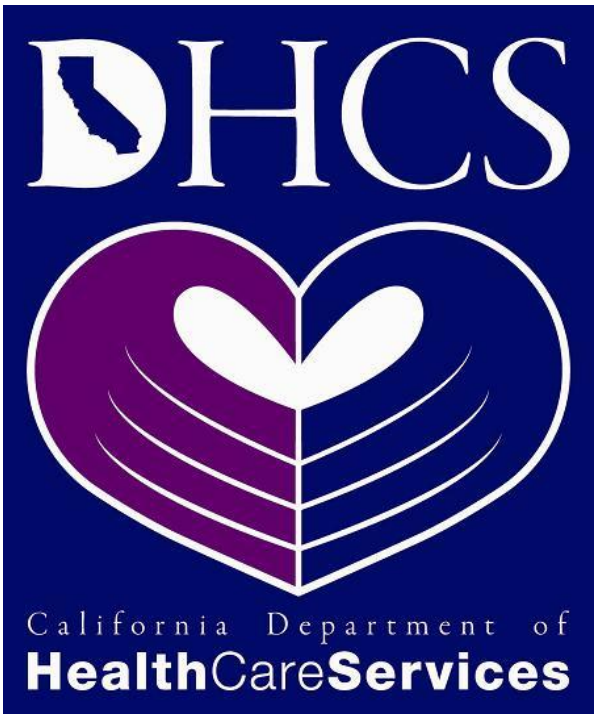
CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)



Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fourteen (07/01/2018 – 06/30/2019)
Second Quarter Reporting Period: 10/01/2018 – 12/31/2018

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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.

Assembly Bill (AB) 1568 (Bonta and Atkins, Chapter 42, Statutes of 2016) established the "Medi-Cal 2020 Demonstration Project Act" that authorizes DHCS to implement the objectives and programs, such as WPC and DTI, of the Waiver Demonstration, consistent with the 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 Senate Bill (SB) 815 (Hernandez and de Leon, Chapter 42, Statutes of 2016). SB 815, chaptered on July 8, 2016, establishes and implements the provisions of the state's Waiver Demonstration as required by the STCs from CMS. The bill also provides clarification for changes to the current Disproportionate Share Hospital (DSH) methodology and its recipients for facilitating the GPP program.

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 18: Post Award Forum

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

In DY14-Q2, DHCS hosted a SAC meeting on October 25, 2018 to provide waiver implementation updates and address stakeholder questions and comments. DHCS reviewed the timing for potential 1115 waiver renewal discussions and stakeholder engagements, in addition to the waiver elements being considered.

The meeting agenda is available on the DHCS website: https://www.dhcs.ca.gov/services/Documents/Oct25SACAgenda.pdf. The meeting minutes are also available online: https://www.dhcs.ca.gov/services/Documents/SAC_102518_MeetingSummary.pdf

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on October 10, 2018, and December 10, 2018, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following topics were discussed: Rady Children's Hospital CCS Pilot, WPC Program Updates, HHP Updates, DY 13 Annual Report, DMC-ODS Grievances and Appeals, and Financial Reporting Activities.

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 Section 1115(a) Medicaid Waiver Demonstration STCs require DHCS to contract with its External Quality Review Organization (EQRO), Health Services Advisory Group, to conduct a one-time access assessment to care.

The EQRO provided DHCS with the Access Assessment data requirements and submitted their data request to DHCS on October 29, 2018. DHCS and the EQRO began bi-monthly meetings on November 7, 2018, to ensure the Access Assessment project continues to move forward. On December 14, 2018, DHCS submitted administrative and survey-based data to the EQRO to begin preliminary analytic review and quality assurance checks.

DHCS and the EQRO will complete the following activities as part of the Access Assessment project:

- Initial draft report meeting with Advisory Committee for review and comment;
- Initial draft report posted for 30-day public comment period;
- Exit Advisory Committee Meeting; and
- Final report submission to CMS ten months following CMS' approval of the Assessment Design and publishing to the DHCS' website.

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 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 of San Mateo (HPSM), DHCS contracted with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning July 1, 2018.

Enrollment Information:

The monthly enrollment for Health Plan San Mateo (HPSM) CCS Demonstration Project (DP) is reflected in the table below. HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-July	0	$2,733.54	$0.00
18-Aug	44	$2,733.54	$120,275.76
18-Sep	128	$2,733.54	$349,893.12
18-Oct	151	$2,733.54	$412,764.54
18-Nov	210	$2,733.54	$574,043.40
18-Dec	321	$2,733.54	$877,466.34
Total			**$2,334,443.16**

RCHSD Monthly Enrollment

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	151	210	321	2	682

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 CMS on December 30, 2015. The Waiver contains 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. DHCS is awaiting approval for the CCS protocols, however DHCS received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design.

Health Plan of San Mateo Demonstration Project

HPSM's contract for the CCS Demonstration Project ceased effective June 30, 2018. All CCS Demonstration members in HPSM were transitioned into HPSM's managed care plan effective July 1, 2018.

Rady Children's Hospital of San Diego Demonstration Project

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

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. RCHSD notified DHCS that there were no member grievances to report for DY14-Q2.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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, and DHCS responded to CMS on October 10, 2017. DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

DHCS sought out applications for the evaluator on October 9, 2018. After reviewing the proposals, DHCS selected the Regents of the University of California, San Francisco (UCSF) for award. This evaluation will run from July 1, 2019, to June 30, 2021, and will be completed in two phases. Phase one will include HPSM, and phase two will include RCHSD. UCSF is slated to begin contracting work on July 1, 2019.

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. DHCS amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR waiver) to include CBAS, which was approved by CMS on March 30, 2012. CBAS was operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

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

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

Program Requirements:

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020 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 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 STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and Fee-for-Service (FFS) members per county for DY14-Q2, represents the period of October to December 2018. CBAS enrollment data is shown in the table, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.* The table titled *CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

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

[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.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY13-Q3		DY13-Q4		DY14-Q1		DY14-Q2	
	Jan -Mar 2018		Apr - Jun 2018		Jul - Sep 2018		Oct - Dec 2018	
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	518	78%	510	77%	539	82%	532	81%
Butte	43	42%	34	33%	37	36%	34	33%
Contra Costa	223	69%	232	72%	240	73%	212	64%
Fresno	634	57%	676	61%	602	46%	658	50%
Humboldt	86	22%	100	26%	95	24%	107	28%
Imperial	338	56%	307	51%	308	51%	305	51%
Kern	79	23%	83	25%	72	21%	96	28%
Los Angeles	21,381	65%	21,983	67%	21,414	63%	21,591	64%
Merced	88	42%	94	45%	94	45%	95	45%
Monterey	109	59%	107	57%	106	57%	105	56%
Orange	2,268	54%	2,329	53%	2,369	54%	2,440	55%
Riverside	449	41%	450	42%	470	43%	465	43%
Sacramento	437	70%	440	70%	367	59%	332	40%
San Bernardino	640	86%	650	87%	677	91%	694	93%
San Diego	2,068	56%	2,138	57%	2,238	60%	2,079	56%
San Francisco	693	44%	672	43%	684	44%	705	45%
San Mateo	56	27%	65	28%	65	28%	63	28%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	617	45%	224	16%	611	43%	606	42%
Santa Cruz	103	68%	110	72%	108	71%	107	70%
Shasta	*	*	*	*	*	*	*	*
Ventura	892	62%	905	63%	898	62%	909	63%
****Yolo**	290	76%	282	74%	287	76%	290	76%
Marin, Napa, Solano	80	16%	80	16%	83	17%	79	16%
Total	**32,104**	**62%**	**32,489**	**61%**	**32,364**	**59%**	**32,504**	**59%**
								FFS and MCP Enrollment Data 12/2018

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

The data provided in the previous table shows that while enrollment has slightly increased between DY14-Q1 and DY14-Q2, it has remained consistent with over 32,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers with the exception of the centers located in San Bernardino County. San Bernardino County is currently operating close to its center capacity due to a steady increase in participant enrollment. However, a majority of CBAS participants are able to choose an alternate CBAS Center in nearby counties should the need arise for ongoing CBAS services.

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 Kern County, there was a more than 5% increase in licensed capacity utilized compared to the previous quarter. This increase of more than 5% capacity utilization for Kern County is likely due to a fluctuation in attendance as there were no center closures during the DY14-Q2 reporting period. No other counties reported significant increases in licensing capacity utilization between the two previous quarters. In Contra Costa and Sacramento Counties, there was more than a 5% decrease of license capacity utilization compared to the previous quarter. CDA approved an increase in overall licensing capacity for Sacramento County, which explains the decrease in capacity utilization. The decrease in license capacity utilization in Contra Costa County is likely due to general attendance fluctuation, as there were no center openings in or near Contra Costa County during the DY14-Q2 reporting period.

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.

The following table, titled *CBAS Assessments Data for MCPs and FFS* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments listed in this table is reported by DHCS.

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY13-Q3 (1/1-3/31/2018)	2,213	2,188 (98.9%)	25 (1.1%)	8	7 (87.5%)	1 (12.5%)
DY13-Q4 (4/1-6/30/2018)	2,446	2,386 (97.5%)	60 (2.5%)	5	5 (100%)	0 (0%)
DY14-Q1 (7/1-9/30/2018)	2,369	2305 (97.3%)	64 (2.7%)	4	4 (100%)	0 (0%)
DY14-Q2 (10/1-12/31/2018)	2,256	2,208 (97.9%)	48 (2.1%)	6	6 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. As indicated in the table above, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. According to the table, for DY14-Q2, there were (2,256) assessments completed by the MCPs, of which (2,208) were determined to be eligible and (48) were determined to be ineligible. The table identifies that 6 participants were assessed for CBAS benefits under FFS, and all were determined eligible by DHCS.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers.

The next table titled *CDA-CBAS Provider Self-Reported Data* identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY14-Q2. The ADA at the 248 operating CBAS Centers is approximately 22,989 participants, which corresponds to 71% Statewide ADA per center. As the result of an increase in the total unduplicated participants in DY14-Q2, a rise in ADA was seen compared to the previous quarter. Additionally, one new CBAS Centers in Los Angeles County opened during DY14-Q2 that resulted in an overall increase in total statewide license capacity at 32,180 compared to the previous quarter.

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	248
Non-Profit Centers	55
For-Profit Centers	193
ADA @ 248 Centers	22,989
Total Licensed Capacity	32,180
Statewide ADA per Center	71%
	CDA - MSSR Data 12/2018

Outreach/Innovative Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans and other interested stakeholders via the *CBAS Updates* newsletter. In the past quarter, CDA distributed two newsletters (October 17, 2018 and December 11, 2018) which included an update on the status of the revised CBAS Individual Plan of Care (IPC), a new ADHC/CBAS History & Physical Form developed by the California Association of Adult Day Services (CAADS) in collaboration with CDA, education and training opportunities such as the California Association of Adult Day Services (CAADS) 2018 Fall Conference, and the new CBAS Center Assessment Tool (CAT) on CBAS training requirements.

CDA provided a webinar training to CBAS providers, MCPs, software vendors and other stakeholders on the new IPC form and instructions on October 3, 2018. The current IPC was revised through a year-long stakeholder process in 2015-2016 to comply with federal Home and Community-Based (HCB) Person-Centered Planning Requirements as directed in the Medi-Cal 2020 Waiver. The new IPC is in the final stage of review for publishing in the Medi-Cal Provider Manual, and implementation of the new IPC is expected to be May 1, 2019. CDA will distribute an All Center Letter (ACL) and *CBAS Updates* newsletter to CBAS providers, MCPs, software vendors and other interested stakeholders informing them of the official IPC implementation date after it is published.

CDA convenes ongoing quarterly calls/outreach with all MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update them on CBAS activities and data including policy directives, and (3) request feedback on any CBAS provider issues requiring CDA assistance. The last quarterly call was on December 12, 2018.

Operational/Policy Developments/Issues:

DHCS and CDA continue to work and communicate with CBAS providers and MCPs on

an ongoing basis to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. This includes conducting quarterly calls with MCPs, distributing All Center Letters and CBAS Updates newsletter for program and policy updates, and responding to ongoing written and telephone inquiries.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY14-Q2. DHCS approved the revised CBAS IPC and revised CBAS sections of the Medi-Cal Provider Manual for publishing, targeted for February 15, 2019. Implementation of the new CBAS IPC is targeted for May 1, 2019. 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.

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 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 the table, titled *Data on CBAS Complaints*, and the table titled, *Data on CBAS Managed Care Plan Complaints*.

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 DY14-Q2, as illustrated in the table, titled *Data on CBAS Complaints*. The table, titled *Data on CBAS Managed Care Plan Complaints* shows that MCPs received 2 beneficiary complaints and 13 provider complaints in DY14-Q2. Overall, provider complaints have increased during the last two quarters, as reported by the managed care plans.

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY13–Q3 (Jan 1 – Mar 31)	0	0	0
DY13–Q4 (Apr 1 – Jun 30)	0	0	0
DY14-Q1 (Jul 1 – Sep 30)	0	0	0
DY14-Q2 (Oct 1 – Dec 31)	0	0	0

CDA Data - Complaints 12/2018

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY13-Q3 (Jan 1 - Mar 31)	2	0	2
DY13-Q4 (Apr 1 - Jun 30)	2	0	2
DY14-Q1 (Jul 1 - Sep 30)	2	8	10
DY14-Q2 (Oct 1 - Dec 31)	2	13	15

Plan data - Phone Center Complaints 12/2018

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

Grievance and appeals data is provided to DHCS by the MCPs. According to the table, titled *Data on CBAS Managed Care Plan Grievances*, 25 grievances were filed with the MCPs for DY14-Q2; 5 grievances were related to “CBAS Providers,” 1 grievance was related to “Contractor Assessment or Reassessment”, and the remaining 19 grievances were related to “Other CBAS Grievances.” Specifically, 17 of these grievances are attributed to one specific provider under a single MCP.

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
DY13-Q3 (Jan 1 - Mar 31)	0	0	0	33	33
DY13-Q4 (Apr 1 - Jun 30)	3	0	0	36	39
DY14-Q1 (Jul 1 - Sep 30)	1	0	0	5	6
DY14-Q2 (Oct 1 - Dec 31)	5	1	0	19	25

Plan data - Grievances 12/2018

For DY14-Q2, 3 CBAS appeals were filed with the MCPs. The table, titled *Data on CBAS Managed Care Plan Appeals*, shows that 1 appeal was related to “Denials or Limited Services” and the other 2 were categorized as “Other CBAS Appeals”.

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY13 – Q3 (Jan 1 – Mar 31)	11	0	0	0	11
DY13 – Q4 (Apr 1 – Jun 30)	8	0	0	0	8
DY14 – Q1 (Jul 1 – Sep 30)	13	1	0	2	16
DY14 – Q2 (Oct 1 – Dec 31)	1	0	0	2	3

Plan data - Grievances 12/2018

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 DY14-Q2, there were no requests for hearings related to CBAS services filed.

Financial/Budget Neutrality Development/Issues:

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

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

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. CDA continues to convene quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. The table, titled *CBAS Centers Licensed Capacity*, indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also shows overall utilization of licensed capacity by CBAS participants statewide for DY14-Q2. Quality Assurance/Monitoring Activity reflects data through January to December 2018.

County	CBAS Centers Licensed Capacity					
	DY13-Q3 Jan-Mar 2018	DY13-Q4 Apr-Jun 2018	DY14-Q1 Jul-Sep 2018	DY14-Q2 Oct-Dec 2018	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	**390**	0.0%	81%
Butte	60	60	60	**60**	0.0%	33%
Contra Costa	190	190	195	**195**	0.0%	64%
Fresno	652	652	772	**772**	0.0%	50%
Humboldt	229	229	229	**229**	0.0%	28%
Imperial	355	355	355	**355**	0.0%	51%
Kern	200	200	200	**200**	0.0%	28%
Los Angeles	19,365	19,380	19,974	**19,984**	0.1%	64%
Merced	124	124	124	**124**	0.0%	45%
Monterey	110	110	110	**110**	0.0%	56%
Orange	2,458	2,608	2608	**2638**	1.2%	55%
Riverside	640	640	640	**640**	0.0%	43%
Sacramento	369	369	369	**489**	33%	40%
San Bernardino	440	440	440	**440**	0.0%	93%
San Diego	2,198	2,198	2198	**2198**	0.0%	56%
San Francisco	926	926	926	**926**	0.0%	45%
San Mateo	135	135	135	**135**	0.0%	28%
Santa Barbara	60	60	60	**60**	0.0%	*
Santa Clara	830	830	830	**850**	2.4%	42%
Santa Cruz	90	90	90	**90**	0.0%	70%
Shasta	85	85	85	**85**	0.0%	*
Ventura	851	851	851	**851**	0.0%	63%
Yolo	224	224	224	**224**	0.0%	76%
Marin, Napa, Solano	295	295	295	**295**	0.0%	16%
Total	31,276	31,441	32,160	**32,340**	0.6%	59%

CDA Licensed Capacity as of 12/2018

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

The above table reflects the average licensed capacity used by CBAS participants at 59% statewide as of December 31, 2018. Overall, most of the CBAS Centers have not

operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STC 52(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 throughout the participating counties in DY14-Q2 compared to the prior quarter, therefore no analysis is needed to addresses such variances. In the table titled *CBAS Centers Licensed Capacity*, Sacramento County saw an increase of 33 percent in their license capacity in DY14-Q2 compared to DY14-Q1, and resulted in an overall increase of in the total licensed capacity statewide.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS*, and *CBAS Centers Licensed Capacity* CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. There were no closures of any CBAS Centers over the DY14-Q2 reporting period, therefore, closures did not negatively affect the 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.

Unbundled Services (STC 48.b.iii.)

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 participant's 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. The table, titled *CBAS Center History*, shows the history of openings and closings of the centers. According to Table

below, for DY14-Q2 (October to December 2018), CDA currently has 248 CBAS Center providers operating in California. In DY14-Q2, no centers closed, and one center opened in Los Angeles County. The table below shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
December 2018	248	0	0	0	**248**
November 2018	248	0	0	0	**248**
October 2018	247	0	1	1	**248**
September 2018	245	0	2	2	**247**
August 2018	244	0	1	1	**245**
July 2018	243	0	1	1	**244**
June 2018	243	0	0	0	**243**
May 2018	242	0	1	1	**243**
April 2018	242	0	0	0	**242**
March 2018	242	0	0	0	**242**
February 2018	241	0	1	1	**242**
January 2018	241	0	0	0	**241**

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

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

Domain 2 is 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 take a training, provide confirmation of completed CRA training as well as submit a provider opt-in attestation form. If the pilot is successful, then this program may be expanded to other counties, contingent on available DTI funding.

The following 11 pilot counties were selected as pilot counties and are currently participating 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 following 17 pilot counties were selected as pilot counties and are currently participating 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.

DTI Program Year	Corresponding DYs
1 (January 1 – December 31, 2016)	11 (January 1 - June 30, 2016) and 12 (July 1, 2016 - June 30, 2017)
2 (January 1 – December 31, 2017)	12 (July 1, 2016 - June 30, 2017) and 13 (July 1, 2017 - June 30, 2018)
3 (January 1 – December 31, 2018)	13 (July 1, 2017 - June 30, 2018) and 14 (July 1, 2018 - June 30, 2019)
4 (January 1 – December 31, 2019)	14 (July 1, 2018 - June 30, 2019) and 15 (July 1, 2019 - June 30, 2020)
5 (January 1 – December 31, 2020)	15 (July 1, 2019 - June 30, 2020) and 16 (July 1, 2020 - Dec 31, 2020)

Enrollment Information:

Statewide Beneficiaries Ages 1-20 with Three Months Continuous Enrollment and Preventive Dental Service Utilization [1]

	September 2018	October 2018	November 2018	December 2018
Measure Period	10/2017-09/2018	11/2017-10/2018	12/2017-11/2018	01/2017-12/2018
Denominator[2]	5,532,860	5,563,744	5,549,171	5,537,891
Numerator[3]	2,532,860	2,530,503	2,518,110	N/A[4]
Preventive Dental	45.5%	45.5%	45.4%	N/A[4]

[1] Data Source - Dental Dashboard DM3 September 2018 MIS/DSS Data. Utilization does not include one-year full run-out allowed for claim submission.
[2] Denominator: Three months continuous enrollment - Number of beneficiaries ages one through 20 enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.
[3] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (D1000-D1999 with or without an SNC dental encounter with ICD 10 codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) in the identified year.
[4] Performance for the third month of each quarter is not available due to claim submission time lag.

State Fiscal Year 2018-2019 Statewide Active Service Offices, Rendering Providers and Safety Net Clinics [1]

Delivery System	Provider Type	Quarter 1			Quarter 2		
		July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
FFS	**Service Offices**	5,780	5,781	5,800	5,777	5,793	5,815
	Rendering	10,270	10,347	10,439	10,518	10,400	10,479
GMC[2]	**Service Offices**	118	113	118	155	158	*
	Rendering	268	376	394	397	399	*
PHP[2]	**Service Offices**	874	933	885	1,090	1,043	*
	Rendering	1,930	1,955	1,997	2,095	2,112	*
Safety Net Clinics		565	564	562	561	556	N/A[3]

[1] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of Safety Net Clinics is based on encounter data from the DHCS data warehouse as of October 2018. Only Safety Net Clinics who submitted at least one dental encounter within a year were included.

[2] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty. DHCS updated the address deduplication methodology, therefore, numbers of GMC and PHP service offices are lower than previous reports.

[3] Count of SNCs for the third month of each quarter is not available due to claim submission time lag. Figures represented by a (*) will be updated when the date is received by DHCS.

Outreach/Innovative Activities:

DTI Small Workgroup

This workgroup now meets on a bi-monthly basis, the third Wednesday of the month. This workgroup met on November 15, 2018 during this quarter. 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. In addition to the DTI small stakeholder workgroup, DHCS has continued its efforts to target specific groups with the assistance of stakeholders.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain.

The subgroup met on December 18, 2018 during this quarter. The possibility of expanding Domain 2 to additional counties was discussed, including criteria used to select prospective counties. In order to address inherent issues with the original pilot county selection, the subgroup emphasized expansion counties should be counties with higher provider and beneficiary counts that could increase participation and then produce sufficient data to evaluate. However, no final expansion decisions were made at this meeting. The next meeting is scheduled February 19, 2019.

DTI Clinic Workgroup

This sub-workgroup is still active; however, it did not convene this quarter.

Domain 3 Subgroup

This subgroup is still active; however, it did not convene this quarter and will reconvene in the next quarter. The purpose of this subgroup is to report on the domain's current activity and discuss ways to increase participation from providers who are eligible to participate in the domain.

DTI Data Subgroup

In July 2018, DHCS established a DTI data subgroup to garner stakeholder feedback on the usefulness of data reported in the DTI PY 1 Annual Report. The subgroup did not convene this quarter. This subgroup will reconvene in the next quarter for discussion of data reported in the DTI PY 2 Annual Report.

Domain 4 Subgroup

This subgroup is still active. DHCS holds bi-monthly calls with the LDPPs to receive status updates and address any outstanding questions. During this reporting period, two LDPP conference calls were held – October 24, 2018 and December 19, 2018.

DTI Webpage

The DTI webpage was updated as information became available during DY14-Q2 and will continue to be updated regularly. This quarter's update included the DTI Domain 2 and 3 county expansion announcement, posted on December 31, 2018.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY14-Q2. 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.

In this quarter, there were 97 inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to the following categories: encounter data submission, payment status and calculations, resource documents, dispute inquiries for Domain 1 PY 1 and 2, and Domain 2 billing and opt-in questions. All requests were researched and responded to within seven business days.

Number of DTI Inbox Inquiries by Domain

Domain	Inquiries
1	76
2	14
3	7
Total	**97**

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

A separate inbox is used for the LDPPs that participate in Domain 4. In this quarter, there were 46 inquiries in the Domain 4 inbox. Inquiries included status requests, budget changes, additional funding requests, and reimbursement questions.

The Domain 4 inbox is LDPPInvoices@dhcs.ca.gov.

Outreach Plans

The Administrative Services Organization (ASO) shares DTI information with providers during outreach events, specifically about domains 1-3. 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:

- October 5-6, 2018: UCLA Oral Health Innovation Forum
- October 18, 2018: LA Stakeholder Meeting (agenda)
- November 6, 2018: Oral Health Subcommittee
- December 6, 2018: Medi-Cal Dental Advisory Committee (agenda)
- December 13, 2018: LA Stakeholder Meeting (agenda)
- December 21, 2018: San Francisco DTI Access Collaborative Expert Meeting

Operational/Policy Developments/Issues:

Domain 1

The next Domain 1 payment is scheduled January 2019.

Domain 2

FFS providers are paid weekly and SNC and DMC providers are paid on a monthly basis. The table below represents incentive claims paid for FFS, SNC, and DMC providers during the DY14-Q2 reporting period. During this time, the total incentive claims paid was $844,218.40, and 21 providers opted into the domain.

County	FFS	DMC	SNC
Sacramento	$139,321.75	$202,351	-
Tulare	$487,677.65	-	-
Kings	$1,386	-	-
Glenn	$630	-	-
Mendocino	-	-	-
Inyo	-	-	$12,852
Total Incentive Claims Paid - $844,218.40			

The next table represents incentive claims paid for FFS, SNC, and DMC providers from the beginning of the Domain 2 program (February 2017) until the end of DY14-Q2 (December 2018). The total incentive claims paid for this period was $5,284,706.24, and 210 providers have opted into the domain.

County	FFS	DMC	SNC
Sacramento	$683,866	$1,902,589	-
Tulare	$2,534,379.34	-	-
Kings	$11,938.50	-	-
Mendocino	-	-	$318,391
Inyo	-	-	$7,434
Glenn	$5,001	-	-
Total Incentive Claims Paid - $4,653,598.84			

Domain 2 Outreach Efforts

DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation which includes follow-up with recently visited providers. The ASO has emphasized outreach in underutilized counties, based on the ratio of beneficiaries to providers. DHCS and the ASO will issue provider notifications and work with local dental societies to initiate outreach activities next quarter in the counties added for this domain.

Domain 2 Expansion

On December 31, 2018, DHCS announced via an electronic stakeholder blast, expanding Domain 2 into 18 new pilot counties, bringing the pilot total to 29 counties. The 18 additional counties, effective January 1, 2019, include:

- Merced
- Contra Costa
- Stanislaus
- Madera
- Orange
- Ventura
- Monterey
- Santa Clara
- Sonoma
- San Joaquin
- San Bernardino
- Santa Barbara
- Kern
- Los Angeles
- Imperial
- Fresno
- Riverside
- San Diego

Selection for these additional counties will incorporate both the requirements stated in the STCs as well as lessons learned from the operation of the pilot thus far. The main selection criteria for the new pilot counties include, but are not limited to:

- A high restorative to preventive services ratio
- A large provider populations

- A large beneficiary populations

Domain 3

Domain 3 Outreach Efforts

In this quarter, the ASO's outreach team visited four of the 17 pilot counties (Alameda, Madera, Riverside, and San Luis Obispo). Separately, upon review of claims activity data, DHCS identified 27 SNCs opted into Domain 3 from which DHCS has not received any Domain 3 claims. On October 2, 2018, DHCS emailed those SNCs with Domain 3 program information and claim submission guidelines along with the deadline for these clinics to opt-in. Of these 27, two SNCs responded to DHCS and verified their participation status, increasing the number of participating SNCs to 68.

Domain 3 Expansion

On December 31, 2018, DHCS announced via an electronic stakeholder blast, expanding Domain 3 into 19 new pilot counties, bringing the pilot to 36 total counties. The 19 additional counties, effective January 1, 2019, include:

- Butte
- Contra Costa
- Imperial
- Merced
- Monterey
- Napa
- Orange
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Mateo
- Santa Barbara
- Santa Clara
- Solano
- Sutter
- Tehama
- Tulare
- Ventura

Additionally, DHCS will increase the Domain 3 annual incentive payment amounts by $60 per beneficiary with dates of service of January 1, 2019 or later. The new payment scale will be implemented beginning in program year 4 and for the June 2020 and June 2021 payments:

Incentive Payment Amounts for Domain 3

Continuous Years of Beneficiary Return	Incentive Payment by Beneficiary	
	Current Payment	New Payment
2	$40	$100
3	$50	$110
4	$60	$120

Continuous Years of Beneficiary Return	Incentive Payment by Beneficiary	
	Current Payment	New Payment
5	$70	$130
6	$80	$140

Domain 4

The LDPPs have utilized the email inbox, LDPPinvoices@dhcs.ca.gov, to submit invoices electronically. Invoices are still submitted on a quarterly basis and may require additional follow up regarding backup documentation from the LDPP. DHCS has received 17 invoices from the LDPPs in this quarter. Ten invoices have been paid during DY14-Q2 for a total of $2,761,598.52, inclusive of invoices submitted during the previous quarter. Seven invoices are awaiting payment totaling $2,238,558.98, and five invoices totaling $3,142,474.84 are under review with DHCS. Once approved by DHCS, invoices are paid within a 3-4 week period. DHCS is expecting additional invoices from the LDPPs who have not complied with timely submission.

The LDPPs continued to submit budget revisions during this reporting period to roll over unused funds from PY 2017 to PY 2018. All budget revisions were reviewed and approved. Additionally, LDPPs submitted requests for additional funding based on dollars available from and originally allocated to the two LDPPs that are no longer participating in Domain 4. DHCS received nine requests for additional funds and DHCS provided all nine initial approvals. Once approval was received, the LDPPs were required to submit a revised narrative and budget. Eight of the LDPPs have submitted these deliverables to support their additional funding request(s), which are currently under review.

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 Dental Fiscal Intermediary, DXC, 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 executed the contract with its DTI Evaluator, Mathematica Policy Research, Inc. (Mathematica) on August 23, 2018.

DHCS met in-person with Mathematica's lead evaluators on November 13, 2018. The purpose of this meeting was to discuss expectations for the evaluation, submission timelines, data questions, and other topics concerning the DTI Evaluation. As of the submission of this report, Mathematica has begun work on tasks associated with the evaluation as well as participate in future DHCS-led DTI stakeholder engagements.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

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

Enrollment Information:

Prior quarters have been updated based on new claims data. For DY14-Q1 and DY14-Q2, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY13-Q3	15,537	8,351	23,600
DY13-Q4	16,726	8,787	25,207
DY14-Q1	20,070	9,883	29,615
DY14-Q2	11,163	5,176	16,195

Member Months:

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. "Current Enrollees (to date)" represents the total number of unique clients for

the quarter. Prior quarters' statistics have been updated, and for DY14-Q1 and DY14-Q2, there is only partial data available at this time since counties have up to six months to submit claims after the month of service.

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	11,585	11,217	11,639	DY13-Q3	15,537
	12,455	12,065	11,621	DY13-Q4	16,726
	14,798	13,690	11,650	DY14-Q1	20,070
	8,581	7,992	5,124	DY14-Q2	11,163
Non-ACA	6,964	6,842	6,888	DY13-Q3	8,351
	7,217	7,011	6,811	DY13-Q4	8,787
	8,066	7,749	6,372	DY14-Q1	9,883
	4,300	3,933	2,734	DY14-Q2	5,176

Outreach/Innovative Activities:

- Monthly Technical Assistance (TA) Calls with Counties' Leads
- Monthly Harbage Consulting Meetings regarding DMC-ODS Waiver
- California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) Bi-Monthly Calls
- SUD Waiver States Bi-Monthly Conference Calls
- California Health Care Foundation (CHCF) Bi-Monthly Calls
- Indian Health Program Organized Delivery System (IHP-ODS) Bi-Monthly Calls
- October 2, 2018: CMS Innovative Accelerator Program (IAP) Conference Call
- October 5, 2018: Colorado SUD Waiver Conference Call
- October 16, 2018: DHCS Opioid Workgroup Meeting
- October 19, 2018: Health Management Webinar Synergizing Master Plan with County Opioid Use Disorder Work
- October 19, 2018: Association of State and Territorial Health Officials (ASTHO) Fourth virtual convening of the Cross-Agency Leaders Roundtable on SUD Prevention and Treatment
- October 19, 2018: CHCF MAT Advisory Group: Treatment Starts Here
- October 24-25, 2018: UCLA Integrated Care Conference: Integrating Substance Use, Mental Health, and Primary Care Services: Disruptive Innovations and Sustaining Change
- October 31, 2018: External Quality Review Organization (EQRO) Annual Report Presentation
- November 5, 2018: California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) SUD External Stakeholder Summit

- November 7, 2018: California Department of Public Health (CDPH) Maternal/Neonatal Task Force Meeting
- November 8, 2018: CAADPE and Coalition of Alcohol & Drug Associations Quarterly Meeting
- November 9, 2018: Substance Abuse and Mental Health Services Administration Conference Call: CA Substance Abuse Treatment field
- November 19, 2018: California Consortium for Urban Indian Health Conference Call: IHP-ODS
- November 27, 2018: CCHS and CDCR Substance Use Disorder External Stakeholder Summit
- November 28, 2018: Judicial Council of California: Collaborative Justice Courts Advisory Committee Meetings
- November 28, 2018: Waiver Evaluation Meeting with Harbage Consulting
- December 3, 2018: Pacific Southwest Addiction Technology Transfer Center Year 2 Virtual Regional Advisory Board Meeting
- December 13, 2018: Managed Care Advisory Group Quarterly Meeting and Webinar
- December 18, 2018: DHCS Opioid Workgroup Meeting

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

County	County/Provider Staff Training Dates	County/Provider Staff Training Attendees
Orange County	October 17-18, 2018	15
Contra Costa County	December 5-6, 2018	10

Operational/Policy Developments/Issues:

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

Consumer Issues:

Grievance and appeal data are as follows:

Grievance	Access to Care	Quality of Care	Program Requirements	Service Denials	Failure to Respect Enrollee's	Interpersonal Relationship Issues	Other	Totals
Alameda	-	-	1	-	-	-	-	**1**
Contra Costa	-	1	-	-	-	-	-	**1**
Imperial	-	-	-	-	-	-	-	**0**
Los Angeles	15	3	61	8	-	5	8	**100**
Marin	-	-	-	-	-	1	2	**3**
Monterey	-	-	-	-	-	-	-	**0**
Napa	-	-	-	-	-	-	-	**0**
Nevada	-	-	-	-	-	-	-	**0**
Orange	1	-	-	-	-	-	-	**1**
Placer	-	-	-	-	-	-	-	**0**
Riverside	-	2	-	-	-	-	-	**2**
San Bernardino	-	-	-	-	-	-	6	**6**
San Diego	-	20	-	-	2	-	2	**24**
San Francisco	-	-	1	-	-	-	2	**3**
San Joaquin	-	-	-	-	-	-	2	**2**
San Luis Obispo	-	1	-	-	-	1	3	**5**
San Mateo	-	-	-	-	2	1	-	**3**
Santa Barbara	-	-	-	-	-	-	-	**0**
Santa Clara	1	2	1	-	-	2	-	**6**
Santa Cruz	-	1	-	-	1	-	1	**3**
Ventura	-	-	-	-	-	-	-	**0**
Yolo	-	-	-	-	-	-	-	**0**

County	Grievances	Appeal	Resolved in Favor of Plan	Resolved in Favor of Beneficiary	Transition of Care Requests	Approved	Denied
Alameda	1	0	-	-	-	-	-
Contra Costa	3	0	-	-	-	-	-
Imperial	0	0	-	-	-	-	-
Los Angeles	45	0	-	-	-	-	-
Marin	3	0	-	-	-	-	-
Monterey	0	0	-	-	-	-	-
Napa	0	0	-	-	-	-	-
Nevada	1	0	-	-	-	-	-
Orange	1	3	2	1	-	-	-
Placer	0	0	-	-	-	-	-
Riverside	1	0	-	-	-	-	-
San Bernardino	6	0	-	-	-	-	-
San Diego	45	0	-	-	-	-	-
San Francisco	2	0	-	-	-	-	-
San Joaquin	2	0	-	-	-	-	-
San Luis Obispo	7	1	-	1	-	-	-
San Mateo	2	0	-	-	-	-	-
Santa Barbara	0	0	-	-	-	-	-
Santa Clara	5	0	-	-	-	-	-
Santa Cruz	2	7	7	-	-	-	-
Ventura	0	0	-	-	2	2	-
Yolo	1	0	-	-	-	-	-

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

DHCS is currently working with Los Angeles County regarding the high number of grievances reported. More specific information will be provided in the next quarterly report.

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY13-Q3					
ACA	1,123,304	$30,552,368.07	$26,885,432.44	$2,430,880.31	$1,236,055.32
Non-ACA	628,809	$12,259,439.64	$6,155,775.22	$2,045,663.03	$4,058,001.39
DY13-Q4					
ACA	852,840	$27,421,684.47	$23,903,362.58	$2,242,059.30	$1,276,262.59
Non-ACA	508,086	$11,088,675.71	$5,615,014.84	$1,445,082.78	$4,028,578.09
DY14-Q1					
ACA	1,146,452	$32,041,665.14	$27,993,675.56	$2,460,028.83	$1,587,960.75
Non-ACA	725,270	$13,734,460.62	$6,938,032.39	$1,711,133.75	$5,085,294.48
DY14-Q2					
ACA	634,243	$17,252,409.34	$15,057,635.58	$1,285,510.41	$909,263.35
Non-ACA	346,800	$6,976,964.60	$3,553,950.35	$1,018,069.92	$2,404,944.33

ACA and Non-ACA Expenditures by Level of Care

For details of ACA and Non-ACA expenditures by level of care, please refer to the attached Excel file, tabs “ODS Totals ACA” and “ODS Totals Non-ACA.” Beginning in DY14-Q1, the new reporting format is being used to report expenses. A level of care is now reported on one line, rather than reported by location. For example, Case Management can be provided in Intensive Outpatient Treatment (IOT) and Outpatient (ODF) settings. Rather than report two lines for Case Management under IOT and ODF, all Case Management expenses are reported on one line.

There are now twenty-two counties participating in the DMC ODS waiver as of December 1, 2018, with eleven new counties implementing the waiver in DY 14. Of the eleven counties, eight started providing services in July, 2018. From DY13-Q4 to DY 14-Q1, there was an increase in total approved claims of 18%, from $38.5 million to

$45.5 million. Over the past four quarters, claims for Methadone dosing and Residential 3.5 comprise 24% and 22%, respectively, of the $150 million in approved claims.

Quality Assurance/Monitoring Activities:

On-site readiness reviews are conducted to ensure counties are prepared to go live with 1115 Waiver services and provide technical assistance with policy development. On-site readiness reviews were conducted in Sacramento County on November 14-16, 2018.

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

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

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

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 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)	$18,718,589	$37,437,178	DY 13	$18,718,589
(Qtr. 2 Oct-Dec)	$0	$0		$0
Total	**$18,718,589**	**$37,437,178**		**$18,718,589**

This quarter, the Department claimed $0 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 DY 3 through DY 9.

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
PY 3, IQ4 (April - June)	$226,102,839.50	$226,102,839.50	DY 13	$452,205,679
PY 3 (July -March) Overpayment collection	*($6,386,583.50)*	*($6,386,583.50)*	DY 13	*($12,773,167)*

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 4, IQ1 (July - September)	$301,281,907	$301,281,907	DY 14	$602,563,814
Total	**$520,998,163**	**$520,998,163**		**$1,041,996,326**

DY14-Q2 reporting includes GPP payments made on October 11, 2018. The payment made during this time period was for PY 3, Interim Quarter (IQ) 4 (April 1, 2018 – June 30, 2018), and PY4-Q1 (July 1, 2018 – September 30, 2018).

In PY 3, IQ4, the PHCS received $226,102,839.50 in federal fund payments and $226,102,839.50 in IGT for GPP. In PY 4, IQ 1, the PHCS received $301,281,907 in federal fund payments and $301,281,907 in IGT for GPP.

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

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

The GPP Final Evaluation Report is currently being developed by the RAND Corporation (RAND). The Final Evaluation Report will include information and findings from both a survey and an interview with each PHCS. The PCHSs will receive the survey in January 2019. The survey will help measure the effectiveness of the GPP program and the services provided to the beneficiaries. In addition, RAND will conduct interviews to supplement the survey responses.

RAND and DHCS are preparing for the GPP Final Evaluation Report that will focus on three research questions:

1. Was the GPP successful in driving a shift in provision of services from inpatient to outpatient settings (including non-traditional services) over the course of the GPP?
2. Did GPP allow PHCS to leverage investments in primary care, behavioral health, data collection and integration, and care coordination to deliver care to the remaining uninsured?
3. Did the percentage of dollars earned based on non-inpatient, non-emergency services increase across PHCS?

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program builds 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:

In DY14-Q2, DHCS continued coordinating and leading Topic-Specific Learning Collaboratives (TLCs), a variety of workgroups offered to help PRIME entities meet their project goals and improve care delivery through peer-to-peer learning, hearing from national and statewide subject matter experts, exchange of ideas, and the dissemination of best practices on common topics. The TLC workgroups address areas including: Health Homes for Foster Children, Mental Health, Non-opioid Management of Chronic Pain, Obesity Prevention, Maternal Health, Tobacco Cessation, Care Transitions, and Disparities Reduction.

DHCS held the annual PRIME Learning Collaborative in-person conference in Sacramento on October 29-30, 2018. PRIME entities from across the state convened to share learnings and best practices through a variety of venues during the two-day event. Participants heard presentations on sustainable quality improvement and care innovation, identifying health disparities and achieving health equity, PRIME data, Medication Assisted Treatment (MAT) for substance use disorders, DSRIP successes and challenges in other states, communicating data to internal and external partners, provider and patient engagement, and had many opportunities for networking.

The official conference took place on Tuesday, October 30, with optional TLC workgroups and hospital-specific activities taking place on Monday, October 29, including “Office Hours” where a limited number of entities were able to sign-up for one-on-one meetings with the following subject matter experts:

- Jane Taylor, PhD, who led a *Fundamentals of Quality Improvement* webinar series in spring 2018, met individually with PRIME entities to discuss specific quality improvement efforts and to offer advice on successful strategies and lessons learned.
- Patricia Lee, PhD, DHCS’ Health Disparities expert, discussed strategies for reducing health disparities in Medi-Cal with PRIME entities.
- Elisa Tong, MD, an internist and professor at UC Davis who also leads the UC Quits initiative, met with PRIME entities to discuss best practices in tobacco cessation initiatives.

Entities also had the opportunity to participate in in-person meetings of the TLC

workgroups in the following four topic areas: Care Transitions, Health Disparities, Obesity Prevention, and Mental Health.

During the conference, Marlies Perez, DHCS' Chief of the Substance Use Disorder Compliance Division, presented available funding opportunities as part of the California MAT Project, which aims to increase access to MAT, reduce unmet treatment need, and reduce opioid overdose related deaths through the provision of prevention, treatment, and recovery activities. The California MAT Expansion Project focuses on populations with limited MAT access, including rural areas and American Indian & Alaska Native tribal communities and is funded by grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). More information can be found on the California MAT Expansion Project's website.

The conference concluded with DHCS announcing the recipients of the PRIMEd Distinguished Improvement Award:

1. DPH: (tie)
    - Contra Costa Regional Medical Center – for over-performing by 100% and reaching the top performance benchmarks on a significant number of metrics through the implementation of a system-wide comprehensive Electronic Health Record within the Contra Costa Behavioral Health Services; patient engagement and outreach activities, and resource management initiatives.
    - Natividad Medical Center – for over-performing by 100% and reaching the top performance benchmarks on a significant number of metrics through the implementation of new workflows, use of a dashboard in conducting targeted improvement, and use of referral modules.

2. DMPH:
    - Salinas Valley Memorial Health Care System – for over-performing by 100% and reaching the top performance benchmarks on a significant number of metrics through provider and staff education and patient engagement and outreach.

DHCS also announced the recipients of the PRIMEd Award of Excellence, which was awarded to the DPH and DMPH whose efforts best exemplify the interventions or improvements that represent a commitment to the experience and health outcomes for Medi-Cal members and to the PRIME Program, as voted on by their peers.

The winners of the PRIMEd Award of Excellence were:

- DPH: Contra Costa Regional Medical Center, for their Inclusive Pride Initiative, improving the health of all with special attention to LGBTQ population.
- DMPH: Bear Valley Community Healthcare District, for their work on developing a pain management program which offered alternative methods such as acupuncture, Reiki, sleep coaching, meditation, hypnotherapy, and mindfulness.

A full conference agenda is available upon request.

Additionally, DHCS continues to release a monthly PRIME newsletter, titled the PRIME Times, which provides updates on upcoming events and important discussions on PRIMEone (DHCS' shared learning website). The PRIME Times also highlights specific PRIME Entities and TLCs.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$9,471,663.13	$9,471,663.13	DY 13	$18,943,326.26
(Qtr. 2 Oct – Dec)	$330,002,762.77	$330,002,762.77	DY 13	$660,005,525.54
Total	**$339,474,425.90**	**$339,474,425.90**		**$678,948,851.80**

In DY14-Q2, 13 DPHs and 26 DMPHs received payments.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received $330,002,762.77 in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

All DY 13 Year-End reports have been approved for completeness and are currently under clinical and comprehensive review. DHCS will follow-up with entities as part of this review process as necessary.

Evaluation:

Status updates for the PRIME Evaluation include:

Data Source	Status
Office of Statewide Health Planning and Development (OSHPD)	OSHPD confidential data will allow UCLA to conduct a pre/post and intervention/control assessment of the impact of PRIME on selected metrics such as All-Cause Readmission. UCLA utilized OSHPD public data in a statistical matching program to identify a set of comparison hospitals to the

Data Source	Status
	PRIME hospitals. In DY 13, UCLA obtained 2014-2017 OSHPD confidential data and analysis, which is nearly complete. In the next quarter, UCLA anticipates finishing the statistical model comparing the match-hospital data to the PRIME hospital data. UCLA analysis will subset the data by DPH, DMPH, and their respective matched hospitals.
Medi-Cal Claims and Enrollment	Medi-Cal claims and encounter data will allow for assessment of the impact of PRIME on Medi-Cal enrollees' inpatient and outpatient service use and expenditures (in a pre/post and intervention/control analysis, as described above). The evaluation will compare data from PRIME hospitals control (matched) hospitals. UCLA obtained preliminary Medi-Cal data from DHCS in April 2018 and has been validating the data and applying code to create the PRIME metrics. This analysis identified gaps in the data, so UCLA obtained IRB approval to add relevant variables on December 3, 2018. Subsequently, DHCS and UCLA are collaborating to ensure UCLA has complete Medi-Cal data for the PRIME and control populations. UCLA anticipates obtaining complete data from DHCS in the next quarter.
Entity Self-Reported Metrics Data	UCLA will utilize the self-reported metrics to assess progress within PRIME entities and comparisons between types of entities (such as DPH, DMPH, and Critical Access). UCLA is evaluating the benchmarks identified by DHCS as well as other applicable benchmarks to compare with self-reported data and the patient-level analysis using OSHPD and Medi-Cal data. National benchmarks are likely to be available for broadly-used metrics such as those developed by NCQA, AHRQ, and CMS. UCLA will also examine the PRIME-established benchmarks. In the following year, UCLA will finish identifying such benchmarks, assess comparability with PRIME metrics, and compare the PRIME metrics with these benchmarks in the evaluation. UCLA anticipates that the DY 14 Mid-Year self-reported data will be available in time to include in the interim report.
Qualitative: Survey, Interviews, Applications, Entity Reports	In DY 13, UCLA implemented a survey and interview to assess the planned and ongoing activities of the PRIME entities, including the level of effort, challenges, and lessons learned implementing the core components. UCLA pilot tested it with selected hospitals and made edits incorporating their feedback. The survey and interviews are complete; in the next year UCLA will continue analysis of the responses. PRIME entities' applications and reports are being used to gain a better understanding of the infrastructure, processes, and characteristics of PRIME-participating hospitals at

Data Source	Status
	baseline and progress since starting PRIME. UCLA is using qualitative coding of the applications and reports to identify 1) project selection logic, 2) the challenges and progress implementing PRIME, and 3) contextualizing the data reported for PRIME projects. UCLA is categorizing this information into overarching constructs (e.g., workflows, staff training/capacity, patient outreach, etc.). In the next quarter, UCLA will receive additional report data and continue this analysis.

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

County	Total Member Months
Alameda	55,801
Contra Costa	34,468
Fresno	47,010
Kern	37,818
Kings	5,185
Los Angeles	386,365
Madera	4,636
Riverside	70,315
San Bernardino	71,109
San Francisco	75,630
San Joaquin	78,872
Santa Clara	27,973
Stanislaus	32,652
Tulare	43,855
Sacramento	23,485
San Diego	20,685
Total	**1,015,859**

Total Member Months for Existing SPDs by County

County	Total Member Months
Alameda	43,168
Contra Costa	20,364
Fresno	27,060
Kern	18,559
Kings	2,804
Los Angeles	685,736
Madera	2,781
Marin	12,676
Mendocino	11,773
Merced	32,188
Monterey	32,292
Napa	9,814
Orange	219,506
Riverside	76,417
Sacramento	43,262
San Bernardino	73,823
San Diego	126,030
San Francisco	28,935
San Joaquin	18,707
San Luis Obispo	16,276
San Mateo	27,085
Santa Barbara	30,576
Santa Clara	80,940
Santa Cruz	20,910
Solano	39,892
Sonoma	34,963
Stanislaus	10,976
Tulare	12,479
Ventura	57,018
Yolo	17,134
Total	**1,834,144**

Total Member Months for SPDs in Rural Non-COHS Counties

County	Total Member Months
Alpine	36
Amador	730
Butte	12,313
Calaveras	1,123
Colusa	561
El Dorado	3,395
Glenn	1,094
Imperial	6,989
Inyo	329
Mariposa	437
Mono	125
Nevada	2,044
Placer	6,482
Plumas	702
San Benito	181
Sierra	78
Sutter	3,929
Tehama	3,413
Tuolumne	1,743
Yuba	4,155
Total	**49,859**

Total Member Months for SPDs in Rural COHS Counties

County	Total Member Months
Del Norte	5,371
Humboldt	17,272
Lake	12,993
Lassen	2,850
Modoc	1,400
Shasta	26,511
Siskiyou	7,304
Trinity	1,805
Total	**75,506**

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WHOLE PERSON CARE PILOT

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

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

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

WPC pilot payments support infrastructure to integrate services among LEs and may support the provision of services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population. These services may include housing components or other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

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

- DHCS approved eight existing LEs to expand their WPC pilots, including Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura counties.
- DHCS approved seven new entities to implement 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 (SCWPCC), which is a consortium of San Benito, Mariposa, and Plumas counties.

The fifteen second round LEs began implementation on July 1, 2017, with the addition of seven new LEs for a total of twenty-five LEs with WPC programs. The eight existing LEs continued their original programs and implemented the new aspects from the second round.

Enrollment Information:

Quarterly enrollment counts are the cumulative number of unique new members enrolled for the reported quarter with year-to-year totals reflected in the table below. The total-to-date column includes all previously submitted data beginning with DY 12 including the July-September data. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (E/U) Reports. The current DY14-Q1 (July-September) data reported is point-in-time as of December 13, 2018. Enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY14-Q1 (Jul-Sept 2018) Unduplicated	Jan 2017 – Sept 2018 Total to Date (Unduplicated)
Alameda	536	4,080
Contra Costa	2,272	27,215
Kern	59	252
Kings*	58	175
LA	3,921	25,448
Marin*	30	87
Mendocino*	50	245
Monterey	6	96
Napa	50	276
Orange	54	5,699
Placer	37	265
Riverside	239	938
Sacramento*	251	729
San Bernardino	220	764
San Diego	74	167
San Francisco	1,322	10,674
San Joaquin	60	377
San Mateo	106	3,056
Santa Clara	3	2,989
Santa Cruz*	15	376
SCWPCC*	18	59
Shasta	37	214
Solano	13	140

Lead Entity	DY14-Q1 (Jul-Sept 2018) Unduplicated	Jan 2017 – Sept 2018 Total to Date (Unduplicated)
Sonoma*	6	10
Ventura	114	943
Total	**9,551**	**85,274**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in availability of data, DY14-Q2 data will be reported in the next quarterly report.*

Member Months:

Quarterly and cumulative year-to-date member months are reflected in the table below. The cumulative year-to-date column includes all previously submitted data beginning with DY 12. Member months are extracted from the LE's self-reported Quarterly E/U Reports. The data reported is point-in-time as of December 13, 2018. Member months are updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY14-Q1 (Jul-Sept 2018) Unduplicated	Jan 2017 – Sept 2018 Total to Date Unduplicated
Alameda	10,195	36,070
Contra Costa	44,838	233,808
Kern	631	1,655
Kings*	273	681
LA	30,833	147,807
Marin*	197	499
Mendocino*	616	1,386
Monterey	188	830
Napa	466	1,620
Orange	10,104	44,617
Placer	400	1,960
Riverside	1,419	2,850
Sacramento*	708	3,170
San Bernardino	1,601	5,545
San Diego	450	649
San Francisco	22,862	128,069
San Joaquin	784	2,606
San Mateo	6,455	42,403
Santa Clara	7,407	42,968

Lead Entity	DY14-Q1 (Jul-Sept 2018) Unduplicated	Jan 2017 – Sept 2018 Total to Date Unduplicated
Santa Cruz*	981	3,711
SCWPCC*	87	227
Shasta	249	1,012
Solano	306	1,326
Sonoma*	18	23
Ventura	2,299	7,408
Total	**144,367**	**712,900**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in availability of data, DY14-Q2 data will be reported in the next quarterly report.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

During the quarter, DHCS, along with the WPC Learning Collaborative (LC), communicated with the LEs through surveys, phone calls, and emails to understand the issues that are of most interest and concern to guide DHCS TA and LC content. The LC structure includes a variety of learning activities, such as topic-specific affinity groups, in-person convenings, and access to a resource portal as a means to address the topics and questions from LEs.

Beginning in 2018, the LC launched five topic-specific affinity groups focused on the following areas: data, care coordination, sustainability, housing, and reentry. Affinity groups are led by LC staff who are responsible for working with their groups to understand the challenges pilots are facing in each area, and then helping the pilots share best practices and work towards finding solutions. All five affinity groups launched in March 2018 and ramped down in the second quarter to make way for other LC activities in 2019, including quarterly webinars, a site visit in Los Angeles, and two in-person meetings.

The data affinity group met on November 6, 2018, and discussed graduation protocol, hospital buy-in to care management platform, improving coordination with hospitals on shared client discharges, and finding new sources of match as agenda topics.

The LC advisory board met on October 20 and November 17, 2018, and focused on evaluating the October 2018 bi-annual in-person meeting and soliciting ideas for 2019 LC activities.

In November and December 2018, the LC and DHCS conducted one-on-one calls with all LEs. The calls informed the LC and DHCS on pilot implementation/operational status

and LEs' possible TA needs for 2019. In each call, DHCS asked LEs for updates on reaching their goals, best practices, operational status, successes, challenges, and any plans for sustainability.

On October 1, 2018, DHCS held the fourth WPC bi-annual in-person meeting in Riverside, California, in collaboration with LC consultants. Attendees included 150 representatives from all LEs, California Association of Public Hospitals/Safety Net Institute, California HealthCare Foundation, and UCLA. The agenda included the following subjects: Impact of WPC, Design Thinking to Improve Medi-Cal Enrollment for WPC Enrollees, WPC External Evaluation Presentation, Health Homes Program and WPC, a panel discussion with state staff and one-on-one meetings between DHCS and LEs to discuss operational issues. Additionally, the meeting included time for LEs to network and discuss challenges and opportunities.

On October 3, 2018, DHCS held a monthly administrative teleconference with LEs dedicated to administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various contract issues such as reporting, reporting templates, timeliness, and expectations. The call included the following topics: PY 3 mid-year invoices, budget adjustment, baseline reporting, and program spotlight on Santa Cruz. DHCS did not hold monthly teleconferences in November and December due to the lack of agenda items.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

In October 2018, DHCS released the WPC payments for DY 14 for all twenty-five LEs. These payments, totaling $203,962,432.56, were made through the IGT process. These payments represented the 50% FFP and 50% local non-federal share amounts of $101,981,216.28 for the time period of January through June of 2018.

DY 14 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 1 (July 1 - Sept 30)	$0	$0	DY 14 (PY 3)	$0
Qtr. 2 (Oct 1 - Dec 31)	$101,981,216.28	$101,981,216.28	DY 14 (PY 3)	$203,962,432.56
Total	**$101,981,216.28**	**$101,981,216.28**		**$203,962,432.56**

Twenty-three LEs submitted their optional budget adjustments for PY 3 mid-year, and for PY 4 and 5 on November 30, 2018. DHCS revised the budget adjustment process to

allow adjustments for PY 3 mid-year in addition to future PY budgets within each LE budget. DHCS anticipates approving budget adjustment requests in the next quarter.

Rollover requests that allow an LE to move budgeted funds from the current year to the next year's budget are due next quarter.

DHCS is considering LE total budget reallocation in order to maximize federal funding and increase or decrease LEs overall WPC budget. A process may be developed in the next quarter if DHCS receives positive feedback from LEs.

Quality Assurance/Monitoring Activities:

During the second quarter, all twenty-five LEs submitted the following:

- Third quarter PY 3 Quarterly E/U report; and
- PY 3 mid-year, PY 4 and 5 budget adjustment.

Accurate reporting is fundamental to the success of WPC. These reports are tools for LEs and DHCS to assess the degree to which the LEs are achieving their goals. In addition, metric tracking will inform decisions on appropriate changes by LEs and DHCS, when necessary, to improve the performance of WPC pilots. DHCS also uses these reports to monitor and evaluate the WPC pilot programs and to verify invoice payments for payment purposes.

During the second quarter, DHCS evaluated the budgetary expenditures, enrollment, and service delivery for the LEs and placed seven LEs under a Corrective Action Plan (CAP). These seven LEs were required to develop and submit a CAP detailing how the LE would meet its contractual obligations. DHCS set up TA calls to finalize CAP milestones and bi-weekly meetings to discuss LEs activities and progress toward completing milestones in addition to monthly enrollment reporting. DHCS anticipates determining if any LEs will continue under a CAP during the next quarter.

Evaluation:

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

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

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

During the first quarter, UCLA, DHCS' independent evaluator:

- Developed a preliminary propensity score model and model specifications to develop a control group. UCLA used this model to match WPC enrollees with controls and is now making further refinements to improve match results and to account for significant differences between enrollees from the various LEs.
- Developed measures to understand program enrollment, enrollment patterns, target populations, and utilization using the 2017 (PY 2) E/U report data. UCLA received E/U report data from the first two quarters of 2018 (PY 3) and has cleaned the data. Additionally, UCLA worked with DHCS to identify a set of measures based mostly on E/U data to include in a bi-annual E/U chart pack.
- Conducted preliminary analysis of the LE questionnaire to understand concepts such as motivation for participation in WPC, communication and decision-making processes, performance monitoring, and inter-agency collaboration with partner organizations.
- Restructured and began preliminary analysis of the LE partner questionnaire. LEs were asked to classify each partner's level of involvement. Partners include: Medi-Cal managed care plans, specialty mental health departments, public agencies/departments (e.g., Public Health, Housing, Probation, Sheriff), and community based organizations.
- Conducted in-person site visits with Los Angeles, Santa Clara, Contra Costa, Alameda, San Francisco, and San Mateo. UCLA conducted phone interviews with Monterey, Solano, Placer, Shasta, San Joaquin, Santa Cruz, and Ventura. Each LE has participated in at least two interviews, one with leadership and key management staff, and another with frontline care coordinators and/or supervisors.
- Submitted an updated data request to DHCS in December 2018, adding 14 new variables or variable categories to the initial request. UCLA's next data pull is scheduled for May 2019. UCLA has requested an update of these additional elements to the June 30, 2018, data pull, prior to the data delivery scheduled for May 2019.