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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Thirteen (07/01/2017 – 06/30/2018)
First Quarter Reporting Period: 07/01/2017 – 09/30/2017

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INTRODUCTION:

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

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

- Global Payment Program for services to the uninsured in designated public hospital (DPH) systems
- Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals, known as PRIME
- Dental Transformation Incentive program
- Whole Person Care pilot program that would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations
- Independent assessment of access to care and network adequacy for Medi-Cal managed care members
- Independent studies of uncompensated care and hospital financing
- The continuation of programs currently authorized in the Bridge to Reform waiver, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Coordinated Care Initiative, and Community-Based Adult Services (CBAS)

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

The periods for each Demonstration Year (DY) of the Waiver 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

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

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

The Global Payment Program (GPP) streamlines funding sources for care for California's remaining uninsured population and creates a value-based mechanism. The GPP establishes a statewide pool of funding for the remaining uninsured by combining federal DSH and uncompensated care funding, where county DPH systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high-cost, avoidable services to providing higher-value, preventive services.

To improve the oral health of children in California, the Dental Transformation Initiative (DTI) will implement dental pilot projects that will focus on high-value care, improved access, and utilization of performance measures to drive delivery system reform. This strategy more specifically aims to increase the use of preventive dental services for children, to prevent and treat more early childhood caries, and to increase continuity of care for children. The DTI covers four domains:

- Domain 1: Increase Preventive Services Utilization for Children
- Domain 2: Caries Risk Assessment and Disease Management
- Domain 3: Increase Continuity of Care
- Domain 4: Local Dental Pilot Programs

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

determinants of health and will offer vulnerable beneficiaries with innovative and potentially highly effective services on a pilot basis.

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

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

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

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

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

During a conference call on April 26, 2017, CMS advised the state to convert DHCS’ amendment proposal into a Children Health Insurance Program (CHIP) SPA in its place.

In response to CMS' guidance, DHCS sent CMS an official letter of withdrawal for the MCAP amendment request on May 24, 2017.

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

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

WAIVER DELIVERABLES:

STCs Item 24: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration on July 10, August 24, and September 11, 2017.

The following topics were discussed:

- Negative Account Balances Issues
- Pending Waiver Evaluation Designs
- Budget Neutrality Monitoring Tool
- Health Homes Program Pending Waiver Amendment
- CCS Protocols/Attachment KK
- CMS' Site Visits
- Access Assessment
- DMC-ODS Review Process

STCs Item 201: Budget Neutrality Monitoring Tool

The State and CMS are still jointly developing a budget neutrality monitoring tool for the State to use for quarterly budget neutrality status updates and for other situations when an analysis of budget neutrality is required.

ACCESS ASSESSMENT

California's Medi-Cal 2020 Section 1115(a) Medicaid Waiver Demonstration (Medi-Cal 2020 Waiver Demonstration), Special Terms and Conditions (STCs), paragraphs 65-69 require the Department of Health Care Services (DHCS) to contract with its External Quality Review Organization (EQRO), Health Services Advisory Group, to conduct a one-time access assessment to care (Assessment).

On April 21, 2017, DHCS submitted the Assessment Design to the Centers for Medicare and Medicaid Services (CMS) for review and approval. Once approved by CMS, the EQRO will prepare data requirements, begin data collection, and conduct the analysis. After the analysis is complete, the EQRO will produce and publish an initial draft report and a final report that will include 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. Throughout the process, the Advisory Committee will be included to provide input and feedback.

The following activities will be completed as part of this process:

- Assessment design approval by CMS.
- Assessment conducted by EQRO.
- Initial draft report meeting with Advisory Committee for review and comment.
- Initial draft report posted for public comment.
- Exit Advisory Committee Meeting.
- Final report submission to CMS ten months following CMS' approval of the Assessment Design.

There has been no activity in DY13-Q1.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

The pilot project under the 1115 Waiver titled Medi-Cal 2020 is focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction, and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improvement of care for all 186,000 children enrolled in CCS.

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

The two (2) health care delivery models include:

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

In addition to Health Plan San Mateo, it is anticipated DHCS will contract with Rady Children's Hospital of San Diego (RCHSD), an ACO.

Enrollment Information:

The monthly enrollment for Health Plan San Mateo (HPSM) CCS Demonstration Project (DP) is reflected in the table below. Eligibility data is extracted from the Children's Medical Services Network (CMS Net) utilization management system and is verified by

the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to HPSM. HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
15-Jan	1,526	$1,658.05	$2,530,184
15-Feb	1,501	$1,658.05	$2,488,733
15-Mar	1,545	$1,658.05	$2,561,687
15-Apr	1,551	$1,658.05	$2,571,636
15-May	1,568	$1,658.05	$2,599,822
15-Jun	1,588	$1,658.05	$2,632,983
15-Jul	1,590	$1,535.45	$2,441,366
15-Aug	1,589	$1,535.45	$2,439,830
15-Sep	1,597	$1,535.45	$2,452,114
15-Oct	1,580	$1,535.45	$2,426,011
15-Nov	1,587	$1,535.45	$2,436,759
15-Dec	1,584	$1,535.45	$2,432,153
16-Jan	1,577	$1,535.45	$2,421,405
16-Feb	1,587	$1,535.45	$2,436,759
16-Mar	1,605	$1,535.45	$2,464,397
16-Apr	1,622	$1,535.45	$2,490,500
16-May	1,618	$1,535.45	$2,484,358
16-Jun	1,621	$1,535.45	$2,488,964
16-Jul	1,648	$1,481.08	$2,440,820
16-Aug	1,636	$1,481.08	$2,423,047
16-Sep	1,607	$1,481.08	$2,380,096
16-Oct	1,640	$1,481.08	$2,428,971
16-Nov	1,628	$1,481.08	$2,411,198
16-Dec	1,631	$1,481.08	$2,415,641
17-Jan	1,625	$1,481.08	$2,406,755
17-Feb	1,649	$1,481.08	$2,442,301
17-Mar	1,647	$1,481.08	$2,439,339
17-Apr	1,633	$1,481.08	$2,418,604
17-May	1,630	$1,481.08	$2,414,160
17-Jun	1,617	$1,481.08	$2,394,906
17-Jul	1,609	$1,481.08	$2,383,058
17-Aug	1,614	$1,481.08	$2,390,463
17-Sep	1,616	$1,481.08	$2,393,425
		Total	**$80,982,446**

Member Months:

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
CCS	1,609	1,614	1,616	1	4,839

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by Federal Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration.

STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. As of September 30, 2016, revised Protocols were submitted to CMS.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

Recurring conference calls between DHCS and HPSM are conducted on a regular basis to discuss various contract issues, such as financials, information technology, and deliverable reporting.

Contract Amendments

HPSM contract amendment A02 was approved on November 8, 2017. This amendment extended the contract until June 30, 2017, as allowed by Request for Proposal #11-88024; and increased the total budget to compensate the Contractor for continuing to perform services for an additional year. New rates have been added for State Fiscal Years 14/15, 15/16, and 16/17. Payments for Hepatitis C and Behavioral Health Therapy (BHT) services have also been included. The contract has also been updated to include the aid codes for eligible beneficiaries.

HPSM contract amendment A03 is in process. This amendment will extend the contract for 18 months to 12/31/18 as allowed by Request for Proposal #11-88024. No rates are included. A03 has been approved by DHCS management and was submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

DHCS continued to collaborate with RCHSD on the following: outreach, enrollment, covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model. DHCS has provided RCHSD with a list of potential deliverables required for onboarding as a managed care plan.

Pre-Implementation Contract/Data Use Agreement

DHCS and RCHSD intend to reach out to CCS Demonstration Project pilot-eligible members (approximately 400 clients) to obtain their agreement to participate in the CCS pilot when implemented in San Diego County. DHCS is developing a pre-implementation contract which allows for data-sharing between DHCS and the Plan. This contract will allow the Department to provide RCHSD with member information for potentially eligible members currently working with RCHSD. Contract discussions and rate development are pending until after RCHSD acquires a commitment from the proposed eligible members that they will participate in the pilot program.

Demonstration Schedule

It is anticipated the RCHSD Demonstration will not be operational until after State Fiscal Year 2017/18. It should be noted the projected implementation timetable is contingent on a number of factors including development and acceptance of capitated rates, the ability of the contractor to demonstrate compliance with the new Medicaid Final Rule and readiness to begin operations, and approvals by Federal CMS.

Consumer Issues:

CCS Quarter Grievance Report #16

In October 2017, HPSM submitted a "CCS Quarterly Grievance Report" for the first quarter, July – October 2017. During the reporting period, HPMS received and processed 10 member grievances.

The Grievances Report includes type of grievance, accessibility, benefits/coverage, referral, quality of care/service, or other.

- 2 grievances were designated as Quality of Care/Service
  - 2 were coded as "Plan denial of treatment"; one was resolved in Plan's favor and one was resolved in member's favor.

- 1 grievance was designated for accessibility
  - The grievance was coded for lack of primary care provider availability and resolved in member's favor.

- 7 grievances were labeled as Other:
  - 5 were resolved in favor of the CCS Member and 2 were resolved in favor of the plan.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Report Name	Date Due	Received
Grievance Log/Report (Rpt #16)	11/15/2017	11/3/2017
Provider Network Reports (Rpt #16)	11/15/2017	11/9/2017
Quarterly Financial Statements (Rpt #16)	11/15/2017	11/8/2017
Report of All Denials of Services Requested by Providers (Rpt #15)	11/15/2017	11/7/2017

Evaluation:

The draft CCS evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at: http://www.dhcs.ca.gov/provgovpart/Pages/MediCal2020Evaluations.aspx.

DHCS submitted a revised evaluation design to CMS on May 15, 2017. DHCS received CMS' draft evaluation comments on June 19, 2017, and DHCS responded to CMS on July 14, 2017. DHCS received further CMS comments on September 12, 2017.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

DHCS submitted an 1115 waiver, called "California Medi-Cal 2020 Demonstration" (Medi-Cal 2020) to CMS and was approved on December 30, 2015. CBAS continues as a CMS-approved benefit for the next five years through December 31, 2020, under the Medi-Cal 2020 waiver.

Program Requirements:

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020 waiver; and 4) exhibit ongoing compliance with the requirements listed above.

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

the requested number of days for services requires a face-to-face assessment.

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

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

Enrollment and Assessment Information:

Per Special Terms and Conditions (STC) 48, CBAS enrollment data for both MCP and FFS members per county for Demonstration Year 13 (DY13), Quarter 1 (Q1), represents the period of July 2017 to September 2017. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 8 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. FFS

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

claims data identified in Table 1, reflects data through the quarter of April 2017 to June 2017 because of the lag factor of about two to three months. Data for DY13-Q1, will be reported in the next quarterly report.

Table 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY12 Q1 Jul - Sept 2016		DY12 Q2 Oct - Dec 2016		DY12 Q3 Jan - Mar 2017		DY12 Q4 Apr - June 2017	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	504	76%	542	82%	530	80%	541	82%
Butte	45	44%	37	36%	42	41%	40	39%
Contra Costa	206	64%	240	75%	210	65%	213	66%
Fresno	619	56%	602	55%	615	56%	639	58%
Humboldt	95	24%	94	24%	97	25%	95	24%
Imperial	426	76%	328	59%	330	59%	357	64%
Kern	81	24%	79	23%	73	22%	67	20%
Los Angeles	21,041	67%	21,178	67%	21,299	67%	21,720	68%
Merced	91	43%	95	45%	94	45%	91	43%
Monterey	102	55%	118	63%	116	62%	122	65%
Orange	2,100	54%	2,199	56%	2,256	54%	2,103	51%
Riverside	453	42%	445	41%	459	42%	423	39%
**Sacramento	587	66%	**521	58%	561	63%	520	58%
**San Bernardino	590	109%	**598	110%	601	111%	564	104%
San Diego	1,937	45%	2,031	51%	1,990	54%	1,995	54%
San Francisco	749	51%	723	49%	722	49%	730	50%
San Mateo	172	75%	174	76%	175	77%	174	76%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	655	47%	656	47%	674	48%	643	46%
Santa Cruz	109	72%	114	75%	98	64%	119	78%
Shasta	*	*	*	*	*	*	*	*
Ventura	918	64%	901	63%	943	65%	937	65%
Yolo	74	20%	93	25%	79	21%	80	21%
Marin, Napa, Solano	79	16%	79	16%	74	15%	81	16%
Total	31,648	61%	**31,860	61%	32,044	62%	32,295	62%

FFS and MCP Enrollment Data 06/2017

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.
**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***Data for these counties are updated by the MCPs to reflect accurate information for QY12-Q3.*

Table 1 reflects that enrollment has remained relatively consistent with over 30,000 CBAS participants. The data reflects ample capacity for participant enrollment into most CBAS Centers with exception of the centers located in San Bernardino County. San Bernardino County is operating over its center capacity due to a steady increase in participant enrollment. However, majority of CBAS participants are able to choose an alternate CBAS center in nearby counties should the need arise for ongoing CBAS services.

While the closing of a CBAS Center in a county can contribute to increased utilization of the license capacity in a county, it is important to note the amount of participation can

also play a significant role in the overall amount of licensed capacity used throughout the State. In counties such as Imperial & Santa Cruz, there was more than a 5% increase in licensed capacity used compared to their previous quarter. In Sacramento County, there was more than a 5% decrease of licensed capacity compared to the previous quarter. This decrease was due to the decline in CBAS participant enrollment, not the closure of a center. A decrease in utilization of licensed capacity can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

CBAS Assessments for MCPs and FFS Participants

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

Table 2 entitled "*CBAS Assessments Data for MCPs and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Due to a delay in the availability of data, Table 2 represents data from DY11-Q3 (April 2016 – June 2016) through DY12-Q4 (Apr 2017 – June 2017). Data for DY13-Q1, will be provided in the next quarterly report.

Table 2:

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	**MCPs**			**FFS**		
	New Assessments	**Eligible**	**Not Eligible**	**New Assessments**	**Eligible**	**Not Eligible**
DY11-Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
DY12-Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	11	11 (100%)	0 (0%)
DY12-Q2 (10/1-12/31/2016)	2,741	2,689 (98.1%)	52 (0.02%)	2	2 (100%)	0 (0%)
DY12-Q3 (1/1-3/31/2017)	2,476	2,439 (98.5%)	37 (0.01%)	5	5 (100%)	0 (0%)
DY12-Q4 (4/1-6/30/2017)	2,449	2,408 (98.3%)	41 (0.01%)	8	7 (100%)	1 (0%)
5% Negative change between last Quarter		No	No		No	No

Note: Information is not available for April 2017 to June 2017 due to a delay in the availability of data.

As indicated in Table 2, the number of CBAS FFS participants has remained relatively low due to the transition of CBAS into managed care. In addition, there was a decrease in the number of new assessments completed by MCPs in DY12-Q4. Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to Table 2, for DY12-Q4, there were 2,449 assessments completed by the MCPs, of which 2,408 were determined to be eligible and 41 were determined to be ineligible. For DHCS, it was reported that 33 participants submitted their requests for CBAS benefits under FFS. Twenty-five of the requests were deferred to managed care while eight of the requests were determined to be FFS eligible. Of these eight requests, one of the requests did not follow through due to the individual being enrolled in another health plan simultaneously. Table 2 identifies seven requests were assessed and approved for CBAS FFS by DHCS.

CBAS Provider-Reported Data (per CDA) (STC 48.b)

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 3 entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY12-Q4. Due to a delay in availability of data, DY 13-Q1 data will be reported in the next quarterly report. The ADA at the 240 operating CBAS Centers is approximately 22,184 participants, which corresponds to 72% of total license capacity.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	240
Non-Profit Centers	56
For-Profit Centers	184
ADA @ 240 Centers	22,184
Total Licensed Capacity	30,852
Statewide ADA per Center	72%

CDA - MSSR Data
06/2017

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.

Outreach/Innovative Activities:

Stakeholder Process

On August 29, 2016, DHCS released a revised Statewide Transition Plan (STP) for public comment, including a revised CBAS plan. This was in response to the questions and concerns raised by CMS in the initial submission. Following the public comment period, on November 23, 2016, DHCS submitted the revised STP to CMS for review.

After reviewing stakeholder input in addition to the milestones identified in the CBAS STC, in the Medi-Cal 2020 Waiver, DHCS and CDA initiated work groups to address concerns identified during the stakeholder meetings. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that convened every other month through June 2016. Implementation of the five-year *CBAS Quality Assurance and Improvement Strategy* began in October 2016. The revised IPC is currently under review and projected to be implemented in the early months of 2018. Updates and progress on stakeholder activities for CBAS can be found at:

http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Archives/HCB_Settings_Stakeholder_Process/

Operational/Policy Developments/Issues:

DHCS and CDA continue to work with CBAS providers and MCPs to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. To date, three new CBAS Centers have opened, and CDA has several applications that are currently under review.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY 12. DHCS delayed implementation of the revised CBAS IPC from April 2017 to January 2018. This delay was determined necessary by DHCS and CDA to align the IPC changes with existing IPC instructions in the CBAS Provider Manual. Moving forward, DHCS and CDA have updated the CBAS form/template revision process to include identification of all related forms/templates/publications that will require corresponding updates.

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

Consumer Issues:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 48.e.iv)

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Tables 4 and 5 represent data covering April 2017 to June 2017 (DY12-Q4). Data for July 2017 to September 2017 (DY13-Q1), will be provided in the next quarterly report.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY12-Q4, as illustrated in Table 4. Table 5 shows that MCPs received one beneficiary complaint in DY12-Q4.

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11 - Q3 (Apr 1 - Jun 30)	1	2	3
DY12 - Q1 (Jul 1 - Sept 30)	0	0	0
DY12 - Q2 (Oct 1 - Dec 31)	0	0	0
DY12 - Q3 (Jan 1 - Mar 31)	0	0	0
DY12 - Q4 (Apr 1 - Jun 30)	0	0	0

CDA Data - Complaints 06/2017

Note: Information is not available for July to September 2017 due to a delay in the availability of data.

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY12 - Q1 (Jul 1 - Sept 30)	8	1	9
DY12 - Q2 (Oct 1 - Dec 31)	2	0	2
DY12 - Q3 (Jan 1 - Mar 31)	3	0	3
DY12 - Q4 (Apr 1 - Jun 30)	1	0	0

Plan data - Phone Center Complaints 06/2017

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.

CBAS Grievances / Appeals (FFS / MCP) (STC 48.e.iii)

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the delay in data reporting, grievances and appeals data from the MCPs are reported up to DY12-Q4. According to Table 6 entitled "*Data on CBAS Managed Care Plan Grievances*," seven grievances were filed with the MCPs for DY12-Q4; the grievances were related to CBAS providers.

Table 6:

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	**Grievances:**				
	CBAS Providers	**Contractor Assessment or Reassessment**	**Excessive Travel Times to Access CBAS**	**Other CBAS Grievances**	**Total Grievances**
DY12 - Q1 (Jul 1 - Sep30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	1	0	0	0	1
DY12 - Q3 (Jan 1 - Mar 31)	1	0	0	1	2
DY12 - Q4 (Apr 1 - Jun 30)	4	0	0	3	7

Plan data - Grievances 06/2017

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.

For DY12-Q4, one CBAS appeal was filed with the MCPs. Table 7 entitled "*Data on CBAS Managed Care Plan Appeals*", illustrates that the appeal was related to denial of services or limited services. Due to a delay in information, data for DY13-Q1, will be available in the next quarterly report.

Table 7:

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	**Appeals:**				
	Denials or Limited Services	**Denial to See Requested Provider**	**Excessive Travel Times to Access CABS**	**Other CBAS Appeals**	**Total Appeals**
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	5	0	0	0	5
DY11 - Q3 (Apr 1 - Jun 30)	0	0	0	3	3
DY12 - Q4 April 1 - Jun 31)	1	0	0	0	1

Plan data - Grievances 06/2017

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY12-Q4 (April 2017 to June 2017), there were three requests for hearing related to CBAS services filed.

Financial/Budget Neutrality Development/Issues:

Pursuant to STC item 50(b) of the Medi-Cal 2020 Demonstration, MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP, to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the center's capacity to date and adequate networks remain for this population.

The extension of CBAS, under the Medi-Cal 2020 Demonstration will have no effect on

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

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under the Medi-Cal 2020 Waiver. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to DY12-Q4, due to a delay in availability of data. Data for DY13-Q1 will be discussed in the next quarterly report.

Table 8 reflects the average licensed capacity used by CBAS participants at 62% statewide as of June 30, 2017. Overall, most of the CBAS Centers have not operated at full capacity with the exception of San Bernardino County. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was no decrease in provider capacity of five percent or more across the CBAS counties. In Table 8, Los Angeles County saw a 1% increase in their license capacity in DY12-Q4 compared to DY12-Q3. The changes in this county resulted in an overall statewide increase of 1% in the total licensed capacity.

<u>Access Monitoring (STC 48.e.)</u>

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Tables 1 and 8, CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers with the exception of San Bernardino County which currently is overserving its licensed capacity. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to beneficiaries. There are other centers in nearby counties that can assist should the need arise for ongoing care of CBAS participants.

<u>Unbundled Services (STC 44.b.iii.)</u>

CDA certifies and provides oversight of CBAS Centers. CDA and DHCS continue to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to

the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for each of the CBAS participants they provide services for CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. Table 9 entitled "*CBAS Center History*," illustrates the history of openings and closings of the centers. According to Table 9, for DY12-Q4 (April 2017 to June 2017), CDA currently has 240 CBAS Center providers operating in California. No closures were reported during DY12-Q4. Table 9 shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

Data for DY13-Q1, will be discussed in the next quarterly report due to a delay in availability of data.

Table 8:

County	CBAS Centers Licensed Capacity					
	DY12-Q1 Jul-Sep 2016	DY12-Q2 Oct-Dec 2016	DY12-Q3 Jan-Mar 2017	DY12-Q4 Jan-Mar 2017	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	390	0%	82%
Butte	60	60	60	60	0%	39%
Contra Costa	190	190	190	190	0%	66%
Fresno	652	652	652	652	0%	58%
Humboldt	229	229	229	229	0%	24%
Imperial	330	330	330	330	0%	64%
Kern	200	200	200	200	0%	20%
Los Angeles	18,406	18,731	18,796	18,996	1%	68%
Merced	124	124	124	124	0%	43%
Monterey	110	110	110	110	0%	65%
Orange	2,308	2,308	2,458	2,458	0%	51%
Riverside	640	640	640	640	0%	39%
Sacramento	529	529	529	529	0%	58%
San Bernardino	320	320	320	320	0%	104%
San Diego	2,518	2,353	2,188	2,188	0%	54%
San Francisco	866	866	866	866	0%	50%
San Mateo	135	135	135	135	0%	76%
Santa Barbara	60	60	60	60	0%	1%
Santa Clara	830	830	830	830	0%	46%
Santa Cruz	90	90	90	90	0%	78%
Shasta	85	85	85	85	0%	3%
Ventura	851	851	851	851	0%	65%
Yolo	224	224	224	224	0%	21%
Marin, Napa, Solano	295	295	295	295	0%	16%
TOTAL	30,442	30,602	30,652	30,852	1%	62%

CDA Licensed Capacity as of 06/2017

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

Note: Information is not available for July 2017 to September 2017 due to a delay in the availability of data.

Table 9:

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
June 2017	240	0	0	0	240
May 2017	240	0	0	0	240
April 2017	240	0	0	0	240
March 2017	239	0	1	1	240
February 2017	240	1	0	0	239
January 2017	240	0	0	0	240
December 2016	240	1	1	0	240
November 2016	240	0	0	0	240
October 2016	240	0	0	0	240
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244

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

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS 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;
- Implement effective, efficient, and sustainable health care delivery systems;
- Maintain effective, open communication and engagement with our stakeholders; and
- Hold ourselves and our providers, plans, and partners accountable for performance and health outcomes.

The DTI covers four areas, otherwise referred to as domains:

Domain 1 – Increase Preventive Services for Children

This domain was designed to increase the statewide proportion of children under the age of 20 enrolled in Medi-Cal for 90 continuous days or more who receive preventive dental services. Specifically, the goal is to increase the statewide proportion of children ages 1 to 20 who receive a preventive dental service by at least ten percentage points over a five-year period. The first program year for this domain captured all activity in 2016, and the second program year for this domain will capture all activity in 2017.

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

Domain 2 will be available in eleven (11) pilot counties and is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages 6 and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this domain, a provider must attend training and elect to opt into this domain. If the pilot is successful, then this program may be expanded to other counties, contingent on available DTI funding. The first program year for this domain will capture all activities for 2017. The implementation date for this domain was January 2017.

The following eleven (11) pilot counties have been identified for participation in this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba.

Domain 3 – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between a beneficiary and dental provider in seventeen (17) select pilot counties. Incentive payments will be made to dental service office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods. If the pilots are successful, this domain may be expanded to other counties, contingent on available DTI funding. The first program year for this domain was 2016.

The following seventeen (17) pilot counties have been identified for participation in this domain: Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus, and Yolo.

Domain 4 – Local Dental Pilot Projects (LDPPs)

The LDPPs support the aforementioned domains through up to 15 innovative pilot programs to test alternative methods to increase preventive services, reduce early childhood caries, and establish and maintain continuity of care. DHCS solicited proposals to review, approve, and make payments to LDPPs in accordance with the requirements stipulated. The LDPPs are required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

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

Enrollment Information:

Statewide Eligible Children Age 1-20 and Preventive Service Utilization

Statewide Preventive Service Utilization for Children Age 1-20	July	August	September
Measure Period	08/2016 - 07/2017	09/2016 - 08/2017	10/2016 - 09/2017
Denominator	5,735,200	5,721,485	5,713,997
Numerator	2,452,688	2,468,526	N/A
Preventive Service Utilization	42.8%	43.1%	N/A

*Denominator: Eligible Children Age 1-20 - beneficiaries who are enrolled in the same dental plan for at least three continuous months
*Numerator: Eligible Children age 1-20 who received Preventive Services during the measure period

*Data Source - Dental Dashboard DM3 Oct312017 MIS/DSS Data

*Performance does not include one-year full run-out allowed for claim submission

*Performance for the third month of each quarter is not available due to claim submission time lag. This measure will be available for the next quarterly report

Outreach/Innovative Activities:

DTI Small Workgroup

The objective of these meetings is to review monthly updates regarding all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a monthly basis, each third Wednesday of the month. This quarter, the workgroup met on July 20, August 17, and September 20, 2017.

In addition to the DTI small stakeholder workgroup, DHCS has continued its efforts to target specific groups with the assistance of stakeholders.

Domain 2 Caries Risk Assessment Workgroup

This sub-workgroup is still active; however, it did not convene this quarter. A different sub-workgroup with the same members was created and named Domain 2 Subgroup. This subgroup convened for the first time this quarter on August 8, 2017. The purpose of the meeting was to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

DTI Clinic Workgroup

This sub-workgroup is still active; however, it did not convene this quarter. A different sub-workgroup with the same members was created and named Domain 3 Subgroup. This subgroup convened for the first time this quarter on August 8, 2017. The purpose of the meeting was to report on the domain's current activity and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

DTI Webpage

The DTI webpage was updated regularly during DY13-Q1 and will continue to be updated as new information becomes available. The webpage contains program information, stakeholder engagement information, webinars, timelines, resource materials such as fact sheets, Frequently Asked Questions (FAQs), Medi-Cal 2020 Special Terms and Conditions (STCs), and the DTI inbox to direct comments, questions, or suggestions.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY13-Q1. The inbox is useful for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations, to direct comments, questions, or suggestions about the DTI to DHCS directly. The listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

Most inquiries in the DTI inbox during this reporting period included, but were not limited to the following categories: Domain 1 payment and dispute inquiries and Safety Net Clinics (SNCs) Electronic Data Interchange (EDI) testing; Domain 2 implementation policy and billing questions; Domain 3 payment and dispute inquiries, and SNC EDI testing; and Domain 4 budget changes and reimbursement inquiries. All requests were researched and responded to within seven business days.

The DTI outreach efforts included SNC Encounter Data Resubmission Processes, updated DTI electronic submission instructions, and data submission deadlines. The EDI instructions provided detailed steps for providers to follow to ensure successful EDI testing and subsequent submissions. The EDI testing cutoff date is November 17, 2017, and SNC providers were informed they must complete EDI testing by that date or can initiate EDI testing in January 2018. For Domain 1, the final PY 1 payments will be issued January 2018. SNC providers were informed of the following deadlines via email and on the DTI webpage: December 8, 2017, will be the deadline for proprietary paper claims submission and December 23, 2017, for EDI claims.

The DTI email address is DTI@dhcs.ca.gov

The DTI Listserv registration can be found here:
http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DTIStakeholdes

Outreach Plans

DHCS presented information on the DTI at several venues during this reporting period. Below is a list of venues at which information on DTI was disseminated:

- July 19, 2017: Stakeholder Advisory Committee (SAC) – Meeting Materials
- August 3, 2017: Medi-Cal Dental Advisory Committee (MCDAC) – Meeting Agenda
- August 24, 2017: CDA Presents in San Francisco (cdapresents.com)
- September 15, 2017: Los Angeles Dental Stakeholders Meeting – Meeting Agenda
- September 18, 2017: Dental Directors Peer Network Meeting in San Diego – Presenter Request (Website)
- September 25, 2017: DTI Conference Call (CA & OR)

Operational/Policy Developments/Issues:

Domain 1

On July 31, 2017, DHCS disbursed $2.2 million worth of incentive payments to 2,646 providers (2,426 FFS providers, 156 DMC providers, and 64 SNCs) for the remainder of 2016 claims. The total disbursed for PY 1/Calendar Year 2016 in this Domain to date is $24,248,617.89 across 1,595 unique providers (providers with multiple office locations have been removed). The period of time that was covered by the incentive payments was PY 1/Calendar Year 2016. An explanation of payment was mailed in a separate envelope, which included a break down by the procedure code that was paid and the program year it was allocated to.

The next payment is scheduled for January 31, 2018. DHCS identified dates for the final claim submissions for PY 1 final payment in January 2018. The EDI testing cutoff date is November 17, 2017. All EDI providers must be EDI-tested by this deadline and will have until December 23, 2017 to complete their electronic claim submission. The paper submission deadline is December 8, 2017.

During this reporting period, DHCS has been responding to provider inquiries regarding the payments they received and have not received, the payment amounts, and how they can confirm they were paid the correct amount.

The following Domain 1 documents have been updated during this reporting period:

- Fact Sheet for SNCs
- SNC Frequently Asked Questions and Answers

Domain 2

During this reporting period:

- The total incentive claims paid was $618,217, of this total:
  - FFS: Sacramento $81,030.00; Tulare $328,062.00; Kings $3,528.00.
  - DMC: Sacramento $182,917.00
  - SNC: Mendocino $21,672.00; Inyo $1,008.00
- 20 providers opted into the Domain 2.
- 94 providers completed the TYKE training.

By the end of DY13-Q1:

- The total incentive payments were $914,640.10. This total includes:
  - $184,303.00 DMC incentive payments (Sacramento)

- $707,657.10 FFS incentive payments to three counties (Tulare, Sacramento, and Kings)
- $22,680.00 SNC incentive payments (Inyo and Mendocino)

- 117 providers opted into the Domain 2
- In addition, 233 providers completed the TYKE training.

Domain 2 Outreach Efforts

As mentioned in the last quarterly report, DHCS was actively engaging dental stakeholders to discuss outreach strategies to increase Domain 2 provider participation. DHCS has been working closely with Delta Dental to target outreach efforts in Domain 2 counties, including in-person visits and telephone calls to providers. The Delta Dental FI has been contacting providers via phone and has visited Kings, Plumas, and Yuba counties to increase provider participation in this domain.

The following Domain 2 document was updated during this reporting period:

- Fact Sheet for SNCs (July 13, 2017)

Domain 3

The Domain 3 payments were issued June 30, 2017, at a total amount of $9,432,440. The number of enrolled service office locations (FFS & SNC) was approximately 956.

DHCS has been working on outreach efforts to get more SNC providers to opt into the domain. DHCS identified 17 SNCs that are enrolled in Domain 1 and are eligible to receive incentive payments as part of the DTI Domain 3. An email including the outreach letter and the Domain 3 opt in form was sent out on September 22, 2017.

Domain 4

There were 15 LDPP applications selected to participate in this domain. The final approved applications and budgets are being posted on the DTI webpage as they become available.

DHCS set up an email inbox LDPPinvoices@dhcs.ca.gov to allow for electronic submission invoices. DHCS received the first LDPP invoice from San Joaquin County on August 9, 2017 in the amount of $16,112.26. The California Rural Indian Health Board's invoice was received on September 11, 2017 in the amount of $1,952.62. DHCS is expecting more invoices to come from the LDPPs that have executed agreements.

At the end of DY13-Q1, 4 of the 15 agreements are still in progress as shown in the table below. DHCS has been working with the four applicants regarding their budget calculations and providing technical assistance/feedback on a regular basis. In addition, DHCS scheduled monthly calls with the LDPPs including those that have not finalized their contracts with DHCS. DHCS provided them with a HIPAA training during the September monthly call.

The DTI Domain 4 Summary of LDPP Applications was posted on the DTI Domain 4 webpage.

Lead Entity	Status
Alameda County	Executed April 15, 2017
California Rural Indian Health Board, Inc.	Executed June 21, 2017
California State University, Los Angeles	Executed April 15, 2017
First 5 Kern	Revisions Pending
First 5 San Joaquin	Executed May 31, 2017
First 5 Riverside	Revisions Pending
Fresno County	Executed June 27, 2017
Humboldt County	Executed June 21, 2017
Northern Valley Sierra Consortium	Revisions Pending
Orange County	Executed June 30, 2017
Sacramento County	Executed June 28, 2017
San Luis Obispo County	Revisions Pending
San Francisco City and County Department of Public Health	Executed June 27, 2017
Sonoma County	Executed May 15, 2017
University of California, Los Angeles	Executed May 15, 2017

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

See the *Operational/Policy Developments/Issues* section for information on payments under the respective domains, as applicable.

Quality Assurance/Monitoring Activities:

The Fiscal Intermediary performs electronic analysis of claims submitted, which compares provider baseline data to ensure participating providers are paid accurately. Incentive payments undergo a reconciliation process with each check write of each PY.

With each check write, a total incentive payment amount for the PY to date is calculated for each provider. If the provider receives an interim incentive payment, the interim payment amount(s) are subtracted from what is calculated for the final check write.

Evaluation:

DHCS received CMS approval of the DTI Evaluation Design on September 12, 2017. The final DTI Evaluation Design and the CMS Approval Letter have been posted on the DTI webpage. DHCS has been working with the evaluation contractor in an effort to finalize and implement the contract.

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

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

The state DMC-ODS implementation is occurring in five phases, (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 30, 2017, DHCS received a total of forty implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings and Partnership Health Plan of California. DHCS has approved the following counties' implementations plans: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Los Angeles, Marin, Contra Costa, Monterey, Ventura, Orange, Alameda, Sonoma, San Luis Obispo, Imperial, San Bernardino, Napa, Kern, Yolo, Santa Barbara, Placer, and Stanislaus. The remaining eighteen counties' implementation plans are currently in review by DHCS and CMS.

Enrollment Information:

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
SFY 16-17 DY12-Q3	2,306	911	3,182
SFY 16-17 DY12-Q4	2,886	1,054	3,879
SFY 17-18 DY13-Q1	6,114	4,366	10,444

Member Months:

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA		1,759	2,015	SFY 16-17 DY12-Q3	2,306
	2,057	2,047	2,049	SFY 16-17 DY12-Q4	2,886
	2,147	5,897		SFY 17-18 DY13-Q1	6,114
Non-ACA		721	795	SFY 16-17 DY12-Q3	911
	787	760	774	SFY 16-17 DY12-Q4	1,054
	1,803	4,249		SFY 17-18 DY13-Q1	4,366

Under the DMC-ODS, the enrollees reported are the number unique clients receiving services for the quarter. For SFY 17-18, DY13-Q1, there is only partial data available at time of this report submission.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- July 17, 2017: Drug Medi-Cal - Phase I Meeting
- July 19, 2017: DHCS Stakeholder Advisory Committee (SAC) Meeting
- July 20, 2017: DHCS and CBHDA (County Behavioral Health Directors Association) Executive Call
- July 24, 2017: Indian Health Program Organized Delivery System (IHP-ODS) Meeting with California Rural Indian Health Board (CRIHB)
- July 27, 2017: On-Site Visit with Riverside County and CMS
- July 28, 2017: KHN interview with DHCS
- July 31, 2017: IHP-ODS Conference Call
- August 1, 2017: DHCS Call with CMS to Discuss the Development of Attachment BB
- August 2, 2017: Conference Call with Center for Health Care Strategies Inc. (CHCS) Improving Access to Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services
- August 3, 2017: Conference Call with CMS Regarding Riverside Post-Site Visit
- August 4, 2017: Neonatal Taskforce Meeting
- August 7, 2017: California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) Bi-Monthly Call
- August 9, 2017: DHCS and University California Los Angeles (UCLA) Call regarding DMC-ODS Evaluation Contract Activities and Work Plan
- August 14, 2017: ASAM Opioid Addiction Patient Guideline Discussion with Guideline Central
- August 15, 2017: DHCS Opioid Workgroup Meeting
- August 16, 2017: Quarterly Meeting with Blue Shield of California and DHCS

- August 17, 2017: DHCS and CBHDA Executive Call
- August 18, 2017: DHCS Meeting to discuss expansion of Naltrexone long-acting injectable
- August 21-24, 2017: SUD Statewide Conference
- August 25, 2017: Dr. Mee Lee's ASAM Workshop
- August 28, 2017: Prescription Drug Overdose Prevention (PDOP) Center for Disease Control (CDC) Site Visit - State Leadership
- August 28, 2017: IHP-ODS Consulting Call
- September 6, 2017: Annual California Consortium of Addiction Programs and Professionals (CCAPP) Recovery Happens
- September 11, 2017: Bi-monthly SUD Waiver States Conference Call
- September 11, 2017: DHCS and UCLA Call Regarding DMC-ODS evaluation contract activities and work plan
- September 12-15, 2017: DHCS staff travelled to Riverside to conduct mock utilization reviews, shadow County compliance monitoring staff, and provide comprehensive technical assistance to County staff overseeing the DMC-ODS Waiver implementation in their county.
- September 14, 2017: Year 3 DMC-ODS TA Contract Discussion with Harbage Consulting
- September 19, 2017: Phase 5 Conference call with California HealthCare Foundation (CHCF), Blue Shield of California, and IHP-ODS
- September 21, 2017: DHCS and CBHDA Executive Call
- September 21, 2017: DHCS present at Council on Mentally Ill Offenders (COMIO)
- September 21, 2017: Partnership HealthPlan Discussions with Harbage Consulting
- September 25, 2017: Conference Call with CHCF (medication assisted treatment, residential, and telehealth)
- September 27, 2017: Substance Abuse Prevention and Treatment (SAPT) Committee Meeting
- September 27, 2017: Department of Health and Human Services Live Stream-National Recovery Month Event to Address Opioids
- September 27, 2017: INDIVIOR Meeting Regarding RBP 6000 for Opioid Use Disorders

Operational/Policy Developments/Issues:

On August 1, 2017, DHCS began discussions with CMS regarding the development of Attachment BB for the IHP-ODS.

Consumer Issues:

Grievance	Los Angeles	Marin	Riverside	San Francisco	San Mateo	Santa Clara
Access to Care		1			1	
Quality of Care	1	1				3
Program Requirements						
Service Denials						1
Failure to Respect Enrollee's Rights						
Interpersonal Relationship Issues						
Other						
Other						
Other						
Other						
Totals	**1**	**2**	**0**	**0**	**1**	**4**

Resolution	Los Angeles	Marin	Riverside	San Francisco	San Mateo	Santa Clara
Grievances		1			1	4
Appeals						
Totals	**0**	**1**	**0**	**0**	**1**	**4**

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

DMC-ODS Expenditures	SFY 16-17 DY12-Q3			
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	111,101	$3,236,395.80	$2,829,924.92	$314,315.92
Non-ACA	44,023	$901,391.55	$457,170.22	$189,603.03

DMC-ODS Expenditures	SFY 16-17 DY12-Q4			
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	176,096	$5,811,934.50	$5,177,076.78	$482,580.36
Non-ACA	66,673	$1,715,293.47	$865,639.99	$463,203.01

DMC-ODS Expenditures	SFY 17-18 DY13-Q1			
Population	Units of Service	Approved Amount	FFP Amount	SGF Amount
ACA	436,369	$5,747,822.04	$5,132,613.74	$369,266.12
Non-ACA	280,142	$3,402,445.52	$1,702,337.95	$295,736.08

ACA Expenditures by Level of Care for DY12-Q3

ACA Expenditure by Level of Care	ACA - SFY 16-17 DY12-Q3			
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount
ODS/IOT - Case Management	857	$ 19,669.37	$ 18,112.89	$ 919.79
ODS/IOT - Case Management - Perinatal	-	$ -	$ -	$ -
ODS/IOT - Case Management - Youth	1	$ 9.20	$ 4.60	$ -
ODS/IOT - Counseling	7,584	$ 236,267.86	$ 203,014.51	$ 33,253.35
ODS/IOT - Counseling - Perinatal	-	$ -	$ -	$ -
ODS/IOT - Counseling - Youth	47	$ 1,147.60	$ 573.80	$ -
ODS/NTP - Case Management	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone	46,213	$ 552,245.35	$ 483,817.85	$ 23,188.80
ODS/NTP - Dosing - Methadone - Perinatal	46,213	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone - Youth	60	$ 717.00	$ 363.58	$ 0.60
ODS/NTP - Group Counseling	-	$ -	$ -	$ -
ODS/NTP - Individual Counseling	11,126	$ 154,651.40	$ 135,767.39	$ 6,499.11
ODS/NTP - Individual Counseling - Youth	29	$ 403.10	$ 201.55	$ -
ODS/ODF - Additional MAT	9	$ 368.56	$ 350.11	$ 18.45
ODS/ODF - Case Management	1,179	$ 16,277.11	$ 14,671.83	$ 725.94
ODS/ODF - Case Management - Perinatal	-	$ -	$ -	$ -
ODS/ODF - Case Management - Youth	51	$ 699.20	$ 480.68	$ -
ODS/ODF - Group Counseling	5,075	$ 91,754.82	$ 79,398.10	$ 3,727.27
ODS/ODF - Group Counseling - Perinatal	-	$ -	$ -	$ -
ODS/ODF - Group Counseling - Youth	342	$ 5,527.88	$ 3,684.98	$ 50.79
ODS/ODF - Individual Counseling	6,673	$ 121,028.16	$ 106,255.05	$ 5,084.52
ODS/ODF - Individual Counseling - Perinatal	-	$ -	$ -	$ -
ODS/ODF - Individual Counseling - Youth	815	$ 11,638.17	$ 7,712.40	$ 94.91
RES 3.1	911	$ 105,870.19	$ 89,543.40	$ 16,326.79
RES 3.1 - Case Management	56	$ 2,032.24	$ 1,930.60	$ 101.64
RES 3.1 - Case Management - Youth	-	$ -	$ -	$ -
RES 3.1 - Youth	28	$ 3,360.00	$ 3,192.00	$ 168.00
RES 3.2-WM	28	$ 143,581.97	$ 129,654.48	$ 6,429.46
RES 3.2-WM	28			
RES 3.5	8,357	$ 1,660,603.45	$ 1,491,361.48	$ 169,241.97
RES 3.5 - Case Management	156	$ 5,658.82	$ 5,375.89	$ 282.93

ACA Expenditure by Level of Care	ACA - SFY 16-17 DY12-Q3			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
RES 3.5 - Case Management - Youth	-	$ -	$ -	$ -
RES 3.5 - Perinatal	2	$ 450.00	$ 225.00	$ -
RES 3.5 - Youth	393	$ 102,317.65	$ 54,121.90	$ 48,195.75
Total	**136,233**	**$ 3,236,279.10**	**$ 2,829,814.07**	**$ 314,310.07**

ACA Expenditures by Level of Care for DY12-Q4

ACA Expenditure by Level of Care	ACA - SFY 16-17 DY12-Q4			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ODS/IOT - Case Management	626	$ 8,713.05	$ 7,803.72	$ 383.03
ODS/IOT - Case Management - Perinatal	-	$ -	$ -	$ -
ODS/IOT - Case Management - Youth	6	$ 82.80	$ 53.82	$ 1.38
ODS/IOT - Counseling	9,431	$ 303,045.17	$ 253,937.34	$ 49,107.83
ODS/IOT - Counseling - Perinatal	-	$ -	$ -	$ -
ODS/IOT - Counseling - Youth	175	$ 5,724.16	$ 3,417.26	$ 61.69
ODS/NTP - Case Management	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone	70,534	$ 842,881.30	$ 738,766.32	$ 35,428.79
ODS/NTP - Dosing - Methadone - Perinatal	70,534	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone - Youth	123	$ 1,469.85	$ 917.23	$ 20.40
ODS/NTP - Group Counseling	-	$ -		
ODS/NTP - Individual Counseling	15,720	$ 218,508.00	$ 191,912.64	$ 9,192.56
ODS/NTP - Individual Counseling - Youth	13	$ 180.70	$ 102.86	$ 1.39
ODS/ODF - Additional MAT	46	$ 1,851.02	$ 1,635.14	$ 78.98
ODS/ODF - Case Management	1,705	$ 23,536.60	$ 20,942.87	$ 1,019.46
ODS/ODF - Case Management - Perinatal	-	$ -	$ -	$ -
ODS/ODF - Case Management - Youth	80	$ 1,266.30	$ 849.64	$ 10.08
ODS/ODF - Group Counseling	7,674	$ 142,742.85	$ 125,247.20	$ 5,988.73
ODS/ODF - Group Counseling - Perinatal	-			
ODS/ODF - Group Counseling - Youth	580	$ 9,826.68	$ 5,786.05	$ 73.87
ODS/ODF - Individual Counseling	10,974	$ 213,835.54	$ 187,898.32	$ 9,000.98
ODS/ODF - Individual Counseling - Perinatal	-	$ -	$ -	$ -
ODS/ODF - Individual Counseling - Youth	1,617	$ 26,781.97	$ 15,956.86	$ 105.55
RES 3.1	1,924	$ 216,273.81	$ 196,278.57	$ 19,995.24
RES 3.1 - Case Management	247	$ 8,951.55	$ 7,971.51	$ 388.49
RES 3.1 - Case Management - Youth	-	$ -	$ -	$ -
RES 3.1 - Youth	-	$ -	$ -	$ -
RES 3.2-WM	-	$ 288,906.18	$ 264,956.55	$ 13,389.55
RES 3.2-WM	-	$ 2,139.60	$ 2,032.62	$ 106.98
RES 3.5	17,016	$ 3,376,136.39	$ 3,073,690.11	$ 302,446.28
RES 3.5 - Case Management	439	$ 15,916.84	$ 14,826.94	$ 763.28
RES 3.5 - Case Management - Youth	-	$ -	$ -	$ -
RES 3.5 - Perinatal	60	$ 11,950.31	$ 5,975.00	$ -

ACA Expenditure by Level of Care	ACA - SFY 16-17 DY12-Q4			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
RES 3.5 - Youth	351	$ 89,439.33	$ 54,504.31	$ 34,935.02
Total	**209,875**	**$ 5,810,160.00**	**$ 5,175,462.88**	**$ 482,499.56**

ACA Expenditures by Level of Care for DY13-Q1

ACA Expenditure by Level of Care	ACA - SFY 17-18 DY13-Q1			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ODS/IOT - Case Management	1,515	$ 51,226.00	$ 45,148.22	$ 2,169.68
ODS/IOT - Case Management - Perinatal	208	$ 7,036.64	$ 4,766.68	$ 138.67
ODS/IOT - Case Management - Youth	191	$ 6,461.53	$ 3,443.84	$ 23.67
ODS/IOT - Counseling	87,628	$ 301,846.90	$ 271,264.46	$ 30,582.44
ODS/IOT - Counseling - Perinatal	1,263	$ 32,363.90	$ 24,529.82	$ 927.59
ODS/IOT - Counseling - Youth	4,375	$ 16,689.69	$ 10,045.81	$ 187.54
ODS/NTP - Case Management	34	$ 1,150.22	$ 1,092.73	$ 57.49
ODS/NTP - Dosing - Methadone	151,138	$ 1,981,419.18	$ 1,764,816.08	$ 86,170.89
ODS/NTP - Dosing - Methadone - Perinatal	151,138	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone - Youth	86	$ 1,127.46	$ 728.50	$ 18.48
ODS/NTP - Group Counseling	18	$ 61.74	$ 58.66	$ 3.08
ODS/NTP - Individual Counseling	43,984	$ 676,034.08	$ 611,877.30	$ 30,423.28
ODS/NTP - Individual Counseling - Youth	27	$ 414.99	$ 290.47	$ 9.22
ODS/ODF - Additional MAT	-	$ -	$ -	$ -
ODS/ODF - Case Management	3,008	$ 101,785.90	$ 89,312.85	$ 4,268.45
ODS/ODF - Case Management - Perinatal	4	$ 135.32	$ 98.11	$ 3.38
ODS/ODF - Case Management - Youth	131	$ 4,428.90	$ 3,268.74	$ 82.89
ODS/ODF - Group Counseling	9,222	$ 274,507.64	$ 244,017.93	$ 11,869.86
ODS/ODF - Group Counseling - Perinatal	87	$ 2,571.92	$ 1,812.10	$ 58.52
ODS/ODF - Group Counseling - Youth	575	$ 17,087.45	$ 10,537.57	$ 163.60
ODS/ODF - Individual Counseling	23,356	$ 340,805.41	$ 302,657.06	$ 14,702.11
ODS/ODF - Individual Counseling - Perinatal	48	$ 1,416.32	$ 981.03	$ 30.33
ODS/ODF - Individual Counseling - Youth	1,464	$ 25,892.34	$ 16,674.04	$ 279.18
RES 3.1	13,589	$ 1,518,720.82	$ 1,386,483.71	$ 132,237.11
RES 3.1 - Case Management	1,965	$ 66,650.41	$ 59,919.58	$ 2,954.62
RES 3.1 - Case Management - Youth	145	$ 4,905.35	$ 3,563.60	$ 104.86
RES 3.1 - Youth	481	$ 52,563.68	$ 39,901.44	$ 12,662.24
RES 3.2-WM	481	$ 837.90	$ 796.02	$ 41.88
RES 3.2-WM	481	$ -	$ -	$ -
RES 3.5	3,854	$ 499,164.66	$ 452,715.90	$ 46,448.76
RES 3.5 - Case Management	529	$ 18,221.05	$ 16,259.58	$ 794.23
RES 3.5 - Case Management - Youth	7	$ 236.81	$ 144.11	$ -
RES 3.5 - Perinatal	-	$ -	$ -	$ -
RES 3.5 - Youth	158	$ 19,786.34	$ 12,931.95	$ 6,854.39
Total	**501,190**	**$ 6,025,550.55**	**$ 5,380,137.89**	**$ 384,268.44**

Non-ACA Expenditures by Level of Care for DY12-Q3

Non-ACA Expenditure by Level of Care	Non-ACA - SFY 16-17 DY12-Q3			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ODS/IOT - Case Management	149	$ 3,044.94	$ 1,522.43	$ -
ODS/IOT - Case Management - Perinatal	-	$ -	$ -	$ -
ODS/IOT - Case Management - Youth	-	$ -	$ -	$ -
ODS/IOT - Counseling	1	$ 13.80	$ 6.90	$ -
ODS/IOT - Counseling - Perinatal	1,534	$ 47,562.98	$ 23,780.82	$ 22,473.16
ODS/IOT - Counseling - Youth	17	$ 613.35	$ 306.66	$ -
ODS/NTP - Case Management	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone	92	$ 2,340.87	$ 1,444.00	$ -
ODS/NTP - Dosing - Methadone - Perinatal	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone - Youth	24,149	$ 288,580.55	$ 144,169.53	$ -
ODS/NTP - Group Counseling	28	$ 334.60	$ 167.16	$ -
ODS/NTP - Individual Counseling	-	$ -	$ -	$ -
ODS/NTP - Individual Counseling - Youth	6,322	$ 87,875.80	$ 43,937.90	$ -
ODS/ODF - Additional MAT	-	$ -	$ -	$ -
ODS/ODF - Case Management	5	$ 203.25	$ 101.62	$ -
ODS/ODF - Case Management - Perinatal	392	$ 5,409.37	$ 2,704.68	$ -
ODS/ODF - Case Management - Youth	8	$ 110.40	$ 55.20	$ -
ODS/ODF - Group Counseling	53	$ 726.80	$ 390.55	$ 50.60
ODS/ODF - Group Counseling - Perinatal	1,563	$ 27,844.07	$ 13,919.40	$ -
ODS/ODF - Group Counseling - Youth	-	$ -	$ -	$ -
ODS/ODF - Individual Counseling	319	$ 4,730.68	$ 2,199.64	$ -
ODS/ODF - Individual Counseling - Perinatal	2,184	$ 37,837.03	$ 18,918.37	$ -
ODS/ODF - Individual Counseling - Youth	-	$ -	$ -	$ -
RES 3.1	801	$ 11,629.98	$ 6,217.25	$ 239.40
RES 3.1 - Case Management	277	$ 33,083.69	$ 16,541.19	$ 16,542.50
RES 3.1 - Case Management - Youth	-	$ -	$ -	$ -
RES 3.1 - Youth	-	$ -	$ -	$ -
RES 3.2-WM	7	$ 840.00	$ 739.20	$ 100.80
RES 3.2-WM	7	$ 33,347.89	$ 16,673.76	$ -
RES 3.5	7	$ 4,167.64	$ 2,682.32	$ -
RES 3.5 - Case Management	1,226	$ 242,917.07	$ 121,454.35	$ 121,462.72
RES 3.5 - Case Management - Youth	11	$ 411.29	$ 205.64	$ -
RES 3.5 - Perinatal	-	$ -	$ -	$ -
RES 3.5 - Youth	-	$ -	$ -	$ -
Total	**260**	**$ 67,765.50**	**$ 39,031.65**	**$ 28,733.85**

Non-ACA Expenditures by Level of Care for DY12-Q4

Non-ACA Expenditure by Level of Care	Non-ACA - SFY 16-17 DY12-Q4			
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ODS/IOT - Case Management	123	$ 1,696.58	$ 848.29	$ -
ODS/IOT - Case Management - Perinatal	3	$ 41.40	$ 20.70	$ -
ODS/IOT - Case Management - Youth	-	$ -	$ -	$ -
ODS/IOT - Counseling	1	$ 13.80	$ 12.14	$ -
ODS/IOT - Counseling - Perinatal	1,862	$ 61,646.76	$ 30,822.42	$ 30,442.46
ODS/IOT - Counseling - Youth	16	$ 559.30	$ 279.65	$ -
ODS/NTP - Case Management	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone	22	$ 873.43	$ 700.75	$ -
ODS/NTP - Dosing - Methadone - Perinatal	-	$ -	$ -	$ -
ODS/NTP - Dosing - Methadone - Youth	36,288	$ 433,641.60	$ 216,639.46	$ -
ODS/NTP - Group Counseling	69	$ 824.55	$ 411.93	$ -
ODS/NTP - Individual Counseling	-	$ -	$ -	$ -
ODS/NTP - Individual Counseling - Youth	8,746	$ 121,569.40	$ 60,784.70	$ -
ODS/ODF - Additional MAT	9	$ 125.10	$ 62.55	$ -
ODS/ODF - Case Management	11	$ 439.02	$ 219.50	$ -
ODS/ODF - Case Management - Perinatal	489	$ 6,752.36	$ 3,376.17	$ -
ODS/ODF - Case Management - Youth	-	$ -	$ -	$ -
ODS/ODF - Group Counseling	51	$ 714.76	$ 404.80	$ 31.00
ODS/ODF - Group Counseling - Perinatal	2,094	$ 39,651.13	$ 19,822.25	$ -
ODS/ODF - Group Counseling - Youth	-	$ -	$ -	$ -
ODS/ODF - Individual Counseling	453	$ 7,543.39	$ 4,167.42	$ -
ODS/ODF - Individual Counseling - Perinatal	2,993	$ 59,410.77	$ 29,704.93	$ -
ODS/ODF - Individual Counseling - Youth	-	$ -	$ -	$ -
RES 3.1	1,200	$ 18,491.55	$ 9,632.15	$ 1,444.23
RES 3.1 - Case Management	146	$ 17,093.35	$ 8,546.41	$ 8,546.94
RES 3.1 - Case Management - Youth	8	$ 290.32	$ 145.16	$ -
RES 3.1 - Youth	-	$ -	$ -	$ -
RES 3.2-WM	-	$ -	$ -	$ -
RES 3.2-WM	-	$ 58,646.63	$ 29,323.07	$ -
RES 3.5	-	$ -	$ -	$ -
RES 3.5 - Case Management	3,331	$ 694,836.71	$ 347,406.92	$ 347,429.79
RES 3.5 - Case Management - Youth	117	$ 4,250.78	$ 2,125.30	$ -
RES 3.5 - Perinatal	-	$ -	$ -	$ -
RES 3.5 - Youth	99	$ 20,619.27	$ 10,309.45	$ -
Total	**645**	**$ 164,803.41**	**$ 89,494.82**	**$ 75,308.59**

Non-ACA Expenditures by Level of Care for DY13-Q1

Non-ACA Expenditure by Level of Care	Non-ACA - SFY 17-18 DY13-Q1			
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount
ODS/IOT - Case Management	818	$ 27,672.94	$ 13,833.93	$ -
ODS/IOT - Case Management - Perinatal	71	$ 2,401.93	$ 1,200.90	$ -
ODS/IOT - Case Management - Youth	38	$ 1,285.54	$ 642.77	$ -
ODS/IOT - Counseling	323	$ 10,927.09	$ 5,071.65	$ -
ODS/IOT - Counseling - Perinatal	34,799	$ 105,979.05	$ 52,984.43	$ 52,994.62
ODS/IOT - Counseling - Youth	1,064	$ 22,847.69	$ 11,422.99	$ -
ODS/NTP - Case Management	497	$ 3,424.60	$ 1,712.23	$ -
ODS/NTP - Dosing - Methadone	8,766	$ 26,364.01	$ 14,551.48	$ 1,026.30
ODS/NTP - Dosing - Methadone - Perinatal	16	$ 541.28	$ 270.60	$ -
ODS/NTP - Dosing - Methadone - Youth	138,701	$ 1,818,370.11	$ 909,147.57	$ -
ODS/NTP - Group Counseling	39	$ 511.29	$ 255.45	$ -
ODS/NTP - Individual Counseling	144	$ 493.92	$ 246.91	$ -
ODS/NTP - Individual Counseling - Youth	41,190	$ 633,090.30	$ 316,524.38	$ -
ODS/ODF - Additional MAT	17	$ 261.29	$ 130.62	$ -
ODS/ODF - Case Management	-	$ -	$ -	$ -
ODS/ODF - Case Management - Perinatal	1,312	$ 44,388.90	$ 22,192.61	$ -
ODS/ODF - Case Management - Youth	34	$ 1,150.22	$ 575.08	
ODS/ODF - Group Counseling	415	$ 14,039.45	$ 7,249.53	$ -
ODS/ODF - Group Counseling - Perinatal	3,563	$ 106,090.20	$ 53,038.65	$ -
ODS/ODF - Group Counseling - Youth	133	$ 3,944.70	$ 1,972.15	$ -
ODS/ODF - Individual Counseling	1,057	$ 31,333.08	$ 17,312.33	$ -
ODS/ODF - Individual Counseling - Perinatal	9,587	$ 117,205.63	$ 58,601.97	$ -
ODS/ODF - Individual Counseling - Youth	74	$ 2,204.47	$ 1,102.18	$ -
RES 3.1	2,386	$ 36,672.58	$ 17,164.78	$ -
RES 3.1 - Case Management	2,969	$ 330,279.00	$ 165,139.50	$ 165,139.50
RES 3.1 - Case Management - Youth	425	$ 14,377.75	$ 7,188.59	$ -
RES 3.1 - Youth	67	$ 2,266.61	$ 1,133.24	$ -
RES 3.2-WM	219	$ 23,932.32	$ 11,966.16	$ 11,966.16
RES 3.2-WM	219	$ -	$ -	$ -
RES 3.5	219	$ -	$ -	$ -
RES 3.5 - Case Management	900	$ 114,675.90	$ 57,333.45	$ 57,342.45
RES 3.5 - Case Management - Youth	176	$ 6,077.09	$ 3,038.48	$ -
RES 3.5 - Perinatal	4	$ 135.32	$ 67.65	$ -
RES 3.5 - Youth	-	$ -	$ -	$ -
Total	**137**	**$ 17,156.51**	**$ 8,064.36**	**$ 9,092.15**

After three quarters, seven counties are providing DMC-ODS services. Based on approved claims from DY12-Q3 to DY13-Q1, there has been a 121% increase in units of service from 155,124 to 716,511. The increase in expenses was 362%, from $4,137,787 to $9,150,268. Since thirteen additional counties will begin services in

DY13, these statistics are expected to increase over the next three quarters.

Quality Assurance/Monitoring Activities:

On-site readiness reviews conducted for the following counties:

- August 1-4, 2017: Los Angeles,
- August 14-16, 2017: Sonoma,
- August 14-16, 2017: Napa,
- September 6-7, 2017: San Luis Obispo, and
- September 6-7, 2017: Santa Cruz.

Evaluation:

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

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

UCLA continues to hold monthly conference call with updates, activities, and meetings. The evaluation is posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$18,679,158	$37,358,316	DY 12	$18,679,158
Total	**$18,679,158**	**$37,358,316**		**$18,679,158**

This quarter, the Department claimed **$18,679,158** in federal fund payments for DSHP-eligible services.

Low Income Health Program (LIHP)

The Low Income Health Program (LIHP) included two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE enrollees had family incomes at or below 133 percent of the federal poverty level (FPL). HCCI enrollees had family incomes above 133 through 200 percent of the FPL. LIHP ended December 31, 2013, and, effective January 1, 2014, local LIHPs no longer provided health care services to former LIHP enrollees. Additionally, pursuant to the Affordable Care Act, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California.

This quarter, LIHP received **$0** in federal fund payments. DHCS is still collaborating with the LIHP counties to complete final reconciliation for DY3 through DY9.

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) will assist public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCS in 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. 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 reinforces structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness. The GPP program year began on July 1, 2015.

The total amount available for the GPP is a combination of a portion of 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.

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
Qtr 1 (July – Sept 2017)	$26,091,312.50	$26,091,312.50	July 1, 2015 – June 2016	$52,182,625.00

The payments made during this time period were for PY 1 (July 1, 2015 - June 30, 2016) final reconciliation.

This quarter, the PHCS received **$26,091,312.50** in federal funds payments and **$26,091,312.50** in IGT for GPP.

Quality Assurance/Monitoring Activities:

The PHCS must submit encounter data for PY 2 by March 31, 2018. DHCS developed a secured SharePoint site for the encounter data to be transmitted from the PHCS to DHCS. We are currently in the testing phase where PHCS are submitting data to the SharePoint site to ensure for a smooth transfer of data on March 31, 2018.

Evaluation:

Per STC Item 173 *Evaluations of provider expenditures and activities under the global payment program*, the State must 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. 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. 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 the program.

DHCS awarded a contract to The RAND Corporation in the amount of $999,968.00 on September 11, 2017. The evaluations will inform ways to enhance the delivery of more cost-effective and higher-value care.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program 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 Program are designed to accelerate efforts by participating PRIME entities to change care delivery, to maximize health care value, and to strengthen their ability to successfully perform under risk-based alternative payment models (APMs) in the long term, consistent with CMS and Medi-Cal 2020 goals.

The PRIME Program aims to:

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

PRIME Projects are organized into 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.

Projects included in Domain 1 – Outpatient Delivery System Transformation and Prevention are designed to ensure that patients experience timely access to high-quality and efficient patient-centered care. Participating PRIME entities 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.

The projects in Domain 2 – Targeted High-Risk or High-Cost Populations focus on specific populations that would benefit most significantly from care integration and coordination: individuals with chronic non-malignant pain and those with advanced.

Projects in Domain 3 – Resource Utilization Efficiency 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.

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.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

On August 11, 2017, DHCS hosted a webinar on the topic of Tobacco Assessment and Counseling. The webinar provided an overview of tobacco cessation evidence, including an overview of current smoking in California and associated health and economic costs. It also provided information to help PRIME entities capture the tobacco status and counseling elements of the PRIME metric, a metric included in four different PRIME projects.

On August 22, 2017, DHCS hosted a webinar to walk PRIME entities through technical updates and changes to the PRIME reporting portal.

On September 28, 2017, DHCS presented at a webinar hosted by the Safety Net Institute, and provided entities an overview of how to use an unearned funds calculator tool and how to claim payment for unearned funds based on over-performing metrics.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

DY 12 semi-annual payments were issued by April 30, 2017, and DY 12 annual payments will be issued beginning October 1, 2017.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$0** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

DY12 Year-End reports were received from all participating PRIME entities on

September 30, 2017. These reports will be reviewed in DY13-Q2.

Evaluation:

CMS approved DHCS' PRIME Statewide Evaluation Design on August 23, 2017. DHCS selected the University of California Los Angeles' (UCLA) Center for Health Policy Research as the PRIME external evaluator.

UCLA started to identify variables and acquired permission for Office of Statewide Health Planning and Development (OSHPD) data for the evaluation. OSHPD data will be used in the evaluation for assessment of PRIME's impact on all California inpatient discharges. OSHPD provided a pre-approval letter to UCLA in DY13-Q1 for use of OSHPD data.

Additionally, UCLA started to identify variables and acquired permission for Medi-Cal data. Medi-Cal data will be used for assessment of the impact of PRIME on Medi-Cal enrollees' inpatient and outpatient service use and expenditures. During DY13-Q1, UCLA received approval from the Data and Research Committee of DHCS' Information Management Division to obtain Medi-Cal data from DHCS.

Lastly, UCLA used PRIME entities' applications and reports to create a database of hospital-specific characteristics, including information around payer mix, record systems, cultural competency, and leadership/engagement. This database, created in DY13-Q1, will assist in the design of the hospital survey instrument.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

Seniors and Persons with Disabilities (SPDs) are persons who derive their eligibility from the Medicaid State Plan and are either: aged, blind, or disabled. According to the Special Terms and Conditions of this Demonstration, DHCS may mandatorily enroll SPDs into Medi-Cal managed care programs to receive benefits. This does not include individuals who are:

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

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

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

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

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

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

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

Enrollment Information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
July 2017 – September 2017

County	Total Member Months
Alameda	88,294
Contra Costa	52,878
Fresno	71,846
Kern	56,645
Kings	7,877
Los Angeles	600,056
Madera	7,162
Riverside	105,012
San Bernardino	110,064
San Francisco	115,756
San Joaquin	122,082
Santa Clara	45,211
Stanislaus	50,157
Tulare	67,582
Sacramento	36,325
San Diego	31,934
Total	**1,568,881**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2017 – September 2017

County	Total Member Months
Alameda	60,598
Contra Costa	27,725
Fresno	37,557
Kern	24,869
Kings	3,879
Los Angeles	1,147,732
Madera	3,876
Marin	19,499
Mendocino	17,463
Merced	48,240
Monterey	48,212
Napa	14,328
Orange	370,871
Riverside	160,266
Sacramento	60,762
San Bernardino	155,976
San Diego	226,393
San Francisco	42,096
San Joaquin	25,849
San Luis Obispo	24,844
San Mateo	68,071
Santa Barbara	46,052
Santa Clara	151,207
Santa Cruz	31,612
Solano	59,356
Sonoma	53,329
Stanislaus	14,612
Tulare	16,810
Ventura	85,953
Yolo	26,210
Total	**3,074,247**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
July 2017 – September 2017

County	Total Member Months
Alpine	80
Amador	1,128
Butte	19,333
Calaveras	1,760
Colusa	824
El Dorado	5,254
Glenn	1,671
Imperial	10,336
Inyo	517
Mariposa	689
Mono	201
Nevada	3,297
Placer	9,384
Plumas	1,025
San Benito	279
Sierra	116
Sutter	5,906
Tehama	5,173
Tuolumne	2,645
Yuba	6,589
Total	**76,207**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
July 2017 – September 2017

County	Total Member Months
Del Norte	8,060
Humboldt	26,810
Lake	19,198
Lassen	4,494
Modoc	1,865
Shasta	40,777
Siskiyou	11,169
Trinity	2,797
Total	**115,170**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Not applicable.

WHOLE PERSON CARE (WPC)

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

The local WPC pilots identify high-risk, high-utilizing target populations; share data between systems; provide comprehensive care in a patient-centered manner; coordinate care in real time; and evaluate individual and population health progress. WPC pilots may also choose to focus on homelessness and to expand access to supportive housing options for these high-risk populations. The WPC pilots are developed and operated locally by an organization eligible to serve as the lead entity (LE). LEs must be a county, a city, a city and county, a health or hospital authority, a designated public hospital or a district/municipal public hospital, a federally-recognized tribe, a tribal health program operated under contract with the federal Indian Health Services, or a consortium of any of the above entities.

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

Eighteen LEs implemented WPC pilots and began enrolling WPC members on January 1, 2017.

After approval of the initial 18 WPC pilots, a second round of WPC pilot applications was accepted from new applicants and LEs interested in expanding their WPC pilots. Fifteen WPC pilot applications were received and approved in the second round:

- Eight existing LEs applied to expand their programs, including the counties of Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura.
- Seven applicants applied to implement new WPC pilots, including the counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma; the City of Sacramento; and the Small County Whole Person Care Collaborative, a consortium of small counties including Mariposa, Plumas, and San Benito.

On July 1, 2017, the seven new LEs implemented WPC pilot programs for a total of twenty-five WPC pilots. In addition, eight existing LEs implemented new aspects of their existing WPC programs.

The first and second round WPC Program Year (PY) periods are listed below with the corresponding DY. PYs are based on a calendar year.

WPC First Round

PY (Dates)	DY (Dates)
1 (Jan 1 - Dec 31, 2016)	11 (Jan 1 - June 30, 2016) and 12 (July 1, 2016 - June 30, 2017)
2 (Jan 1 - Dec 31, 2017)	12 (July 1, 2016 - June 30, 2017) and 13 (July 1, 2017 - June 30, 2018)
3 (Jan 1 - Dec 31, 2018)	13 (July 1, 2017 - June 30, 2018) and 14 (July 1, 2018 - June 30, 2019)
4 (Jan 1 - Dec 31, 2019)	14 (July 1, 2018 - June 30, 2019) and 15 (July 1, 2019 - June 30, 2020)
5 (Jan 1 - Dec 31, 2020)	15 (July 1, 2019 - June 30, 2020) and 16 (July 1, 2020 - Dec 31, 2020)

WPC Second Round

PY (Dates)	DY (Dates)
1 (Jan 1 - June 30, 2017)	12 (July 1, 2016 - June 30, 2017)
2 (July 1 - Dec 31, 2017)	13 (July 1, 2017 - June 30, 2018)
3 (Jan 1 - Dec 31, 2018)	13 (July 1, 2017 - June 30, 2018) and 14 (July 1, 2018 - June 30, 2019)
4 (Jan 1 - Dec 31, 2019)	14 (July 1, 2018 - June 30, 2019) and 15 (July 1, 2019 - June 30, 2020)
5 (Jan 1 - Dec 31, 2020	15 (July 1, 2019 - June 30, 2020) and 16 (July 1, 2020 - Dec 31, 2020)

Enrollment Information:

The first quarter data for DY 13 is not available due to a normal data lag. The first quarter data will be reported in the next quarterly report.

WPC Enrollment			
LE	**DY12-Q3 (Jan - Mar) Unduplicated**	**DY12-Q4 (Apr - Jun) Unduplicated**	**Total to Date**
Alameda	171	222	393
Contra Costa	194	7,127	7,321
Kern	0	0	0
Los Angeles	4,764	1,949	6,713
Monterey	7	24	31
Napa	0	0	0
Orange	200	455	655
Placer	0	121	121
Riverside	0	0	0
San Bernardino	0	7	7
San Diego	0	0	0
San Francisco	3,991	2,036	6,027
San Joaquin	0	0	0
San Mateo	2,078	165	2,243
Santa Clara	19	2,480	2,499
Shasta	0	15	15
Solano	8	23	31
Ventura	0	0	0
Total	**11,432**	**14,624**	**26,056**

Member Months:

The first quarter data for DY 13 is not available yet due to a normal data lag. The first quarter data will be reported in the next quarterly report.

WPC Member Months			
LE	**DY12-Q3 (Jan - Mar)**	**DY12-Q4 (Apr - Jun)**	**Cumulative Unduplicated Year-to-Date**
Alameda	355	914	1,269
Contra Costa	550	15,710	16,260
Kern	0	0	0
Los Angeles	12,335	14,682	27,017
Monterey	13	59	72
Napa	0	0	0
Orange	200	455	655
Placer	0	169	169
Riverside	0	0	0
San Bernardino	0	7	7
San Diego	0	0	0
San Francisco	9,204	15,522	24,726
San Joaquin	0	0	0
San Mateo	5,973	5,975	11,948
Santa Clara	336	4,884	5,220
Shasta	0	19	19
Solano	8	23	31
Ventura	0	0	0
Total	**28,974**	**58,419**	**87,393**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

On July 5, 2017, DHCS added the new second round LEs to the regularly scheduled bi-weekly technical assistance (TA) calls. The TA calls provide opportunities for LEs to

engage with DHCS, the Learning Collaborative team, and one another. Calls alternate focuses on administrative topics and concerns, allowing the pilots to ask questions about DHCS guidance, reporting templates, timelines, and expectations, and the Learning Collaborative, with topics generated in response to LE needs. Learning Collaborative topics this quarter included Data Sharing Workforce Challenges and Plan Do Study Act (PDSA) Reporting Guidance.

The following list of resources and documents are available at the WPC Learning Collaborative Portal:

- Project calendar.
- Project contacts.
- Meeting materials.
- DHCS Reporting Templates and Technical Specifications Manual.
- Request for Information from Marin County seeking information from housing-focused community-based organizations about their capacity, willingness, and ideas for providing services under WPC.
- Memorandum of Understanding and Client Welcome Notice from San Francisco.

On July 12, 2017, DHCS held a Learning Collaborative webinar on data sharing and ways to navigate challenges with sharing data across organizations presented by DHCS' Dr. Linette Scott, Chief Medical Information Officer.

On July 20, 2017, LEs were sent the revised Quarterly enrollment and Utilization Reporting Template with instructions and the Data Dictionary for use beginning with the July 2017 enrollment and utilization. As this template contains new data elements that have not been reported in the prior Monthly Enrollment Reporting Template, the new data elements for prior January to June 2017 time period were required to be reported retrospectively.

On July 21, 2017, the quarterly Learning Collaborative webinar focused on workforce and staffing issues with strategies to ensure their workforce meets the needs of their WPC pilot.

On August 29, 2017, CMS conducted a site visit with a tour of an Alameda clinic and WPC presentation on member engagement and access services, challenges, successes, and lessons learned. CMS met with DHCS, the California Association of Public Hospitals, and the California Health Care Safety Net Institute to discuss the impact, implementation issues, challenges, and lessons learned from the WPC local programs.

On September 6, 2017, DHCS held a Learning Collaborative webinar on PDSA reporting. DHCS' Anna Lee Amarnath, Medical Program Consultant, presented PDSA reporting guidance, followed by examples of PDSA cycles and reports from a LE.

On September 8, 2017, DHCS held an in-person meeting in collaboration with Learning

Collaborative consultants for the new second round LEs that began implementation on July 1, 2017. The agenda included guidance on reporting, intergovernmental transfer (IGT) payment process, enrollment, metrics, PDSAs, start-up issues, insights from the first round implementation and Learning Collaborative portal resources.

On September 11, 2017, DHCS held a Variant and Universal Metrics Reporting Webinar to provide LEs with information and resources needed to report accurately on the universal and variant metrics. Accurate reporting and tracking of the metrics is fundamental to the success of the WPC as it is the tool by which each county and DHCS can assess if the LEs are achieving their goals.

On September 12, 2017, the Mid-Year/Annual Narrative Report review tool and the Updated Deliverables and Payment Schedule was provided to LEs for informational purposes.

On September 13, 2017, the Mid-Year/Annual Narrative Report Template was provided for LEs to use when submitting their reports. Pursuant to the WPC Agreement and the Medi-Cal 2020 Demonstration Waiver STCs, each WPC LE must submit Mid-Year/Annual reports for the duration of the WPC pilot in accordance with WPC Reporting and Evaluation guidelines and Attachment GG. This report includes the narrative report, invoice, variant and universal metrics report, administrative metrics, PDSA reports, and certification of the LE deliverables.

On September 13, 2017, DHCS released the Budget Adjustment and Rollover Templates for comments.

On September 14, 2017, the final Variant and Universal Metrics Report Template was provided to LEs for use when submitting their reports. This template was revised in response to LE feedback during the September 11, 2017 webinar.

On September 22, 2017, the aid code list for Medi-Cal beneficiaries who are ineligible for WPC was released for LE use. Medi-Cal beneficiaries who are not included on this list are eligible for WPC.

Consumer Issues:

DHCS continues to work with stakeholders on the implementation and operation of the WPC pilot program.

Financial/Budget Neutrality Development/Issues:

On August 25, 2017, DHCS released the first WPC payments for DY12 for the seven new second round LEs. These payments, totaling $19,461,301.00, were made through the IGT process. These payments represented the 50% federal financial participation (FFP) and 50% local non-federal share amounts of $9,730,650.50.

Payments

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 3 (Jan 1 - March 31)	$216,844,940.25	$216,844,940.25	DY 11 (PY 1)	$433,689,880.50
Qtr 4 (April 1 - June 30)	$22,206,521.50	$22,206,521.50	DY 11 (PY 1)	$44,413,043.00
DY 13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr 1 (July 1 - Sept 30)	$9,730,650.50	$9,730,650.50	DY 12 (PY 1)	$19,461,301.00
Total	**$248,782,112.25**	**$248,782,112.25**		**$497,564,224.50**

DHCS continues to develop both the budget adjustment and rollover processes. The budget adjustment process allows adjustments to future PY budgets within each WPC LE budget, while the rollover process allows an LE to move budgeted funds from the current year to the next year's budget. DHCS released the budget adjustment and rollover templates for comment. The final templates are anticipated to be released early next quarter.

Quality Assurance/Monitoring Activities:

The Variant and Universal Metrics reporting template was released in July 2017 for comment. These metrics allow DHCS to measure success and progress consistently across LEs in achieving the goals and strategies specified in the STCs, and allow flexibility for reflecting the variety of strategies.

All first round LEs submitted their second quarter enrollment and utilization report, which was due on July 31, 2017. This report includes required data elements for enrollment status, homeless status, and disenrollment.

The quarterly enrollment and utilization report was revised to include new data elements for target populations, fee-for-service, and per-member-per-month utilization. These reports and new data elements are used to monitor and evaluate the program and for payment purposes to verify invoice payments. The new data elements for the prior January to June time period were submitted in the revised report due August 31, 2017, from all first round LEs.

DHCS monitors enrollment on at least a quarterly basis. Two LEs with no member enrollment after the first six months of program implementation, and without delayed enrollment included in their approved applications, were required to submit improvement plans to DHCS with specified enrollment goals to attain by December 31,

2017. DHCS reviewed and accepted the improvement plans submitted, including the proposed action steps.

Evaluation:

On October 16, 2017, DHCS executed a contract with the University of California at Los Angeles to provide evaluation services for the WPC pilot program with an effective date of November 1, 2017.