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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Twelve (07/01/2016 – 06/30/2017)
First Quarter Reporting Period: 07/01/2016 – 09/30/2016

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

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

- DY 11: January 1, 2016 through June 30, 2016
- DY 12: July 1, 2016 through June 30, 2017
- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019

- DY 15: July 1, 2019 through June 30, 2020
- DY 16: July 1, 2020 through December 31, 2020

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 24: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Demonstration on August 8, 2016.

The main topics discussed were: various waiver deliverables, WPC tribal amendment, financial reporting for the waiver, and updates on the pending STCs technical corrections.

STCs Items 178-180: Uncompensated Care Reporting

The State must commission two reports from an independent entity on uncompensated care in the state. The first independent report will focus on Designated Public Hospitals (DPHs). The Blue Shield of California Foundation funded the completion of this report, and the State selected Navigant as the contractor to conduct the first report. The objective of the report is to support a determination of the appropriate level of the Uncompensated Care Pool component of the total Global Payment Program (GPP) funding for participating DPHs in Demonstration Years Two through Five. More information is provided in the GPP section of this report.

The second report will be due to CMS on June 1, 2017, and it will focus on uncompensated care, provider payments, and financing across all California hospitals that serve Medi-Cal beneficiaries and the under-insured population, using data from the first report for DPHs. The report will include information that will inform discussions

about potential reforms that will improve Medicaid payment systems and funding mechanisms and will enhance the quality of health care services.

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

The Section 1115 Medicaid Waiver Special Terms and Conditions (STCs) paragraphs 65-69 require the Department of Health Care Services (DHCS) to amend its contract with its External Quality Review Organization (EQRO) to conduct an access assessment (Assessment) to evaluate primary, core specialty, and facility access to care for Medi-Cal managed care beneficiaries based upon requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 and DHCS/Medi-Cal managed care health plan contracts, as applicable. The Assessment will consider State Fair Hearing and Independent Medical Review (IMR) decisions, as well as grievances and appeals, and complaints data. An advisory committee has been established to provide input into the structure, draft report, and recommendations of the Assessment.

The EQRO will produce and publish an initial draft and a final access assessment report that will include a comparison of health plan network adequacy compliance across different lines of business and recommendations in response to any systemic network adequacy issues, if identified. The initial draft and final report will describe the State's current compliance with the access and network adequacy standards set forth in federal regulations (42 Code of Federal Regulations 438).

Governor Brown signed Assembly Bill (AB) 1568 (Chapter 42, Statutes of 2016) and Senate Bill (SB) 815 (Chapter 111, Statutes of 2016), establishing the Medi-Cal 2020 Demonstration and requirements for implementation of the STCs. DHCS is required to complete an amendment to the EQRO contract within 90 days of signature. SB 815 which provided authority to DHCS pertaining to the Assessment was signed by the Governor on July 25, 2016.

Below is the estimated Assessment timeline:

- November 2016: First Advisory Committee Meeting – Input into the Assessment Design
- April 2017: Second Advisory Committee Meeting – Review of and comment on Assessment Design
- April 2017: Assessment Design submitted to the Centers for Medicare and Medicaid Services (CMS)
- TBD: Assessment Design approved by CMS
- TBD: EQRO begins to conduct the Assessment (assuming CMS approval of Assessment Design in June)
- TBD: Initial draft report posted for public comment and meeting to present to the advisory committee for review and comment
- 10 months following CMS design approval: Final report submission to CMS

DHCS and its EQRO, Health Services Advisory Group (HSAG), finalized and signed the EQRO contract amendment to include the Access Assessment project. On

September 23, 2016, DHCS sent the EQRO contract amendment to CMS for its review and approval.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

DHCS has been meeting with HSAG on a regular basis in preparation for the first advisory committee meeting, which will be held on November 18, 2016. DHCS has created an Assessment email inbox and checks it daily to respond to questions. In addition, the Assessment webpage is kept up to date.

The Assessment inbox is: Access.Assessment@dhcs.ca.gov.

The Assessment webpage can be accessed at the following link: http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

Nothing to report.

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 the Department of Health Care Services (DHCS). Approximately 75 percent of CCS-eligible children are Medi-Cal eligible.

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

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

The two (2) health care delivery models include:

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

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

Enrollment information:

The monthly enrollment for Health Plan San Mateo (HPSM) CCS Demonstration Project (DP) is reflected in the table below. Eligibility data is extracted from the Children's

Medical Services Network (CMS Net) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to HPSM. HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	HPSM Enrollment Numbers*	Difference Prior Month	Month	HPSM Enrollment Numbers	Difference Prior Month
July 2014	1,472		September 2015	1,600	9
August 2014	1,477	5	October 2015	1,583	-17
September 2014	1,535	58	November 2015	1,591	8
October 2014	1,502	-33	December 2015	1,588	-3
November 2014	1,505	3	January 2016	1,581	-7
December 2014	1,560	55	February 2016	1,591	10
January 2015	1,527	-33	March 2016	1,609	18
February 2015	1,502	-25	April 2016	1,626	17
March 2015	1,546	44	May 2016	1,621	-5
April 2015	1,552	6	June 2016	1,622	1
May 2014	1,569	17	July 2016	1,653	31
June 2015	1,589	20	August 2016	1,640	-13
July 2015	1,592	3	September 2016	1,593	-47
August 2015	1,591	-1			

Data source is MIS/DSS Data Warehouse

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

<u>CCS Pilot Protocols</u>

California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by Federal Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. On September 29, 2016, revised Protocols were submitted to CMS.

Goal

The goal of the DPs is to identify the model or models of health care delivery for children and youth enrolled in the CCS Program; resulting in improved timely access to care, improved coordination of care, promotion of increased use of community-based services, improved satisfaction with care, and improved health outcomes. Both HPSM and RCHSD will design and implement a Member satisfaction survey (Member Survey) with input and review from DHCS and meet the four objectives below.

Objectives

- Objective 1
  By December 31, 2020, there will be a reduction in the annual rate of growth of expenditures for children and youth enrolled in a DP.

- Objective 2
  By December 31, 2020, there will be an increase in satisfaction with the delivery of health care services among children and youth enrolled in the CCS Program and their families. Measurement of the changes in satisfaction will be accomplished through surveys of the Members and their families.

- Objective 3
  By December 31, 2020, there will be an increase in satisfaction with the delivery of health care services among providers serving children and youth enrolled in the CCS Program. Measurement of the changes in satisfaction will be accomplished through surveys of providers participating in the DPs' networks.

- Objective 4
  By December 31, 2020, there will be improved health outcomes among the children and youth enrolled in a DP.

Measures

DHCS will propose one (1) provider satisfaction measure, one (1) patient satisfaction measure, one (1) whole person average cost of care measure, and two (2) measures of participant health outcomes. Proposed Protocol measures include the following:

Enrollment Measures
Measure 1: Percent of new enrollment
Measure 2: Average length of enrollment

Access to Care Measures
Measure 1: The percentage of children and young adults 12 months – 20 years of age who had a visit with a PCP.
Measure 2: Referral of a Child to Special Care Center (SCC)
Measure 3: Screening for Clinical Depression and Follow-Up Plan

Clients' Satisfaction Measures
Measure 1: Surveys of families related to satisfaction with participation CCS Pilot including both primary care and subspecialty care access and quality of services.
Measure 2: Grievance and Appeals

Providers' Satisfaction Measure
Measure 1: Surveys of physicians, hospitals/clinics, in-home pharmacy and Durable Medical Equipment (DME) providers for satisfaction, including changes in reimbursement under the CCS Pilot.

Quality of Care Measures
Measure 1: Childhood Immunization Status
Measure 2: Subspecialty care for Diabetes - HbA1c Testing
Measure 3: Lung Function for Cystic Fibrosis patients

Care Coordination Measures
Measure 1: Family Experiences with Care Coordination (FECC) Survey
Measure 2: Medi-Cal Managed Care Performance Dashboard Indicators for all unique children, with CCS-eligible medical condition

Total Cost of Care Measure
Measure 1: Total cost of care

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

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

Contract Amendments

HPSM contract amendment A02 is in process. This amendment is to extend the contract one year as allowed by Request for Proposal #11-88024; and increase the total budget to compensate the Contractor for continuing to perform services for an additional year. New rates have been added for State Fiscal Years 14/15, 15/16, and 16/17. Payments for Hepatitis C and Behavioral Health Therapy (BHT) services have also been included. The contract has also been updated to include the aid codes for eligible beneficiaries. Once A02 has been approved by DHCS management, it will be submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

DHCS continued to collaborate with RCHSD on the following: outreach, enrollment,

covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model. DHCS is in the process of confirming contractual compliance with the new Medicaid Final Rule.

Data Use Agreement

DHCS is requesting RCHSD outreach to CCS Demonstration Project pilot-eligible members (approximately 400 clients) to obtain their agreement to participate in the CCS pilot when implemented in San Diego County. DHCS's Privacy Officer, Office of Legal Services (OLS), Information Security Officer (ISO), and upper management agreed that a Data Use Agreement (DUA) would be the appropriate administrative vehicle to allow the Department to provide a list of eligible potential members prior to the execution of the contract to RCHSD. Contract discussions are pending until after RCHSD acquires a commitment from the proposed eligible members that they will participate in the pilot program.

Demonstration Schedule

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

Consumer Issues:

CCS Quarter Grievance Report #13

On September 2016, HPSM submitted a "CCS Quarterly Grievance Report" for the second quarter, April – June 2016. During the reporting period, HPMS received and processed 11 member grievances.

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

- 4 grievances were designated as Quality of Care/Service:
  - 4 were coded as "Plan denial of treatment"; 4 were resolved in favor of Plan.

- 7 grievances were labeled as Other:
  - 4 were coded as "Access" and all were resolved in favor of the CCS Member.
  - 3 was coded as "Billing", 2 were resolved in favor of the CCS Member, and 1 was resolved in favor of Plan.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

HPSM deliverables submitted during this quarter are located in the table below.

Report Name	Date Due	Received
Grievance Log/Report (Rpt #13)	7/30/2016	8/1/2016
Quality Improvement Report (Rpt #3)	8/1/2016	8/15/2016
Provider Network Report (Rpt #13)	8/15/2016	8/17/2016
Report of all Denials of Services Requested by Providers (Rpt #12)	8/17/2016	8/12/2016

Evaluations:

Per STC 211 Waiver, the draft evaluation design was submitted to CMS on September 19, 2016. The draft CCS evaluation is located at http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx for stakeholder review and comment. The final design will include a summary of stakeholder comments and questions and a description of any changes made to the final design based upon stakeholder input.

Goal and Objectives

The overarching goal of the CCS pilot project is for the State to test two integrated delivery models for the CCS population that results in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes, and greater cost-effectiveness. The two models of care delivery include a provider-based Accountable Care Organization (ACO) and an existing Medi-Cal Managed Care Plan (MCP).

The objective of the evaluation is to demonstrate the effectiveness of an integrated delivery model for the CCS population by:

1. Ensuring that the CCS population has access to timely and appropriate, high quality, and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.
2. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
3. Increasing satisfaction with both the delivery of and the reimbursement of services.

4. The State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
5. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
6. Reducing the annual rate of growth of expenditures for the CCS population.

Enclosures/Attachments:

Attached enclosure "Number of Children Enrolled and Cost of Care".

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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. Initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every 12 months for individuals

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

The State must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[1]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service (FFS) benefit. On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model (available in 14 counties) Geographic Managed Care plans (available in two counties) and the final COHS county (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS-eligible members 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 members can receive unbundled services (i.e. component parts of CBAS delivered outside of centers with a similar objective of supporting members, allowing them to remain in the community) if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services include local senior centers to engage members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the members with Activities of Daily Living or Instrumental Activities of Daily Living) through the Medi-Cal State Plan. If the member is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Enrollment and Assessment Information:

Per Special Terms and Conditions (STC) 48, the CBAS Enrollment data for both MCP and FFS members per county for Demonstration Year 12 (DY12), Quarter 1 (Q1), represents the period of July 2016 to September 2016. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 7 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the

[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.

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. FFS claims data identified in Table 1, reflects data up to the period of April 2016 to June 2016 because of the lag factor of about two to three months.

Table 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS						
	DY11 Q1 Oct - Dec 2015		DY11 Q2 Jan - Mar 2016		DY11 Q3 Apr - Jun 2016	
County	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used
Alameda	534	96%	507	103%	502	102%
Butte	*	*	*	*	35	34%
Contra Costa	227	71%	214	67%	208	65%
Fresno	631	65%	548	50%	585	53%
Humboldt	164	42%	94	24%	95	24%
Imperial	363	65%	344	62%	345	62%
Kern	95	28%	77	23%	75	22%
Los Angeles	20,149	64%	19,786	63%	21,311	69%
Merced	92	50%	85	40%	91	43%
Monterey	98	53%	89	48%	106	57%
Orange	2,004	60%	2,051	57%	2,073	55%
Riverside	425	39%	428	39%	459	42%
Sacramento	697	78%	585	65%	563	63%
San Bernardino	610	113%	594	110%	574	106%
San Diego	2,353	62%	1,885	50%	1,549	38%
San Francisco	775	53%	747	51%	752	51%
San Mateo	156	68%	157	69%	166	73%
Santa Barbara	*	*	*	*	*	*
Santa Clara	655	47%	660	47%	656	47%
Santa Cruz	113	74%	90	59%	103	68%
Shasta	12	8%	54	38%	*	*
Ventura	915	63%	920	64%	916	64%
Yolo	75	20%	75	20%	74	20%
Marin, Napa, Solano	167	33%	68	14%	70	14%
Total	**31,348**	**62%**	**30,091**	**59%**	**31,318**	**62%**

FFS and MCP Enrollment Data 06/2016

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

Data for DY12, Q1, will be reported in the next quarterly report. Table 1 reflects that enrollment has remained relatively consistent for DY11. Additionally, the data reflects that there is ample capacity for participant enrollment into most CBAS Centers with the exception of the centers located in Alameda and San Bernardino Counties. Both

Alameda and San Bernardino Counties' CBAS centers are currently operating over center capacity. Alameda County's licensed capacity was reduced in December 2015 due to the closing of one CBAS Center. This resulted in an over-extension of the county's maximum capacity used due to the number of participants they were providing services for. San Bernardino County's licensed capacity has been impacted by a steady increase in participant enrollment. In addition, no new CBAS Centers have been opened in San Bernardino County so the existing CBAS Centers have been accommodating the needs of new participants. For the first quarter of DY 11 which covered the period of October 2015 through December 2015, San Bernardino County CBAS Centers had a total of 606 MCP participants, four FFS participants and had a licensed capacity of 113%. However, San Bernardino County experienced a slight decrease in enrollment during the last two quarters of DY 11 which resulted in its overall licensed capacity decreasing from 113% to 106%.

While the closing of a CBAS Center in Alameda County contributed to increased utilization of license capacity in Alameda County in December 2015, it is important to note the amount of member participation also plays a significant role in the amount of overall license capacity used throughout the state. For example, from April 2016 to June 2016, there was a three percent (3%) increase in the total number of participants enrolled in the CBAS Centers. As a result, Butte, Los Angeles, Monterey, Merced, and Santa Cruz Counties experienced a five percent (5%) increase in their total capacity. However, San Diego, Santa Barbara, and Shasta Counties experienced an overall decrease in CBAS participation which resulted in a decrease of more than five percent (5%) of capacity used. The utilization of licensed capacity in these counties was impacted by changes in member enrollment; not the closure of a center. A decrease in utilization can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

CBAS Assessments for MCPs and FFS Participants

Individuals requesting to receive 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 that individual is eligible based on medical information and/or history that the plan possesses.

Table 2 entitled "*CBAS Assessment Data for MCP and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Due to delay in availability of data, Table 2 represents data to DY11, Q3. Data for DY12, Q1, will be reported in the next quarterly report.

Table 2:

CBAS Assessments Data for MCPs and FFS:						
Demonstration Year	**MCPs**			**FFS**		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY11 Q1 (10/1-12/31/2015)	2,301	2,258 (98.1%)	43 (1.9%)	26	25 (96.2%)	1 (3.8%)
DY11 Q2 (1/1-3/31/2016)	2,404	2,370 (98.6%)	34 (1.4%)	19	19 (100%)	0 (0%)
DY11 Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

Requests for CBAS services were collected by MCPs and DHCS. For DY11, 7,352 assessments were completed by the MCPs. Of which 7,236 were determined to be eligible and 116 were determined to be ineligible. Sixty-three participants submitted requests and were assessed for CBAS benefits under FFS. A total of 62 participants were determined to be FFS eligible by DHCS. One request for CBAS services was denied by DHCS. Table 2 reflects that the total number of eligible FFS participants continues to decline due to the CBAS transition to managed care.

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

CBAS enrollment and CBAS Center licensed capacity is directly impacted by the opening or closing of a CBAS Center. The closing of a CBAS Center decreases licensed capacity and enrollment while conversely, new CBAS Center openings increase capacity and enrollment. CBAS Centers are licensed by the California Department of Public Health and CDA certifies the Centers to provide CBAS benefits and facilitates monitoring and oversight of the Centers. The number of counties with CBAS Centers and the average daily attendance (ADA) of each center are listed in Table 3 entitled "*CDA – CBAS Provider Self-Reported Data*." As of DY11, on average, the ADA at the 241 operating CBAS Centers is approximately 21,347 participants which corresponds to 71% of total capacity. Information for DY12, Q1, are not yet available due to the delay in data reporting but will be included in the next quarterly report.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	241
Non-Profit Centers	57
For-Profit Centers	184
ADA @ 241 Centers	21,347
Total Capacity	30,049
ADA per Centers	71%
	CDA - MSSR Data 06/2016

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

Outreach/Innovative Activities:

Stakeholder Process

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

After reviewing stakeholder input in addition to the milestones identified in the CBAS STC, in the Medi-Cal 2020 Waiver, DHCS and CDA decided to initiate work groups to address concerns identified during the stakeholder meetings. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that have convened every other month through June 2016. Implementation of the five-year *CBAS Quality Assurance and Improvement Strategy* is scheduled to begin in October 2016. The revised IPC will be implemented in early 2017. Updates and progress on stakeholder activities for CBAS can be found at:

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

Operational/Policy Developments/Issues:

DHCS and CDA continue to work with CBAS providers and MCPs to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. To

date no new CBAS centers have opened, but CDA has received several applications that are currently undergoing review and processing.

Consumer Issues:

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

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. 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 below in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Table 4 and Table 5 represents data covering DY11. Data for DY 12, Q1, will be reported in the next quarterly report.

Table 4 illustrates a total of five complaints were collected by CDA for DY11. For complaints received by MCPs, Table 5 illustrates that beneficiaries' complaints were between four to six from October 2015 to March 2016 and reflect a lower than usual number of complaints. From April 2016 to June 2016, the number of beneficiaries' complaints increased to 26 which is within the range that was previously reported by the MCPs.

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q 1 (Oct 1 - Dec 31)	1	0	1
DY11 - Q2 (Jan 1 - Mar 31)	1	0	1
DY11 - Q3 (Apr 1 - Jun 30)	1	2	3
			CDA Data - Complaints 06/2016

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q 1 (Oct 1 - Dec 31)	4	0	4
DY11 - Q2 (Jan 1 - Mar 31)	6	1	7
DY11 - Q3 (Apr 1 - Jun 30)	26	0	26
		Plan data - Phone Center Complaints 06/2016	

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

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

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the lag factor in data reporting, grievances and appeals data from the MCPs are reported up DY11, Q3. Table 6 entitled, "Data on CBAS Managed Care Plan Grievances," summarize grievances data for DY11. According to the data provided in Table 6, a total of 21 grievances were filed with MCPs during DY 11. Eight of the grievances were regarding CBAS providers, contractor assessment or reassessment, and excessive travel times to access CBAS. Thirteen of the grievances were related to other CBAS issues.

Table 6:

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY11 - Q 1 (Oct 1 - Dec 31)	0	1	1	5	7
DY11 - Q2 (Jan 1 - Mar 31)	2	0	0	4	6
DY11 - Q3 (Apr 1 - Jun 30)	4	0	0	4	8
		Plan data - Grievances 06/2016			

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

For DY11, there were 15 CBAS appeals filed with MCPs. The appeals were related to denial of services, limited services, or were related to other CBAS issues. Data for DY12, Q1, will be available in the next quarterly report.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY12, Q1, there was one CBAS hearing related to denial of services, and the participant was approved services after the hearing.

Quality Assurance/Monitoring Activities:

DHCS and CDA convened six stakeholder work group meetings between July 2015 and June 2016 to develop a quality strategy for CBAS. The CBAS Quality Assurance and Improvement Strategy was released for comment on September 19, 2016 and is scheduled to be implemented in October 2016.

DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 7 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 7 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to the third quarter of DY11 as a result of delay in availability of data. Data for DY12, Q1, will be discussed in the next quarterly report.

Table 7:

County	CBAS Centers Licensed Capacity						
	DY11-Q1 Oct-Dec 2015	DY11-Q2 Jan-Mar 2016	Percent Change Between Last Two Quarters	Capacity Used	DY11-Q3 Apr-Jun 2016	Percent Change Between Last Two Quarters	Capacity Used
Alameda	330	290	-12%	103%	290	0%	102%
Butte	60	60	0%	28%	60	0%	34%
Contra Costa	190	190	0%	67%	190	0%	65%
Fresno	572	652	14%	50%	652	0%	53%
Humboldt	229	229	0%	24%	229	0%	24%
Imperial	330	330	0%	62%	330	0%	62%
Kern	200	200	0%	23%	200	0%	22%
Los Angeles	18,508	18,536	0%	63%	18,291	-1%	63%
Merced	109	124	14%	40%	124	0%	43%
Monterey	110	110	0%	48%	110	0%	57%
Orange	1,960	2,120	8%	57%	2,240	6%	55%
Riverside	640	640	0%	39%	640	0%	42%
Sacramento	529	529	0%	65%	529	0%	63%
San Bernardino	320	320	0%	110%	320	0%	106%
San Diego	2,233	2,233	0%	50%	2,408	8%	38%
San Francisco	866	866	0%	51%	866	0%	51%
San Mateo	135	135	0%	69%	135	0%	73%
Santa Barbara	60	60	0%	5%	60	0%	0%
Santa Clara	830	830	0%	47%	830	0%	47%
Santa Cruz	90	90	0%	59%	90	0%	68%
Shasta	85	85	0%	38%	85	0%	7%
Ventura	851	851	0%	64%	851	0%	64%
Yolo	224	224	0%	1%	224	0%	20%
Marin, Napa, Solano	295	295	0%	14%	295	0%	14%
SUM =	29,756	29,999	24%	59%	30,049	13%	62%

CDA Licensed Capacity as of 06/2016

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

Note: Information is not available for July 2016 to September 2016 due to a delay in the availability of data.

Table 7 reflects that the average licensed capacity used by CBAS participants is 62% statewide since June 2016. Overall, almost all of the CBAS Centers have not operated at full capacity except for Alameda and San Bernardino Counties. This allows for the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider capacity per county and an analysis that

addresses such variance. There was a decrease in provider capacity of 5% or more for DY11. Alameda County's licensed capacity was reduced from 330 to 290 between January 2016 to March 2016, therefore causing a decrease of more than 5%. The decrease was caused by the Berkeley Adult Day Health Care Center closing in December 2015.

Access Monitoring (STC 48.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Table 1, CBAS capacity is adequate to serve Medi-Cal members in almost all counties with CBAS Centers with the exception of Alameda and San Bernardino Counties. These two counties are serving in excess of their allotted capacities. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to beneficiaries. There are other centers in nearby counties that can assist should the need arise for ongoing care of CBAS participants.

Unbundled Services (STC 44.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans will work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct disch arge 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. For DY12, Q1, CDA has 240 CBAS Center providers operating in California. During the period of March 1, 2015 to June 30, 2016, San Ysidro Adult Day Healthcare Center in San Diego operated as both a Program of All-Inclusive Care for the Elderly (PACE) and CBAS Center. This allowed for continued service to the members under each product line during the transition of the PACE program being fully implemented into the area. Table 8 entitled "*CBAS Center History*," illustrates that effective July 1, 2016, San Ysidro Adult Day Healthcare Center was converted exclusively to serve only member enrolled under the PACE program and no longer serving any CBAS participants that were not enrolled in PACE.

Table 8:

CBAS Center History					
Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
November 2013	245	1	0	-1	244
October 2013	245	0	0	0	245
September 2013	243	0	2	2	245
August 2013	244	1	0	-1	243
July 2013	243	0	1	1	244
June 2013	244	1	0	-1	243
May 2013	245	1	0	-1	244
April 2013	246	1	0	-1	245
March 2013	247	0	0	0	246
February 2013	247	1	0	-1	246*
January 2013	248	1	0	-1	247
December 2012	249	2	1	-1	248
November 2012	253	4	0	-4	249
October 2012	255	2	0	-2	253
September 2012	256	1	0	-1	255
August 2012	259	3	0	-3	256
July 2102	259	0	0	0	259
June 2012	260	1	0	-1	259
May 2012	259	0	1	1	260
April 2012	260	1	0	-1	259

Table 8 shows there was no negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

Financial/Budget Neutrality Development/Issues:

Pursuant to STC item 50 (b) of the Medi-Cal 2020 Waiver, the MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP at least 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 centers capacity to date and adequate networks remains for this population.

The extension of CBAS, under Medi-Cal 2020, will have no effect on budget neutrality as it is currently a pass-through, meaning the cost of CBAS is assumed to be the same with the waiver as it would be without the waiver. As such, no savings can be realized from the program and the extension of the program will have no effect on overall waiver budget neutrality.

Enclosures/Attachments:

None.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

- Domain 1 – Increase Preventive Services for Children

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

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

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

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

- Domain 3 – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between a beneficiary and dental provider in seventeen (17) select pilot counties. Incentive payments will be made to dental service office locations who 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, it may be expanded to other counties, contingent on available DTI funding.

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

- Domain 4 – Local Dental Pilot Projects (LDPPs)

The LDPPs will support the aforementioned domains through up to 15 innovative pilot programs to test alternative methods, to increase preventive services, to manage early childhood caries, and to establish and maintain continuity of care. DHCS will solicit proposals and shall review, approve, and make payments to LDPPs in accordance with the requirements stipulated.

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

<u>Small Stakeholder Workgroup</u>

This workgroup is still active, and they met on July 20, 2016 and September 21, 2016.

<u>DTI Small Stakeholder Subgroups:</u>

In addition to the DTI small stakeholder workgroup, DHCS assembled the following sub-workgroups:

Caries Risk Assessment Sub-Workgroup

This sub-workgroup is still active, and they met on August 1, 2016 and September 27, 2016.

Safety Net Clinic Sub-Workgroup

On August 8, 2016, the SNC instructions and spreadsheet templates for Domains 1 and 3 were finalized and posted on the DTI webpage. This sub-workgroup was not active

during this reporting period but are expected to be engaged in the next period. DHCS also intends to host a webinar in October that will provide SNCs the opportunity to discuss DTI baseline data submission specifics related to Domains 1 and 3. DHCS will also review and provide guidance on the data collection templates posted on the DTI webpage.

Webinars

On August 18, 2016, DHCS held a DTI Stakeholder Webinar and provided the participants with the following:

- Domain 4 Local Dental Pilot Project Application Budget Template and Instructions;
- Updates to the Frequently Asked Questions;
- Proposed Medi-Cal 2020 DTI Waiver Evaluation; and
- Updates regarding Domains 1, 2, and 3.

The webinar presentation may be accessed at the following link:
http://www.dhcs.ca.gov/provgovpart/Documents/DTIWebinar8.18.16.pdf

DTI Webpage

The DTI webpage was updated regularly during DY12 Q1 and will continue to be updated as new information becomes available. The webpage contains: program information, stakeholder engagement information, webinars, timelines, Frequently Asked Questions (FAQs), Medi-Cal 2020 Special Terms and Conditions (STCs), and an inbox to direct comments, questions, or suggestions.

The DTI webpage may be accessed at the following link:
http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY12 Q1. DHCS created the e-mail address and listserv below in March 2016. The email address 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 us directly and the listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

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=DTIStakeholders

DTI FAQs

On August 31, 2016, DHCS updated its DTI FAQs document. The document provided responses to stakeholders' frequently asked questions for DTI. The FAQs document is a living document and is continuously updated as new questions are submitted and responded to; these questions are raised and received through the DTI e-mail inbox, DTI webinars, and other venues. The link to the FAQs is: http://www.dhcs.ca.gov/provgovpart/Documents/FAQs_DTI08.31.16.pdf

Outreach Plans

As part of the Denti-Cal program, our Dental FI, Delta Dental, is required to perform outreach activities and submit two plans for approval each year as listed below.

- Beneficiary Dental Outreach and Education Plan - targeted toward the Medi-Cal beneficiaries
- Provider Outreach and Utilization Improvement Plan – targeted toward the provider community

These plans were updated as part of the 2016 outreach plans to include the DTI efforts. On August 29, 2016, a call center script was finalized and provided to the Dental FI to accurately respond to inquiries/requests via their customer service lines by providers and beneficiaries for a DTI overview and domain-specific information.

In addition, DHCS presented information on the DTI at several venues during this reporting period. The following page provides a list of venues at which information on DTI was disseminated:

- July 22, 2016 – Perinatal Infant Oral Health Quality Improvement (PIOHQI) Provider Workshop
- July 26, 2016 – State Child Health and Disability Prevention (CHDP) Oral Health Subcommittee
- August 10, 2016 – Northern California Legislative District Directors Meeting
- August 11, 2016 – DHCS Stakeholder Advisory Committee (SAC) Meeting
- August 25, 2016 – Medi-Cal Dental Advisory Committee (MCDAC)
- September 9, 2016 – California Dental Association (CDA) Presents, San Francisco
- September 13, 2016 – Medi-Cal Children's Health Panel (MCHAP) Meeting
- September 19, 2016 – CDPH-DHCS Oral Health Workgroup

Operational/Policy Developments/Issues:

Domain 1 DY12 Q1 Update

DHCS continued to work with CMS to amend the DTI Domain 1 STCs. On July 14, 2016, DHCS sent out a tribal notice to begin the 30-day review process for questions/comments as required for waiver amendments. On August 15, 2016, DHCS submitted its waiver amendment request package to CMS. On August 29, 2016, CMS determined that the State's amendment request has met the requirements for a complete amendment request as specified in the STCs. The CMS open-comment period will end on October 1, 2016.

The amendments will revise the methodology DHCS uses to determine the baseline metrics for incentive payments to new and existing dental service office locations. The metrics proposed that the baseline metrics be calculated at the individual service office level, rather than county average. New service office locations would receive a county pre-determined benchmark and be reassessed at the end of their first program participation year. Additionally, DHCS sought authority to provide partial incentive payments to provider service office locations that partially meet annual increases in the preventive services provided to children above the pre-determined baseline. This modification would allow benchmark increases from 1.00% to 1.99% to receive an incentive payment of 37.5% for each qualified service above the current Schedule of Maximum Allowances. Once the amendment is approved, DHCS will be sending baseline data to the applicable service office locations.

The DTI Domain 1 STCs amendment revisions can be found at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain1STCsChanges.pdf

The DTI Domain 1 amendment tribal notice can be found at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020WaiverAmendmentDTI.pdf

On August 8, 2016, the Domain 1 SNC data collection instructions and template were finalized and posted to the DTI webpage. On August 23, 2016, DHCS sent corresponding letters out to SNCs. In September 2016, DHCS began collecting Domain 1 SNC data.

Domain 2 DY12 Q1 Update

Efforts progressed to finalize a CRA tool as well as training materials and resources for implementation. In August 2016, 11 dentists pilot tested the CRA Sub-Workgroup's

developed CRA tool. According to feedback received by Dr. Jayanth Kumar, provided post-pilot, 10 of the 11 dentists were able to use the form to assess risk factors, follow the directions, classify children correctly, and identify self-management goals. They found the assessment followed a logical sequence and was simple and easy to carry out. Nine dentists submitted comments to improve the form. On September 9, 2016, the sub-workgroup submitted a revised tool based on these comments. The next step is to finalize the tool, which is anticipated in October 2016.

DHCS, in collaboration with CDA, is also developing a training curricula for use under this domain; the provider(s) will be offered continuing education units for the completion of the required training course. The target finalization date of all training and resource materials for the pilot is January 2017.

Additionally, the Domain 2 Fact Sheet was finalized and posted to the DTI webpage on August 25, 2016. The fact sheet is located at:
http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain2FactSheet.pdf

Domain 3 DY12 Q1 Update

On August 8, 2016, Domain 3 SNC data collection instructions and template were finalized and posted to the DTI webpage, and Domain 3 SNC letters were printed and mailed out to providers in the 17 selected counties. On September 9, 2016, initial letters were sent out to all Denti-Cal service offices.

Domain 4 DY12 Q1 Update

On July 28, 2016, DHCS revised its LDPP Application and posted it to the DTI webpage. DHCS also notified DTI stakeholders, via the DTI Listserv, of a new LDPP application due date. The due date moved from August 16, 2016 to September 30, 2016.

On August 3, 2016, DHCS finalized and posted its LDPP Budget Template and Instructions. Its delayed release resulted in the new LDPP application due date.

On September 30, 2016, DHCS received 23 LDPP applications from around the state. DHCS will work to finalize the LDPP application review structure, timeline, process, and tools for LDPP application reviewers.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

Nothing to report at this time.

Quality Assurance/Monitoring Activities:

Nothing to report at this time.

Evaluation:

On September 19, 2016, DHCS submitted a draft DTI evaluation design to CMS. DHCS posted the draft evaluation online and will be accepting public comments until Mid-October 2016. Throughout this quarter, DHCS began reaching out to potential evaluators for their capacity and interest in submitting proposals to perform the DTI evaluation.

The aim of the evaluation is to determine the causal impacts of the DTI Demonstration on how incentive payments influence:

- Increased statewide numbers of Medi-Cal children ages 1 through 20 that receive preventive dental services by at least 10 percentage points over a five-year period;
- Diagnoses of early childhood caries for targeted children 6 and under by utilizing a predefined CRA tool and treatment planning for managing this condition as a chronic disease based on the beneficiary's risk assessment in lieu of more invasive and costly procedures and restorative treatment; and
- Improved continuity of care for targeted children under the age of 21 through regular examinations with their established dental provider.

The DTI draft evaluation plan can be viewed at the following link:
http://www.dhcs.ca.gov/provgovpart/Documents/DTIDraftEvaluationDesign.pdf

Enclosures/Attachments:

None.

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

The Drug Medical 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, and promotes a strategy to coordinate and integrate across systems of care. Additionally, the DMC-ODS creates utilization controls to improve care and efficient use of resources, reports specific quality measures, and ensures there are the necessary program integrity safeguards and a benefit management strategy in place. The DMC-ODS allows counties to selectively contract with providers in a managed care environment to deliver a full array of services consistent with the American Society of Addiction Medicine (ASAM) Treatment Criteria, including recovery supports and services. As part of their participation in the DMC-ODS, CMS requires all residential providers to meet the ASAM requirements and obtain a Department of Health Care Services (DHCS) issued ASAM designation. The DMC-ODS includes residential treatment service for all DMC beneficiaries in facilities with no bed limit.

The state DMC-ODS implementation is occurring in five phases, (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. DHCS is currently assisting phase three and have received a total of fourteen implementation plans from: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, and Sonoma. The following counties' implementation plans have been DHCS approved: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Los Angeles, Marin, and Contra Costa. The remaining six counties' implementation plans are currently in review by DHCS and CMS.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

- Bi-Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Wavier
- July 1, 2016: Indian Health Service Teleconference
- July 11, 2016: Indian Health Service Plan Questions
- July 13, 2016: DHCS and UCLA Conference Call
- July 14, 2016: Fiscal Webinar Part 3
- July 15, 2016: Yolo County In-person Technical Assistance
- July 19, 2016: California Pan Ethnic Health Network Coordinating a Community Engagement Strategy around the DMC-ODS
- July 20, 2016: UCLA and External Quality Review Organization Meeting
- July 22, 2016: DHCS Phase I Program Meeting
- July 25, 2016: California Indian Health Service Follow-up Plan/Questions Call
- July 29, 2016: CMS and DHCS Overview of CMS Tribal Consultation Policy

- August 1, 2016: Aegis Treatment Centers Meeting regarding Medication Assisted Treatment
- August 1, 2016: California Association of Alcohol and Drug Program Executive, Inc. Quarterly Meeting
- August 2, 2016: DMC-ODS Waiver Reporting Meeting
- August 4, 2016: DMC-ODS Monthly County Technical Assistance Call
- August 8, 2016: Monthly DHCS and CMS 1115 Waiver Monitoring Call
- August 9, 2016: Tribal Consultation on Indian Organized Delivery System for Substance Use Disorder Services
- August 10, 2016: Blue Shield of California Foundation (BSCF) and California HealthCare Foundation (CHCF) Support for Indian Health Program Organized Delivery System (Conference Call)
- August 10, 2016: County Behavioral Health Directors Association of California Meeting
- August 17, 2016: DHCS and CMS Meeting for Indian Health Program Organized Delivery System
- August 18, 2016: Network Adequacy Review with CMS
- August 22 – August 25, 2016: Statewide Substance Use Disorder Conference
- August 26, 2016: Dr. Mee Lee's ASAM Presentation
- August 29, 2016: California Indian Health Services Follow-up Plan/Questions
- August 31, 2016: Medicaid Institutions for Mental Diseases (IMD) Exclusion and Substance Use Treatment Conference Call
- September 1, 2016: DMC-ODS Medication Assisted Treatment Webinar
- September 7, 2016: Narcotic Treatment Program Advisory Committee Meeting
- September 13, 2016: MCHAP Meeting
- September 14, 2016: California Health & Human Services Agency Office of Health Information Integrity Stakeholder Meeting
- September 21, 2016: County Behavioral Health Directors Association In-Person Medi-Cal Meeting
- September 21, 2016: DMC-ODS Informational Webinar for Providers
- September 23, 2016: Indian Health Program Organized Delivery System Grant Program
- September 26, 2016: DMC-ODS Reporting Meeting
- September 27, 2016: DHCS, BSCF, and CHCF Meeting on DMC-ODS
- September 28, 2016: Substance Abuse Prevention and Treatment (SAPT) Committee Meeting
- September 29, 2016: Medicaid Evidence Based Decisions pre-conference call. Redesigning Substance Use Disorder Delivery Systems: Adult Residential Treatment as part of the Continuum of Care Conference Call

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

The evaluation will focus on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and the 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 holds monthly conference call with updates, activities, and meetings. The evaluation is posted on UCLA's DMC-ODS website at http://www.uclaisap.org/ca-policy/.

Enclosures/Attachments:

None.

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/DSRIP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
Designated State Health Program (DSHP)				
(Qtr 1 July - Sept)	$21,004,142	$42,008,284	DY 11	$21,004,142
Total	**$21,004,142**	**$42,008,284**		**$21,004,142**

This quarter, the Department claimed **$21,004,412** in federal fund payments for DSHP-eligible services.

Delivery System Reform Incentive Pool (DSRIP)

Within the Safety Net Care Pool (SNCP), a Delivery System Reform Incentive Pool (DSRIP) is available for the development of a program of activity that supports California's public hospitals' efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable and directly sensitive to the needs and characteristics of an individual hospital's population and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.

Payment	FFP	IGT	Service Period	Total Funds Payment
Delivery System Reform Incentive Pool (DSRIP)				
(Qtr 3 July - Sept)	$97,936.54	$97,936.55	DY 10	$195,873.09
Total	**$97,936.54)**	**$97,936.55**		**$195,873.09**

DY 12 quarter 1, DSRIP had two payments and one recoupment totaling ($195,873.09). These payments and recoupments were for DSRIP's DY 10 annual report for achievements between July 1, 2014 – October 31, 2015.

This quarter, Designated Public Hospitals received **$97,936.54** in federal fund payments for DSRIP-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 reconciliations for DY3 through DY9.

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) will assist public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCS in their key role in providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Under the GPP, participating PHCS will receive GPP payments that will be calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforces structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness. The GPP program year began on July 1, 2015.

The total amount available for the GPP is a combination of a portion of the state's DSH allotment that would otherwise be allocated to the PHCS and the amount associated with the Safety Net Care Uncompensated Care Pool under the Bridge to Reform Demonstration.

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
Global Payment Program (GPP)				
(Qtr 2 April – June)	$249,946,244	$249,946,244	DY 11	$499,892,488
(Qtr 1 July – Sept.)	$286,502,138.50	$286,502,138.50	DY 12	$573,004,277
Total	$536,448,382.50	$536,448,382.50		$ 1,072,896,765

DY 12 QTR 1 reporting is the third GPP payment for services from April 2016 through June 2016 and July 2016 through September 2016.

This quarter, PHCS received $536,488,382.50 in federal funds payments and $536,448,382.50 in IGT for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Per STC Items 178-180 *Uncompensated Care Reporting*, the State must commission two reports from an independent entity on uncompensated care in the state. The first independent report will focus on Designated Public Hospitals and will be due to CMS on May 15, 2016. More information about the report can be found at the following link: http://www.dhcs.ca.gov/provgovpart/Pages/UncompensatedCareReport.aspx.

Navigant, as the contractor to conduct the first report, submitted the Evaluation of Uncompensated Care Financing for California Designated Public Hospitals to CMS on May 15, 2016. CMS responded on July 14, 2016, in which CMS authorized up to $472 million in total funds for the Uncompensated Care component of the GPP program for each demonstration years two through five.

Enclosures/Attachments:

None.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

PRIME Projects are organized into 3 domains. Participating DPH systems will implement at least 9 PRIME projects, and participating DMPHs will implement at least one PRIME project, as part of the participating PRIME entity's Five-year PRIME Plan. Participating DPH systems must select at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project.

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

On June 1, 2016, DHCS began the process of development and internal review of the PRIME draft evaluation design. On August 29, 2016, DHCS submitted a draft evaluation design to CMS for review and feedback. CMS will have 60 days to review and provide written feedback on the draft design. DHCS will consider CMS feedback and amend the draft design accordingly prior to submission of the final evaluation design and final CMS review.

Per STC Item 83 *Evaluation Requirement,* DHCS must engage the public in the development of its evaluation design. From September 7, 2016 through October 8, 2016, DHCS solicited public comment for the PRIME Draft Evaluation Design. The draft design was posted to the PRIME Webpage under Stakeholder Engagement, and public comment was submitted through the PRIME Inbox at: PRIME@dhcs.ca.gov.

Operational/Policy Developments/Issues:

On March 3, 2016, CMS approved the PRIME Operational Protocols (Attachments D, Q, and II). Following these approvals, on March 4, 2016, DHCS released the PRIME 5-Year Plan Template to the 54 participating PRIME entities, and the project applications were due back to DHCS on April 4, 2016. Eligible PRIME entities, which include Designated Public Hospitals and District/Municipal Public Hospitals as identified in Attachment D, *Participating Prime Entities*, used a standardized template in submitting their applications. DHCS reviewed the 5-year plan applications to assess each entity's ability to meet the requirements specified in the STCs and to ensure that each institution has the capacity to successfully participate in the PRIME program.

Each 5-year plan application was scored on a "Pass/Fail" basis. The state evaluated the responses to each section to determine if they were sufficient to demonstrate that the applicant could effectively implement the selected PRIME Projects while simultaneously conducting the regular business of operating the hospital system. As of June 10, 2016, all 54 five-year plans were approved for program participation. One DMPH hospital, Tehachapi, removed themselves from the application process as they were beginning the process of being acquired by a private facility.

Per STC Item 100(a), *Monitoring and Review of Metric Target Achievement,* these 5-

year plan applications were submitted in place of the Interim Mid-Year Report for PRIME DY11 only. The first PRIME payment to participating entities will be contingent on the approval of each hospital's PRIME 5-year plan.

On September 30, 2016, all 54 participating PRIME entities submitted their DY 11 final year-end reports. Incentive payments will be awarded based on a completeness review as well as a comprehensive clinical and administrative review of metric data and performance narratives.

Financial/Budget Neutrality Development/Issues:

Payments for the PRIME hospitals 5-year plans (1st Semi-Annual Payment) went out in July 2016 due to the late submission and approval of the plans.

Payment	FFP	IGT	Service Period	Total Funds Payment
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)				
(Qtr 1 July-Sept)	$199,810,000	$199,810,000	DY 11	$399,620,000
Total	**$199,810,000**	**$199,810,000**		**$399,620,000**

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$199,810,000** in federal fund payments for PRIME-eligible services.

Consumer Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

DHCS has tentatively scheduled the first in-person learning collaborative event for mid-October 2016. This collaborative will include all participating PRIME entities. The meeting agenda is still being developed.

Evaluations:

On June 1, 2016, DHCS began the process of development and internal review of the PRIME draft evaluation design. On August 29, 2016, DHCS submitted a draft evaluation design to CMS for review and feedback. CMS will have 60 days to review and provide written feedback on the draft design. DHCS will consider CMS feedback and amend the draft design accordingly prior to submission of the final evaluation design and final CMS review.

Enclosures/Attachments:

None.

WHOLE PERSON CARE (WPC)

The Whole Person Care (WPC) pilot is a five-year program authorized under the Medi-Cal Section 1115(a) waiver, entitled *California Medi-Cal 2020 Demonstration* that provides, through more efficient and effective use of resources, an opportunity to test locally-based initiatives that coordinate physical health, behavioral health, and social services for Medi-Cal beneficiaries who are high users of multiple health care systems with poor health outcomes.

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

On the due date of July 1, 2016, eighteen applications for the WPC Pilot Program were received from the following counties listed below:

- Alameda County Health Care Services Agency
- Contra Costa Health Services
- Kern Medical Center
- Los Angeles County Department of Health Services
- Monterey County Health Department
- Napa County Health and Human Services
- County of Orange Health Care Agency

- Placer County Health and Human Services
- Riverside University Health System
- Arrowhead Regional Medical Center (San Bernardino County)
- San Diego Health and Human Services Agency
- San Francisco Department of Public Health
- San Joaquin County Health Care Services Agency
- San Mateo County Health System
- Santa Clara Valley Health and Hospital System
- Shasta County Health and Human Services Agency
- Solano County Health and Social Services
- Ventura County Health Care Agency

Applications were extensively reviewed and determined qualified for participation in the application process based on the quality and scope of each application. Additionally, each application received a numerical score with a required minimum needed to be eligible to participate. Review included comparisons to similarly-sized pilots, target populations, population size, geography, infrastructure, services provided, value of the intervention, outcomes, and budget. Outliers were further investigated to determine reasonableness. None of the eighteen applications were disqualified.

During the first quarter, DHCS and CMS held teleconferences to review initial application summaries and discuss remaining application issues. Discussions included an overview of Los Angeles with CMS on July 29, 2016.

On July 22, 2016, DHCS provided CMS the variant metrics from the pilot applications for review. Discussion were held with CMS on the detailed variant metrics provided by applicants.

In August and September, DHCS provided technical assistance to individual applicants through emails and teleconferences at least three times a week.

On August 22 and September 13, 2016, DHCS held teleconferences for all applicants on application issues and modifications needed.

In September 2016, DHCS submitted the standardized variant metrics menu to CMS for approval of the pilot standardized health outcomes variant metrics. DHCS received feedback from CMS on the draft variant metrics menu. DHCS revised and resubmitted these metrics based on CMS comments.

DHCS is in the beginning stages for development of the purpose, goals, structure, and potential key topics for the Learning Collaborative.

DHCS anticipates notifying the approved WPC Pilot Programs at the end of October after receiving CMS approval. The approved pilots will be required to provide formal acceptance to DHCS in November.

Consumer Issues:

DHCS continues to work with stakeholders in the development of the WPC pilot.

Financial/Budget Neutrality Development/Issues:

DHCS is developing the policies and procedures for the intergovernmental transfer funding process.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

DHCS is drafting the evaluation design for submission to CMS and developing the process for contracting with an independent evaluator. DHCS will be submitting the draft to CMS in November.

Enclosures/Attachments:

None.