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)
Fourth Quarter Reporting Period: 04/01/2017 – 06/30/2017

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INTRODUCTION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On December 8, 2016, DHCS received approval from CMS for the DTI and WPC amendments. These amendments will expand the definition of the lead entity for the WPC pilots to include federally recognized Tribes and Tribal Health Programs, and 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.

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.

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

WAIVER DELIVERABLES:

STCs Item 24: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration on January 9, 2017, February 13, 2017, and March 12, 2017.

The following topics were discussed:

- Negative Account Balances Issues
- CMS Comments on Draft Evaluation Designs
- CCS Counties' Implementation Efforts
- Access Assessment
- Budget Neutrality Monitoring Tool
- DMC-ODS Program Updates and Tribal Discussions
- DTI Program Updates
- WPC Second Round of Applications
- Attachment R/Alternate Payment Methodology (APM) Framework
- Attachment N Amendment for Acupuncture and Non-Medical Transportation
- Health Homes Program Waiver Amendment
- Managed Care Final Rule Timelines

STCs Items 178-180: Uncompensated Care Reporting

Per STCs Items 178-180, *Uncompensated Care Reporting*, the State must commission two reports from an independent entity on uncompensated care in the state. The second independent report will focus on uncompensated care, provider payments and financing across hospital providers that serve Medicaid beneficiaries and the uninsured under the current demonstration and will be due to CMS on June 1, 2017. The report will include information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California's Medicaid beneficiaries for the uninsured.

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

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

On July 25, 2016, 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 and providing DHCS the authority to conduct the Assessment. Within 90 days of the signature of the legislation, DHCS completed an amendment to its EQRO contract to perform the Assessment.

The goal of the Assessment is to evaluate primary, core specialty, and facility access to care for managed care beneficiaries, based on the current health plan network adequacy requirements set forth in the State's Knox-Keene Health Care Service Plan Act of 1975 and 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.

Per the STCs, DHCS established an advisory committee to provide input into the Assessment design, including network adequacy requirements and metrics, as well as feedback on the initial draft report and final report. The Advisory Committee includes representatives from consumer advocacy organizations, providers, provider associations, health plans, health plan associations, and legislative staff.

DHCS submitted the Assessment design to CMS in April 2017 for review and approval. Once approved, the EQRO will produce and publish an initial draft report and a final report that will include a comparison of health plan network adequacy compliance across different lines of business and recommendations in response to any systemic network adequacy issues, if identified. The initial draft report and final report will describe the State's current compliance with the access and network adequacy standards set forth in federal regulations (Title 42 Code of Federal Regulations Part 438).

Assessment Milestones:

- September 23, 2016: DHCS submitted finalized and signed EQRO contract amendment to CMS for approval
- November 18, 2016: First Advisory Committee Meeting – Input into the Assessment design
- January 31, 2017: Second Advisory Committee Meeting – Input into the Assessment design
- March 28, 2017: Third Advisory Committee Meeting – Review of and comment of Assessment design

- April 21, 2017: Submission of Assessment design to CMS

Projected Assessment Timeline:

- TBD: Assessment design approved by CMS
- TBD: EQRO begins to conduct the Assessment (assuming CMS approval of Assessment design)
- TBD: Initial draft report posted for public comment and meeting to present to the advisory committee for review and comment
- Ten months following CMS design approval: Final report submission to CMS

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

TBD: Additional Advisory Committee meetings.

Operational/Policy Developments/Issues:

The first advisory committee was held on November 18, 2016 and subsequent meetings were held on January 31 and March 28, 2017. Once CMS approves the Assessment design, EQRO will begin to conduct the Assessment. An advisory committee meeting will be scheduled to provide feedback on the initial draft report. The Assessment webpage is updated regularly and can be accessed using the following link: http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx

Consumer Issues:

Not applicable.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

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 DHCS. Approximately 75 percent of CCS-eligible children are Medi-Cal eligible.

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

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

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

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

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
15-Jan	1,526	$1,658.05	$2,530,184
15-Feb	1,501	$1,658.05	$2,488,733
15-Mar	1,545	$1,658.05	$2,561,687
15-Apr	1,551	$1,658.05	$2,571,636
15-May	1,568	$1,658.05	$2,599,822
15-Jun	1,588	$1,658.05	$2,632,983
15-Jul	1,590	$1,535.45	$2,441,366
15-Aug	1,589	$1,535.45	$2,439,830
15-Sep	1,597	$1,535.45	$2,452,114
15-Oct	1,580	$1,535.45	$2,426,011
15-Nov	1,587	$1,535.45	$2,436,759
15-Dec	1,584	$1,535.45	$2,432,153
16-Jan	1,577	$1,535.45	$2,421,405
16-Feb	1,587	$1,535.45	$2,436,759
16-Mar	1,605	$1,535.45	$2,464,397
16-Apr	1,622	$1,535.45	$2,490,500
16-May	1,618	$1,535.45	$2,484,358
16-Jun	1,621	$1,535.45	$2,488,964
16-Jul	1,649	$1,481.08	$2,442,301
16-Aug	1,636	$1,481.08	$2,423,047
16-Sep	1,607	$1,481.08	$2,380,096
16-Oct	1,641	$1,481.08	$2,430,452
16-Nov	1,629	$1,481.08	$2,412,679
16-Dec	1,632	$1,481.08	$2,417,123
17-Jan	1,626	$1,481.08	$2,408,236
17-Feb	1,650	$1,481.08	$2,443,782
17-Mar	1,648	$1,481.08	$2,440,820
17-Apr	1,634	$1,481.08	$2,420,085
17-May	1,630	$1,481.08	$2,414,160
17-Jun	1,614	$1,481.08	$2,390,463
		TOTAL	**$73,822,905**

Member Months:

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
CCS	**1,634**	**1,630**	**1,614**	**4**	**4,878**

Data source is MIS/DSS Data Warehouse

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

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

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

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

Contract Amendments

HPSM contract amendment A02 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. A02 has been approved by DHCS management and was submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

DHCS continued to collaborate with RCHSD on the following: outreach, enrollment, covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model. DHCS 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 #15

In July 2017, HPSM submitted a "CCS Quarterly Grievance Report" for the fourth quarter, April – June 2017. During the reporting period, HPMS received and processed 9 member grievances.

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

- 6 grievances were designated as Quality of Care/Service
  - 5 were coded as "Plan denial of treatment"; 1 was coded as "Poor provider/staff attitude and was resolved in favor of Plan.

- 3 grievances were labeled as Other:
  - 3 were resolved in favor of the CCS Member.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

DHCS submitted a revised CCS Evaluation Design to CMS on May 15, 2017, in response to CMS' initial feedback on the Draft Evaluation Design. On June 29, 2017, DHCS received additional CMS comments on the CCS Draft Evaluation Design.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

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

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

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

Enrollment and Assessment Information:

Per Special Terms and Conditions (STC) 48, CBAS enrollment data for both MCP and FFS members per county for Demonstration Year 12 (DY12), Quarter 4 (Q4), represents the period of April 2017 to June 2017. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 8 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

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

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

claims data identified in Table 1, reflects data through the January 2017 to March 2017 quarter because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report.

Table 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY11 Q3 Apr - Jun 2016		DY12 Q1 Jul - Sept 2016		DY12 Q2 Oct - Dec 2016		DY12 Q3 Jan - Mar 2017	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	502	102%	504	76%	542	82%	530	80%
Butte	35	34%	45	44%	37	36%	42	41%
Contra Costa	208	65%	206	64%	240	75%	210	65%
Fresno	585	53%	619	56%	602	55%	615	56%
Humboldt	95	24%	95	24%	94	24%	97	25%
Imperial	345	62%	426	76%	328	59%	330	59%
Kern	75	22%	81	24%	79	23%	73	22%
Los Angeles	21,311	69%	21,041	67%	21,178	67%	21,299	67%
Merced	91	43%	91	43%	95	45%	94	45%
Monterey	106	57%	102	55%	118	63%	116	62%
Orange	2,073	55%	2,100	54%	2,199	56%	2,256	54%
Riverside	459	42%	453	42%	445	41%	459	42%
**Sacramento	563	63%	587	66%	**521	58%	561	63%
**San Bernardino	574	106%	590	109%	**598	110%	601	111%
San Diego	1,549	38%	1,937	45%	2,031	51%	1,990	54%
San Francisco	752	51%	749	51%	723	49%	722	49%
San Mateo	166	73%	172	75%	174	76%	175	77%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	656	47%	655	47%	656	47%	674	48%
Santa Cruz	103	68%	109	72%	114	75%	98	64%
Shasta	*	*	*	*	*	*	*	*
Ventura	916	64%	918	64%	901	63%	943	65%
Yolo	74	20%	74	20%	93	25%	79	21%
Marin, Napa, Solano	70	14%	79	16%	79	16%	74	15%
Total	**31,318**	**62%**	**31,648**	**61%**	****31,860**	**61%**	**32,044**	**62%**

FFS and MCP Enrollment Data 03/2017

Note: Information is not available for April 2017 to June 2017 due to a delay in the availability of data.
**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***Data for these counties are updated by the MCPs to reflect accurate information for QY12-Q2.*

Table 1 reflects that enrollment has remained relatively consistent with over 30,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers with the exception of the centers located in San Bernardino County. San Bernardino County is currently operating over its center

capacity due to a steady increase in participant enrollment. However, a majority of CBAS participants are able to choose an alternate CBAS Center in nearby counties should the need arise for ongoing CBAS services. As a result of reporting errors made by the MCPs, DY12-Q2's participation data for Sacramento and San Bernardino counties were modified from last quarter's report to reflect accurate information. The corrections in participation data for Sacramento and San Bernardino counties resulted in the increase of statewide participation for CBAS services in DY12-Q2.

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. For example, in Contra Costa and Santa Cruz counties, there was more than a 5% decrease of licensed capacity used compared to the previous quarter. This decrease was due to the decline in CBAS participant enrollment, not the closure of a center. A decrease in utilization of licensed capacity can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

CBAS Assessments for MCPs and FFS Participants

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

Table 2 entitled "*CBAS Assessments Data for MCPs and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Data for April 2017 to June 2017 (DY12-Q4) will not be available until August 2017 due to the 30-day lag time. As a result, DY12-Q4 data will be provided in the next quarterly report. Table 2 represents data from DY11-Q3 through DY12-Q3.

Table 2:

CBAS Assessments Data for MCPs and FFS:						
	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
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%)
DY12 Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	11	11 (100%)	0 (0%)
DY12 Q2 (10/1-12/31/2016)	2,741	2,689 (98.1%)	52 (0.02%)	2	2 (100%)	0 (0%)

5% Negative change between last Quarter		No	No		No	No

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

Table 2 reflects a steady decrease in the number of CBAS FFS participants due to the transition of CBAS into managed care. In addition, there was a decrease in the number of new assessments completed by MCPs in DY12,-Q3. Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to Table 2, for DY12-Q3, there were 2,476 assessments completed by the MCPs, of which 2,439 were determined to be eligible and 37 were determined to be ineligible. For DHCS, it was reported that 33 participants submitted their requests for CBAS benefits under FFS. Twenty-five of the requests were deferred to managed care while eight of the requests were determined to be FFS-eligible. Of these eight requests, three of the requests did not follow through with the assessment. Table 2 identifies the five requests that were assessed and approved for CBAS FFS by DHCS.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 3 entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY12-Q3. Due to a delay in availability of data, DY 12-Q4 data will be reported in the next quarterly report. The ADA at the 240 operating CBAS Centers is approximately 23,020 participants, which corresponds to 75% of total license capacity.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	240
Non-Profit Centers	56
For-Profit Centers	184
ADA @ 240 Centers	23,020
Total Licensed Capacity	30,652
Statewide ADA per Center	75%
CDA - MSSR Data 03/2017	

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

Outreach/Innovative Activities:

Stakeholder Process

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

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

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

Operational/Policy Developments/Issues:

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

Consumer Issues:

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

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services

from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Table 4 and Table 5 represents data covering January 2017 to March 2017 (DY12-Q3). Data for April 2017 to June 2017 (DY12-Q4), will be provided in the next quarterly report.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. Table 4 illustrates there were no complaints received by CDA for DY12-Q3. For complaints received by MCPs, Table 5 illustrates there were three beneficiary complaints collected by the MCPs for DY12-Q3.

Table 4:

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

CDA Data - Complaints 03/2017

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

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11 - Q3 (Apr 1 - Jun 30)	8	0	8
DY12 - Q1 (Jul 1 - Sept 30)	8	1	9
DY12 - Q2 (Oct 1 - Dec 31)	2	0	2
DY12 - Q3 (Jan 1 - Mar 31)	3	0	3

Plan data - Phone Center Complaints 03/2017

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

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

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the delay in data reporting, grievances and appeals data from the MCPs are reported up to DY12-Q3. According to Table 6 entitled "*Data on CBAS Managed Care Plan Grievances*," two grievances were filed with the MCPs for DY12-Q3; the grievances were related to CBAS providers and other CBAS services.

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 - Q3 (Apr 1 - Jun 30)	4	0	0	4	8
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	1	0	0	0	1
DY12 - Q3 (Jan 1 - Mar 31)	1	0	0	1	2

Plan data - Grievances 03/2017

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

For DY12-Q3, one CBAS appeal was filed with the MCPs. Table 7 entitled "*Data on CBAS Managed Care Plan Appeals*", illustrates that the appeal was related to denial of services or limited services. Due to a delay in information, data for DY12-Q4, will be available in the next quarterly report.

Table 7:

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

Plan data - Grievances 03/2017

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

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

Financial/Budget Neutrality Development/Issues:

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

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

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to DY12-Q3, because of delay in availability of data. Data for DY12-Q4, will be discussed in the next quarterly report.

Table 8:

County	CBAS Centers Licensed Capacity					
	DY11-Q3 Apr-Jun 2016	DY12-Q1 Jul-Sep 2016	DY12-Q2 Oct-Dec 2016	DY12-Q3 Jan-Mar 2017	Percent Change Between Last Two Quarters	Capacity Used
Alameda	290	390	390	390	0%	80%
Butte	60	60	60	60	0%	41%
Contra Costa	190	190	190	190	0%	65%
Fresno	652	652	652	652	0%	56%
Humboldt	229	229	229	229	0%	25%
Imperial	330	330	330	330	0%	59%
Kern	200	200	200	200	0%	22%
Los Angeles	18,291	18,406	18,731	18,796	0%	67%
Merced	124	124	124	124	0%	45%
Monterey	110	110	110	110	0%	62%
Orange	2,240	2,308	2,308	2,458	6%	54%
Riverside	640	640	640	640	0%	42%
Sacramento	529	529	529	529	0%	63%
San Bernardino	320	320	320	320	0%	111%
San Diego	2,408	2,518	2,353	2,188	-7%	54%
San Francisco	866	866	866	866	0%	49%
San Mateo	135	135	135	135	0%	77%
Santa Barbara	60	60	60	60	0%	1%
Santa Clara	830	830	830	830	0%	48%
Santa Cruz	90	90	90	90	0%	64%
Shasta	85	85	85	85	0%	3%
Ventura	851	851	851	851	0%	65%
Yolo	224	224	224	224	0%	21%
Marin, Napa, Solano	295	295	295	295	0%	15%
SUM =	30,049	30,442	30,602	30,652	-1%	62%

CDA Licensed Capacity as of 03/2017

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

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

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

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was a decrease in provider capacity of five percent or more for San Diego County in DY12-Q3. San Diego County's licensed capacity was decreased by seven percent when Clairemont Villa Adult Day Health Center closed in February 2017 reducing the licensed capacity from 2,353 to 2,188. However, Orange

County licensed capacity increase by six percent when El Toro Adult Day Services Center opened in March 2017, which increased the licensed capacity from 2,308 to 2,458. The changes in these two counties resulted in an overall statewide decrease of one percent in the total licensed capacity.

Access Monitoring (STC 48.e.)

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

Unbundled Services (STC 44.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. Table 9 entitled "*CBAS Center History*," illustrates the history of openings and closings of the centers. According to Table 9, for DY12-Q4 (April 2017 to June 2017), CDA currently has 240 CBAS Center providers operating in California.

Table 9:

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
June 2017	240	0	0	0	240
May 2017	240	0	0	0	240
April 2017	240	0	0	0	240
March 2017	239	0	1	1	240
February 2017	240	1	0	0	239
January 2017	240	0	0	0	240
December 2016	240	1	1	0	240
November 2016	240	0	0	0	240
October 2016	240	0	0	0	240
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
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 9 also shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

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

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

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

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

Domain 3 – Continuity of Care

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

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

Domain 4 – Local Dental Pilot Projects (LDPPs)

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

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

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

<u>DTI Small Workgroup</u>

The objective of these meetings is to review monthly updates regarding all Domains with provider, dental plan, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a monthly basis, each third Wednesday of the month. This quarter, the workgroup met on April 26, May 17, and June 21, 2017.

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

Domain 2 Caries Risk Assessment Workgroup

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

DTI Clinic Workgroup

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

DTI Webpage

DHCS developed a more user-friendly DTI webpage. The Domains 1, 2, 3, and 4 are separated by category; the documents are more organized and easier to locate.

The DTI webpage was updated regularly during DY12-Q4 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 the DTI inbox to direct comments, questions, or suggestions.

The Medi-Cal Dental Program developed its own webpage, housed on the larger Department website. The updated and refreshed webpage includes information and resources on the following categories:

- Dental Fee-for-Service (FFS)
- Dental Managed Care
- Dental Transformation Initiative (DTI)
- Denti-Cal Website
- Stakeholder Engagement
- Contact Us

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY12-Q4. 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 the Department directly. The listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

Most inquiries in the DTI inbox during this reporting period, included but were not limited to the following categories: incentive check qualification and benchmark letters, provider participation status, and opt-in questions for Domains 1 and 3. An automatic reply was set up to acknowledge receipt of the inquiry. All requests were researched and responded to within seven business days. Additionally, the DTI inbox sent three reminder emails to Safety Net Clinics (SNCs) to submit their encounter data, the process by which to submit, and the data submission deadlines to encourage increased participation.

The DTI outreach efforts included SNC Encounter Data Resubmission Processes for Domains 1 and 3, updated DTI electronic submission instructions, and data submission deadlines. Specifically, SNCs were required to submit proprietary forms by May 31, 2017 while electronic data submissions were due by June 23, 2017 to be included in the July 31, 2017 payment. The Electronic Data Interchange (EDI) instructions provided detailed steps for providers to follow to ensure successful EDI testing and subsequent submissions.

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

Outreach Plans

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

- April 14, 2017: Los Angeles Dental Stakeholder Meeting (Agenda)
- April 18, 2017: Medi-Cal Children's Health Advisory Panel (Meeting Minutes)
- April 20, 2017: DHCS-CPCA Meeting for SNC Fact Sheet
- April 24, 2017: Assembly Subcommittee Hearing #1
- April 27, 2017: Senate Subcommittee Hearing #3 (Waiver Updates and Contract Resources)
- May 1, 2017: Assembly Subcommittee Hearing #1 (Cont. of Waiver Updates)
- May 2, 2017: CHDP Statewide Oral Health Subcommittee Meeting
- May 5, 2017: CDA Presents "The Art and Science of Dentistry" in Anaheim (Program)
- May 17, 2017: DHCS-CPCA Meeting for SNC Encounter Submissions (Technical Guide and Submitter Identification)
- June 1, 2017: Medi-Cal Dental Advisory Committee (MCDAC) (Meeting Materials)
- June 9, 2017: Los Angeles Dental Stakeholder Meeting (Meeting Materials)

Operational/Policy Developments/Issues:

Domain 1

The first incentive payment for this domain was issued in January 2017; the second will be July 2017. In January, DHCS disbursed $21 million worth of incentive payments to 2,646 providers (2,426 FFS providers, 156 DMC provider, and 64 Safety Net Clinics) for services provided in calendar year 2016.

SNC data submission deadlines for July 2017 payments were May 31, 2017 and June 23, 2017. DHCS advised the SNCs to submit data electronically, rather than via proprietary form, which resulted in 108 SNCs submitting data electronically out of the 204 SNCs that opted-in for Domain 1. Electronic data submission is the preferred method of data delivery since it allows for the data to transfer via software which is much more time efficient. The proprietary forms require the mailing of data on paper, which require manual review and input, and it is very time-consuming. DHCS estimates the July 2017 incentive payment amount, for any remaining services provided in calendar year 2016, to be on track with anticipated utilization.

To facilitate the submission process, DHCS posted the following documents on the DTI webpage:

- DTI Proprietary Encounter Form for Paper Billing
- SNC Electronic Data Interchange Application
- Domain 1 Increase Preventive Services Utilization - Explanation of Payment

Domain 2

During this reporting period:

- The total incentive claims paid was $269,649.50 and 41 providers opted into the Domain.
- In addition, 81 providers took the TYKE training.

By the end of DY12-Q4, total provider participation and incentive payments in Domain 2 were as follows:

- 162 providers completed the TYKE training
- 81 providers opted-in to Domain 2 (50% of those who completed TYKE).
- $268,263.50 FFS incentive payments went to two counties – Tulare and Sacramento.
- $1,386 DMC incentive payments were paid (Sacramento).

In May and June 2017, DHCS contacted 35 clinics and 10 of them opted-into the Domain. The Domain 2 Sub-workgroup will reconvene and continue to meet on a monthly basis in the next quarter to discuss outreach efforts. DHCS also met with CDA to discuss provider outreach strategies.

Domain 3

On June 30, 2017, Program Year (PY) 1 incentive payments totaled $9,432,440 and were issued to 956 FFS and SNC service office locations. The next incentive payment for PY 2 is scheduled for release on June 30, 2018. For Domain 3, 25 SNCs submitted electronic data out of the 50 that opted-in. A Domain 3 Sub-workgroup will be established and convened in the next quarter to discuss outreach efforts.

Domain 4

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

At the end of DY12-Q4, 11 of the 15 agreements have been executed and four are still in progress as identified in the table below.

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

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

Nothing to report at this time.

Quality Assurance/Monitoring Activities:

The Fiscal Intermediary performs electronic analysis of claims submitted, which compares provider baseline data to ensure participating providers are paid accurately. Incentive payments undergo a reconciliation process with each check write of each PY. With each check write, a total incentive payment amount for the PY to date is calculated for each provider. If the provider receives an interim incentive payment, the interim payment amount(s) are subtracted from what is calculated for the final check write.

Evaluation:

DHCS submitted the DTI Final Evaluation Design to CMS on May 15, 2017, and received CMS' feedback for that report on June 29, 2017.

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

The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides an evidence-based benefit design covering the full continuum of care, requires providers to meet industry standards of care, 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 four and have received a total of twenty six implementation plans from: 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, and Sacramento and Partnership Health Plan of California. DHCS has approved the following counties' implementations plans: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Los Angeles, Marin, Contra Costa, Monterey, Ventura, Orange, Alameda, Sonoma, San Luis Obispo, Imperial, San Bernardino, and Santa Barbara. The remaining nine counties' implementation plans are currently in review by DHCS and CMS.

Enrollment Information:

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	Beneficiary Count
DY12-Q3	596
DY12-Q4	82

Member Months:

Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
-	484	402	Qtr 3	596
64	10	33	Qtr 4	83

This table shows the total number of clients who received DMC-ODS services with FFP, State General Funds (SGF), or Behavioral Health Services (BHS) funds. At the time of this report submission, only partial data was available for DY12-Q4.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- April 3, 2017: Assembly Budget Subcommittee No. 1
- April 5, 2017: Indian Health System (IHS) 2101 Tribal Consultation
- April 7, 2017: Meeting with California Health Care Foundation (CHCF) of DMC-ODS Projects
- April 12, 2017: DHCS and University of California Los Angeles (UCLA) Deliverables Conference Call
- April 13, 2017: DHCS Parity Meeting
- April 14, 2017: DHCS County of Responsibility Workgroup
- April 14, 2017: Assembly Budget Subcommittee No. 1
- April 17, 2017: Quarterly Meeting with Blue Shield of California Foundation (BSCF) and DHCS
- April 15-22, 2017: National Rx Drug Abuse Heroin Summit
- April 18, 2017: Medi-Cal Children's Health Advisory Panel (MCHAP)
- April 18, 2017: DHCS Opioid Workgroup Meeting
- April 21, 2017: DHCS Parity Meeting
- April 24, 2017: Phase Four Dual County Managed Care Plan Meeting
- April 24, 2017: IHS-ODS MAT Project Meeting
- April 28, 2017: Conference Call with Substance Abuse and Mental Health Services Administration (SAMHSA) regarding Innovation
- May 4, 2017: Meeting with CHCF for Coalition Support
- May 5, 2017: Indian Health Program: Speaking Engagement
- May 10, 2017: Indian Health Program Meeting with California Rural Indian Health Board
- May 16, 2017: Coalition of Alcohol and Drug Association's (CADA) 2017 Public Policy Conference
- May 16, 2017: BSCF and California Institute for Behavioral Health Solutions (CIBHS) Meeting
- May 18, 2017: Assembly Budget Subcommittee No. 1
- May 19, 2017: BSCF and CHCF Meeting regarding DMC-ODS IHS Implementation
- May 22, 2017: Medicaid Innovation Acceleration Program (IAP) SUD evaluation
- May 22, 2017: Tribal Programs Directors Meeting
- May 23, 2017: DHCS and CHCF Quarterly Meeting
- May 24, 2017: Direct Relief Non Profit Conference Call regarding the Opioid Epidemic in California
- May 24, 2017: California Association of DUI Treatment Programs (CADTP) Spring Forum

- May 25, 2017: BayMark Health Services Conference Call
- May 25, 2017: New Treatment Taskforce Meetings
- May 25, 2017: Los Angeles County SAPC Transition Plan
- June 1, 2017: Opioid Crisis and Related Public Health Issues Summit
- June 1, 2017: Conference Call with CHCF regarding SUD Conference
- June 7, 2017: State Opioid Treatment Authority (SOTA), SAMHSA and Drug Enforcement Agency (DEA) Conference Call
- June 9, 2017: Teleconference with County Behavioral Health Directors Association of California (CBHDA)
- June 14, 2017: Indian Health Program Meeting
- June 19, 2017: State Health Information Guidance (SHIG) Advisory Group Meeting
- June 20, 2017: DHCS Opioid Workgroup Meeting
- June 28, 2017: CMS IAP Webinar

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

No complaints during the time period from active counties. San Francisco, Contra Costa, and Santa Clara were provided with the Complaint, Grievance & Appeal logs and instructions.

Financial/Budget Neutrality Development/Issues:

	3rd Quarter				4th Quarter			
County	Units of Service	Approved Amount	FFP Amount	SGF Amount	Units of Service	Approved Amount	FFP Amount	SGF Amount
Marin					732	$29,968.92	$23,280.61	$4,416.07
Riverside	2,132	$391,474.05	$332,762.60	$51,217.41	0	$0.00	$0.00	$0.00
San Mateo	22,747	$445,427.98	$348,348.45	$30,338.76	3,041	$101,005.86	$86,631.38	$9,489.27
Santa Clara					74	$4,103.60	$3,473.08	$157.96

	3rd Quarter				4th Quarter			
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	Units of Service	Approved Amount	FFP Amount	SGF Amount
ODS/IOT - Case Management	403	$14,287.52	$12,761.42	$624.18	4	$124.00	$117.80	$6.20
ODS/IOT - Counseling	537	$15,485.08	$12,136.90	$3,348.18	425	$20,139.76	$16,570.85	$3,509.75
ODS/NTP - Dosing - Methadone	14,579	$174,219.05	$128,059.13	$4,575.00	2,162	$25,835.90	$20,729.86	$872.39
ODS/NTP - Individual Counseling	5,583	$77,603.70	$56,326.35	$1,949.40	451	$6,268.90	$5,085.76	$217.09
ODS/ODF - Case Management	0	$0.00	$0.00	$0.00	11	$326.54	$194.88	$31.00
ODS/ODF - Group Counseling	0	$0.00	$0.00	$0.00	104	$3,740.62	$2,778.58	$100.90
ODS/ODF - Individual Counseling	829	$25,623.10	$19,815.42	$778.20	202	$8,904.40	$6,629.99	$865.06
RES 3.1	397	$45,282.14	$35,099.02	$10,183.12	290	$32,465.50	$29,229.34	$3,236.16
RES 3.2	181	$33,205.36	$24,893.78	$921.04	0	$0.00	$0.00	$0.00
RES 3.5	2,370	$451,196.08	$392,019.03	$59,177.05	198	$37,272.76	$32,048.01	$5,224.75

Due to DHCS' Accounting policies for end-of-year processes, claims submitted after May 23rd were not processed until after the start of the new state fiscal year, July 1, 2017. This impacts the data available, including client count and units of service, and explains the drop from third to fourth quarter. In the next quarterly report, the data will be a more accurate reflection of beneficiary count for DY12-Q4.

Marin County's DMC-ODS implementation started in April 2017. Santa Clara County's implementation started in June 2017.

At this point in time, Riverside County's data was affected by the end-of-year Accounting policy noted above. If there are any errors or denials, claims must also be resubmitted.

Quality Assurance/Monitoring Activities:

- April 18-19, 2017: Technical Assistance for Marin County. DHCS provided a checklist, grievance and appeals log, and expectations.

DHCS hosted the following Compliance Monitoring Workshops and Webinars:

- May 4, 2017: Quality Management Rule Requirements
- May 9, 2017: Compliance Workshops in Northern California
- June 6, 2017: Compliance Workshops in Northern California
- June 23, 2017: Compliance Workshops in Northern California
- July 1, 2017 Developing Readiness Review instrument for Counties that opt in to the Waiver. Three Counties are scheduled for Readiness Reviews in August.

Evaluation:

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

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

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

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$21,004,142	$42,008,284	DY 11	$21,004,142
(Qtr 2 Oct - Dec)	$18,731,270	$37,462,540	DY 11	$18,731,270
(Qtr 3 Jan – Mar)	$18,647,737	$37,295,474	DY 11	$18,647,737
(Qtr 4 Apr – June)	$16,616,851	$33,233,702	DY 11	$16,616,851
Total	**$75,000,000**	**$150,000,000**		**$75,000,000**

This quarter, the Department claimed **$16,616,851** 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.

Payment	FFP	IGT	Service Category	Service Period	Total Funds Payment
Low Income Health Program (LIHP)					
(Qtr 2 Oct-Dec)	$0	$0			$0
(Qtr 3 Jan-Mar)	$0	$0			$0
(Qtr 4 Apr-Jun)	$81,314.26	$0	HCCI	DY3	$162,628.52
(Qtr 4 Apr-Jun)	$2,852,990.27	$0	HCCI	DY4	$4,602,784.83
(Qtr 4 Apr-Jun)	$2,831,489.30	$0	HCCI	DY5	$4,566,905.00
(Qtr 4 Apr-Jun)	$4,992,152.61	$0	HCCI	DY6	$7,639,897.78
(Qtr 4 Apr-Jun)	$77,678.73	$0	HCCI	DY7	$155,357.46
(Qtr 4 Apr-Jun)	$724,392.28	$0	MCE	DY7	$1,448,784.55
(Qtr 4 Apr-Jun)	$658,721.35	$0	HCCI	DY8	$1,317,442.70
(Qtr 4 Apr-Jun)	$9,205,730.86	$0	MCE	DY8	$16,504,487.26
(Qtr 4 Apr-Jun)	$2,249,544.99	$0	HCCI	DY9	$4,499,089.97
(Qtr 4 Apr-Jun)	$11,145,350.49	$0	MCE	DY9	$20,250,628.51
Total	**$34,819,365.14**	**$0**			**$61,148,006.58**

This quarter, LIHP counties received $34,819,365.14 in federal fund payments for interim reconciliations. Federal fund payments include American Recovery and Reinvestment Act of 2009 for DY 4, DY 5, and DY 6. DHCS is still collaborating with the LIHP counties to complete the remaining 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				
GPP				
Qtr 4 (Mar – June 2017)	$286,502,138.50	$286,502,138.50	Jan. 2017 – Mar. 2017	$573,004,277.00

DY12-Q4 reporting is for services from January 2017 through March 2017.

This quarter, PHCS received $286,502,138.50 in federal funds payments and $286,502,138.50 in IGT for GPP.

Quality Assurance/Monitoring Activities:

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

Evaluation:

Per STC Item 173 *Evaluations of provider expenditures and activities under the global payment program*, the State must conduct two evaluations of provider expenditures and activities under the global payment methodology. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of GPP PY 4. The two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstration. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by PHCS, and patients' experience, with a focus on understanding the benefits and challenges of the program.

DHCS submitted a revised GPP Evaluation Design to CMS on May 15, 2017, and received CMS' feedback for that report on June 13, 2017. DHCS developed the revised Evaluation Design in response to CMS' feedback on the original GPP Draft Evaluation Design.

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 April 10, 2017, California Department of Health Care Services (DHCS) held a PRIME Northern California Regional Learning Collaborative in Sacramento, CA. Twenty-seven of the participating PRIME entities attended this in-person meeting to engage in a discussion of best practices and challenges in PRIME program implementation. Areas of focus were derived from direct input from the PRIME entities and included various elective PRIME projects, engaging providers and leadership, data governance, patient perceptions of changes to utilization, and electronic health record systems.

On June 2, 2017, DHCS held a similar PRIME Southern California Regional Learning Collaborative in Riverside, CA. The remainder of the participating PRIME entities as well as some repeat entities attended this in-person meeting.

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)	$199,810,000	$199,810,000	DY 11	$399,620,000
(Qtr 2 Oct – Dec)	$598,626,428.57	$598,626,428.57	DY 11	$1,197,252,857.14
(Qtr 3 Jan-Mar)	$562,500.00	$562,500.00	DY 11	$1,125,000.00
(Qtr 4 Apr – June)	$314,688,578.33	$314,688,578.32	DY 12	$629,377,156.65
Total	**$1,113,687,506.90**	**$1,113,687,506.89**		**$2,227,375,013.79**

In DY12-Q4, interim DY 12 Mid-Year payments were issued by April 30, 2017. Eastern Plumas Health Care, Mendocino Coast District Hospital, and Salinas Valley Memorial Healthcare System were unable to earn any incentive funds for their DY 12 Mid-Year Reports for achievements between January 1, 2016 – December 31, 2016.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$314,688,578.33** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

DY 12 Interim Mid-Year Reports from all participating PRIME entities were reviewed and passed for data completeness by DHCS before April 14, 2017. These reports are currently under comprehensive administrative and clinical review.

Evaluation:

DHCS selected the University of California Los Angeles Center for Health Policy Research (UCLA) as the PRIME external evaluator.

On April 12, 2017, DHCS and CMS discussed feedback regarding the PRIME Draft Evaluation Design. Based on a discussion CMS provided feedback on April 27, 2017. On May 10, 2017, DHCS provided a response to CMS feedback along with an updated Evaluation Design and supporting documents.

On June 9, 2017, CMS provided an additional recommendation for the Evaluation Design. DHCS provided CMS a response to the additional recommendation and updated supporting documents on June 21, 2017. DHCS is currently awaiting review and approval from CMS.

During DY12 Q4, UCLA prepared an Office of Statewide Health Planning and Development (OSHPD) data analysis plan and submitted an application to OSHPD to obtain data that will allow for assessment of impact of PRIME on all California inpatient discharges. In addition, UCLA has prepared the Medi-Cal data analysis plan and has held several discussions with DHCS to determine what Medi-Cal data will be needed by UCLA for evaluation purposes.

UCLA has developed a statistical matching methodology to select control hospitals for comparison to entities participating in PRIME. The selection of these hospitals is in process.

UCLA began to review PRIME applications and create a database of hospital-specific characteristics, including information around patient mix, record systems, cultural competency, and leadership/engagement. UCLA has begun to create a data dictionary that identifies keywords and will assist in automating this process for future reporting periods. Additionally, to gain a better understanding of the infrastructure, processes,

and characteristics of PRIME participating hospitals at baseline, UCLA extracted sections from PRIME entities' applications and reports related to project selection logic and challenges/advantages to implementation and data reporting for PRIME projects. These sections will be used in later qualitative analysis.

Using the DY 11 reports, challenges to project implementation and data reporting have been categorized into overarching constructs (e.g. workflows, staff training/capacity, patient outreach, etc.) for the majority of hospitals. This will be used to help understand PRIME project implementation and assist in the design of the hospital survey instrument.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

The “mandatory SPDs 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 SPDs 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
April 2017 – June 2017

County	Total Member Months
Alameda	88,157
Contra Costa	52,888
Fresno	71,541
Kern	5,6273
Kings	7,852
Los Angeles	60,1695
Madera	7,170
Riverside	104,755
San Bernardino	110,153
San Francisco	115,348
San Joaquin	121,992
Santa Clara	45,594
Stanislaus	50,234
Tulare	67,802
Sacramento	36,300
San Diego	32,121
Total	**1,569,875**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
April 2017 – June 2017

County	Total Member Months
Alameda	59,019
Contra Costa	26,691
Fresno	36,490
Kern	23,851
Kings	3,678
Los Angeles	1,130,170
Madera	3,726
Marin	19,386
Mendocino	17,325
Merced	48,130
Monterey	48,245
Napa	14,163
Orange	370,235
Riverside	155,884
Sacramento	58,541
San Bernardino	152,506
San Diego	221,321
San Francisco	40,841
San Joaquin	24,852
San Luis Obispo	24,736
San Mateo	68,138
Santa Barbara	45,655
Santa Clara	149,893
Santa Cruz	31,309
Solano	59,078
Sonoma	52,920
Stanislaus	13,844
Tulare	16,229
Ventura	85,267
Yolo	26,071
Total	**3,028,194**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
April 2017 – June 2017

County	Total Member Months
Alpine	69
Amador	1,127
Butte	19,382
Calaveras	1,801
Colusa	812
El Dorado	5,226
Glenn	1,659
Imperial	10,256
Inyo	532
Mariposa	689
Mono	198
Nevada	3,281
Placer	9,346
Plumas	1,033
San Benito	274
Sierra	108
Sutter	5,838
Tehama	5,187
Tuolumne	2,656
Yuba	6,663
Total	**76,137**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
April 2017 – June 2017

County	Total Member Months
Del Norte	7,958
Humboldt	26,839
Lake	19,047
Lassen	4,420
Modoc	1,862
Shasta	40,585
Siskiyou	11,070
Trinity	2,809
Total	**114,590**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Not applicable.

WHOLE PERSON CARE (WPC)

The Whole Person Care (WPC) pilot is a five-year program authorized under the Medi-Cal 2020 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 are developed and operated locally by an organization eligible to serve as the lead entity (LE), 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.

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

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

- Eight existing WPC pilots interested in expanding their programs including the counties of Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura.
- Seven new applicants including the counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma; the City of Sacramento; and a consortium of small counties (San Benito, Mariposa and Plumas).

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

DHCS continued regularly scheduled bi-weekly technical assistance (TA) calls with the 18 first round LEs implementing WPC pilots (legacy LEs) on administrative topics and issues, allowing the LEs to ask questions about DHCS guidance, reporting templates, timelines, expectations, and other relevant topics. Three calls focused on the Learning Collaborative, including the topics: Systems, Tools and Vendors – Sharing Ideas for Technology Across the Pilots; Debrief with LEs on First In-Person Convening, Pilot Highlights; and Plan Do Study Act cycles.

The following list of resource documents were uploaded to the WPC Learning Collaborative Portal:

- slides and the recording from the March 24th webinar on Start-Up Issues and Considerations
- a data use agreement between multiple departments in San Mateo County and the Health Plan of San Mateo (HPSM) to identify shared clients, and
- a data use agreement between behavioral health providers and HPSM to share behavioral health data.

DHCS continued extensive review of the applications and funding requests, including review by executive management prior to submission to CMS for approval. DHCS assessed the quality, scope, and valuation of each application.

Beginning April 2017, DHCS began revising and preparing the WPC agreement for the second round applications.

On May 2, 2017, DHCS held an informational teleconference with the second round applicants, discussing the process and timelines for the second round of WPC application approvals, intergovernmental transfers (IGT), and contract execution process in preparation for the July implementation of the second round WPC pilots.

Throughout the quarter, DHCS continued to provide guidance on second round implementation through individual calls, question and answer guidance, and bi-weekly TA calls with the legacy LEs.

On May 12, 2017, DHCS held a pre-meeting with CMS and its contractor, National Opinion Research Center (NORC), to discuss the plan for review of the 15 second round applications. It was determined that the review would follow the same process used in the first round in which all applications were uploaded to NORC's SharePoint site. The applications were uploaded to the NORC Share-Point site on May 19, 2017, and CMS and NORC reviewed them during teleconferences on May 24 - June 2, 2017.

On May 15, 2017, DHCS held an in-person meeting in collaboration with the Learning Collaborative consultants for the LEs of the approved WPC pilots. Topics included: Prioritizing the Needs of Medicaid Patients; What Keeps You Up at Night; DHCS Vision for WPC: Toward Seamless Care Coordination; Open Questions and Answers with

DHCS; and breakout sessions on Care Transitions, Ed Communications, Bio-Psycho-Social Integration and Care Coordination Tools. On average, six to eight representatives from each of the 18 WPC pilots attended the daylong meeting, totaling more than 120 LE attendees in Sacramento.

On June 1, 2017, CMS approved the technical correction to the STCs allowing DHCS to designate a city to be a LE for the WPC pilot program. This approval allowed DHCS to accept the City of Sacramento's application and designate the City of Sacramento as an LE.

On June 8, 2017, CMS determined that the 15 second round applications complied with the STCs and approved protocols for the demonstration.

On June 12, 2017, after receiving CMS approval, DHCS approved the 15 second round WPC applications received for the WPC pilot.

DHCS released approval notices to these applicants with the amounts of their total funds allocation, and a WPC agreement for their signature and formal acceptance. A total of $305 million in federal funds was allocated in the second round.

All agreements were executed by June 30, 2017. The second round agreement included, but was not limited to, total funds allocation for each calendar year, IGT payment process, Health Insurance Portability and Accountability Act business associate addendum, business associate data security requirements, the approved application, and terms of the agreement.

Consumer Issues:

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

Financial/Budget Neutrality Development/Issues:

In the prior quarter, DHCS released the first WPC pilot program payments for Program Year 1 (PY1), which was January 1 – December 31, 2016. On April 5, 2017, DHCS released the remaining WPC pilot program payments for PY 1. The remaining payments, totaling $44,413,043.00, were made through the IGT process. These payments represented the 50% federal financial participation (FFP) amount of $22,206,521.50 and 50% local non-federal share amount of $22,206,521.50.

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 3 (Jan 1 - March 31)	$216,844,940.25	$216,844,940.25	DY11 (PY1)	$433,689,880.50
Qtr 4 (April 1 - June 30)	$22,206,521.50	$22,206,521.50	DY11 (PY1)	$44,413,043.00
Total	**$239,051,461.75**	**$239,051,461.75**		**$478,102,923.50**

DHCS began developing the process to allow the rollover of unspent funds to future budget years and budget adjustment process for PY 3-5. The budget adjustment process allows adjustments and transfers between fund sources within each WPC pilot budget. DHCS anticipates releasing these processes for stakeholder and LE comment in the next quarter.

Quality Assurance/Monitoring Activities:

On May 26, 2017, DHCS released for comment the WPC Invoice and Revised Quarterly Enrollment and Utilization Report, which will replace the Monthly Enrollment Report. It will include additional data including target population, fee-for-service utilization and per member per month utilization. DHCS anticipates releasing these final documents in the next quarter.

DHCS continues to work on the development of the WPC baseline, mid-year, and annual report templates and anticipates releasing the reports for comment next quarter.

Evaluation:

DHCS submitted a WPC evaluation design to CMS on November 7, 2016. On May 11, 2017, CMS notified DHCS that a review of the evaluation design had been completed in accordance with the STCs with 12 comments and recommendations on the WPC evaluation design. In general, CMS recommended that the evaluation design be strengthened with specific details about the research design and organized around key components of the evaluation design. DHCS submitted the revised evaluation design to CMS on June 27, 2017, with the requested research and evaluation design details.

On June 6, 2017, DHCS selected the University of California, Los Angeles (UCLA) as the WPC independent evaluator from the request for proposals submitted. DHCS anticipates beginning contract negotiations in the next quarter with UCLA.