complaints, grievances and appeals
- Telephone access line and services in the prevalent non-English languages.

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a minimum, plans shall specify:

- How to submit a grievance, appeal, and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record Keeping
- Continuation of Benefits
- Requirements of state fair hearings.

13. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

14. Regional Model. If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

15. Memorandum of Understanding. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 "Care Coordination" of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

16. Telehealth Services. If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

17. Contracting. Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

18. Additional Medication Assisted Treatment (MAT). If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

19. Residential Authorization. Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

20. One Year Provisional Period. For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC-ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

_____	_____	_____
County Behavioral Health Director*	County	Date

(*for Los Angeles and Napa AOD Program Director)

Attachment AA
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol
(Updated October 26, 2017)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by fFederal law to be used for such purpose.

The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver to eligible Medi-Cal beneficiaries.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services.. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

These county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

As the State reviews proposed county interim rates, the additional information that is considered in the review includes data that illustrates the contract providers' projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process

and request additional justification and/or correction to the projections.

DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(g) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types.

There is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS.

For the purposes of determining DMC ODS county certified public expenditures under the 1115 waiver, each county as contractor with the State receives and aggregates the provider cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) providers (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.
2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. "DHCS" means the California Department of Health Care Services.

4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. "DMC" means Drug Medi-Cal.
6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).
7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).
9. "IOT" means intensive outpatient treatment.
10. "Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.
11. "NTP" or "OTP" means narcotic treatment program treatment.
12. "ODF" means outpatient drug free treatment.
13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.
14. "PH" means partial hospitalization.
15. "SUD" means substance use disorder.

SUMMARY OF STATE-DEVELOPED COST REPORT

<u>Modifications to the Current CMS Approved SUD Cost Report Forms</u>

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services,

and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs should submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)

This worksheet collects provider details, including entity name, address, other contact information, DMC number and National Provider Identifier (NPI). This worksheet is also where the provider representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)

This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)

This worksheet requires the provider to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the provider related to their SUD services and it must demonstrate the allocation methodologies used by the provider (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 – ODF; Tab 8 – PH; Tab 12 – IOT; Tab 16 – Residential; Tab 20 – NTP)

This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 – ODF; Tab 9 – PH; Tab 13 – IOT; Tab 17 – Residential; Tab 21 – NTP

This worksheet allows the provider to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 – ODF; Tab 10 – PH; Tab 14 – IOT; Tab 18 – Residential; Tab 22 – NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The provider will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 – ODF; Tab 11 – PH; Tab 15 – IOT; Tab 19 – Residential; Tab 23 – NTP)

This worksheet requires the provider to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates for the covered services. Annual interim rates for each covered service will be developed by the county and approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51, and all certified public expenditures will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Proposed rates must be developed for each required and (if indicated) optional service modality. The proposed rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and settlement.

The proposed county interim rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be

calculated for each service including both county directly delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers are considered to be actual expenditures according to the terms and conditions of the waiver. If the county elects to contract for covered services through a contracted managed care plan, the county will provide reimbursement for the services delivered by the managed care organization subject to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.

For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county-operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.

Interim payments for FFP will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFR 433.51, and all certified public expenditures continue to be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process

outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.

All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final reconciliation and settlement of the cost report within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State determines that the county received an underpayment, the State makes an additional payment to the county.

Attachment BB
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Tribal Delivery System

In order to participate in the DMC-ODS pilot, tribal providers must deliver care consistent with the American Society of Addiction Medicine (ASAM) Criteria, as well as be part of an organized delivery system (ODS) that coordinates care across the continuum specified by the ASAM criteria. Delivering care consistent with the ASAM Criteria is the applicable standard for provider participation in the DMC-ODS pilot. The state must comply with the statutory exemption from state or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act. After approval of this amendment, DHCS will consult with tribal 638 facilities, Urban Indian Health Programs, tribes and stakeholders to develop the specific process for these tribal and Indian health care providers to participate in Medi-Cal and in the DMC-ODS program. All providers participating in the DMC-ODS pilot must comply with quality reporting and monitoring activities.

Medications to assist with treatment for substance use disorder are available in the DMC-ODS Pilot and in California's larger Medi-Cal system. The reimbursements of these medications are detailed in the following table:

MAT Drug Reimbursement Through the DMC-ODS and Medical System

Medication	TAR* Required	Availability
Methadone	No	Only in NTP/OTP
Buprenorphine	Yes, unless provided in an NTP/OTP	Pharmacy Benefit, NTP/OTP
Naltrexone tablets	No	Pharmacy Benefit, ODF DMC Benefit
Naltrexone long-acting injection	Yes	Pharmacy Benefit, Physician Administered Drug
Disulfiram	No	Pharmacy Benefit, NTP/OTP
Acamprosate	Yes	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit; NTP/OTP

*TAR (Treatment Authorization Request)

There are different doors patients in need of Medication Assisted Treatment (MAT) enter the Medi-Cal system in California. Therefore, California makes the medications and the treatment services available in various settings. Depending on the setting the patient is initially diagnosed with a substance use disorder, the administering and dispensing of MAT will vary. If a patient comes through the county system or directly to a Narcotic Treatment Program (NTP), the program is responsible for the prescribing, ordering, and monitoring service. The NTP also dispenses and administrates the MAT and all of this is reimbursed with a bundled rate. If a client is diagnosed by their non-DMC primary care doctor, the prescribing, ordering, and monitoring of the medication occurs during the office visit. After the office visit, the patient will fill the prescription at a pharmacy. Pharmacies are then reimbursed for the medication and dispensing of the medication. In some cases, the physician may administer the drug in the office. This is termed a "physician administered drug" and the physician is reimbursed for the drug and the administration directly. Patients receiving DMC outpatient services may also be prescribed MAT through a physician working at the program. The patient would then fill the prescription at the pharmacy.

DHCS will report the relevant Medicaid Adult and Children's Quality Measures for individuals with SUD (located at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-core-set.pdf and http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf). These include the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004). To the extent possible, DHCS will also report the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) measure and the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures.

DHCS and UCLA propose to measure the following domains:

Access
Has access to treatment increased in counties that have opted in to the waiver? Analyses to be performed by county, race, ethnicity, and gender where possible.

- Availability and use of full required continuum of care (CalOMS-Tx)
- Use of medication assisted treatment (DMC Claims, Medi-Cal claims)
- Number of Admissions (DMC Claims, CalOMS-Tx)
- Numbers and trends by type of service (e.g. NTP) (CalOMS-Tx)
- Penetration rates –, analyzed also by primary drug (alcohol/drug) not by demographics
- Adequacy of network
    - First available appointment (UCLA will call and try to make appointments)
    - Average distance to provider (CalOMS, SMART6i)
    - Time from ASAM assessment to admission (county ASAM data, CalOMS)
    - Newly certified sites (SMART 6i)
    - Residential, detoxification capacity (DATAR)
    - Outpatient capacity (in development)
    - Retention in treatment
- Existence of a 24/ 7 functioning beneficiary access number
- Existence of a 24/7 functioning beneficiary access number in languages other than English
- Availability of services in language other than English
- Availability of provider directory to patients

Quality

Has quality of care improved in counties that have opted in to the waiver?

- Appropriate placement:
  - Percent of individuals receiving ASAM criteria-based assessment prior to an admission in level of care.
  - Comparison of ASAM indicated level of care and actual placement and reasons documented for the difference if they do not match.
  - Use of continuing ASAM assessments, appropriate movement
- Appropriate treatment consistent with level of care after placement:
  - ASAM Audits
  - % of referrals with successful treatment engagement (based on length of stay)
- Successful care transitions
- Successful discharge
  - Discharges against medical advice
- Will need to collect supplemental data from Chemical Dependency Recovery Hospitals and free standing psych, since they do not report to CalOMS-Tx (surveys or interviews, OSHPD data).
- Where possible, collect data from county EBP monitoring, assess adequacy of such monitoring
- Data indicator reports
- Follow-up patient surveys and interviews
  - Patient perceptions of care
- Provider surveys and interviews
  - Quality of care, perceptions of system (other providers), measures of patient centered care.
- Outcome Measures
  - CalOMS, Patient surveys
    - AOD use
    - Social support
    - Living arrangements
    - Employment
    - Quality of Life / Functioning
  - Grievance reports
  - Effectiveness of all levels of care
    - Readmissions to withdrawal management, residential and intensive outpatient treatment
  - Effectiveness of Residential treatment

- Change in health care costs for individuals who receive residential care (pre/post and vs comparable patients placed in other modalities)
    - Change in ED utilization and costs
    - Change in inpatient utilization and costs
    - Change in SUD treatment utilization and costs
    - Are there differences that result from the use of different treatment modalities in health outcomes and/or costs?
    - Are there differences that result from different residential lengths of stay in health outcomes and/or costs?

- Differences in health care costs among patients who receive SUD medications versus patients who do not receive SUD medications

Cost

- Is the waiver cost-effective? Total health costs pre/post waiver implementation among comparable patients

Integration and Coordination of Care

Is SUD treatment being coordinated as intended with primary care, mental health, and recovery support services?

- Existence of required MOUs with
    - bidirectional referral protocols between plans
    - availability of clinical consultation, including consultation on medications, the management of a beneficiary's care, including procedures for the exchanges of medical information and a process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved
- Assessment of coordination goals (provider & patient surveys/interviews)
    - Comprehensive substance use, physical, and mental health screening;
    - Beneficiary engagement and participation in an integrated care program as needed;
    - Shared development of care plans by the beneficiary, caregivers and all providers;
    - Care coordination and effective communication among providers;
    - Navigation support for patients and caregivers; and
    - Facilitation and tracking of referrals between systems.

- Quantify referrals to and from primary care and mental health

- Quantify referrals to and from recovery services paid for by the DMC-ODS

A. Public Health Care Systems (PHCS)

GPP Payments are available for PHCS, which are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C.
The GPP provides support for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS will provide an assurance that, to the extent the GPP exceeds the amount that is attributable to the state's Adjusted DSH (determined pursuant to STC 167), a percentage of GPP points earned by each PHCS will be associated with care and activities that are furnished through charity care and discount payment policies for financially qualified, uninsured individuals that adhere to California state law ability-to-pay requirements. The required percentage is equal to the amount of the GPP that is in excess of the Adjusted DSH divided by the total GPP for the year. For the first year of the GPP, each PHCS is required in the aggregate to satisfy the above assurance for at least 21.4% of GPP points earned.
Each PHCS shall identify to DHCS the affiliated and contracted providers that will constitute the PHCS, and shall notify DHCS of changes.

B. Determination of GPP Annual Limits

For each GPP PY, DHCS shall work with CMS to determine the annual limit for the GPP consistent with STC 167. The annual limit shall be calculated as the sum of the Adjusted DSH allotment and the Uncompensated Care Component. The Adjusted DSH allotment shall be determined consistent with the provisions of Attachment NN (DSH Coordination Methodology).

C. Establishment of Participating PHCS global budgets

DHCS will determine for each PHCS a global budget for each GPP PY, which is the total amount of funding each PHCS will earn if it meets or exceeds its applicable threshold. Threshold amounts for each PHCS for GPP PY1 are set forth in Attachment FF, section B. Threshold amounts for subsequent GPP PYs will be calculated through adjustments in proportion to changes in the size of the aggregate GPP annual limits, as set forth in Attachment FF, section B.

To determine a PHCS' global budget for a GPP year, DHCS shall calculate the PHCS' allocation percentage, which is the PHCS's point threshold for a GPP PY divided by the sum of all PHCS point thresholds for the same GPP PY. The PHCS's global budget shall equal the allocation percentage multiplied by the total computable annual limit for the GPP, as set forth in ¶ 167 of the Special Terms and Conditions ("Funding and Annual Limits").
DHCS shall determine an initial total computable annual limit for a GPP PY based on the initial CA DSH allotment published by CMS for the applicable GPP PY and any uncompensated care funding allocated under the Medi-Cal 2020 Waiver. DHCS shall determine initial threshold amounts and annual budgets for each PHCS based on this information and publish the information on its GPP webpage within 10 days of the determination. DHCS shall determine the final total computable annual limit for a GPP PY once the final CA DSH allotment is published by CMS and shall publish the final amounts, and associated PHCS threshold amounts and annual budgets within 10 days of such determination.

D. Reporting Requirements

By August 15th following each GPP PY, each PHCS shall submit an interim year-end summary report

summarizing the aggregate number of uninsured units of service provided during the GPP PY, broken out by the service categories, tiers, and types as defined in Attachment FF (Valuation Protocol). The summary report will also compute the number of points earned based on the corresponding point valuations for the services provided, and the payments due to the PHCS (net of any payments previously received for the GPP PY). Data contained in the interim year-end summary report will be based on the best data available through the close of the GPP PY. Revisions to the interim data will be reflected in the final reconciliation report.

By March 31st following the close of each GPP PY, each PHCS shall submit a final year-end reconciliation summary report in the same format as the interim year-end summary report referenced above that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Starting with GPP PY 2, each PHCS shall submit encounter-level data on their uninsured services in order to provide auditable verification that the reported uninsured services were provided. For this purpose, encounter-level data may include line-level encounters or documentation of claims or other reliable methods for determining the number of contracted units of service to the uninsured by contracted providers. Such reporting shall be provided at the time of the final reconciliation summary reports. All reports shall be submitted in a manner and format as set forth by DHCS. In addition, for all GPP PYs, PHCS shall maintain documentation of services and shall make such information available to DHCS or CMS upon request.

DHCS shall review all summary reports and data submitted for accuracy and compliance with established procedures, and perform tests for reasonableness. If discrepancies or inconsistencies are identified, DHCS shall work directly with PHCS staff to promptly resolve issues and correct data and reporting. PHCS shall provide a formal response to DHCS inquiries within five (5) business days of receipt of an inquiry or question; additional time to respond may be requested by the PHCS and approved by DHCS.

The interim year-end summary report and the final year-end reconciliation summary report shall be due at the times specified in Table 1 below. If the identified date falls on a weekend or holiday, the report shall be due at the close of the following business day.

Table 1: Reporting timeline

Report name	**Reporting period**	**Report due date to DHCS**		
Interim year-end summary report	July 1 – June 30	August 15 (following program year)		
Final year-end reconciliation summary report	July 1 – June 30	March 31 (following program year)		

E. Payment schedule.

Interim Payments

PHCS shall receive interim quarterly GPP payments based on 25% of their annual global budget for the first three quarters of the GPP PY. DHCS will notify PHCS of the IGT due dates and payment dates according to Table 2. Payments will be made within 15 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Table 2. For a PHCS that is comprised of more than one

DPH, payments will be made to the health system under which the DPHs operate.

For the fourth quarter of each GPP PY, an interim payment shall be made to each PHCS that is sufficient to bring the PHCS' interim payments for the GPP PY to the amount earned by the PHCS based on its interim year-end summary report. The total Interim payments earned by a PHCS shall be determined by multiplying the PHCS's annual global budget by the ratio of the value of the points earned during the GPP PY to the PHCS's threshold, as reported in the interim year-end summary report; however, no PHCS may earn more than its annual global budget prorated by the number of months in the reporting period. The fourth quarter interim payment shall be calculated based on the amount earned by the PHCS for the GPP PY, net of any GPP payments previously received by the PHCS for the GPP PY. If the PHCS' interim year-end summary report reflects an annual payment that is less than 75% of its total annual budget, no additional interim payment shall be made for the fourth quarter. DHCS shall calculate the amount of the required IGTs for the fourth quarter and make GPP IGT notifications to all PHCS no later than 30 calendar days after submission of the interim year-end summary report, as shown in Table 2. PHCS shall submit IGTs within 7 days of receiving notification. Interim payments will be made to all PHCS no later than one month following their respective IGT notification date, if IGTs are received within the required 7 days.

Final Reconciliation and Redistribution Process

There will be a final reconciliation annually following the submission of each PHCS' final reconciliation summary report and (beginning with GPP PY 2) the required supporting encounter data. DHCS shall determine the amount earned by each PHCS based on the total number of points earned by each PHCS for the GPP PY, as reported in the final year-end reconciliation summary reports. For PHCS that exceeded their threshold for the GPP PY, the amount earned is subject to adjustment in accordance with the following redistribution process set forth below.

DHCS will identify any GPP global budget amounts that PHCS were individually unable to claim and redistribute such unclaimed amounts to the PHCS that exceeded their point thresholds for the applicable GPP PY. To determine redistribution amounts, DHCS shall first calculate a dollar amount of funding per GPP point by dividing the total GPP annual limit for the GPP PY by the aggregate threshold points for all PHCS. DHCS will then multiply this dollar amount by the amount by which each PHCS has exceeded its threshold to determine the PHCS's maximum redistribution amount. Each PHCS that has exceeded its threshold will receive its maximum redistribution amount if there are sufficient unused funds for the year from other PHCS. If there are insufficient unused funds to pay all PHCS that exceeded their thresholds their maximum redistribution amount, then each PHCS will receive an adjusted redistribution amount, prorating the amount of unused funds available by the number of points each PHCS is above its applicable threshold. The redistributed amounts following this determination shall be added to the GPP amounts earned by the applicable PHCS for the purposes of the final reconciliation.

Based on the final reconciliation amounts determined as set forth above, DHCS shall adjust, as necessary, the interim payments previously made to the PHCS for the GPP PY. Within 90 calendar days of receiving the final reconciliation summary reports from the PHCS DHCS shall calculate the amount of the required IGTs for the reconciliation and make GPP IGT notifications to all PHCS, as shown in Table 2 above. PHCS shall submit IGTs within 14 days of receiving notification. Final payments will be made to all PHCS no later than 45 days following their respective IGT notification date, if PHCS have submitted the IGTs within the 14 day requirement. If the necessary IGTs are submitted past the 14 day requirement, final payments, as well as any other associated payments, will be made no later than 45 days following submission of the necessary IGT amounts. If, at the end of the reconciliation process, it is determined that the interim GPP funds for a GPP PY exceeded the amounts due upon final reconciliation, DHCS shall recoup the amounts from the appropriate PHCS. In the event of any recoupments, DHCS shall return the

associated IGT funds to the transferring entity within 14 calendar days.

Payment Summary Report to CMS

For each GPP PY, DHCS will submit a Payment Summary Report to CMS (following the schedule in Table 2) that summarizes all GPP transactions to date which pertain to that GPP PY and includes a list of entities that have provided IGTs during the report period and the amount of the IGTs provided. Transactions include interim payments, final payments, and recoupments. Each transaction record will include the name of the PHCS to which the transaction pertains, whether the transaction is an interim, reconciliation, or redistribution payment, the interim year-end Summary Report or Final Reconciliation Summary Report that supports the transaction, and the Quarterly Expenditure Report on which the transaction was or will be reported. The Payment Summary Report following the Final Reconciliation Summary Report will show how the sum of all transactions for each PHCS matches the PHCS final reconciliation amount.

Table 2: Interim and Final Payment timeline

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	25% of Annual	December 15	December 22	January 15	February 15
Interim Quarter 3	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 4	Final Interim based on interim year-end summary report	September 15 following the GPP PY end	September 22 following the GPP PY end	October 15 following GPP PY end	November 15 following GPP PY end
Final Reconciliation	Final reconciled amount	June 30 following the GPP PY end	July 14 after notification date	August 15 after notification date	September 15 after notification date

Attachment FF
Global Payment Program Valuation

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-4) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.

Categories 1 through 4 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically-mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services.

Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in-person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

Table 1: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis stabilization	T	250
	D	High-intensity outpatient services	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community-based face-to-face encounters	Home nursing visit	NT	75
			Paramedic treat and release	NT	75
			Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-provider care team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C		Telehealth (patient - provider) - Store & Forward	NT	50

		Store and forward telehealth	Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store & Forward	NT	65
	D	Real-time telehealth	Telephone consultation with PCP	NT	75
			Telehealth (patient - provider) - real time	NT	90
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services, low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient, high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community services	Trauma	T	863
			Transplant/burn	T	1,131

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as "traditional" services, will receive initial point valuations based on their cost per unit of service in the historical year SFY2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation, non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payors, and are often provided as substitutes for or complementary to traditional services. These services are assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.
The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care

team, which would both help address and treat the presenting condition, as well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration enhances the PCPs' capacity to provide high-quality, patient-centered care, and allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. This increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services will receive fewer points over time. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible.

Point revaluation will be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4. This phase-in is illustrated in Table 2.

Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

Table 2: Revaluations to categories of service, by year, compared to initial point value

Category of service	Initial point value (cost-based)	Point value (% change), GPP PY 1	Point value (% change), GPP PY 2	Point value (% change), GPP PY 3	Point value (% change), GPP PY 4	Point value (% change), GPP PY 5
OP ER	160	160 (0%)	158 (-1%)	156 (-2.5%)	152 (-5%)	152 (-5%)
Mental health ER / crisis stabilization	250	250 (0%)	248 (-1%)	244 (-2.5%)	238 (-5%)	238 (-5%)
IP med/surg	634	634 (0%)	630 (-0.6%)	624 (-1.5%)	615 (-3%)	615 (-3%)
IP mental health	341	341 (0%)	339 (-0.6%)	336 (-1.5%)	331 (-3%)	331 (-3%)

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

DHCS established GPP PY 1 point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.

For GPP PY 2 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 167, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

Table 3: GPP PY 1 PHCS Thresholds, Based on FY2014-15 Uninsured Services

Public Health Care System	System Threshold, GPP PY1
Los Angeles County Health System	101,573,445
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Natividad Medical Center	2,959,964
Riverside University Health System – Medical Center	8,066,127
San Francisco General Hospital	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Appendix 1
Table 4: Categories of Service and Point Values, Traditional

Category	Tier	Service Name	Cost/unit	Initial point value
1: Outpatient	B	OP Primary / Specialty (**benchmark, 100)**	587	**100**
	B	Dental	365	**62**
	B	MH Outpatient	225	**38**
	B	SU Outpatient	62	**11**
	B	SU Methadone	11	**2**
	B	Contracted Prim/Spec	110	**19**
	C	OP ER	942	**160**
	C	Contracted ER	411	**70**
	C	MH ER/Crisis Stabilization	1,470	**250**
	D	OP Surgery	4,554	**776**
4: Inpatient	A	SNF	829	**141**
	A	MH/SU Residential	138	**23**
	B	Med/surg	3,721	**634**
	B	MH Inpatient	2,000	**341**
	C	ICU/CCU	5,663	**964**
	D	Trauma	5,069	**863**
	D	Transplant/Burn	6,644	**1,131**

Table 5: Categories of Service and Point Values, Non-Traditional

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
Service Category 1: Outpatient				
A	RN Visit[84][85] (includes Wound Assessment visits)	**99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		50
A	PharmD Visit[86]	**99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided;		75
A	Complex Care Manager[87]	**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored.		75
Service Category 2: Complementary Patient Support and Care Services				
A	Wellness[88,89]	G0438 Annual wellness visit; includes a personalized prevention plan of service (PPPS),		15

[84] CMS Source: https://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215, Accessed 11/14/2015

[85] Understanding When to Use 99211, Family Practice Management, http://www.aafp.org/fpm/2004/0600/p32.html, Accessed 11/10/2015

[86] Pharmacist Services Technical Advisory Coalition, http://www.pstac.org/services/mtms-codes.html, accessed 11/15/2015

[87] CMS Medicare Learning Network, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf, Accessed 11/15/2015

[88] https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINATION_CODES.pdf

[89] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		initial visit G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit **S5190** Wellness assessment, performed by non-physician **Z00.00, Z00.01x`**		
A	Patient Support Group	**Non-physician Health Care Professional CPT Code** **98961** Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients **98962** Education And Training as above; 5-8 Patients		15
A	Community Health Worker (CHW)		Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs[90]	15
A	Health Education		Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change interventions.	25
A	Nutrition	**97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient		25

[90] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. http://www.bls.gov/soc/2010/soc211094.htm, Accessed 11/24/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	Education[91,92]			
A	Case management		Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[93] **Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[94]	25
A	Health coach		Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[95]	15
A	Panel management		Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment	15

[91] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=252&ncdver=1&NCAId=53&NcaName=Medical+Nutrition+Therapy+Benefit+for+Diabetes+%2526+ESRD&IsPopup=y&bc=AAAAAAAAIAAA&, Accessed 11/24/2015

[92] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries With Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A02115.pdf, Accessed 11/10/2015

[93] Case Management Society of America, http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx, Accessed 11/15/2015

[94] Oregon APM Patient Touches, direct communication with Oregon Health Authority

[95] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			options[96]	
A	Oral Hygiene Encounters		Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists	30
B	Group medical visits	**99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting **99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions)		50
B	Integrative medical therapies	**97810-97811:** Acupuncture, one or more needles, without electrical stimulation, personal one-on-one contact with the patient		50
B	Palliative Care	**0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.	Encounters with non-provider care team members that focus on preventing and relieving suffering, and improving the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning.	50
B	Pain management		Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders	50
C	Physician Home	**99341 - 99347** Home visit, new patient; **99347 - 99350** Home visit, established patient		125

[96] Oregon APM Patient Touches

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	Visits[97]			
C	Home nursing visits	**G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications.	75
C	Mobile Clinic Visits	**CPT Physician Code** **99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service **99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service **99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service Use POS code 15 with the above codes to signify a services provided in a mobile setting[98]		90
C	Paramedic treat and release		Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[99]	75
Service Category 3: Technology-Based Outpatient[100]				
A	Texting		Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must not originate from a related assessment and management service provided	1

[97] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31613_1/L31613_PHYS081_CBG_050111.pdf, Accessed 11/10/2015

[98] https://www.supercoder.com/my-ask-an-expert/topic/mobile-clinic

[99] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, http://www.naemsp.org/Documents/Position%20Papers/POSITION%20Determinationoftransport-Resource%20Doc-PEC_2011.pdf, Accessed 11/24/2015

[100] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. http://www.americantelemed.org/docs/default-source/policy/medicare-code-request-for-2015.pdf?sfvrsn=4, Accessed 10/28/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	
A	Video Observed Therapy		Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[101]	10
A	Nurse advice line[102,103]	**98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment		10
A	RN e-Visit[104]	**98969** Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network		10
B	Email consultation with PCP[105]	**99444** Online evaluation and management service provided by a physician or other qualified health care professional who may		30

[101] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. https://www.cdph.ca.gov/programs/tb/Documents/TBCB-SPM-Cert-Guidance-VOT-Policy-And-Procedures.doc, Accessed 11/24/15

[102] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[103] American Academy of Pediatrics, Charging for Nurse Telephone Triage. https://www.aap.org/en-us/professional-resources/practice-support/Telephone-Care/pages/Charging-for-Nurse-Telephone-Triage.aspx, Accessed 10/20/2015

[104] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

[105] *Ibid*

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network		
C	Telehealth (patient - provider) - Store & Forward[106,107]	Digital Retinal Screening **92250** (global) Fundus photography with interpretation and report		50
C	Telehealth – Store & Forward	+GQ modifier for distant site: **99241-99243** Office consultation, new or established patient **99251-99253** Initial inpatient consultation **99211-99214** Office or other outpatient visit **99231-99233** Subsequent hospital care OR **99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations	Store and Forward services that include images, such as Teleophthalmology and Teledermatology	65
C	Telehealth (provider - provider) – eConsult/ eReferral[108]	**99446-99449**, the new "Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations OR **99241-5** with GT modifier for distant site		50
D	Telephone consultation with PCP[109]	**CPT Physician Code** **99441** through 99443. Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options	75
D	Telehealth (patient -	**99201-99215** with modifier **GT**		90

[106] July 2015, Medi-Cal Ophthalmology Update. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ophthal_m01o03.doc, Accessed 10/15/2015

[107] communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs

[108] RTR- ECONSULT CPT CODES, UC Davis. https://static1.squarespace.com/static/52d9c6c5e4b021f2d93416db/t/534c2d9fe4b0d8fffdf288f5/1397501343957/CPT+Codes.pdf, plus communication 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.

[109] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	provider) - real time[110,111]	"Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems"		
D	Telehealth (provider - provider) - real time[112]		Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems	90
Service Category 4: Inpatient				
A	Sobering Center[113]		Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[114]	50
A	Recuperative/Respite Care[115]		Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy (e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[116]	85

[110] CMS Medicare Learning Network: Telehealth Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, Accessed 10/28/2015

[111] Medi-Cal Provider Manual: Telehealth, December 2013. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc, Accessed 10/28/2015

[112] *Ibid*

[113] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp, Accessed 11/25/2015

[114] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.

[115] National Health Care *for the* Homeless Council, definition of Recuperative Care https://www.nhchc.org/ accessed 11/24/2015

[116] Ibid 12/23/2015 communication with Dr. Hammer.

a. **Progress Reports**. Each WPC Pilot Lead Entity ("Lead Entity") shall submit mid-year and annual reports for the duration of the WPC Pilot according to the requirements in this Attachment. The State shall specify the manner and format in which WPC Pilots shall submit data for the mid-year and annual reports.

b. **Mid-Year Reports**. Lead Entities of WPC Pilots shall submit a mid-year report to the State.
    i. Reporting requirements shall be specified in guidance set forth by the State, and shall include:
        1. A minimum standard required data set for all WPC Pilots. The minimum required data shall include data points from the following categories at a minimum:
            a. Participant characteristics
            b. Number of participants
            c. Type and volume of medical and non-medical services utilized
            d. Type and volume of emergency department and inpatient services utilized
            e. Total amount of overall funds spent
        2. Additional data and information as specified in Attachment MM WPC Requirements and Metrics and the approved WPC Pilot application.
        3. Additional data and information to support measurement of the purpose of the WPC evaluation as set forth in STC 123 including:
            a. Improve coordination across participating entities including data and information sharing;
            b. Improve beneficiary health outcomes;
            c. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
            d. Increase access to social services;
            e. Improve care coordination across participating entities; and
            f. Improve housing stability, if applicable.
        4. A list of participating entity and/or stakeholder meetings, as applicable, held during the period, including agendas, and a narrative description of program activities during the period including identified barriers, challenges, and successes.
        5. Data and other documentation as described in the WPC Pilot application demonstrating progress in the approved activities.
        6. The data described in the approved WPC Pilot application demonstrating the progress toward WPC Pilot goals in relation to the infrastructure, services, and other strategies as described in the

approved WPC Pilot application and WPC Pilot Special Terms and Conditions.

ii. The mid-year report including data and information through June 30 shall be due to the State no later than 60 days after June 30 each year.

iii. For Program Year 1, no mid-year report shall be submitted.

iv. Upon submission of a complete (as determined by the State) mid-year report, the State will determine whether progress toward the WPC Pilot requirements approved in the WPC Application has been made. To the extent that progress has been made in a manner approved in the Application, notification of such and an interim payment in an amount proportional to the progress toward achievement of the WPC Pilot goals based on the approved annual total computable funding agreed to in the approved WPC Pilot application shall be paid to the WPC Pilot Lead Entity. If the state determines that less than 50% of the annual payment is due, the WPC Pilot will be given 14 days to respond and revise reports as appropriate. At the discretion of the State, a proportional amount of interim funding will be adjusted and paid.

v. Within 30 days of the determination of the interim payment due based on the mid-year report, the State will issue requests to the WPC Pilot for the necessary intergovernmental transfer amounts. The WPC Pilot entities will make intergovernmental transfer of funds to the State in the amount specified within 7 days of receiving the State's request. If the intergovernmental transfers are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

c. **Annual Reports**. On an annual basis, Lead Entities shall submit an annual report to the State for the purpose of demonstrating that the WPC Pilot is conducted in compliance with the requirements of the WPC Pilot as set forth in the STCs and attachments, the WPC Pilot approved application, any agreement between the State and the WPC Pilot Lead Entity, and/or policy letters and guidance set forth by the State. Lead Entities will submit their reports using the structured report template provided for this purpose by the State. The annual report will also be used to determine if the interventions were performed in the manner agreed upon in the WPC Pilot approved application and to report on the impact of the WPC Pilot interventions, as applicable and as described in the approved WPC Pilot application.

i. Annual reporting requirements shall be specified in guidance put forth for WPC Pilot applications by the State and shall include at a minimum:

1. The same data elements included in the minimum standard required data set from the mid-year report.
2. The same additional data elements set forth in Attachment MM WPC Reporting and Requirements and as agreed to in the approved WPC Pilot application.
3. A narrative describing the activities and interventions the WPC Pilot performed during the year for each component as described in the application including barriers, challenges, and successes.

4. A narrative of how the WPC Pilot is making progress toward accomplishing the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies)
5. Progress achieved in the activities and interventions in the approved WPC Pilot application.
6. For Program Year 1, the annual report shall consist of baseline data and information as set forth in this Attachment and Attachment MM, WPC Requirements and Metrics.

ii. The annual report shall be due no later than 60 calendar days after the end of the program year unless otherwise specified by the State.

iii. Upon submission of a complete (as determined by the State) annual report, the State will determine whether the WPC Pilot requirements approved in the WPC Application have been met. If the requirements for a deliverable have been fully met, the State will notify the WPC Pilot and provide funding in an amount equal to the amount agreed to in the WPC Pilot Application for that deliverable, less any amount already received from the mid-year report. If the required deliverables have been partially met, notification of such partial completion will be sent to the WPC Pilot entity, and the WPC Pilot entity will be given 14 days to respond and revise reports as appropriate. At the discretion of the State, an adjusted amount of proportional funding will be determined. The amount of such proportional payments shall reflect the activities or progress performed as documented in the annual report, less any amounts already received from the mid-year report.

iv. Within 30 days of the determination of the end of year payment due based on the annual report, the State will issue requests to the WPC Pilot for the necessary intergovernmental transfer amounts. The WPC Pilot entities will make intergovernmental transfer of funds to the State in the amount specified within 7 days of receiving the State's request. If the intergovernmental transfers are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

v. The State may impose sanctions, including the recoupment of funds from the WPC Pilot, should it be determined that the WPC Pilot is out of compliance with its requirements as set for in the STCs and attachments, the agreement between the WPC Pilot and the State, and/or policy letters or guidance set forth by the State. In addition to the requirements accompanying recoupment described above, any recoupment imposed as a sanction shall only occur after technical assistance has been provided by the State and failure to comply with corrective action occurs by the WPC site. Prior to initiating any recoupment of WPC Pilot funds, the State shall provide the Lead Entity notice and an opportunity to comment regarding the identified area of non-compliance and the expected amount of recoupment, as appropriate. In the event of such recoupments, the State must return the associated IGT funds to the transferring entities within 14 calendar days of funds being recouped.

vi. The State shall make the annual reports available to the public on its website.

II. WPC Evaluation

The state will identify an independent entity to conduct a mid-point and final evaluation. The independent entity shall work with the State to draft an evaluation proposal for approval by CMS. The draft will be shared with WPC Pilot sites and the public for comment. The mid-point and final evaluations will meet standards of leading academic institutions and academic peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings. The purpose of the evaluations will be to understand the extent to which the WPC Pilot interventions:

v. Improve coordination across participating entities including data and information sharing;
vi. Improve beneficiary health outcomes;
vii. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
viii. Increase access to social services;
ix. Improve care coordination across participating entities; and
x. Improve housing stability, if applicable.

a. The mid-point evaluation will be due one year prior to the expiration of the demonstration and will include data from program years 1 (as applicable), 2, and (to the extent possible) 3. The final evaluation will be completed no later than six months following the expiration of the demonstration.
    i. Using the data reported in the annual reports pursuant to Section I(b)(i) above, and other data requested from the WPC Pilot sites as specified by the State, the evaluations shall evaluate the extent to which the WPC Pilots individually and collectively accomplished the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies).
    ii. Evaluators shall interview state staff, each WPC Pilot and participating entities (as appropriate), and other stakeholders, for purposes of conducting the evaluations.
b. Data collected for purposes of the evaluation shall not be used by the independent entity for purposes other than the evaluation of the objectives described in STC 123 (Mid-Point and Final Evaluations) and STC 112 (WPC Strategies).
c. The mid-point and final evaluations shall be made available to the public on the State's website.

Whole Person Care (WPC) Pilot Evaluation Design

The Whole Person Care (WPC) is implemented under the Section 1115 Medicaid Waiver in California called "Medi-Cal 2020". The program is a 5-year pilot to test county-based initiatives that target high risk high utilizing Medi-Cal beneficiaries, including those with multiple acute and long term care visits, two or more chronic conditions, mental health or substance use disorders, and/or who are homeless or at risk of homelessness. Pilots are to develop the needed administrative and delivery system infrastructure to support provision of high quality coordinated and appropriate care, and improve both process and patient outcomes. These objectives are to improve care delivery, health, and lower costs through reductions in avoidable utilization such as inpatient and emergency department utilization.

Eighteen WPC pilots were approved in the first application round and began operation on January 1, 2017. Seven additional pilots were approved in the second application round and will begin operation on July 1, 2017. Eight of the first round pilots also expanded their pilots in the second application round. The majority have chosen to target beneficiaries with multiple acute visits and those that are homeless or at risk of homelessness. Less than half explicitly focus on beneficiaries with mental health and/or substance use disorders and recently institutionalized populations. There is also variation in care coordination strategies; however, most pilots have chosen to develop a navigation infrastructure, standardize assessment tools being used by participating entities, and expand or develop new data sharing systems. Enrolled beneficiaries have to opt-in and can opt-out at will.

The WPC Pilot Evaluation will assess: 1) if the pilots 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 evaluation design and research questions are based on the Medi-Cal 2020 Demonstration Special Terms and Conditions (STC) Pilot goals, which include:

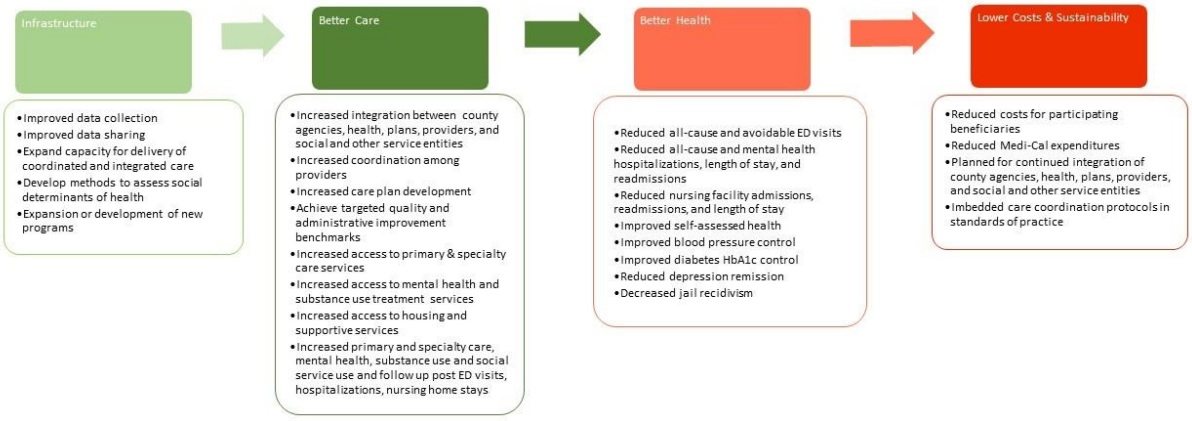
- Increase integration among county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term;
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries;
- Reduce inappropriate emergency and inpatient utilization;
- Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
- Achieve targeted quality and administrative improvement benchmarks;
- Increase access to housing and supportive services (optional); and
- Improve health outcomes for the WPC population.

The evaluation will be completed in compliance with all requirements in the Medi-Cal 2020 Demonstration STCs 112, 123, and 213; STC Attachment GG "WPC Reporting and Evaluation;" and STC Attachment MM "Whole Person Care Requirement and Metrics. In accordance with STC 213, the evaluation will meet standards of leading academic institutions and academic peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

Preliminary Evaluation Framework

WPC evaluation will be based on the preliminary framework displayed in Exhibit 1. The framework incorporates the overarching goals of WPC, program interventions and outcomes. The framework highlights how the program is expected to improve service delivery (better care) and health outcomes (better health), and enhance sustainability of infrastructure improvements and program interventions and reduce costs through reductions in avoidable utilization.

Exhibit 1. WPC Evaluation Conceptual Framework



The evaluation will assess how the pilots achieved the goals of the program through development of infrastructure, delivery of better care, improvements in population health, cost reduction and sustained the practices that led to these outcomes. The delivery of infrastructures is expected to contribute to delivery of better care, which in turn is anticipated to lead to improved population health outcomes. Better care delivery and improved population health are anticipated to lead to reduced costs or improved efficiencies, which would also contribute to sustainability of practices established under WPC pilots in counties and collaborative organizations. The conceptual framework in Exhibit 1 identifies the specific aspects of how the pilots achieved the evaluation goals. For example, the evaluator will examine whether the pilots developed the needed infrastructure such as data collection and data sharing tools, expanded the capacity for coordinating and integrating care, and the methodology to assess social determinants of health. To assess the delivery of better care, the evaluator will examine the improvements in process of care delivery such as increased integration between pilot entities and increased coordination between providers. Increases in a number of services such as more primary and specialty care visits, mental health and substance use treatment visits, and increased access to housing and supporting services will be used as measures of better care.

The improvements in health of the population (better health) will be measured using two types of

measures. One set would include increased rates of the population with outcomes such as controlled blood pressure and diabetes HbA1c control. The other set of measures include reductions in acute and potentially avoidable services such as emergency department (ED) visits or readmissions.

Lower costs would be measured by assessing the costs for targeted beneficiaries as well as a subsequent reduction in Medi-Cal expenditures overall. Sustainability would be measured by the degree to which pilots embedded care coordination activities and integration across pilot entities and their stated plans in continuing these activities after WPC pilots have ended.

Evaluation Data Sources and Measures

Data sources for the evaluation will include WPC pilot applications, mid-year and annual progress reports, quarterly pilot enrollment and WPC service utilization reports, and Medi-Cal enrollment, claims, and encounter data. These data will be supplemented with a structured questionnaire of each WPC Pilot leadership team followed up with key informant interviews. Structured questionnaires and interviews will gather information on multiple domains not systematically addressed in pilot reports, e.g., changes in interagency collaboration and in partners' overall collaborative capacity, synergies with other concurrent programs, alignment with each partner's strategic priorities, program fit with existing work processes in each participating entity, unintended consequences, relevant implementation processes, etc. The questionnaire will be completed by pilots using an online instrument such as SurveyMonkey that allows multiple participants that are most knowledgeable about specific strategies to respond to appropriate questions.

The interviews will follow the questionnaire and will include individuals from pilots who are most knowledgeable about the pilot implementation process and successes and challenges faced to date. It is expected that pilots will vary in how many individuals can provide the necessary information required by the evaluation, and pilots will identify those individuals to participate in the interview. A second set of questionnaires will be completed near the end of WPC by pilots focusing on assessing the sustainability of the pilot strategies. This questionnaire may also be used to address gaps in the information on implementation of pilots gathered in the first round of data collection.

Additional key informant interviews with DHCS staff, Medi-Cal managed care health plans participating in pilots, and other pilot entity participants may be conducted to gain a better understanding of the challenges and successes of the implementation of pilots and to contextualize the quantitative analyses.

The WPC self-reported data, such as mid-year and annual progress reports and quarterly pilot enrollment and service utilization reports, will provide information on pilot infrastructure, approaches to care coordination, data and information sharing infrastructure, services and interventions including housing services (as applicable), physical and behavioral health outcomes, Plan-Do-Study-Act (PDSA) efforts, and lessons learned.

The Medi-Cal enrollment, encounter, and claims data will include data prior to (baseline) and during WPC implementation. Specific universal and variant metrics are required of all WPC

pilots and indicated in Attachment MM of the STCs. In addition to these metrics, the evaluation will assess the utility of including additional quantitative metrics using claims and encounter data as applicable for specific target populations. Examples of additional metrics include number of mental health admissions and readmissions, and outpatient service use by subgroups such as the homeless.

Overall Hypothesis and Related Evaluation Questions

The pilots vary in the populations they target and mix of interventions they implemented. In addition, multiple interventions may be implemented simultaneously. For example, a pilot may target jail re-entry and homeless enrollees and design services specifically for these populations with a "package of interventions" that includes infrastructure development, collaboration and information sharing among pilot participants, and care coordination strategies, and other services that are expected to lead to improvements in health outcomes. It is anticipated that the impact of each individual service, or intervention, cannot be observed independently of the other interventions implemented simultaneously. Therefore, the evaluation will 1) assess the impact of the "package of interventions" for each target population within each pilot; and 2) be able to compare the impacts of the various pilots' interventions for similar target populations.

The evaluation will test the overall hypothesis that the WPC pilot program has achieved the pilot goals in addition to achieving cost savings to the Medi-Cal program. It is hypothesized that WPC will achieve its goals by development of infrastructure to promote integration among pilot entities. Infrastructure will in turn improve collaboration and delivery of high quality care by WPC pilots. These improvements will subsequently lead to better outcomes both in health of the high-risk, high utilizing Medi-Cal beneficiaries and in reducing their health expenditures through reductions in avoidable utilization such as inpatient and emergency department utilization. WPC interventions are sustained when WPC pilots plan to maintain the relationships developed during the program and have embedded care coordination practices in their routine operations.

The specific research questions, as well as data types and sources and the metrics used to address these questions, are displayed in Exhibit 2. The evaluation will assess and report results for all research questions 1) for each pilot and 2) for the entire program.

The evaluation will dedicate the majority of its resources and reporting to answering the research questions that address health outcomes and avoidable utilization reductions of the various pilot packages of interventions for target populations and comparing the outcomes for these packages of interventions. The answers to these questions are of primary importance for determining which interventions were effective and for prioritizing continuation of pilot interventions in the future. As a secondary focus, the evaluation will determine whether challenges in meeting milestones for building pilot infrastructure, enrollment, and service delivery had a detrimental impact on the ability of the pilot interventions to improve health outcome. The evaluation will also determine what other factors promoted or hindered the success of specific strategies in achieving the intended outcomes.

Mid-point and Final Evaluations

The midpoint and final evaluations will report results for the evaluation questions listed in Exhibit 2 to the extent possible with the data available at the points in time when the two reports

are completed. The midpoint report, due to CMS on December 30, 2019, or the midpoint of DY 15, will include a more complete assessment of pilot population demographics, pilot intervention descriptions, and progress toward meeting implementation milestones and pilot implementation challenges. The midpoint report will include assessment of care and outcome improvements, though only preliminary pilot outcome data will be available. The final report will provide the complete assessment of pilot care and outcome improvements, including the 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, pilot challenges and best practices, and assessments of sustainability.

Analyses Methods

The evaluation will first assess the infrastructure established by WPC pilots including the planning process, improvements in data collection capacity and effort, improvements in data sharing capacity and effort, programmatic changes, and any other successes in integration across pilot participants. Collectively, these efforts are expected to improve the infrastructure needed to coordinate care across diverse health, behavioral health and social service needs of the pilot enrollees. This infrastructure is also essential in ability of the pilots to conduct continuous quality improvement activities, including PDSA cycles to adapt and improve WPC pilot activities.

The evaluation will next assess whether WPC pilots provide "better care" by assessing the planned care coordination activities, availability of care coordination protocols, level of care coordination services delivered, frequency and types of PDSA conducted to improve coordination among pilot participants, and successes and challenges of different pilots' care coordination strategies. The evaluation will also assess other indicators of better care as identified in Exhibit 1. These include changes in access to health, mental health, substance use, and social and housing services as well as improved use of follow up outpatient services post-acute and residential service use.

The evaluation will assess whether the infrastructure developed and care coordination strategies implemented by pilots led to better health, measured by improved health status measures as well as reductions in avoidable acute and residential services. The evaluation will use the data available to it to describe any significant external factors that may limit pilot improvements in these areas.

The overall sustainability of the program will be assessed through an examination of the pilots' success in establishing lasting relationships between pilot participants, care coordination process protocols that are embedded in routine practice. The evaluation will also assess the impact of WPC on reduction in Medi-Cal expenditures anticipating that potential cost savings may motivate and promote sustainability in the long term. Assessing the impact of WPC pilots on avoidable utilization, such as inpatient and emergency department utilization, and associated Medi-Cal expenditures, is also important in the decision to scale the program statewide.

The analyses will begin by examining pilot applications and developing a database of program details such as interventions, targeted populations, population selection methods and criteria, universal and variant measures identified in pilot reports, and targets for quantitative universal and variant measures. The evaluation will incorporate new data as they become available, analyze trends in universal and variant metrics, analyze whether pilots met their targets, and

compare performance on metrics to targets and national benchmarks as applicable and available. The evaluator will host this information and DHCS will provide the quantitative and the qualitative data needed for the evaluation.

The evaluation team will also develop the questionnaires and key informant interview protocols; pilot test these instruments and protocols with two WPC pilots; and share the instrument with DHCS for feedback. Following pilot tests, the evaluation team will obtain list of key informants; administer the questionnaires online; follow up with key informant interviews; and analyze these data. Simultaneous with other activities and as soon as possible, the evaluation will obtain Medi-Cal data and begin baseline and intervention period analyses.

The quantitative evaluation questions (e.g., outcomes such as hospitalizations and ED visits, mix of mental health and social services, expenditures) will be assessed for the program overall and for specific pilots using a pre-post intervention-control approach to quantitative analyses. The quantitative universal metrics that are available from DHCS Medi-Cal claims and encounter data, such as ED visits and hospitalizations, will be calculated using DHCS claims and encounter data for two baseline years (2015 and 2016 calendar years) to establish an adequate trend in utilization prior to WPC pilot implementation for all pilot enrollees for whom the data is available. This two-year baseline analysis is intended for evaluation of quantitative claims/encounter data. Thus, for universal and variant metrics that are not available in claims and encounter data, such as metrics that require chart review, the evaluation will rely on self-reported data by each pilot. The evaluation will assess the sample sizes for the variant metrics to determine those most suitable for rigorous impact evaluation and determine alternative methods of assessing these metrics when feasible. For all self-reported data, the baseline year will be 2016. The post implementation trend will be identified for the entire length of the pilot. Please note that the methods listed in this paragraph relate only to the evaluation analysis.(Please note that for calculating metric achievement against pilot goals for incentive payment purposes, DHCS measures PY2 results against baseline data from calendar 2016.)

A control group will also be selected, with consideration of the challenges of this task.
This task is challenging because participation in the pilot is not random since pilots frequently target highest risk beneficiaries and those targeted for the intervention have to opt-in and can opt-out at any time. A control group can also be selected from counties not in the pilot, though differences in county delivery systems and population characteristics exist. Therefore, three comparison groups for the evaluation will be considered: 1) beneficiaries selected for participation by the pilot who did not opt-in who have similar risk profile but were unwilling to participate in the program; 2) beneficiaries at the next lower tier of risk within the pilot; and 3) beneficiaries with the same risk profile and similar demographics who reside in non-pilot counties. These comparisons allow an assessment of the program impact that is more independent of potential confounding factors than a simple pre-post evaluation. The evaluation will use the propensity score method to identify the control group from one or more of the groups above when feasible.

The control group will be used to assess the impact of the collective pilot population. A single control group allows for assessment of the overall impact of WPC. It is also more likely to be representative of the entire population targeted by WPC in all the pilot programs than a separate control group for each pilot population. This is particularly because of the potential self-selection

bias by specific counties and the lower likelihood of finding counties with similar populations. This strategy would avoid the anticipated difficulty of identifying an adequate number of Medi-Cal beneficiaries in the control group with similar characteristics for each pilot. Because the control group population profile will be designed with the collective pilot population in mind, further assessment is required to determine to what extent the control group can be used as a benchmark to assess the impact of individual pilots and specific target populations within pilots. Also, metric data that is only available by pilot collection and reporting will not be available for the control group. If needed, multiple comparison groups may be included allowing for comparison of the results for each group to gain a better understanding of the WPC impact. DHCS Medi-Cal claims and encounter data will be available for the control group.

If the above strategies in selecting a control group do not lead to selection of a reasonable control group, UCLA will develop a model to predict the counterfactual outcomes of interest (e.g., expenditures) after implementation of the pilots, or as if the pilots were not implemented. The observed outcomes during WPC will then be compared to the counterfactual predicted outcome during WPC. UCLA will examine all the above methodologies to identify a control group to be used in the analyses of the quantitative data. When quantitative data are not available, for example for social services, UCLA will examine the self-reported data by pilots for baseline and implementation years.

Additional quantitative analyses will be conducted by assessing the degree to which pilots met universal and variant quantitative metrics (such as HEDIS or NQF metrics) and exceeded their own targets and available national benchmarks.

Both descriptive and multivariate regression methods will be used in the quantitative evaluation. The descriptive methods will be used to create a profile of the pilot enrollees overall, and by pilot, in terms of their demographics, health status, WPC pilot service utilization and specific categories of Medi-Cal service utilization. Multivariate methods will be used to assess the overall impact of the WPC demonstration on service use and health outcomes using difference-in-difference (DD) methodology. For example, the DD methodology allows for assessment of the change in number of all-cause ED visits during baseline and pilot implementation periods in both the intervention and control populations. The DD methodology allows for attribution of change to implementation of WPC pilot, if the rate of ED visits declined significantly and at a higher rate among pilot enrollees than the comparison groups. The regression models will control for confounding factors such as demographics, health status and condition severity, length of time enrolled in the pilot, and pilot characteristics when possible. Random effects regression for dichotomous, count, and continuous dependent variables will be constructed, accounting for hierarchical nature of the data and repeated measures from the enrollees.

The descriptive analyses will be reported for WPC overall and for each pilot. The multivariate models will be conducted for the WPC overall.

The qualitative data (e.g., progress reports, questionnaires, and key informant interviews) will be analyzed using a multiple case study design, with counties as the unit of analysis. Case study methods are well suited for studying context-specific processes and will allow for in-depth analyses of individual counties as well as systematic cross-county comparisons. This approach involves three steps: coding, within-case analyses, and between-case analyses. Qualitative data

will be analyzed to identify overarching themes (e.g., data and information sharing infrastructure, other collaborative capacity, programmatic changes, barriers to implementation, factors affecting sustainability, promising strategies identified using PDSA cycles) The relative importance of each theme will be examined within and across counties. Sectoral differences will also be assessed. Configurational comparative methods such as qualitative comparative analysis (QCA) will also be applied to the data to identify emerging patterns across counties that result in specified outcomes. A key strength of QCA is that it allows for causal heterogeneity, i.e., more than one way to achieve a specific outcome. Use of this approach will allow a more systematic identification of different combinations of factors resulting in program failure or success. The qualitative data will also be used to contextualize the quantitative findings.

Evaluation Challenges and Approaches to Address Such Challenges

The WPC pilots evaluation present several challenges:

1) The pilot enrollees have to opt-in and can out-out at will. Some will graduate and others will be newly enrolled. These challenges will be met through employing the DD analyses, incorporating measures of length of enrollment and churn, and analyzing characteristics of those who do not opt-in vs. the eligible population and those who opt-out vs. those who do not.

2) External contextual factors may impact individual pilot results, such as other local or state initiatives that were ongoing or newly embarked on by pilots. These challenges will be met through use of DD analyses and comparing the pilot results with selected comparison groups. In addition, the pilot questionnaires will identify other concurrent or new initiatives that may be complementary or supplemental to WPC strategies.

3) As noted previously, it is anticipated that the impact of each individual service, or intervention, is not likely to be observable independently because the interventions for each pilot's various target populations are provided at the same time as a "package of interventions." Therefore, the evaluation will 1) assess the impact of the "package of interventions" for each target population within each pilot; and 2) compare the impacts of the various pilots' interventions for similar target populations regarding appropriate use of care, reduced inappropriate utilization and improved health outcomes. As part of this comparison, the evaluation will include a description of the package of interventions that each pilot delivered to each target population. Regarding the package of interventions for each pilot target population, the following factors will be described to provide context for the corresponding outcome data analysis:
    a. Eligibility requirements for FFS/PMPM services
    b. Bundled services
    c. Beneficiaries receiving more than one service/intervention
    d. Duration of services
    e. Case manager to beneficiary ratio
    f. Intensity of services: short and intense services vs long and constant
    g. Mechanisms of approach: All-inclusive vs Tiered bundles that lead to "graduation", etc.

4) There are limitations to evaluation's ability to independently assess all the metrics. It is anticipated that universal metrics such as all-cause hospitalizations and emergency department visits can be assessed using Medi-Cal enrollment and claims data. For measures such as jail recidivism or suicide risk assessment, however, only self-reported data by pilots will be available. Similarly, information on use of care coordination policies and procedures or utilization of PDSAs by pilots are limited to data reported by pilots in their annual reports as well as questionnaire and key-informant data. Therefore, the analyses of such quantitative data will be limited to pre-post analysis and comparison to national benchmarks if such benchmarks are available.

5) Assessing the reductions in avoidable utilization and associated costs due to the pilot is dependent on the availability of expenditure data, particularly for individuals enrolled in Medi-Cal managed care plans, which lack payment information. DHCS will work with the evaluator to assess the feasibility of creating shadow-prices for services delivered to enrolled populations and to calculate the overall expenditures and savings that may be attributed to WPC.

6) The sustainability of WPC strategies in pilots can only be assessed definitively if further assessment of pilot efforts and analyses of metrics were completed at one year or later following conclusion of the pilot. In the absence of such assessment, pilots will be asked to indicate which strategies they plan to continue following WPC conclusion and whether these strategies are embedded within the routine practices of the organization.

Evaluator Selection

The State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct an evaluation of the WPC Pilots. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (DHCS). The evaluator will not conduct separate evaluations of individual pilots outside of the WPC evaluation contract with DHCS, but the evaluator may evaluate other Medi-Cal 2020 Demonstration Programs. A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducing the evaluation. The State sought applications from interested entities that were identified based on prior experience and expertise in analyzing the experience of the population and working with the data that would be analyzed. DHCS scored the proposals and the proposals exceeded the minimum score requirement. The UCLA Center for Health Policy Research was the successful proposer.

Timeline

The proposed timeline for the WPC evaluation is presented below. This timeline identifies the proposed start dates of major evaluation activities. Many of the activities such as analyses of PDSA data, annual reports, and Medi-Cal data will be on-going throughout and to the end of the evaluation. Specific activities such as obtaining IRB approvals are not indicated in the timeline. UCLA will begin the IRB process prior to analyses of claims/encounter data and collection of data from key informants. Obtaining claims and encounter data require an extensive lead-time, particularly due to an anticipated 6 month lag in receipt of claims and encounter data from providers as well as a 3 month lag in adjudicating claims. UCLA will begin negotiations with DHCS to obtain data and anticipates to receive the data within 4-6 months of that request. Pilots

submit semi-annual progress reports (including PDSA information), which are due August 31 (mid-year) and April 1 (annual). Quarterly pilot enrollment and WPC service utilization reports are due 30 days after the end of the quarter. DHCS will provide this information to UCLA when it is received from the pilots.

- July 1, 2017 - Evaluator Selection and Contracting.
- November 1, 2017- Begin analyses of pilot applications and annual reports.
- December 1, 2017- Initiate the process for receipt of Medi-Cal data.
- January 1, 2018- Begin analyses of PDSA data.
- April 1, 2018- Begin first round of questionnaires of WPC pilots and key informant interviews (regarding on multiple domains not systematically addressed in pilot reports).
- May 1, 2018 – Begin analyses of questionnaire and interview data.
- June 1, 2018, Begin analyses of Medi-Cal data.
- December 30, 2019 – Submit Midpoint Evaluation report using all available data, including PDSA and other pilot quarterly and semi-annual reports, questionnaires and interviews, and Medi-Cal data.
- September 1, 2020 – Begin questionnaire of sustainability of pilot strategies.
- November 1, 2020 – Begin analyses of sustainability questionnaire data.
- June 30, 2021 – Submit Final Evaluation report: using all available data, including PDSA and other pilot quarterly and semi-annual reports, questionnaires and interviews, and Medi-Cal data.

Exhibit 2: **Evaluation Questions and Data Sources**	
Evaluation Question	**Data** See the DHCS WPC Technical Specifications Manual in the Appendix for more information about Universal and Variant Metrics Specifications and Sources.
Overarching	
1) What are the demographics of pilot enrollees? What services did they receive?	Individual Pilot Mid-Year and Annual Reports: participant information including: 1. Number of beneficiaries participating; active and those that have graduated or transitioned from pilot; 2. Participant characteristics (e.g., demographics, physical and behavioral health diagnoses, baseline rates of ED/IP utilization, housing needs, jail involvement, etc.); and 3. Description of how WPC pilots selected their target population, determined eligibility and if there have been any changes to this group over time.
	Pilot Quarterly Enrollment and WPC Service Reports DHCS Claims and Encounter Data
2) What key factors aided or hindered the success of specific strategies in implementation or in achieving the intended outcomes and what measures are pilots taking to address these barriers?	Key Informant Questionnaires or Interviews with Pilot County Leadership to provide additional context for pilot report and PDSA information.
3) What are the structural differences of the various pilots and how are differential pilot outcomes related to structural differences?	Review of Pilot Applications and Key Informant Questionnaires or Interviews with County Pilot Leadership 1. Lead and participating entities, their roles and collaboration; 2. Infrastructure, including governance; 3. Overview of the types of care coordination infrastructure pilots have put in place, including navigation infrastructure, coordinated entry, common assessment tools used among participating entities, collection and use of social determinants data, increased access to social services, etc.; 4. Overview of the types of data sharing infrastructure pilots have put in place, including bi-directional data sharing with managed care health plans and participating entities, use

	of health information exchanges, use of population management systems and predictive modeling, implementation of care and case management software solutions; and use of real time data sharing and notifications to improve health outcomes and coordination of services; 5. Type of services and interventions, including a description of the package of interventions that each pilot delivered to each target population. Regarding the package of interventions for each pilot target population, the following factors will be described to provide context for the corresponding outcome data analysis: a. Eligibility requirements for FFS/PMPM services b. Bundled services c. Beneficiaries receiving more than one service/intervention d. Duration of services e. Case manager to beneficiary ratio f. Intensity of services: short and intense services vs long and constant g. Mechanisms of approach: All-inclusive vs Tiered bundles that lead to "graduation", etc. 6. Types of incentive payments, Pay for Reporting and Pay for Outcomes, including to downstream providers; 7. Housing pool information, if applicable; and 8. Other local related efforts that may interact with and/or support WPC (i.e., health homes, DMC waiver).
Infrastructure	
4) To what extent did the pilot: A) develop collaborative leadership, infrastructure, and systematic coordination among public and private WPC Pilot entities, including county agencies, health plans, and providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries; and B) achieve the approved application deliverables relating to collaboration, infrastructure and coordination?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation demonstrating progress toward WPC Pilot goals in relation to the infrastructure and other coordination and collaboration strategies. 2. A narrative describing the activities and interventions the WPC Pilot performed as described in the application including barriers, challenges, and successes. . Key informant Questionnaires or Interviews with County Pilot Leadership and other Pilot Entities to provide further context to the report information described above.

5) To what extent did the pilot: A) improve data collection and information sharing amongst local entities to support identification of target populations, ongoing case management, monitoring, and strategic program improvements in a sustainable fashion; and B) achieve the approved application deliverables relating to data collection and information sharing?	Individual Pilot Mid-Year and Annual Report: 1. Data and other documentation as described in the WPC Pilot application demonstrating progress toward WPC Pilot data collection and information sharing goals, infrastructure, and strategies, such as bidirectional data sharing with Medi-Cal Managed Care Plans, Health Information Exchange, Real-time data sharing between pilot entities 2. A narrative describing the data collection and information sharing activities and interventions, including barriers, challenges, and successes.
	Universal Metric Data and Information Sharing Policy and Procedure Deliverable: Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and· strategic improvements, to the extent permitted by applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval. These shall include processes to monitor, compile and assess monitoring information, and update policies as needed in accordance with a PDSA process. (See Attachment MM for additional information.)
	Key Informant Questionnaires or Interviews with County Pilot Leadership or other Pilot Entities to provide additional context for the information noted above.
Better care	
6) To what extent did the pilot: A) improve comprehensive care coordination, including in-real-time coordination, across participating entities; and B) achieve the approved application deliverables relating to care coordination?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation as described in the WPC Pilot application demonstrating progress toward WPC Pilot goals in relation to the infrastructure, services, and other strategies for care coordination, including standardized care plans and “in real time” coordination. 2. A narrative describing the care coordination activities and interventions, including barriers, challenges, and successes.

	Universal Metric: Proportion of participating beneficiaries with a comprehensive care plan accessible by the entire care team within 30 days of: 1. Enrollment into the WPC Pilot. 2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually).
	Universal Metric Care Coordination Policy and Procedure Deliverable: Submission of documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC Pilot leads and all participating entities, which provide for streamlined beneficiary case management. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval. These shall include processes to monitor, compile and assess monitoring information, and update policies as needed in accordance with a PDSA process. (See Attachment MM for more information.)
	Key Informant Questionnaires or Interviews with Pilot County Leadership and Other Pilot Entities to Provide Additional Context for the Data Noted Above. DHCS Claims and Encounter Data
7) To what extent did the pilot: A) increase appropriate access to care and social services; and B) achieve approved application deliverables relating to WPC service delivery?	Individual Pilot Mid-Year and Annual Report information: 1. Data and other documentation demonstrating progress toward WPC Pilot goals in relation to the infrastructure, medical and social services, and other strategies. 2. A narrative describing the activities and interventions for each component as described in the application including barriers, challenges, and successes.
	Key Informant Questionnaires or Interviews with Pilot County Leadership and Other Pilot Entities.
	DHCS Claims and Encounter Data: This data source will be used to gather DHCS-provided universal and variant metric data as well as any of other utilization data that the evaluation determines to be useful to measure increases in appropriate access to care such as preventive outpatient services.
	Pilot Quarterly Enrollment and WPC Service Reports.

8) To what extent did the pilot increase access to housing and supportive services and improve housing stability, if applicable?	Variant Metric: Percent of Homeless Permanently Housed for Greater Than Six Months.
	Variant Metric: Percent of Homeless Receiving Housing Services in the Pilot Year That Were Referred for Housing Services.
	Variant Metric: Percent of Homeless Referred from Supportive Housing Who Received Supportive Housing.
Better Health	
9) To what extent did the pilot (and individual target population packages of services): A) improve beneficiary care and health outcomes, including reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient); and B) improve outcomes such as controlled blood pressure and HbA1c?	Individual Pilot Mid-Year and Annual Reports. Pilot Quarterly Enrollment and WPC Service Reports DHCS Claims and Encounter Data
	Universal Metric: Ambulatory Care – Emergency Department Visits (modified from HEDIS).
	Universal Metric: Inpatient Utilization – General Hospital/Acute Care (IPU) (modified from HEDIS).
	Universal Metric: Follow-up After Hospitalization for Mental Illness (FUH) (modified from HEDIS).
	Universal Metric: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (modified from HEDIS).
	Variant Metric: 30 Day All Cause Readmissions (modified from HEDIS).
	Variant Metric: Decrease Jail Recidivism.
	Variant Metric: Overall Beneficiary Health (derived from CAHPS).
	Variant Metric: Controlling High Blood Pressure (modified from HEDIS).
	Variant Metric: Comprehensive Diabetes Care – HbA1c Control (modified from HEDIS).
	Variant Metric: Depression Remission at 12 months (PHQ-9).
	Variant Metric: Suicide Risk Assessment Completion.
	Other Optional Pilot-developed Metrics.
	Other DHCS Medi-Cal Claims and Encounter Data as Needed.
Lower costs and sustainability	
10) To what extent did WPC pilots reduce costs of care for enrolled beneficiaries compared to the control group and were	DHCS Claims and Encounter Data: These data will be used to assess the impact of the pilot on the costs incurred by beneficiaries compared to those incurred by the comparison group(s)

total Medi-Cal expenditures reduced during the pilot?	before and after the intervention. The impact of the WPC on Medi-Cal expenditures before and after the pilot implementation will also be assessed.
11) What lasting collaboration between pilot participants and care coordination protocols will continue after the pilot? In addition, how will counties ensure that improvements achieved by the pilots are sustained after pilot funding is exhausted?	Key Informant Questionnaires or Interviews with County Pilot Leadership.

I. Application Process

a. Release of WPC Pilot Application and Guidance

i. By April 1, 2016, or within 90 days following approval of the WPC Pilot Requirements and Metrics, Attachment MM, WPC Pilot Requirements and Application Process, Attachment HH, and WPC Reporting Evaluation, Attachment GG, whichever is later, the State will publish a WPC Pilot application (including a structured application template), the list of the entities eligible to apply as a Lead WPC Pilot Entity ("Lead Entity"), the application process, detailed timelines, data and reporting requirements, and selection criteria.

ii. At least 10 calendar days prior to the planned publication date, the State will share a courtesy copy of the draft application with CMS, and consider any timely comments and feedback that CMS may provide.

iii. Upon release of the application and accompanying materials, the State will conduct a conference call open to all interested applicants to help explain the opportunity and application, and answer prospective applicants' questions.

iv. The application shall include a description about the type and quantity of data that WPC Pilots will be required to submit for the mid-year and annual reports, as specified in Attachments GG and MM. It shall also include mid-point and final evaluation requirements as set forth in STC 123 which are to:

a. Improve coordination across participating entities including and information sharing;
b. Improve beneficiary health outcomes;
c. Reduce avoidable utilization of emergency and inpatient services (ED, hospital and psychiatric inpatient);
d. Increase access to social services;
e. Improve care coordination across participating entities; and
f. Improve housing stability, if applicable.

v. Applicants shall attest that they will report and submit timely and complete data to the State in a format specified by the State. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the State. Applicants shall also attest that federal funding received shall be returned if the Pilot, or a component of it as determined by the state, is not subsequently implemented. The application shall include information about the State's role and the role of the Lead Entity with regard to pilot monitoring, provision of technical assistance, and imposition of corrective action and Pilot termination.

vi. The application shall include the total and maximum amounts of funding available for the WPC Pilots for each program year, and the process the State will use to select and approve WPC Pilots.
The application shall include a structured template for applicants to address the required elements, including those listed in I.b.

b. **Required Application Elements**

i. WPC Pilot applicants shall address all elements in STC 117(b).

ii. WPC Pilot applicants shall identify high-risk, high-utilizing Medi-Cal beneficiaries in the geographic area that they serve and assess their unmet need, as described in WPC Pilot Special Terms and Conditions STC 112. Applications shall identify the target population, the expected number of individuals served or affected by the Pilot, and the number of those individuals that are Medi-Cal beneficiaries.

iii. Applicants shall list all Universal and Variant metrics that they plan to meet for each program year, how they will document their achievement of metrics, and describe how payments for pilots will comport with STC 113, given the three broad aims of WPC.

iv. Applicants shall define and describe the services they will provide that are not otherwise covered or directly reimbursed by Medi-Cal. If housing services are to be provided or a housing pool is to be utilized, the applicant must be precise about which services will be funded by Pilot funds, and limited to housing-related activities and services described in the June 26, 2015 CMCS Informational Bulletin. The applicant must describe the relationship between Pilot funding and provision of services broadly, and how federal financial participation will be received only for services provided to Medi-Cal beneficiaries.

v. Applicants shall identify as Pilot participants at least one Medi-Cal managed care health plan operating in the geographic area of the Pilot, both the health services and specialty mental health agencies or department, at least one other public agency or department, and at least two community partners that have significant experience serving the target population, in accordance with STC 115.

vi. Applicants shall make an attestation that the WPC Pilot lead entity will enter into an agreement with the State, if necessary (as specified by the State), which specifies the requirements of the WPC Pilot, including data sharing agreement in accordance with STC 118.

vii. Applicants shall make an attestation that the WPC Pilot lead entity shall agree to help develop and participate in regular learning collaboratives to share best practices among Pilot entities, in accordance with STC 119.

viii. Applicants shall make attestation that the funds transferred for the IGT qualify for federal financial participating pursuant to 42 CFR 433, subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations in accordance with STC 126.a.

ix. Applicants shall make attestation that they will respond to general inquiries from the State pertaining to the WPC Pilot initially within one business day after acknowledging receipt and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by the State. The State will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.

x. Applicants shall acknowledge that payments for WPC pilots will be contingent on certain deliverables or achievements, denoted in STC 126(f), and will not be distributed or may be recouped if pilots fail to demonstrate achievement or submission of deliverables.

c. **Submission of WPC Pilot Applications by Lead Entities**

i. Applications shall comply with all application processes and requirements as specified by the State, including but not limited to those elements listed in Whole Person Care Special Terms and Conditions STC 117(b).

ii. Lead Entities shall submit complete WPC Pilot applications consistent with the application requirements listed in STC 117 and Attachment HH to the State by May 15, 2016, or 45 days after the State issues the WPC Pilot application, whichever is later.

iii. As part of the review and approval process described in Section III below, funding shall be designated for the applications. In the event that available funding remains within the annual limits of the WPC Pilot, additional funding may be requested by approved WPC Pilot sites or applications may be requested and accepted by the state after the initial application period. Nothing shall preclude an applicant from reapplying with a strengthened application if they were not approved in the first round, following request by the State. All initial application requirements would remain in effect, with the exception of specified dates.

II. State Review Process

a. Within 60 days after submission of the application, the State will complete its review of the application, respond to the Lead Entity in writing with any questions, concerns or problems identified. Upon receipt, the Lead Entity will respond to questions and concerns in writing within 5 business days.

b. Within 30 days after submission of the final responses to the State's questions, the State will complete its review of the application and shall take action on the application and notify the applicant. Notification to CMS of recommended approved applications by the State will also occur.

c. Within 10 days of the State's notification to CMS of the State approval of APC Pilot applications, CMS shall notify the State of any concerns or questions regarding final approval Within 10 days of final approval, the Lead Entity shall formally accept or decline approval of the application.

d. In the event that an approved WPC Pilot application is approved for less than 90 percent of its requested funding, the State shall allow the Lead Entity to withdraw its application. The State shall offer the WPC Pilot the opportunity to modify its application per the reduction in funding during the question and answer process, as determined appropriate by the State**.**

III. Pilot Funding

a. The State shall review each WPC Pilot application and consider equal valuation across requests. The State shall consider differences in proposed interventions, target populations, and geographic areas when conducting this review.

b. The State shall issue no sooner than October 1, 2016 guidance to WPC Pilots specifying when funding may be decreased prospectively and retrospectively as a

result of a WPC Pilot not completing a component of the Pilot's intervention(s) as specified in its approved application, and non-progress on universal and/or variant metrics, as determined by the State.

IV. Pilot Termination

a. The State may suspend or terminate a WPC Pilot if corrective action has been imposed and persistent poor performance continues.
    i. If a deficiency is identified by the State, the State shall first provide technical assistance to the WPC Pilot.
    ii. If the WPC Pilot continues to demonstrate poor performance, a corrective action plan (CAP) will be imposed. The CAP will include specific milestones and timelines as approved by the State. The State will work with the WPC Pilot to develop the CAP; however, final issuance of the CAP will be done by the State.
    iii. If the WPC Pilot does not come into compliance with the CAP, the State may impose penalties, sanctions, or terminate the WPC Pilot.

b. Should a WPC Pilot be terminated, the State shall provide notice to the Pilot and request a close-out plan due to the State within thirty calendar days unless significant harm to beneficiaries is occurring in which case the State may request a close-out plan within ten business days. The State shall approve the close-out plan upon determining all components are acceptable. The close-out plan shall include:
    i. A timeline for close-out of the WPC Pilot;
    ii. A process to notify all Pilot participating entities of termination of the Pilot;
    iii. A process to notify all participating beneficiaries of termination of the Pilot which will include:
        1. The effective date of the termination;
        2. A description of how the termination will affect the beneficiary's access to services;
        3. Who the beneficiary should call if they need information or have questions about the termination;
        4. A referral to a community resource or entity that can provide any of the terminated services, whenever possible.

    Notices shall indicate that disenrollment from the Pilot will be terminated within thirty days of the date of the notice. The State may determine a shorter time frame should it be determined that beneficiary harm is occurring. Notices shall be approved by the State and must be mailed in the appropriate threshold language.
    iv. A process to call all beneficiaries a minimum of five times prior to the termination. The call script shall include the same information included in the aforementioned notices and shall be approved by the State.
    v. A process for notifying the public in the geographic area where the WPC Pilot operates of its termination.
    vi. A timeline for reporting final data and information to the State as required in Attachments GG and MM in a manner specified by the State.
    vii. A budget to close out the Pilot.

V. Learning Collaboratives

a. WPC Pilot lead and participating entities shall participate in all WPC learning collaborative activities. Participation of lead and/or participating entities in any specific learning collaborative activity shall be determined by the State.
b. Learning collaborative activities shall be structured to provide information about and assist with Pilot implementation and close-out; share best practices and learnings across WPC Pilots; and for the State to provide information, discuss requirements, and report data about the Pilots.
c. A subset of WPC Pilot lead entities shall be identified to assist the State with planning and providing direction about how learning collaboratives will be structured.
d. The State shall convene a minimum of bi-weekly calls during the first year after approval of Pilot applications to discuss implementation issues, answer Pilot questions, and clarify Pilot requirements. The frequency of these calls shall be decreased following this initial year dependent on the need for them, however, shall be no less than monthly.
e. The State shall convene a minimum of two in-person learning collaboratives during each WPC program year with the exception of year 1. These meetings shall be focused on the sharing of best practices across WPC pilots; when possible, national policy and practice information will be shared; reporting of WPC Pilot performance; and to help establish working relationships across pilots to promote discussion and sharing of information amongst pilots in between meetings without direction.

Attachment II
PRIME Program Funding and Mechanics

I. Table of Contents

II. Preface 460
A. Public Hospital Redesign and Incentives in Medi-Cal 460
B. PRIME Protocols 460
III. Eligible Hospital Systems to Receive Funding 460
IV. PRIME Domains and Projects 461
V. Key Elements of Five- Year PRIME Project Plans 462
VI. Plan Review and Approval Process 462
A. DHCS Plan Approval Process 462
B. Plan Modification Process 463
C. Metric Modification Process 464
VII. Allocation and Disbursement of Pool Funds 465
A. Total Available PRIME Incentive Payments for a DPH Five-Year PRIME Pool Plan...465
Table 1: Total Computable PRIME Payments for DPHs 465
B. Total Available PRIME Incentive Payments for a DMPH Five-Year PRIME 467
Table 4: Total Computable PRIME Payments for DMPHs 467
C. Payment Based on Metric Target Achievement 469
Table 6: Interim Mid-Year Metric Performance Achievement 471
Table 7: Final Year-End Metric Performance Achievement 471
D. Progress and Payment Reconciliation 472
E. Reporting for Payment 472
F. Intergovernmental (IGT) Transfer Process 473
VIII. STATE REVIEW PROCESS 473
IX. Reinvestment of Unallocated Funds 474
A. Unused Pool Fund 474
B. Unclaimed Pool Payment 474
Table 9: Unearned Claiming (for current DY) 475
X. Learning Collaboratives 478

II. Preface

A. Public Hospital Redesign and Incentives in Medi-Cal

On December 30, 2015, the Centers for Medicare and Medicaid Services (CMS) approved California's request for a renewal to California's section 1115(a) Medicaid demonstration (hereinafter "demonstration") authorizing the creation of a Public Hospital Redesign and Incentives in Medi-Cal (hereinafter "PRIME"). This demonstration is approved through December 31, 2020. Paragraphs 70-103 of the Special Terms and Conditions (STCs) describe the general rules and requirements of PRIME.

B. PRIME Protocols

The PRIME requirements specified in the STCs are supplemented by the following attachments to the STCs:

Attachment D.	Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME entities
Attachment Q.	PRIME Projects and Metrics: This Attachment details the specific delivery system improvement activities ("projects"), including requirements regarding project metrics, that are eligible for PRIME funding; for each project, Attachment Q specifies the details of the projects, projects' metrics, and metrics' targets that will be the basis for earning PRIME incentive payments. Attachment Q also specifies the key elements of and the review and approval process for participating PRIME entities' 5-year PRIME Project Plans. Participating PRIME entities will utilize this document for purposes of selecting projects (each of which specifies required metrics) to include in their 5-year PRIME Project Plans.
Attachment R.	Alternative Payment Methodologies: Attachment R will outline additional payment methodologies that will qualify as APM outside of the capitation payment methodologies.
Attachment S.	PRIME Evaluation and Monitoring: Attachment S will describe the state's plan for meeting PRIME monitoring requirements as well as will include the final evaluation plan.
Attachment II.	PRIME Funding and Mechanics: Attachment II describes the general requirements for receiving incentive payments under PRIME, including the allocation, payment mechanisms and disbursement of pool funds; reporting requirements; and reinvestment of unallocated funds.

III. Eligible Hospital Systems to Receive Funding

As identified in Attachment D, designated public hospital (DPH) systems, (which include their affiliated governmental providers and contracted governmental and non-governmental entities as applicable), and District and Municipal public hospitals (DMPHs) are eligible to receive PRIME incentive payments (hereinafter "participating PRIME entities"), subject to each DPH system and DMPH submitting a completed Five-year PRIME Project Plan and approval of that Plan by the state. Multiple DPH systems operating under common government ownership may be considered a single participating PRIME entity, or may submit separate applications and be treated as separate participating PRIME entities. Multiple DMPHs operating under common government ownership may submit separate applications or a single application. DMPHs that are under different government ownership may submit a joint plan for consideration, however, a lead DMPH must be identified.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for DPHs and DMPHs to support reforms for care delivery, provider organization

and adoption of APMs. The demonstration will provide up to $1.4 billion annually for the DPHs within the DPH Sub-Pool and $200 million annually for the DMPHs within the DMPH Sub-Pool for the first three years of the demonstration. The respective Sub Pools will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration

PRIME incentive funds shall be disbursed solely to the DPHs and DMPHs listed on Attachment D as eligible participating PRIME entities in accordance with their approved PRIME Project plans. A specified amount of incentive funding will be available annually to each eligible participating PRIME entity for the project metrics approved for that participating PRIME entity in its PRIME plan. The actual receipt of funds will be conditioned on reporting by the participating PRIME entity of progress towards and achievement of the specified targets approved in the PRIME Project Plan. Aside from early stage process metrics, awards in later years will be based on per beneficiary measures of improvement. Each participating PRIME entity (for multiple DPHs operating under a single PRIME project plan or multiple DMPHs operating under a single PRIME project plan, the combined DPHS or DMPHs are collectively considered the participating PRIME entity) will be individually responsible for performance on its metrics in order to receive its potential incentive funding. The inability of one participating PRIME entity to meet a specified target will not preclude other participating PRIME entities operating under separate PRIME Project Plans from receiving incentive payments for achievement of a target.

IV. PRIME Domains and Projects

PRIME projects are grouped into three domains (listed below), each of which has explicit connection to the achievement of: (a) patient-centered, data-driven, team-based care; (b) point-of-care services, complex care management, population health management driven by electronic health records and data analytic capacity for system-level improvement and culturally competent care; and (c) improved health outcomes as evidenced by clinical, preventable events, and patient experience metrics. The below three domains represent important themes that drive quality improvement and population health advancement:

Domain 1: Outpatient Delivery System Transformation and Prevention: Projects in this domain are intended to achieve major improvements in clinical quality and population health, with a particular focus on ambulatory care redesign, integration of physical and behavioral health, patient safety and prevention. These projects are intended to help make sure that patients experience timely access to high-quality, efficient, and patient-centered care. The menu of projects under this domain includes:

1.1 Integration of Physical and Behavioral Health (required for DPH)
1.2. Ambulatory Care Redesign: Primary Care (required for DPH)
1.3 Ambulatory Care Redesign: Specialty Care (required for DPH)
1.4 Patient Safety in the Ambulatory Setting
1.5 Million Hearts Initiative
1.6 Cancer Screening and Follow-up
1.7 Obesity Prevention and Healthier Foods Initiative

Domain 2: Targeted High-Risk or High-Cost Populations: Projects in this domain are focused on specific populations that would benefit most significantly from care coordination and alignment. The menu of projects under this domain includes:

2.1 Improved Perinatal Care (required for DPH)
2.2 Care Transitions: Integration of Post-Acute Care (required for DPH)
2.3 Complex Care Management for High Risk Medical Populations (Required for DPH)
2.4 Integrated Health Home for Foster Children
2.5 Transition to Integrated Care: Post Incarceration
2.6 Chronic Non-Malignant Pain Management
2.7 Comprehensive Advanced Illness Planning and Care

Domain 3: Resource Utilization Efficiency: Projects in this domain are designed to reduce ineffective or harmful clinical services and reduce unwarranted variation in the use of evidence-based diagnostics and treatments. The menu of projects under this domain includes:

3.1 Antibiotic Stewardship
3.2 Resource Stewardship: High-Cost Imaging
3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals
3.4 Resource Stewardship: Blood Products.

V. Key Elements of Five- Year PRIME Project Plans

PRIME participating DPH systems will implement a minimum of 9 PRIME projects: at least four Domain 1 projects (of which three specific projects are required projects), at least four Domain 2 projects (of which three specific projects are required), and at least one Domain 3 project. PRIME participating DMPHs will implement at least one PRIME project, selected from the Projects and Metrics Protocol (Attachment Q), however, may implement additional projects as approved by the state in the PRIME Plan Application.

PRIME projects will be implemented over the course of five PRIME demonstration years, each corresponding to the state fiscal year from July 1 through June 30 ("PRIME DY"). The first PRIME DY is from July 1, 2015, through June 30, 2016.

No later than one week following the approval of the PRIME protocols, DHCS will provide participating PRIME entities with a standardized Five-year PRIME Project Plan template, consistent with the requirements in STC 75 in Section IX. The plan shall include the following sections:

1. Participating Entity Information
2. Executive Summary of 5-Year Plan that includes a summary of the overall Five-year PRIME Project Plan, a description of the participating PRIME entity and local needs, and goals and objectives for being a high-performing safety net system
3. Narrative on how the Five-year PRIME Project Plan will result in improved care for the patients they serve and a path for sustained delivery system improvement
4. Project Selection
5. Statement of Understanding of Project Metrics
6. Program Incentive Payment Amounts
7. Signed Certification statement attesting that the leadership of PRIME participating entities attests to the accuracy of all PRIME-related information submitted to DHCS.

VI. Plan Review and Approval Process

A. DHCS Plan Approval Process

DHCS will review all Five-year PRIME Project Plans according to the following timeline:

1. By February 1, 2016, or 30 days after the approval of the PRIME protocols (whichever is later), each participating PRIME entity seeking to participate in PRIME will submit the completed Five-year PRIME Pool Plan to DHCS for review.

2. DHCS shall review each plan to verify that it conforms to the below checklist:

    a. The plan is in the prescribed format.
    b. The plan contains and completes all required elements described herein and is consistent with the STCs.
    c. The plan conforms to the requirements for Domains 1, 2 and 3 as described herein, as well as in the Projects and Metrics Protocol (Attachment Q).
    d. The amount and distribution of funding is in accordance with Section VII of this protocol "Disbursement of Pool Funds."

3. By March 15, 2016, or 45 days following the due date for submission of the Five-year PRIME Project Plans, DHCS will complete its review of the plan, and will respond to the participating PRIME entity in writing with any questions, concerns or problems identified.

4. The participating PRIME entity will respond to any of DHCS' questions and concerns in writing within 3 business days of notification by DHCS.

5. By April 1, 2016, or 60 days following the due date for submission of the Five-year PRIME Project Plans DHCS will take action on all plans, and will approve or disapprove each plan.

B. Plan Modification Process

1. Consistent with the recognized need to provide flexibility for participating PRIME entities to modify their plans over time and take into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances, no more than once a year, and by June 30th of each PRIME DY, a participating PRIME entity may submit a request to DHCS to modify its plan. The modification shall be effective as of the date approved by DHCS. PRIME Plan modifications are limited to the circumstances described below.

2. Project removals:
    a. Should a participating PRIME entity no longer meet the minimum 30 patient volume criteria, as specified in Projects and Metrics Protocol (Attachment Q), or no longer finds it practical (e.g. from a clinical or operational standpoint) to continue one or more projects in its approved plan, a participating PRIME entity may seek to remove a project:
        i. A DPH system may seek to remove an optional project as long as the minimum requirement of 9 total projects, including the 6 required projects, continues to be met, which may be satisfied through a substitute project in the same domain as necessary.
        ii. A DPH system may seek to remove a required project if it meets the Exclusions for Project criteria in the Projects and Metrics Protocol (Attachment Q) at the end of DY 11. A DPH system may seek to remove a required project after DY 11 but only in the case that the DPH system no longer meets the 30 patient volume requirement for that project. If a DPH system removes a required project, it must select another project in the same domain as the project that was removed. A DMPH may seek to

remove a project from its plan, as long as it meets the 1 project minimum, or terminate its participation in PRIME.

b. A participating PRIME entity as of the effective date of a project's removal will forfeit any further funding for that project. The participating PRIME entity system shall retain all incentive payments associated with achievements related to that project prior to the removal of that project.

3. Should a participating PRIME entity undergo significant changes in data sources, such a wholesale implementation of a new electronic health record, a plan modification can be submitted for DHCS approval to change annual targets. In addition, should a participating PRIME entity securing a new Medi-Cal managed care contract that results in a significant increase in the number of assigned lives a plan modification can be submitted for DHCS approval to change annual targets.

4. Requests for modification must describe the basis for the proposed modification. If the participating PRIME entity seeks to replace one project with another, it must indicate this proposed change in the request for modification. The 60-day timeline for DHCS to review that is delineated for the Five-year PRIME Project Plans will apply. In the event that DHCS does not approve a modification to a participating PRIME entity's plan, the participating PRIME entity may seek redress by requesting a meeting with the DHCS Director to resolve any issues. The meeting shall take place in a timely manner.

C. Metric Modification Process

1. Over the course of the PRIME, participating PRIME entities may request a project metric change. DPHs must submit one request on behalf of all of the DPHs that are implementing projects that include a relevant metric, and DMPHs must submit a request on behalf of all DMPHs on behalf of all DMPHs that are implementing a project that include a relevant metric. Requests must include evidence of concurrence by all other DPHs or DMPHs reporting on the applicable metric.

2. Request for metric changes may be submitted no more than once a year and by June 30th of the Demonstration Year. Requests for metric changes must describe the basis for the proposed change, the proposed change itself, and the applicable project. Requests may recommend metric substitution or removal.
3. For innovative metrics only (as defined in the PRIME Projects and Metrics Protocol Attachment Q), in addition to substitutions or removal, requests may also recommend metric modification. Metric modification requests will be forwarded to the Measure Steward for review. The Measure Steward may accept or reject the modification request. In the case of acceptance, the modified metric will enter a rigorous testing process (as described in the Metrics and Specifications manual), and if approved for use in PRIME by DHCS, the modified metric will be used in all applicable projects as Pay for Reporting until which time it has been deemed acceptable for Pay for Performance status. Should the modification request be rejected by the Measure Steward, DHCS will review whether or not to continue to use the metric for the specified project.

4. DHCS will seek input from all participating PRIME entities engaged in projects that include the metric in question. The 60 day timeline for DHCS to review that is delineated for the Five-year

PRIME Project Plans will apply. In the event that DHCS does not approve the requested metric change, the original metric will remain in use for the specified projects and the participating PRIME entities may seek redress by requesting a meeting with the DHCS Director to resolve any issues. The meeting shall take place in a timely manner.

VII. Allocation and Disbursement of Pool Funds

Subject to the annual limits set forth in the STCs, aggregate incentive payments available over the 5-year demonstration period to a participating entity will be based on the methodology described below.

A. Total Available PRIME Incentive Payments for a DPH Five-Year PRIME Pool Plan

PRIME payments for each participating PRIME entity are contingent on that entity meeting project metrics' targets in its approved Five-year PRIME Pool Plans.

For PRIME DY 11 only, 25% of the total available PRIME funding will be paid based on the submission and approval of the Five-year PRIME Project Plan, pursuant to STC 100a. The remaining 75% will be paid based on the submission and approval of project baseline data collected through July 1, 2015 – June 30, 2016 in conjunction with the final year-end report. All of the PRIME funding in subsequent DYs will be available as incentive payments based on metric achievement to each DPH system across the three domains. The measurement year for all metrics will coincide with the applicable demonstration year, and for DY 11, metrics for the baseline year will be measured based on July 1, 2015 – June 30, 2016.

The maximum available PRIME payment amount by PRIME DY by domain under the DPH systems pool is summarized in Table 1 below.

Table 1: Total Computable PRIME Payments for DPHs

$ (total computable)	**DY 11**		**DY 12**		**DY 13**		**DY 14**		**DY 15**	
5-Year PRIME Plan	25.0%	350,000,000	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Domain 1: System Transformation	37.5%	525,000,000	50.0%	700,000,000	50.0%	700,000,000	50.0%	630,000,000	50.0%	535,500,000
Domain 2: High-Risk Populations	30%	420,000,000	40.0%	560,000,000	40.0%	560,000,000	40.0%	504,000,000	40.0%	428,400,000
Domain 3: Resource Utilization	7.5%	105,000,000	10.0%	140,000,000	10.0%	140,000,000	10.0%	126,000,000	10.0%	107,100,000
Total	100.0%	1,400,000,000	100.0%	1,400,000,000	100.0%	1,400,000,000	100.0%	1,260,000,000	100.0%	1,071,000,000

1. Every PRIME metric in a given domain will have an annual base value that is calculated by dividing the annual total available amount of PRIME funds in the domain by the base number of metrics across all projects, which is thirty one for domain 1, twenty-three for domain 2, and four for domain 3. The base number of metrics (31, 23, and 4) are estimated averages based on the number of metrics for each required project by domain, plus the average number of metrics per optional project in each domain. The annual base value per metric by domain and per year is summarized in Table 2 below.

Table 2: Annual Base Value Per Metric and Domain for DPHs

$ (total computable)	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**

Domain 1: System Transformation	16,935,484	22,580,645	22,580,645	20,322,581	17,274,194
Domain 2: High-Risk Populations	18,260,870	24,347,826	24,347,826	21,913,043	18,626,087
Domain 3: Resource Utilization	26,250,000	35,000,000	35,000,000	31,500,000	26,775,000

2. If the number of projects and metrics within a domain in the DPH system's Five-Year PRIME Project Plan varies from the applicable base number of 31, 23, or 4, the base metric value for the domain for the DPH system will be adjusted by multiplying by the following ratio: (base metric number / number of metrics in all projects in domain in approved PRIME Project Plan for given year).
3. The amount of PRIME funding available to a DPH system for each metric will be equal to the base value for each metric, adjusted as necessary in step 2, multiplied by a DPH system-specific proportional allotment factor. The DPH system-specific proportional allotment factor is developed from system-specific data, reflecting each DPH system's unique number of Medi-Cal beneficiaries treated as well as overall costs incurred for those patients, to reflect the different mixes of services provided and acuities of patient populations treated by different DPH systems participating in PRIME. The DPH system-specific proportional allotment factor is set forth in Table 3 below for each DPH system.

Table 3: Proportional allotment factors

Eligible DPH System	*Proportional allotment factor*
UC Davis Medical Center	0.041738
UC Irvine Medical Center	0.026019
UC San Diego Medical Center	0.025031
UC San Francisco Medical Center	0.031586
UC Los Angeles Medical Center and Santa Monica UCLA Medical Center	0.018658
Los Angeles County health system	0.319584
Alameda Health System	0.045959
Arrowhead Regional Medical Center	0.061520
Contra Costa Regional Medical Center	0.053761
Kern Medical Center	0.045296
Natividad Medical Center	0.022714
Riverside University Health System - Medical Center	0.047685
San Francisco General Hospital	0.048880
San Joaquin General Hospital	0.028667
San Mateo County General Hospital	0.029885
Santa Clara Valley Medical Center	0.085631
Ventura County Medical Center	0.067386

4. To determine the amount distributed available to DPH systems upon approval of their Five-Year PRIME Project Plan in DY 11, each DPH system must multiply the aggregate amount available contingent on such approval by its own proportional allotment factor in Table 3 above.

B. Total Available PRIME Incentive Payments for a DMPH Five-Year PRIME

PRIME payments for each participating PRIME entity are contingent on that entity meeting project metrics' targets in its approved Five-year PRIME Pool Plans.

Table 4: Total Computable PRIME Payments for DMPHs

$ (total computable)	**DY 11**	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Total	$200,000,000	$200,000,000	$200,000,000	$180,000,000	$153,000,000

1. The maximum available PRIME funding shall be allocated across all DMPH systems as follows:
2. A proportional allotment factor for each DMPH (reflected in Table 5) is using the following factors:
    a. Medi-Cal and uninsured acute net revenue (using data from 2014 Office of Statewide Health Planning and Development).
    b. An adjustment factor based on the number of projects undertaken by each DMPH to recognize the diversity among these facilities.
    c. A baseline floor amount of .0075 in recognition of small/rural hospitals and the baseline effort required of any participating entity
3. The proportional allotment factors were determined using the above factors as follows:
    a. Initially, 80% of the total annual PRIME funding for DMPHs is allocated to each DMPH based on their pro-rata share of total Medi-Cal and uninsured acute net revenue from (2)(a)
    b. The initial remaining 20% of the total annual PRIME funding for DMPHs is divided by the total number of projects projected to be undertaken by participating DMPHs (108) to determine a per project additional amount to recognize the diversity among the facilities and the additional effort of doing multiple projects.
    c. An initial allocation of total annual PRIME funding across the DMPHs is then done by adding the results of (a) and (b).
    d. In order to ensure a baseline floor amount of funding as noted in (2)(a) any DMPH-specific allocation determined in (c) that would result in an allocation factor below .0075 is adjust to achieve the baseline floor allocation equal to the .0075 allotment factor
    e. The remaining DMPHs not adjusted to achieve the baseline floor of .0075, are adjusted on a pro-rata basis so as to not exceed the total funding available.
    f. The resulting allocations after the adjustments in (e) and (f) are then converted into proportional allotment factors by dividing the individual allocation amount by the total PRIME funding for all DMPHs. Table 5 represents the final proportional allotment factors.

Table 5: Proportional allotment factors

Eligible DMPH	*Proportional allotment factor*
Antelope Valley Hospital	0.1193
Bear Valley Community Hospital	0.0075
Coalinga Regional Medical Center	0.0075
Eastern Plumas Health Care	0.0075
El Camino Hospital	0.0234
El Centro Regional Medical Center	0.0453
Hazel Hawkins Memorial Hospital	0.0131
Healdsburg District Hospital	0.0113
Jerold Phelps Community Hospital	0.0075
John C. Fremont Healthcare District	0.0075

Kaweah Delta Health Care District	0.1579
Kern Valley Healthcare District	0.0075
Lompoc Valley Medical Center	0.0285
Mammoth Hospital	0.0116
Marin General Hospital	0.0122
Mayers Memorial Hospital District	0.0075
Mendocino Coast District Hospital	0.0075
Modoc Medical Center	0.0075
Northern Inyo Hospital	0.0198
Oak Valley Hospital District	0.0178
Palo Verde Hospital	0.0175
Palomar Medical Center *(Includes both Palomar Medical Center and Pomerado Hospital)*	0.1010
Pioneers Memorial Healthcare District	0.0308
Plumas District Hospital	0.0075
Salinas Valley Memorial Healthcare System	0.0509
San Bernardino Mountains Community Hospital	0.0075
San Gorgonio Memorial Hospital	0.0175
Seneca Healthcare District	0.0075
Sierra View District Hospital	0.0470
Sonoma Valley Hospital	0.0075
Sonoma West Medical Center	0.0075
Southern Inyo Hospital	0.0075
Tahoe Forest Hospital District	0.0085
Tehachapi Valley Healthcare District	0.0075
Tri-City Medical Center	0.0702
Trinity Hospital	0.0075
Tulare Regional Medical Center	0.0306
Washington Hospital Healthcare System	0.0382

4. To determine the amount available to the DMPH upon approval of their Five-Year PRIME Project Plan in DY 11, each DMPH must multiply the aggregate annual amount available to all DMPHs by its own proportional allotment factor in Table 5 above.

5. Total available PRIME payments for each DMPH are allocated as follows:

    a. In DY 11 only, 25% of the total available PRIME funding will be paid based on the submission and approval of the Five-year PRIME Project Plan, pursuant to STC 100a.
        i. For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, the remaining 75% will be based on the achievement of the approved DY11 infrastructure building metrics for the DMPH through the final year-end report. The annual base value for each infrastructure building metric shall be calculated by dividing the value of the remaining 75% by the number of infrastructure building metrics in the DMPH's approved PRIME Project Plan.
        ii. For DMPHs not requiring infrastructure building metrics, the remaining 75% will be based on the submission and approval of project baseline data, through the final year-end report.

6. In DY 12 only:

a. For DMPHs requiring infrastructure building metrics that are approved in the PRIME Project Plan:
    i. Up to 40% of the total PRIME funding will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The annual base value for each infrastructure building metric shall be calculated by dividing the value of the infrastructure building funding percentage by the number of infrastructure building metrics in the DMPH's approved PRIME Project Plan.
    ii. The remaining 60% or more will be available as incentive payments based on the metric achievement. The annual base value for each metric shall be calculated by dividing the value of the remaining percentage by the number of metrics in the DMPH's approved PRIME Project Plan.
b. For DMPHs not requiring infrastructure building metrics, all of the PRIME funds will be available as incentive payments based on the metric achievement. The annual base value of each metric shall be calculated by dividing the total DY12 PRIME Project Plan funding for the DMPH by the number of metrics across all the projects included in the DMPH's approved PRIME Project Plan

7. For DYs 13-15: All of the PRIME funds will be available as incentive payments based on metric achievement to each DMPH as contained in their PRIME Project Plan.
    a. Each DMPH's PRIME metric will have an annual base value which is calculated by dividing the annual total PRIME Project Plan funding for the DMPH by the number of metrics across all the projects included in the DMPH's approved PRIME Project Plan.

C. Payment Based on Metric Target Achievement

1. Each participating PRIME entity will be individually responsible for performance on its metrics in order to receive its potential incentive funding from the relevant Sub-Pool. Every 6 months, participating PRIME entities will be able to receive incentive payments related to performance on metrics, as specified below.

2. In order to receive incentive funding, the participating PRIME entity must submit the required Mid-Year Report and Final Year-End Report as described in this Attachment.

3. Incentive payments are calculated separately for each metric. The amount of the incentive funding paid to a participating PRIME entity will be based on the amount of progress made on each specific metrics, and the incentive payment amounts associated with those metrics as determined in Sections A & B above and contained in the entity's Prime Project Plan.

4. Calculating Achievement Values
    a. *Pay-for-Reporting Project (P4R) Metrics:* Progress for a metric target will be categorized as fully achieved or not achieved. As an interim payment, the DPH or DMPH is eligible to receive 50% of the metric value for a P4R metric if reported in the Mid-Year Report. The DPH or DMPH may earn the full incentive amount for reporting a P4R metric in the Final Year-End Report.

b. *Pay-for-Performance Project Metrics:* The amount of the incentive funding paid to a participating PRIME entity will be based on the amount of progress made toward achieving its performance target on the standard metric. Based on the progress reported, Tables 6 and 7 will be used to determine the achievement value for metrics with established 90th percentile and 25th percentile benchmarks, which comprise a significant majority of standard metrics. Tables 8 and 9 will be used to determine achievement value for metrics with established benchmarks but without 90th and 25th percentile rankings. Targets for these metrics will be established based on a standard percent improvement relative to a participating PRIME entity prior end-of-year performance. Achievement value for these non-ranked benchmark metrics will be based on the ability of the PRIME entity to close the gap between the prior end-of-year performance and their individual target.

Table 6: Interim Mid-Year Metric Performance Achievement

	Interim Mid-Year Metric Performance Achievement Values (AV)	
End of Year Metric Performance in Prior DY	AV = 0	AV = 0.5
≥ 90th percentile	Performance below 90th percentile	Performance ≥90th percentile
≥ 25th and < 90th percentile	< 50% of the 10% Gap is closed	≥ 50 % of the 10% Gap is closed
< 25th percentile Track A: If gap between performance and 25th percentile is ≥ 10% gap between performance and 90th percentile	Performance ≤25th percentile	Performance ≥25th percentile
< 25th percentile Track B: If gap between performance and 25th percentile is < 10% gap between performance and 90th percentile	Performance < 25th percentile, or performance ≥25th percentile and < 50% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 50 % of the 10% Gap is closed

Table 7: Final Year-End Metric Performance Achievement

	Final Year-End Metric Performance Achievement Values (AV)			
End of Year Metric Performance in Prior DY	AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
≥ 90th percentile	Performance below 90th percentile	NA	NA	Performance at or above 90th percentile
≥ 25th and < 90th percentile	< 50% of the 10% Gap is closed	≥ 50 % to <75% of the 10% Gap is closed	≥ 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed
< 25th percentile Track A: If gap between performance and 25th percentile is ≥ 10% gap between performance and 90th percentile	Performance <25th percentile	NA	NA	Performance at or above 25th percentile
< 25th percentile Track B: If gap between performance and 25th percentile is < 10% gap between performance and 90th percentile	Performance <25th percentile, or performance ≥25th percentile and < 50% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 50 % to <75% of the 10% Gap is closed	Performance ≥25th percentile and ≥ 75 % to <99% of the 10% Gap is closed	100% of the 10% Gap is closed

Table 8: Interim Mid-Year Metric Performance Achievement for Metrics without National/State Benchmarks

Interim Mid-Year Metric Performance Achievement Values (AV)	
AV = 0	AV = 0.5
< 50% of the gap between end of year performance and current year target* is closed	≥ 50 % of the gap between end of year performance and current year target* is closed

*DHCS to set a standard percent improvement target relative to individual current annual performance

Table 9: Final Year-End Metric Performance Achievement for Metrics without National/State Benchmarks

Final Year-End Metric Performance Achievement Values (AV)			
AV = 0	AV = 0.5	AV = 0.75	AV = 1.0
< 50% of the gap between end of year performance and current year target* is closed	≥ 50 % to <75% of the gap between end of year performance and current year target* is closed	≥ 75 % to <99% of the gap between end of year performance and current year target* is closed	100% of the gap between end of year performance and current year target* is closed

*DHCS to set a standard percent improvement target relative to individual current annual performance

b. The participating PRIME entity is eligible to receive an amount of incentive funding for the project metric determined by multiplying the total amount of funding related to the metric by the reported achievement value.

c. If a participating PRIME entity has received funding during a previous reporting period for a given metric, only the remaining amount is eligible for funding in the current reporting period.

D. Progress and Payment Reconciliation

If within a given DY a participating PRIME entity has reported progress on a metric in an interim mid-year report and received partial funding based on that reported mid-year performance, only the remaining funding for full performance in the year is eligible to be earned upon submission of the final year-end report that documents the applicable full year metric performance.

If, upon review of the interim mid-year and final year-end reports, it is determined that the progress by the participating PRIME entity had not been achieved as reported and that such progress would have resulted in a lower payment amount, the participating PRIME entity will be required to re-pay the federal portion of the overpayment amount. If the review of the report determines that actual progress exceeded the progress previously reported and paid for, and the actual progress would have resulted in increased payment (up to the maximum allocated for the metric), then the participating PRIME entity will be able to receive the appropriate additional payment in conjunction with an updated report subject to the intergovernmental transfer process below.

E. Reporting for Payment

All participating PRIME entities will produce an interim mid-year and final year report on metric progress specific to the participating PRIME entity's project and its PRIME defined population. The reports shall be submitted using the standardized reporting mechanism approved by DHCS and CMS. The standardized reporting mechanism shall calculate the incentive payment amount being requested for the progress achieved in accordance with the metric achievement values estimated above.

The report must include submission of the data for each of the metrics for which the participating PRIME entity has achieved progress and seeks payment under the PRIME, except that a PRIME entity may provide

estimates or reasonable projections if particular data is unavailable due to circumstances beyond the PRIME entity's control, including data that is collected and maintained by an external entity, such as a managed care organization, which has not been provided to the participating PRIME entity in a timely and accurate manner. The reports will be due in accordance with the following:

1. Interim Mid-Year Report: Reporting on metrics measuring through December 31. The report and request for payment is due March 31, with payment occurring no later than April 30. For PRIME DY 11 only, the submission of the Five-year PRIME Project Plan will constitute the submission of the Interim Mid-Year Report.
2. Final Year-End Report: Reporting on metrics measuring through June 30. The report and request for payment is due September 30, with payment occurring no later than October 30. For PRIME DY 11 only, the final year-end report must include the submission of the baseline data and a narrative that describes the source of this information, the reporting infrastructure, how it was developed, and how this data will serve as the basis for improvement over the remaining Demonstration.

The Measurement Period for Mid-Year and Final Year-End Reports is listed in the Projects and Metrics Protocol (Attachment Q).
The State must use this documentation in support of PRIME claims made on the MBES/CBES 64.9 Waiver form.

F. Intergovernmental (IGT) Transfer Process

DHCS will issue requests to the entities for intergovernmental transfer amounts necessary for the nonfederal share of the applicable incentive payment amounts, and within the timeframe necessary for the payments to be paid by the dates specified in E(1) and E (2) above. A DPH or DMPH, or its affiliated public agencies, will make an intergovernmental transfer of funds to DHCS in the amount specified within 7 days of receiving the DHCS request. Upon timely receipt of the intergovernmental transfers, DHCS will draw the federal funding and pay both the non-federal and federal shares of the payment to DPHs or DMPHs as applicable. In the event of any misreported or insufficient data, DHCS will not be bound to the 30 day payment timelines in E(1) and E(2), as otherwise applicable, with respect to a participating PRIME entity until its reports are adequately corrected for approval for payment.

VIII. STATE REVIEW PROCESS

Hospital payments will be initiated by the submission of complete reports. DHCS will conduct an initial review of all submitted reports for data completeness. If reports are complete, DHCS will issue IGT letters consistent with the timeframe for payment described above. DHCS will then conduct the administrative and clinical reviews, as outlined below, and will adhere to Progress and Payment Reconciliation Procedures as outlined in section VII.B above. The reviews consist of the following:

1. *Administrative Review:* DHCS will conduct an administrative review of the reports for technical and administrative issues using guidelines approved by CMS.

Clinical Review: DHCS will conduct a review of the reports for clinical issues using the guidelines approved by CMS.

2. Reviews will be issued to participating PRIME entities. The PRIME entities will be given up to fourteen (14) calendar days to respond to issues and to revise reports as needed.

3. DHCS will review revisions and will coordinate any further revisions with the participating PRIME entity.

IX. Reinvestment of Unallocated Funds

Notwithstanding the annual limits set forth in the STCs, participating PRIME entities will have the opportunity to recapture unused or unclaimed PRIME pool payments:

A. Unused Pool Fund

1. If, through the PRIME Project plan submission and approval process, there is Pool funding that remains unallocated pursuant to Section VII.A and B. above, then the affected participating PRIME entity, in addition to all other participating PRIME entities, may implement additional projects or demonstrate greater performance that will be applicable to the remaining Demonstration Years to earn the unused funds.

2. The opportunity to submit earn additional funding will be offered and allocated first to the affected participating PRIME entity, then to participating PRIME entities within the same Sub Pool, then among participating PRIME entities in the same Pool.

3. Requests for additional projects must be approved by the state.

B. Unclaimed Pool Payment

1. As set forth in section VII C. above, pay-for-performance metrics have annual pay-for-performance targets with an identified quantitative achievement target set at the beginning of each demonstration year. Pay-for-performance metrics will earn incentive payments proportional to the achievement value on a percentage basis, whereas pay-for-reporting metrics do not have a quantitative achievement target, and thus may only earn the full incentive payment value based on submission of the metric report.

2. If, at the end of the DY, a pay-for-performance project metric target is not met by a participating PRIME entity and that entity is not able to fully claim funds that otherwise would have been earned for meeting the metric target ("unearned funds"), a participating PRIME entity shall have the opportunity to claim such unearned funds through the following mechanisms. This 90% limitation applies to the aggregate amount of unearned funds that can be reclaimed through the mechanisms described in both IX.B.2.a. and IX.B.2.b.

a) Within a PRIME DY, participating PRIME entities can reclaim up to 90% of any unearned funds on pay-for-performance metrics by over performing (exceeding the

target) in other pay-for-performance metrics in any PRIME project in that same demonstration year.

(1) Over-performance must be demonstrated by exceeding other project metric targets by at least 50% or greater.

(2) Table 9: Unearned Claiming (for current DY) demonstrates the amount of unearned funds that can be claimed through over-performance on pay-for-performance on a metric. The total amount of unearned funds that can be claimed by a participating PRIME entity will be proportional to the amount of over performance on all other pay for performance metric targets in the aggregate.

Table 9: Unearned Claiming (for current DY)

End of Year Metric Performance	**Amount of unearned funds that are eligible for re-claiming**
50-74% over performance	25% of the metric value
75%-99% over performance	37.5% of the metric value
100% over performance	50% of the metric value

(3) Participating PRIME entities are eligible to claim up to 90% of the amount of its total unearned funds based on the aggregate value of the over performance on the other metrics.

(4) The remaining 10% of unearned PRIME funds will be withheld and will be included in the DPH or DMPH PRIME High Performance Pool, described in (c) below. Unearned PRIME funds from DPHs will be included in the DPH High Performance Pool and unearned PRIME funds from DMPHs will be included in the DMPH High Performance Pool.

(5) When participating PRIME entities submit their year-end reports, they must indicate which, if any, metrics they have not fully met and have unearned funds, and which metrics they have over-performed and are being used to claim such unearned funds.

b) If a participating PRIME entity is not able to earn the full 90% value of its unearned funds through the mechanisms set forth in paragraph a. above, the participating PRIME entity will have another opportunity to earn and claim the remainder up to 90% of unearned funds during the subsequent demonstration year on any unmet pay-for-performance metric by demonstrating over-performance on the same unmet metric in the following manner:

(1) Over-performance must be demonstrated by exceeding an unearned funds metric demonstration year target by a minimum of 50% or greater.

(2) The proportion of unearned funds from a given metric that can be claimed will be based on the percentage of over-performance on that same metric. Table 10: Unearned Claiming (for subsequent DY) below demonstrates the amount of unearned funds that can be claimed through over-performance on pay-for-performance metrics.

Table 10: Unearned Claiming (for subsequent DY)

End of Year Metric Performance	**Amount of the same metric's prior year's unearned funds that are eligible for re-claiming**
50-74% over performance	25% of a metric's unearned funds
75%-99% over performance	37.5% of a metric's unearned funds
100% over performance	50% of a metric's unearned funds

(3) If a participating PRIME entity experiences two consecutive years of not meeting the applicable annual targets for a metric, it will no longer be eligible for any over-performance reclaiming in that demonstration year or subsequent demonstration year for that metric.

(4) When a participating PRIME entity submits its year-end final report, it must indicate which, if any, over performance metrics are being used to reclaim funds on prior unmet targets for those same metrics.

c) If, through the above mechanisms set forth above in paragraph a. and b. above a participating DPH system or DMPH is not able to claim 90% of their unearned funds from the prior year, any remainder of the 90% of unearned funds for that metric from DPH systems shall be available to be earned by any DPH system through the establishment of a DPH PRIME High Performance Pool and any remainder of the 90% of unearned funds for that metric from DMPHs shall be available to be earned by any DMPH through the establishment of a DMPH PRIME High Performance Pool. The High Performance Pools will also include the 10% withhold of unearned funds referenced in (a) above for the respective DPHs and DMPHs separately.

(1) The DPH High Performance Pool

(a) The DPH PRIME High Performance Pools will be available annually for DY 13 through DY 15 for any DPH system achieving high performance (defined as achieving ≥90th percentile benchmark performance or 20% gap closure) in any of the eligible 19 National Quality Forum (NQF) metrics in the six DPH required PRIME projects.

(b) Eligible metrics in the PRIME High Performance fund do not include any metrics for which a DPH system used to reclaim unearned PRIME funds through mechanisms IX.B.2.a. and b. above.

(c) DPH PRIME High Performance Pool funds shall be allocated on a pro rata basis to each eligible DPH system, based on the value of each DPH system's eligible NQF metrics for which they have achieved high performance (herein referred to as "high performance metrics"), the aggregate of those values and the total amount of funding available in the pool.

i. Should the total remaining prior year unearned funds from all the DPH systems exceed the aggregate value of all DPH systems' high performance metrics, all DPH systems will be paid the full value of each of their high performance metrics.

ii. Should the total remaining prior year unearned funds from all the DPH systems be less than the aggregate value of all DPH systems' high performance metrics, all DPH systems will be paid a proportion of the full value of each of their high performing metrics. That proportion of funds will be equal to the ratio of the total remaining prior year unearned funds and the aggregate value of all DPH systems high performance metrics.

(d) For DY 13, the DPH High Performance Pool includes the DY 12's remaining of the 90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 12 and DY 13. For DY 14, the DPH High Performance Pool includes the DY 13's remaining of the 90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 14. For DY 15, the DPH High Performance Pool includes DY 14's remaining of the 90% unearned DPH funds (after application of the mechanisms described in IX.B.2.a and b), DY 15's remaining of the 90% unearned DPH funds (after application of the mechanism described in IX.B.2.a), and the 10% withhold for DY 15. The DPH High Performance Pool for each DY does not carry over to the next DY.

(e) When participating DPH PRIME entities submit their year-end final reports, they must indicate which, if any, eligible NQF metrics were used to claim funds from the DPH High Performance Pool.

(2) The DMPH High Performance Pool

(a) The DMPH PRIME High Performance Pools will be available annually for DY 13 through DY 15 for any DMPH achieving high performance (defined as achieving ≥90th percentile benchmark performance or 20% gap closure) in any of the eligible 19 National Quality Forum (NQF) metrics in the following projects as numbered in Attachment Q: Project 1.1, 1.2, 1.3, 2.1, 2.2 or 2.3.

(b) Eligible metrics in the PRIME High Performance fund do not include any metrics for which a DMPH used to reclaim unearned PRIME funds through mechanisms IX.B.2.a. and b. above.

(c) DMPH PRIME High Performance Pool funds shall be allocated on a pro rata basis to each eligible DMPH, based on the value of each DMPH's eligible NQF metrics for which they have achieved high performance (herein referred to as "high performance metrics"), the aggregate of those values and the total amount of funding available in the pool.

iii. Should the total remaining prior year unearned funds from all the DMPHs exceed the aggregate value of all DMPHs' high performance metrics, all DMPHs will be paid the full value of each of their high performance metrics.

iv. Should the total remaining prior year unearned funds from all the DMPHs be less than the aggregate value of all DMPHs' high performance metrics, all DMPHs will be paid a proportion of the full value of each of their high performing metrics. That proportion of funds will be equal to the ratio of the total remaining prior year unearned funds and the aggregate value of all DMPH high performance metrics.

(d) For DY 13, the DMPH High Performance Pool includes the DY 12's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 12 and DY 13. For DY 14, the DMPH High Performance Pool includes the DY 13's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b above) and the 10% withhold described in IX.B.2.a.4 above for DY 14. For DY 15, the DMPH High Performance Pool includes DY 14's remaining of the 90% unearned DMPH funds (after application of the mechanisms described in IX.B.2.a and b), DY 15's remaining of the 90% unearned DMPH funds (after application of the mechanism described in IX.B.2.a), and the 10% withhold for DY 15. The DMPH High Performance Pool for each DY does not carry over to the next DY.

(e) When participating DMPH PRIME entities submit their year-end final reports, they must indicate which, if any, eligible NQF metrics were used to claim funds from the DMPH High Performance Pool.

X. Learning Collaboratives

As part of this demonstration, DHCS will work in collaboration with participating PRIME entities to support regular learning collaboratives, which will be a required activity for all participating PRIME entities, and may be organized by the goals of PRIME or by the specific PRIME projects as described in the PRIME Funding and Mechanics Protocol (Attachment II). Learning collaboratives are forums for participating PRIME entities to share best practices and get assistance with implementing their PRIME projects. Learning collaboratives should primarily be

focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but DHCS should coordinate with participating PRIME entities to organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help participating PRIME entities share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals with training in quality improvement who can answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others. Participating PRIME entities shall fund the non-federal share to support the conducting and operations of learning collaboratives.

Program Purpose and Goals

Within the Medi-Cal 2020 waiver, the Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this strategy aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Given the importance of oral health to the overall health of an individual, California views improvements in dental as critical to achieving overall better health outcomes for Medi-Cal beneficiaries, particularly children. The dental strategies implemented in this pool would be developed and operated by the Department and our Fee-For-Service (FFS) and Dental Managed Care (DMC) contractors.

The DTI will be funded at a maximum of $148 million annually, except as provided below, for five (5) years totaling a maximum of $740 million (DTI Pool). To the extent any of the funds associated with the DTI are not fully expended in a given DY, those remaining prior DY funds may be available for DTI payments in subsequent years, notwithstanding the annual limits stated above. The program will include three (3) domains: preventive services, caries risk assessment and management, and continuity of care, in addition to making funding available for local pilots that address one (1) or more of these three (3) domains. Specific incentive payments within each domain will be available to qualified providers, along with messaging and education to providers and beneficiaries about programs and efforts in their local communities. The Department also intends to have participation from providers in both the FFS and DMC delivery systems beginning in DY 1. The Department will make incentive payments directly to contracted service office locations that participate in the FFS and/or DMC delivery systems that qualify for incentive payments. The service office location is the business or pay-to address where services are rendered by the provider (which may be an individual, partnership, group, association, corporation, institution, or entity that provides dental services). Incentive payments shall be issued to the service office location based on the services rendered at the location and compliance with the criteria enumerated in the STCs.

Dental Program Background

The Medi-Cal Dental Program provides services to 5.5 million Medi-Cal child beneficiaries age twenty (20) and under. Dental services are provided through two (2) delivery systems: Medi-Cal Dental FFS, referred to as Denti-Cal, and DMC. Most beneficiaries are served through the dental FFS delivery system. The Department of Health Care Services (DHCS, Department) conducts oversight of the FFS contractor(s) and six (6) DMC contracts. As the expansion of dental benefits continues to cover more Californians, increased monitoring of beneficiary utilization and provider participation is crucial for identifying any access to dental care issues for children enrolled in the Medi-

Cal Dental Program.

DHCS facilitates access to oral health services for the FFS and DMC delivery systems in multiple ways, including through telephone service centers and correspondence controls for beneficiaries and providers; conducting beneficiary and provider outreach and education; strategies for monitoring and augmenting provider network adequacy and beneficiary utilization; and providing regular reports to the Legislature, stakeholders, and Federal and State government entities. All data and measurement reporting associated with the DTI will be based on an annual reporting period by Demonstration Year (DY).

Project 1: Increase Preventive Service Utilization for Children
Required Project

Project Domain	Increase Preventive Services Utilization for Children
Rationale (Evidence base and reasoning behind project idea)	
Based on reports produced by the Department of Health Care Services (DHCS), as of September 2015 the Denti-Cal provider network had 5,370 service office locations across California. DHCS is proposing to incentivize dental provider service office locations to increase preventive oral care to Medi-Cal children.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

- Increase the statewide proportion of children ages one (1) through twenty (20) and under enrolled in the Medi-Cal Dental Program and who receive a preventive dental service by ten (10) percentage points over a five (5) year period
- Maintain preventive oral care for children who previously received this service

The incentive program will provide semi-annual incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. Eligible providers will receive payments based on them achieving an increased number of Medi-Cal children who received eligible preventive dental services, as compared to a baseline pre-determined by the Department. Providers who render preventive services to a number of children that meets or exceeds a Department pre-determined number of beneficiaries, by service of location, would qualify for the incentive payment.

Further, the program will also disburse incentive payments to providers who were not previously participating in Medi-Cal and rendering preventive services, but who do so during the demonstration, on the condition that they meet or exceed the provision of services based on the Department pre- determined number of beneficiaries, by county, needed to be served to achieve the goal. The new service office location's pre-determined number will be the average number of additional beneficiaries among all existing service office locations in the county needed to increase the statewide goal of two (2) percentage points. In subsequent demonstration years, the Department will re-evaluate the new service office location and develop a benchmark using the same methodology as described above for existing dental providers in the program.

Safety net clinics would also be eligible for these incentives and would be supplied with incentive payments separate and apart from their Prospective Payment System (PPS) or Memorandum of Agreement (MOA) rates for Federally Qualified Health Centers/Rural Health Centers and Tribal Health Centers, respectively. Each safety net clinic office location would be considered a dental service office location for purposes of this domain.

The Department will determine the number of additional beneficiaries to be served in order to achieve the goal of ten (10) percentage point utilization increase statewide. To illustrate, if a service office location provided preventative services to 1,000 beneficiaries for the selected benchmark year, its baseline benchmark is 1,000. In the first year, the annual target benchmark will be to increase by two (2) percent of 1,000; thus this service office location would need to provide preventive services to an additional 20 new beneficiaries (1,000 x 0.02 = 20).

DHCS may earn additional demonstration authority, up to a maximum of $10 million, to be added to the DTI Pool for use in paying incentives to qualifying providers under DTI, by achieving higher performance improvement, as indicated in the below table:

DY	Target	$1 million in additional demonstration authority for achieving:	$2 million in additional demonstration authority for achieving:
1	+ two (2) percentage points over baseline year	Not Applicable	+ three (3) or more percentage points over baseline year
2	+ four (4) percentage points over baseline year	+5 or more percentage points over the baseline	+ six (6) or more percentage points over baseline year
3	+ six (6) percentage points over baseline year	+7.5 or more percentage points over the baseline	+ nine (9) or more percentage points over baseline year
4	+ eight (8) percentage points over baseline year	+10 or more percentage points over the baseline	+ twelve (12) or more percentage points over baseline year
5	+ ten (10) percentage points over baseline year	+12.5 or more percentage points over the baseline	+ fifteen (15) or more percentage points over baseline year

Incentive payments will be based on each service office location that meets or exceeds the Department pre-determined goal for increases in preventive services provided to every child within frequency limitations regardless of whether that child is a previously established patient of that service office location.

The incentive payment for preventive services will equate to a payment of approximately seventy-five (75) percent above the Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service on an annual basis, above the predetermined baseline number of children receiving a preventive dental service in the previous year. Alternatively, incentive payments for preventive services will equate to a payment of approximately thirty-seven and a half (37.5) percent above the SMA incentive payment for service office locations that meet at least a 1 percentage point increase, but less than 2 percentage point increase in number of children receiving a preventive dental service on an annual basis above the predetermined baseline number of children served with a preventive dental service in the previous year. To the extent that the projected funding limit would be reached for this Domain, incentive payment amounts will be reduced for each claim by the percentage by which incentive payments would otherwise exceed the annual limit. These payments are subject to annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in the Medi-Cal 2020 Waiver

Special Terms and Conditions (STCs).

The results of this project will be used to determine if provider incentive payments are an effective method by which to encourage service office locations to provide medically necessary preventive dental services to more Medi-Cal children and to what extent an incentive payment is an effective method for increasing Medi-Cal provider participation

and improving access to care for children. The Department anticipates that increased preventive services will result in decreased long term costs for more invasive procedures, one of the core tenants of the Triple Aim concept.

A reassessment of this Domain and the applicable benchmarks will take place between years two and three in order to evaluate program effectiveness, increases in preventive services, adjustments for population growth or decline throughout the state, and other factors as may be appropriate.

Core Components

The baseline year will consist of data from the most recent complete year preceding implementation of the waiver. Beneficiary utilization and service office location participation will be reassessed on an annual basis thereafter. The metrics that will be used for monitoring domain success are:

1. Percentage of beneficiaries who received any preventive dental service during the measurement period, which is calculated as follows:

   Numerator: Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days who received any Medi-Cal covered preventive dental service (D1000-D1999) in the measurement period.

   Denominator: Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days during the measurement period.

2. Claims data to determine the number of service office locations in each county that are providing preventive dental services to children, compared to number of these locations in the baseline year.

3. Statewide the number and percentage change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.

Projects Metrics

Clinical Event Outcomes	1. <u>Prevention</u> • Increase the utilization of children ages one (1) through twenty (20) enrolled in Medi-Cal who receive any preventive dental service, by at least ten (10) percentage points over a five (5) year period. 2. <u>Access to Care</u> Increase the number of actively participating providers in each county who provide preventive services.

Project 2: Caries Risk Assessment and Disease Management Pilot
Required Project

Project Domain	Caries Risk Assessment and Disease Management Pilot
Rationale (Evidence base and reasoning behind project idea)	
Dentists today are embracing a philosophy of prevention and taking proactive measures to prevent and mitigate oral disease. The key elements of this model are to formally assess and manage caries risk and to emphasize the provision of preventive services in lieu of more invasive and costly procedures for Medi-Cal children age six (6) and under enrolled in the Medi-Cal Dental Program. Caries Risk Assessment (CRA) incorporates an evidence-based philosophy which focuses on preventive and intervention therapy based on an individual patient's caries risk through prevention, intervention, education, and identification. Ultimately, this will enable DHCS to work toward the achievement of the CMS Triple Aim goals by implementing provider incentives based on performing a CRA to identify a child's risk level, and developing and completing a beneficiary specific treatment plan. Additionally, it will enable the Medi-Cal Dental Program to improve the overall oral health of the enrolled beneficiary population.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

- Diagnose early childhood caries and treat it as a chronic disease
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventative services in lieu of more invasive and costly procedures, aimed at improving the population's oral health
- Track the target population's utilization of preventive and restorative services

This four (4) year domain will only be available initially to dentists in pilot counties that elect and are approved by the Department to participate in the program. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2. Through this effort, Medi-Cal dentists voluntarily participating in the domain will be eligible to receive incentive payments for performing pre-identified treatment plans for children based upon the beneficiary's risk level as determined by the dentist via a caries risk assessment which include motivational interviewing and use of antimicrobials, as indicated. Pilot counties will be identified and selected by the Department through an analysis of counties with a high percentage of restorative services, a low percentage of preventive services, and indication of likely enrolled service office location participation. The incentive program will only be available for services performed on child beneficiaries age six (6) and under.

Dentists participating in the domain will be authorized to perform an increased number of services per year in accordance with the pre-identified treatment plan options based

upon caries risk level, and are eligible to receive an incentive payment under this program for each additional service not currently covered under the California State Plan and frequency limitations listed in the Manual of Criteria. Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, qualifying service office locations will receive an incentive payment for providing each of these additional services. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal 2020 Waiver STCs.

The results of this project will be used to determine if this provider incentive program is effective in encouraging providers to perform a CRA for the targeted population and to ensure completion of the appropriate treatment plan for the management of childhood caries, if the utilization of emergency room visits for dental issues among the targeted children declines, if expenditures of emergency room visits non-traumatic dental issues among targeted children declines, and if the utilization of and expenditures (including anesthesia and facility fees) for the targeted children receiving dental related general anesthesia declines.

Core Components

Dentists must first complete a CRA to determine the appropriate treatment plan for a child, and report the results of the CRA to DHCS on a claim. Once the risk level and the treatment plan have been determined, the beneficiary may be eligible for increased frequency limitations on prophylaxis, topical fluoride varnish, and exams. The pre-identified treatment plans will be composed of the following procedures: CRA (which will globally include motivational interviewing, behavior modification/nutritional counseling, and interim caries arresting medication application), application of topical fluoride varnish, prophylaxis, and exams. Increased frequencies for prophylaxis, fluoride varnish, and exams will be permitted for children evaluated and determined to be at a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: “high risk” will be authorized to visit their provider four (4) times; “moderate risk” children will be authorized to visit three (3) times; and “low risk” children two (2) times. Dentists will receive payment for completion of a CRA as well as each of the following services: application of topical fluoride varnish, toothbrush prophylaxis, and exams at their respective appropriate increased frequency limitations.

The Department will collect data and report on the following performance measures:

1. Number of, and percentage change in, restorative services;
2. Number of, and percentage change in, preventive dental services;
3. Utilization of CRA CDT codes and reduction of caries risk levels (not available in the baseline year prior to the Waiver implementation);
4. Change in use of emergency rooms for dental related reasons among the targeted children for this domain; and
5. Change in number and proportion of children receiving dental surgery under general anesthesia.

The Department will also track and report on, for children in age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6), the utilization rates for restorative procedures against preventive services to determine if the domain has been effective in reducing the number of restorations being performed. Because preventive services do not yield immediate effects, the Department will be required to collect data on these performance measures at annual intervals for a number of years to determine correlation and statistical significance. The Department will inform CMS of the number of additional years this data will be collected and reported no later than the end of DY 1. The Department will also track and report on the utilization of CRA and treatment plan service to monitor utilization and domain participation. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.	
Project Metrics	
Clinical Event Outcomes	1. <u>Caries Risk Assessment</u> • Increase utilization of CRA CDT codes and monitor movement between risk levels 2. <u>Caries Management</u> • Increase ratio of utilization of preventive services versus restorative • Decrease utilization of use of emergency room and oral surgery for dental related reasons among children

Project 3: Increase Continuity of Care
Required Project

Project Domain	Increase Continuity of Care
Rationale (Evidence base and reasoning behind project idea)	
Maintaining a consistent relationship with a primary care dental provider can encourage children and their families to receive regular preventive care and to actively manage their care.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	
➢ Increase dental continuity of care among Medi-Cal children enrolled in the Medi-Cal Dental Program The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2. The results of this project will be used to determine if incentive payments are effective in promoting continuity of care, consistent with the enumerated Triple Aim goals.	
Core Components	

To encourage the continuity of care within the beneficiary population, an incentive payment would be paid to dental provider service office locations who have maintained continuity of care through providing examinations for their enrolled child beneficiaries, age twenty (20) and under for two (2), three (3), four (4), five (5), and six (6) year continuous periods. The incentive will be a flat payment for providing continuity of care to the beneficiary. Incentive payments will be made annually.

The baseline year will be based on data from the most recent complete state fiscal year. Using claims data, DHCS will determine the number of beneficiaries who have remained with their same service office location for two (2), three (3), four (4), five (5), and six (6) year continuous periods following the establishment of the baseline year throughout the demonstration period. This will be calculated as follows:

> Numerator: Number of children age twenty (20) and under who received an examination from the same service office location with no gap in service for two (2), three (3), four (4), five (5), and six (6) year continuous periods.
>
> Denominator: Number of children age twenty (20) and under enrolled in the delivery system during the measurement periods.

This measure is similar to the Dental Quality Alliance measure Usual Source of Services, with the exception that the Department would incent over a longer continuous period.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.	
Project Metrics	
Clinical Event Outcomes	1. Continuity of Care • Increase utilization of children continuously enrolled in the Medi-Cal Dental Program who received services performed by the same provider in two (2), three (3), four (4), five (5), and six (6) consecutive year periods.

Project 4: Local Dental Pilot Programs
Optional Project

Project Domain	Pediatric Oral Disease Prevention, Caries Risk Assessment and Management, and Dental Health Homes
Project Title	Local Dental Pilot Programs (LDPPs)
Rationale (Evidence base and reasoning behind project idea)	
LDPPs shall address one (1) or more of the three (3) domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of the Department in any of the domains specified above.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

Increase dental prevention, caries risk assessment and disease management, and continuity of care among Medi-Cal children.

DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments to LDPPs in accordance with the requirements as outlined below; a maximum of fifteen (15) LDPPs shall be approved. DHCS will work in collaboration with the CMS in the development of evaluation criteria for the LDPPs.

a. LDPPs should include the potential for statewide expansion.

b. LDPPs shall include specific strategies to meet one (1) or more of the three (3) DTI domains.
   i. Increase preventive services utilization for children;
   ii. Increase caries risk assessment and disease management; and
   iii. Increase continuity of care

c. LDPPs are intended to target individuals in need of dental services. LDPPs will identify the needs of their population and proposed interventions that would be supported through the LDPP in their application. LDPPs must be complementary and not redundant with the efforts describe in the aforementioned domains.

d. The specific strategies, target populations, payment methodologies, and participating entities shall be established by the entity submitting the application. DHCS shall approve applications that meet the requirements as outlined by CMS and the Department established criteria and that further the goals of the DTI. Each LDPP is intended to be in operation from the date of approval through the end of the demonstration. However, DHCS reserves the right to suspend or terminate a LDPP at any time if the enumerated goals are not met, corrective

action has been imposed, and/or poor performance continues.

e. Financing for LDPPs is contingent upon the structure and design of approved proposals and is limited to a maximum of twenty-five (25) percent of the annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal 2020 Waiver STCs.

Lead and Participating Entities.

a. DHCS will accept applications for LDPPs from a county, a city and county, a consortium of counties serving a region consisting of more than one (1) county, a Tribe, an Indian Health program, UC or CSU campus. Each LDPP application shall designate a "lead entity" that will be a county, Tribe, Indian Health Program, UC or CSU campus that will coordinate the LDPP and be the single point of contact for DHCS and CMS.

b. The LDPP application shall identify other entities that shall participate in the project.

Application Process.

a. *Timing.* Lead entities shall submit LDPP applications to DHCS no later than 60 days after the applicable protocols are approved.

b. *Application Contents*. LDPP applications must include:

i. identification of a LDPP lead entity;
ii. a collaboration plan that includes local partners and details how decisions will be made;
iii. a description of the needs assessment that was conducted to identify the target population(s), including the data used;
iv. a description of services and care coordination that will be available to beneficiaries under the LDPP;
v. a description of how the lead entity and participating providers will be accountable for ensuring that the patient's receive timely, medically necessary care;
vi. detail of the specific interventions, including how a process improvement plan will be incorporated to modify and learn from the interventions during the LDPP;
vii. a description of how data sharing will occur between the entities, including what data will be shared with which entities;
viii. a description of other strategies and outreach efforts that will be implemented to achieve the goals of the LDPP in the form of an awareness plan;
ix. a plan for the lead entity to conduct ongoing monitoring of the LDPP and make subsequent adjustments when issues are identified;

x. letters of support from participating providers and other relevant stakeholders indicating their agreement to participate in or support the

LDPP;

xi. a financing structure including a description of how and to whom LDPP payments will be distributed; and

xii. a total requested annual dollar amount, which shall be based on budgeted costs for infrastructure and overall LDPP support and the expected value or impact of the LDPP. Budgets shall exclude costs for services reimbursable with Medi-Cal Dental or other federal funding resources.

c. *DHCS Review Process*. DHCS will review all LDPP applications according to the guidelines to be established by DHCS and CMS.

i. DHCS shall review each application for projects to verify that they conform to the relevant requirements and meet the selection criteria as established by DHCS and CMS. DHCS will complete its review of the application, and will respond to the LDPP lead entity in writing with any questions, concerns, or problems identified. The lead entity will respond to DHCS' questions and concerns in writing within five (5) business days.

ii. Following the submission of final responses to questions about the application, DHCS will take action on the application and promptly notify the applicant and CMS of that decision.

Termination. DHCS reserves the right to suspend or terminate a LDPP at any time if the enumerated goals are not met, corrective action has been imposed, and/or poor performance continues.

Progress Reports. The LDPP shall submit quarterly and annual reports as agreed upon by DHCS and CMS upon acceptance of the LDPP. Continuation of the LDPP shall be contingent on timely submission of all the required reports.

The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2.

Core Components

DHCS intends to review, approve, and make incentive payments available to pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established by the Department and deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department. DHCS shall approve only those applications that meet the requirements to further the goals of one (1) or more of the three (3) dental domains. Each pilot application shall designate a responsible county who will coordinate the pilot. DHCS reserves the right to suspend or terminate a pilot at

any time if the enumerated goals are not met, corrective action has been imposed, and/or poor performance continues. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.	
Project Metrics	
Clinical Event Outcomes	Local dental pilot projects will be evaluated consistent with the performance metrics of the aforementioned dental domains and the goals outlined in the individual proposals. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met. Any of the following, or other measures that are closely tied the DTI domains. **Increase Preventive Services Utilization for Children** 1. <u>Prevention</u> • CMS Oral Health Initiative Goal: To increase the utilization of children ages twenty (20) and under enrolled in Medicaid or CHIP who receive any preventive dental service, by ten (10) percentage points over a five (5) year period. 2. <u>Access to Care</u> • Increase the number of actively participating providers in each county who provide preventive services. **Caries Risk Assessment and Disease Management Pilot** 1. <u>Caries Risk Assessment</u> • Increase utilization of CRA CDT codes and monitor movement between risk levels 2. <u>Caries Management</u> • Increase ratio of utilization of preventive services versus restorative • Decrease utilization of use of emergency room and oral surgery for dental related reasons among children **Increase Continuity of Care** 1. <u>Continuity of Care</u> • Increase utilization of children continuously enrolled in the Medi-Cal Dental Program who received services performed by the same provider in two (2), three (3), four (4), five (5), and six (6) consecutive year periods.

Attachment KK
California Children's Services Pilot Protocol

(Reserved)

Attachment LL
Historical Information-Budget Neutrality Test

(Reserved)

I. **WPC Pilot Performance**. All WPC pilots will report universal and variant metrics mid-year and annually, unless otherwise specified below. Universal metrics will be a same set of metrics required of all WPC pilots; Variant metrics will differ between pilots and will be tailored to the unique strategies and target population(s) of each individual WPC Pilot. Data reported during WPC Program Year (PY) 1 shall be for a time period prior to implementation and will establish a baseline. WPC Pilot metric performance may be calculated by the State or WPC Pilot, as specified by the State in a reporting template with instructions.

When utilizing and reporting Plan Do Study Act (PDSA) for purposes of Universal and Variant metrics, WPC pilots shall utilize a template developed by the State, which may be modified as appropriate when reporting on its target population(s) and interventions (as approved by the State). The template shall also demonstrate a change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out the change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. It shall include requirements pertaining to when new versions of policies and procedures shall be submitted as a result of use of PDSA. The template shall also provide an opportunity for WPC pilots to document when additional changes are not needed based on study results, as approved by the State. The PDSA approach shall be measured within the timelines set forth below for each measure in this Attachment and approved in the application. Reporting including supporting documentation of all measures will be included in and submitted with the mid-year and annual reports as specified in Attachment GG. Health outcomes metrics rates shall be measured annually, however, progress and supporting documentation shall be submitted semi-annually. Administrative Metrics shall include a written description of the structure, barriers and challenges, and activities, if any, relating to the operationalization of them during PY 1; for all other program years PDSA reporting will occur.

II. **Universal Metrics.** Universal metrics will assess the success of all WPC pilots in achieving the WPC goals and strategies as specified in STCs 110 and 112. They will be reported by all WPC Pilots for the duration of the demonstration and shall include:

i. <u>Health Outcomes:</u> Ambulatory Care – Emergency Department Visits (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly.
    1. Children (as applicable)
    2. Adults (as applicable)
    3. Total

ii. <u>Health Outcomes:</u> Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly.
    1. Children (as applicable)

2. Adults (as applicable)
3. Total

iii. Health Outcomes: Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)
1. Children (ages 6 – 17) (as applicable)
2. Adults (as applicable)
3. Total

iv. Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)
1. Adolescents (ages 13 – 17) (as applicable)
2. Adults (as applicable)
3. Total

v. Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of:
1. Enrollment into the WPC Pilot
2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)

Utilization of PDSA with measurement and necessary changes a minimum of quarterly to determine any necessary changes to meet the timelines and ensure care plans are comprehensive in nature and accessible by the entire care team.

vi. Administrative: Care coordination, case management, and referral infrastructure.
1. Measured by:
a. Submission of documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC Pilot lead and all participating entities which provide for streamlined beneficiary case management. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.
i. The WPC lead entity may serve as the central communication point across all participating entities. However, all participating entities must have access to and be provided with timely access and updates to beneficiary information for care coordination and case management purposes.
ii. The policies and procedures shall establish a communication structure for participating beneficiaries. The number of participating entities for purposes of the Pilot as points of contact for beneficiaries shall be minimalized.
b. Monitoring procedures for oversight of how the policies and procedures set forth in iv.1(a) are being operationalized

– including a regular review to determine any needed modifications.

i. Utilization of PDSA with measurement and necessary changes a minimum of semi-annually.

c. A method to compile and analyze information and findings from the monitoring procedures set forth in iv.1(b). And a process to modify the policies and procedures set forth in iv.1(a) in a streamlined manner and within a reasonable timeframe.

vii. Administrative: Data and information sharing infrastructure

1. Measured by:

a. Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements, to the extent permitted by applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.

i. The WPC lead entity may serve as the central data and information sharing entity across all participating entities. However, all participating entities must have access to and be provided with timely access and updates to necessary beneficiary data and information to the extent permitted by applicable state and federal law for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements.

b. Monitoring procedures for oversight of how the policies and procedures set forth in v.1(a) are being operationalized – including a regular review to determine any needed modifications.

i. Utilization of PDSA with measurement and necessary changes a minimum of semi-annually.

c. A method to compile and analyze information and findings from the monitoring procedures set forth in v.1(b), and a process to update as appropriate the policies and procedures set forth in v.1(a) in a streamlined manner and within a reasonable timeframe in accordance with PDSA.

III. **Variant Metrics.** Variant metrics will assess the success of individual WPC pilots in achieving the WPC goals and strategies as specified in STCs 110 and 112. These metrics shall be specific to the WPC Pilot target population(s), strategies, and interventions. Variant metrics may vary by PY, though some metrics shall be consistent across all PYs of the Pilot. The metrics may include process and/or outcome measures and will utilize PDSA as is set forth above in this Attachment. Variant metrics shall be approved by the State in the WPC Pilot application. The State

may request modifications or changes be made to proposed application metrics. Additional documentation may be requested and reviewed for approval by the State for Variant Administrative metrics. WPC Pilots must utilize the attached WPC Variant Metrics menu for purposes of selecting variant metrics.

1. Each WPC Pilot shall report on a minimum of:
    1. i. Four Variant metrics for each PY, including at a minimum items 1, 2, 3, and 4 below (or for pilots implementing a housing component, five Variant metrics for each PY, including at a minimum items 1, 2, 3, 4, and 5):One administrative metrics in addition to the Universal care coordination and data sharing metrics.
    2. One standard health outcomes metrics (e.g., HEDIS) applicable to the WPC Pilot population across all five program years for each target population.
    3. WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric; all other Pilots shall report one alternative health outcomes metric.
    4. WPC Pilots including a severely mentally ill (SMI) target population shall report the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) WPC Pilots; all other Pilots shall report one alternative health outcomes metric.
    5. WPC Pilots implementing a housing component shall report a fifth metric specific to this intervention.
2. Variant metrics must be created through the following standardized process:
    i. Conduct an assessment of:
        1. The target population(s) characteristics and needs (utilizing available data resources); and
        2. Gaps in the WPC Pilot service area infrastructure to meet the identified needs of the target population(s).
    ii. Define specific objectives/strategies that provide for process improvement pertaining to the identified needs and gaps.
    iii. Conduct the following steps based on the identified objectives/strategies:
        1. A literature review including identification of any existing metrics used on a national level to measure outcomes pertaining to the WPC Pilot target population(s)
        2. Consider metrics that are already being captured by one or more participating entities for local programs
    iv. Select metrics that measure progress towards the objectives/strategies, using the following guidelines:
        1. Select metrics that measure changes in infrastructure, processes, and/or outcomes

IV. Annual performance accountability. Universal and Variant metric performance may be assessed according to directional change relative to the initial baseline data and assessment. Performance of individual metrics may also be measured and calculated based on established thresholds as compared to other WPC Pilot performance (adjustments for target population(s), structure, geographic area, and

other factors, may be made as needed). For health outcomes metrics, the following measurement process shall be used:

1. PY 1: Approved WPC Pilots shall gather and report baseline data on their target population(s) against which changes in future years will be assessed. Data should only include time periods prior to the beginning of the WPC Pilot interventions. Partial data for PY 1 shall be reported for time periods after the WPC Pilot is implemented, as applicable.
2. PYs 2-3: WPC Pilots will report on all Universal and Variant metrics, and describe in their mid-year and annual reports early trends, potential explanations, and plans to incorporate lessons into a continual cycle of performance improvement (using a PDSA methodology).
3. PYs 4-5: WPC Pilots will report on all Universal and Variant metrics, including discussing the direction of the changes shown in the data. If changes are in the predicted direction, WPC Pilots shall comment on what they believe contributed to the improvement. If changes are not in the predicted direction, WPC Pilots shall comment on what may be hindering improvement, and how interventions will be adapted to improve performance.

For administrative metrics, the following measurement process shall be used:

a. PY 1: Approved WPC Pilots shall report on Universal and Variant administrative metrics including activities relating to establishing the infrastructure to implement them. A description of the infrastructure and/or processes for the time period prior to the beginning of the WPC Pilot interventions shall be included.
b. PYs 2-5: WPC Pilots will report on all Universal and Variant administrative metrics and describe in their mid-year and annual reports early trends, potential explanations, and plans to incorporate lessons into modifications to the supporting infrastructures for the administrative metrics. If the State determines a WPC Pilot does not demonstrate appropriate performance pertaining to administrative metrics as set forth, DHCS may impose corrective action or discontinue operation of the Pilot.

Whole Person Care Variant Metrics Menu

Metric ID:	**Variant Metric 1**	**Variant Metric 2 Options**				
Target Population:	All	All target populations across all program years	All target populations across all program years	All target populations across all program years	All target populations across all program years	All target populations across all program years
Measure Type:	Administrative	Health Outcomes: 30 day All Cause Readmissions	Health Outcomes: Decrease Jail Recidivism	Health Outcomes: Overall Beneficiary Health	Health Outcomes: Controlling Blood Pressure	Health Outcomes: HbA1c Poor Control <8%
Description:	To be developed and submitted by each WPC Pilot Applicant and approved by DHCS	30 day All Cause Readmissions	Decrease Jail Recidivism	Improve self reported health status and reported quality of life at prior assessment	Controlling High Blood Pressure	Comprehensive diabetes care: HbA1c Poor Control <8%
Numerator:	--	Count of 30-day readmission	Total number of incarcerations of WPC participants during the reporting period	Total score of the Likert scale response of WPC participants who responded to a health status survey during the reporting period	Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg	Within the denominator, who had HbA1c control (<8.0%)
Denominator:	--	Count of index hospital stay (HIS)	Total number of WPC participants during the reporting period	Total number of WPC participants who responded	Members 18–85 years of age who had a diagnosis of hypertension (HTN)	Members 18–75 years of age with diabetes (type 1 and type 2)

				to a health status survey during the reporting period		

Metric ID:	**Variant Metric 3**	**Variant Metric 4**	**Variant Metric 5 Options**		
Target Population:	PHQ-9/depression	SMI population	Homeless/ at-risk for homelessness	Homeless/at-risk for homelessness	Homeless/at-risk for homelessness
Measure Type:	Health Outcomes: Required for Pilots using PHQ-9	Health Outcomes: Required for Pilots w/SMI Target Population	Housing : Permanent Housing	Housing: Housing Services	Housing: Supportive Housing
Description:	NQF 0710: Depression Remission at 12 Months	NQF: 0104 Suicide Risk Assessment	Percent of homeless who are permanently housed for greater than 6 months	Percent of homeless receiving housing services in PY that were referred for housing services	Percent of homeless referred for supportive housing who receive supportive housing
Numerator:	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five	Patients who had suicide risk assessment completed at each visit	Number of participants in housing over 6 months	Number of participants referred for housing services that receive services	Number of participants referred for supportive housing who receive supportive housing
Denominator:	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Number of participants in housing for at least 6 months	Number of participants referred for housing services	Number of participants referred for supportive housing

Attachment NN
DSH Coordination Methodology

During any year in which the State of California conducts the Global Payment Program ("GPP"), the state shall make the modifications listed in this Attachment NN to its methodologies for making disproportionate share hospital payments under the DSH State Plan provisions (Attachment 4.19-A, commencing with page 18).

1. The state shall not make disproportionate share hospital payments during a state fiscal year to any designated public hospital listed in Attachment C that participates in the Global Payment Program during that year.

2. Prior to the start of the applicable GPP PY, or as soon thereafter as possible, the full amount of the federal DSH allotment under SSA § 1923(f) for the FFY that commences in the applicable GPP PY shall be determined. For this purpose, the allotment identified for California for the applicable FFY in the Preliminary Disproportionate Share Hospital Allotments that is published by CMS shall be initially used.

3. Hospitals that meet DSH eligibility criteria and are "non cost-based DSH facilities," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non cost-based DSH facilities, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

4. Hospitals that meet DSH eligibility criteria and are "non-government operated hospitals," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-government operated hospitals, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

5. The federal DSH allotment set-aside amounts determined above for non cost-based DSH facilities in paragraph 3, and for non-government operated hospitals in paragraph 4, will be subtracted from the full federal DSH allotment amount identified in paragraph 2.

6. Hospitals that meet DSH eligibility criteria, and are "cost-based DSH facilities" as defined under the DSH State Plan provisions, and which are licensed to the University of California, will receive DSH payments pursuant to the applicable State Plan methodology, subject to an annual aggregate cap on the associated federal DSH allotment for those payments. The annual aggregate cap is equal to an applicable percentage multiplied by the amount of the federal DSH allotment that is left after the set-asides for non cost-based DSH facilities and non-government operated hospitals, as calculated in paragraph 5, which shall be the DSH allotment amount set aside for the University of California DSH facilities. The applicable percentages for each GPP PY are as follows:

   GPP PY 1: 26.296%
   GPP PY 2: 24.053%
   GPP PY 3: 23.150%
   GPP PY 4: 21.896%
   GPP PY 5: 21.896%

7. The full federal DSH allotment amount, less the aggregate DSH allotment set-aside amounts determined for non cost-based DSH facilities in paragraph 3, for non-government operated hospitals in paragraph 4, and for cost-based DSH facilities licensed to the University of California in paragraph 6, shall constitute the initial "Adjusted DSH" component of the funding for the GPP described in STC 167. The initial "Adjusted DSH" component is determined no later than May 15 prior to the start of each GPP program year.

8. The final Adjusted DSH component of the GPP shall be determined pursuant to the steps in paragraphs 1 – 7 above, which shall take into account the following:

    a. The allotment identified for California for the applicable FFY in the Final Disproportionate Share Hospital Allotments that is published by CMS;

    b. The actual amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the results of the applicable DSH audits for the hospitals, including any adjustments that increase or decrease DSH payments to the hospitals.

9. Adjustments shall be made to the GPP total computable annual limit and GPP annual budgets to take into account the final Adjusted DSH component for the applicable GPP PY determined in paragraph 8, and, notwithstanding the final payment timeline set forth in Attachment EE, all final reconciliation payments for the applicable GPP PY made pursuant to Attachment EE shall be subject to these adjustments.

10. Within 30 days of its determination of the initial "Adjusted DSH" component discussed in step 7, the state will submit a report to CMS stating the amount of the initial "Adjusted DSH" component for the applicable GPP PY (with explanation for how "Adjusted DSH" component was calculated) and projected DSH payment amounts for all hospitals that will receive DSH payments.

11. Within 30 days of its determination of the final "Adjusted DSH" component discussed in step 7, the state will submit a report to CMS stating the amount of the final "Adjusted DSH" component for the applicable GPP PY, the actual and final amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the final GPP total paid to each GPP hospital.

12. The state will report all DSH payments to "non cost-based DSH facilities," "non-government operated hospitals," "cost-based DSH facilities" licensed to the University of California, and designated public hospitals not participating in the Global Payment Program, on Forms CMS-64.9 WAIVER, with waiver number 11-W-00193/9, under Waiver Name "DSH," and with project number extension indicating the demonstration year corresponding to the federal fiscal year of the DSH allotment for which the payments were made.

(Reserved)

Following a determination that a credible allegation of fraud exists with respect to a CBAS provider, and that there is no good cause not to suspend payments, the State will initiate an email notification within one business day to all contracted Managed Care Plans (MCPs) that have provider networks in which the CBAS provider participates. Commencing with payments made by an MCP on or after April 1, 2016, MCPs will be required to report to the State all payments made to a CBAS provider for whom a credible allegation of fraud exists for dates of services rendered after the date the MCP was notified. The procedures below outline details regarding the reporting and recoupment process:

- The State's notification email to the MCPs will contain specific instructions for reporting requirements. MCPs will utilize the "Total MCP Payments to CBAS under Credible Allegation of Fraud" form to track total payments made to the applicable CBAS provider on a quarterly basis, commencing with the first quarter that the MCP was notified of the credible allegation of fraud. Reports for all subsequent quarters will indicate the total payments made for the given quarter, as well as the cumulative total payments made to the CBAS provider from the date following initial notification of the credible allegation of fraud.

- MCPs will submit quarterly reports to the State within seven business days from the end date of each quarter. The State will, in turn, submit quarterly reports to CMS reflecting all MCP payments made to applicable CBAS providers within fifteen business days from the end date of each quarter.

- Reporting requirements will remain in effect until the State notifies the MCP that the law enforcement agency investigating the credible allegation of fraud has either charged the CBAS provider with fraud or has informed the State that there is insufficient evidence to bring charges. Upon receipt of such information from the investigating agency, the State will notify the MCPs of the determination via email within three business days.

- The notification of the MCP by the State that there no longer exists a credible allegation of fraud against a CBAS provider will immediately extinguish the MCP's responsibility for quarterly reporting to the State and the State's responsibility for quarterly reports regarding payments to that CBAS provider to CMS.

- If, after investigation, the law enforcement agency brings charges against a CBAS provider for fraud, and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs, the following actions will be required to ensure recovery of all payments made to the CBAS provider:

Recoupment to the State	Recoupment to CMS
1. The MCP will submit to the State within 15 business days of notification of a final report reflecting payments for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs. 2. Within 90 days of receiving the final report, the State will recoup the CBAS provider fraud amount from the MCP capitated payment. The statement issued to the MCP will reflect the CBAS provider fraud amount.	1. The State will submit to CMS within 15 business days of receipt of a final report reflecting MCP payments made to the applicable CBAS provider for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement indicating fault by the provider occurs. 2. The State will reimburse CMS in accordance with its established repayment system by: A. Setting up an Accounts Receivable to reimburse the State General Fund through the MCP's recoupment for the Total Computable (federal and state share), and B. When applicable, completing Federal repayment paper work to reimburse CMS from the State General Fund.

Attachment PP
Negative Balance Payment Schedule

(Reserved)

Attachment QQ
Out-of-State Former Foster Care Youth Evaluation

The purpose of this demonstration is to continue to provide Medicaid coverage for Former Foster Youth (FFY) who aged out of foster care under the responsibility of another state, were enrolled in Medicaid while in foster care, and are now applying for Medicaid in the state in which they live. The demonstration is a means of increasing and strengthening overall coverage of FFY and improving health outcomes for these youth.

The Department of Health Care Services (DHCS) will gather and compare data between the FFYs and youths in Medicaid in the same age group to assess how the FFYs are accessing eight specific categories of age appropriate health care services and to demonstrate a positive health outcome for the FFY.

1) **Demonstration Goal 1: Access to Care**
   a) Question: Does the demonstration provide continuous health insurance coverage?
      i) Hypotheses: Beneficiaries will be continuously enrolled for 12-month periods until they reach 26 years of age. Beneficiaries will be continuously enrolled during the measurement year if enrolled in January and not age 26 by December 31st of measurement year.
      ii) Measure: Number of beneficiaries continuously enrolled/total number of enrollments.
   b) Question: How did beneficiaries utilize health services?
      i) Hypotheses: Beneficiaries will access covered health services under the Medi-Cal program.
      ii) Measure:
         (1) Health Care Utilization for those enrolled at least 11/12 months: count of number of beneficiaries with an ambulatory visit/Total number of beneficiaries.
         (2) Health Care Utilization for those enrolled at least 11/12 months: count of number of beneficiaries with a behavioral health visit/Total number of beneficiaries.
         (3) Health Care Utilization for those enrolled at least 11/12 months: count of number of beneficiaries with an emergency department visit/Total number of beneficiaries.
         (4) Health Care Utilization for those enrolled at least 11/12 months: count of number of beneficiaries with an inpatient visit/Total number of beneficiaries.

2) **Demonstration Goal 2: Health Outcomes**
   a) Question: What are the health outcomes for beneficiaries?
   b) Hypotheses: Beneficiaries will have positive health outcomes
   c) Measure:
      i) Chlamydia screening in women (CHL)/Total number of beneficiaries with chlamydia screening
      ii) Initiation and engagement of alcohol and other drug treatment (IET)/Total number of beneficiaries with alcohol and other drug treatment
      iii) Cervical cancer screening (CCS)/Total number of beneficiaries with cervical cancer screening
      iv) Antidepressant medication management (AMM) – Continuous Phase/Total number of beneficiaries with antidepressant medication management

v) Follow-up after hospitalizations for mental illness (FUH) – 30 day/Total number of beneficiaries with hospitalization.
vi) Use of opioids at high dosage (OHD)/Total number of beneficiaries with use of opioids at high dosage
vii) Medication management for people with asthma (MMA) - 50%/Total number of beneficiaries on medication for asthma.
viii) Annual monitoring for patients on persistent medication (MPM) - ACE or ARB/Total number of beneficiaries on annual monitoring for persistent medication

3) Methodology:

a) Evaluation design: The evaluation design will utilize a post-only assessment. The time frame for the post-only period will begin when the demonstration begins, and ends when the demonstration ends.

b) Data Collection and Sources: Data will be collected through the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) and Medi-Cal Management Information System/Decision Support System (MIS/DSS).

CalHEERS serves as the consolidated system for eligibility, enrollment, and retention for the California Health Benefit Exchange (also known as Covered California) and Medi-Cal. The administrative data is collected in real time on the Covered California website. All data will be collected retrospectively through this administrative data.

MIS/DSS is DHCS' primary data warehouse, contains Medi-Cal data beginning from October 1, 2004, and integrates data from approximately 30 different sources into a relational database. Data is collected on a daily basis and uploaded to the MIS/DSS on a weekly/monthly basis. Data for the demonstration will be evaluated at yearly intervals, approximately six months after the measurement year, to allow for data completeness. The first report will be provided to CMS in November 2018 and will cover 7/1/2017 to 6/30/2018.

The comparison groups will be the entire FFY to all Medi-Cal enrollees ages 18-25. The entire FFY population will be used as a proxy for the Out-of-State FFY since the youths receive the same services through the same delivery system. The initial draft evaluation design used the 2015 enrollment data to describe the two groups, 10,000 FFY and 1,300,000 Medi-Cal enrollees ages 18-25. However, the number of enrollees in the two groups will change on an annual basis.

No statistical testing will be conducted on the Out-of-State FFY population since the sample size limits the power of the statistical tests. The raw data for the Out-of-State FFY will be posted with the comparison groups. Baseline data is not available for the target population, Out-of-State FFY since they are coming from out-of-state.

c) Data Analysis Strategy:

California will utilize quantitative methods to answer the evaluation questions. The descriptive statistics include frequency count and a percentage comparison of all FFY to the general Medi-Cal population ages 18-25. All data will come from MIS/DSS. All measures conform to the Centers for Medicare and Medicaid Services Adult Health Care Quality Measures.

4) **Baseline Data:**
Baseline data is not available for the target population, since they are coming from out-of-state. There is no data to which to compare the youth before or after the demonstration project is completed.

5) **Comparison Group:**
California is expecting to enroll 220 Out-of-State FFY annually and will not be able to meet the criteria for having at least 500 potential Out-of-State FFY enrollees to provide statistically useful data in the health outcome criteria selected. Therefore, the State has modified the evaluation design to conduct statistical significance testing of all FFY to the Medi-Cal population ages 18-25 comparison group. The State will capture all proposed metrics on the complete FFY population. Attached is a draft of the proposed report, entitled "Attachment A for 2015 Enrollment, Utilization, and Access Measures".

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[i] See http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx.

[ii] http://cfirguide.org/index.html