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

Section 1115 Waiver Annual Report

Demonstration Reporting Period:
Demonstration Year: Thirteen (July 1, 2017 – June 30, 2018)

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INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 13 to the Centers for Medicare & Medicaid Services (CMS), in accordance with Item 28 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 13:

- Accomplishments
- Program Highlights
- Qualitative and Quantitative Findings
- Policy and Administrative Issues or Challenges
- Progress on the Evaluation and Findings

DHCS submitted an application to renew the State's Section 1115 Waiver Demonstration to CMS on March 27, 2015 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 STCs. The conceptual agreement included the following core elements:

- Global Payment Program for services to the uninsured in designated public hospital (DPH) systems
- Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals, known as PRIME
- Dental Transformation Incentive program
- Whole Person Care pilot program that would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations
- Independent assessment of access to care and network adequacy for Medi-Cal managed care members
- Independent studies of uncompensated care and hospital financing

- The continuation of programs currently authorized in the Bridge to Reform waiver, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Coordinated Care Initiative, and Community-Based Adult Services (CBAS)

Effective on December 30, 2015, CMS approved the extension of California's section 1115(a) Demonstration (11-W-00193/9). 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.

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

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

The Global Payment Program (GPP) streamlines funding sources for care for California's remaining uninsured population and creates a value-based mechanism. The GPP establishes a statewide pool of funding for the remaining uninsured by combining federal DSH and uncompensated care funding, where county DPH systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high-cost, avoidable services to providing higher-value, preventive services.
To improve the oral health of children in California, the Dental Transformation Initiative (DTI) will implement dental pilot projects that will focus on high-value care, improved access, and utilization of performance measures to drive delivery system reform. This strategy more specifically aims to increase the use of preventive dental services for children, to prevent and treat more early childhood caries, and to increase continuity of care for children. The DTI covers four domains:

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

- Domain 4: Local Dental Pilot Programs

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

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

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

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

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

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

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

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

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

TIME PERIODS:

Demonstration Year

The periods for each demonstration year of the Waiver will consist of 12 months, except for DY 11 and DY 16, which will be 6 months respectively. The DY timeframes are indicated below:

- 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

Annual Report

This report covers the period from July 1, 2017 through June 30, 2018.

GENERAL REPORTING REQUIREMENTS:

- **Item 8 of the STCs – Amendment Process**

Health Homes Program (HHP)

DHCS submitted an amendment to the STCs of the California Medi-Cal 2020 demonstration waiver, in November 2016, to allow a freedom of choice waiver to provide HHP services through the Medi-Cal managed care delivery system to members enrolled in managed care. This amendment was approved by CMS on December 19, 2017. DHCS sent CMS California's official acceptance letter on January 3, 2018.

Out-of-State Former Foster Care Youth (OOS FFCY) Amendment

On August 18, 2017, CMS approved a waiver amendment to allow DHCS to continue providing Medicaid coverage for former foster care youth under age 26 consistent with federal requirements for coverage of this population. Given the waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category.

On September 8, 2017, in a letter to CMS, DHCS accepted the STCs for the FFCY Amendment.

- **Item 17 of the STCs – Public Notice, Tribal Consultation, and Consultation with Interested Parties**

OOS FFCY Amendment

DHCS publicly shared the acceptance of the amendment through the following channels:

  - FFCY stakeholder meetings on September 14, 2017, November 9, 2017, and January 11, 2018.
  - Stakeholder call on August 23, 2017, September 27, 2017, and October 1, 2017.
  - Notice was posted to the DHCS Medi-Cal 2020 Demonstration Amendments website.
  - The amended STCs were posted to the to DHCS Medi-Cal 2020 Demonstration Waiver STCs website.

No stakeholder questions or comments were received regarding the approval of this waiver amendment request to CMS.

- **Item 18 of the STCs – Post Award Forum**

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

In DY 13, DHCS hosted four SAC Meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- July 19, 2017
- October 19, 2017
- February 8, 2018
- May 17, 2018

Beginning in April 2018, SAC meetings are funded through a combination of state general funds, federal funds, and funds from the California HealthCare Foundation. Meeting information, materials, and minutes are available on the DHCS website at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx.

- **Item 25 of the STCs – Contractor Reviews**

Seniors and Persons with Disabilities (SPDs)

Under the authority of the Section 1115 Medicaid Demonstration titled "California Bridge to Reform Demonstration," California transitioned the SPD population from the Medi-Cal Fee-For-Service delivery system into the managed care delivery system. This transition occurred between June 2011 and May 2012. In order to evaluate the success of California's Bridge to Reform waiver, the Medi-Cal 2020 Demonstration waiver requires the State to provide evaluations on several waiver programs, including the SPD program. The SPD program evaluation must include:

- An evaluation of the impact of the program on member experience as well as the impact of the State's administration of the program overall using measures that describe three specific content areas: access to care, quality of care, and costs of coverage.
- A focused evaluation on the specific health care needs of SPDs, including specific needs associated with multiple complex conditions.

CMS approved the SPD Final Evaluation Design in November 2017. In early 2018, DHCS sought applications from entities that have prior experience in performing comprehensive program evaluations, expertise in analyzing the experience of similar population sets, and experience working with the type of data being evaluated. After scoring all proposals, DHCS contracted with a selected evaluator to begin work starting October 1, 2018. The final evaluation report is due to be completed on December 31, 2021.

- **Item 26 of the STCs – Monthly Calls**

CMS and DHCS schedules monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. During DY 13, the conference calls were held on the following dates:

  - July 10, 2017
  - August 14, 2017
  - September 11, 2017
  - October 20, 2017
  - November 13, 2017
  - December 11, 2017
  - February 26, 2018
  - April 9, 2018
  - May 14, 2018
  - June 11, 2018

The main discussion topics included: STCs technical updates, CCS protocols, access assessment report, waiver financial reporting, DTI funding redistribution, WPC pilots, WPC/HHP interactions, CMS' site visit planning, waiver evaluation designs, and various waiver program implementation updates and deliverables.

- **Item 27 of the STCs – Demonstration Quarterly Reports**

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 13, DHCS submitted three quarterly reports to CMS electronically on the following dates:

  - Quarter 1 (July 1, 2017 – September 30, 2017): Submitted November 28, 2017
  - Quarter 2 (October 1, 2017 – December 31, 2017): Submitted February 27, 2018
  - Quarter 3 (January 1, 2018 – March 31, 2018) – Submitted May 24, 2018

Per CMS' guidance, the fourth quarterly reporting information have been folded into the annual reports beginning in this demonstration year.

- **Item 28b of the STCs – Primary Care Access Measures for Children**

Each year, DHCS selects a set of performance measures, called the External Accountability Set (EAS), to assess the quality of care Managed Care Plan (MCPs) provide. DHCS utilizes benchmarks from the National Committee for Quality Assurance Quality Compass for setting the Minimum Performance Level (MPL) at the 25th percentile and the goal performance, High-Performance Level (HPL), at the 90th percentile. DHCS contracts require MCPs to reach the MPL as a minimum, meaning they must perform at least as well as the bottom 25 percent of all Medicaid plans nationwide on each EAS measure.

During DY 13, data for the relative Reporting Year (RY) 2018 included data from January 1 – December 31, 2017. The MCPs' EAS included measures on rates for *Children's and Adolescents' Access to Primary Care Practitioners*. These measures were distributed by the following age groups:

- 12 - 24 months (CAP-1224),
- 25 months - 6 years (CAP-256),
- 7 - 11 years (CAP-711), and
- 12 - 19 years (CAP-1219).

In RY 2018, the difference between the MPL and the HPL was less than 9 percentage points for the EAS measures listed above, making it difficult for MCPs to demonstrate significant quality improvement. Therefore, DHCS chose not to hold MCPs to the MPL for these EAS measures during this RY.

- **Item 30 of the STCs – Revision of the State Quality Strategy**

On behalf of DHCS, the Office of the Medical Director (OMD) has taken the lead role in overseeing the annual revision to the DHCS Strategy for Quality Improvement in Health Care (Quality Strategy), most recently published in March 2018. This was the sixth version distributed by the Department and can be found on the DHCS website at: http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2018.pdf.

The Quality Strategy serves as a blueprint, outlining specific programs and policies the Department is undertaking and prioritizing to improve clinical quality and advance population health among the members, patients, and families we serve. It was developed to align with other state QI initiatives and with the National Strategy for Quality Improvement in Health Care and published on a yearly basis. It describes the goals, priorities, guiding principles, and specific DHCS program activities related

to quality improvement for Medi-Cal, and covers both managed care and fee-for-service delivery systems.

On April 25, 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule) which aligns the Medicaid managed care program with other health insurance coverage programs. The Final Rule, at 42 Code of Federal Regulations (CFR) 438.340, required each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities in that state. In compliance with 42 CFR 438.202(a), DHCS prepared and submitted a Medi-Cal Managed Care Quality Strategy report on June 29, 2018. The report can be found on the DHCS website at:
http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

This report was created in collaboration with multiple divisions across the Department and describes California's Medicaid quality strategy and how it meets the requirements of the federal regulations. It includes quality strategies across all of California's Medicaid managed care delivery systems, including: i.) MCPs; ii) County Mental Health Plans (MHPs); iii) Drug Medi-Cal Organized Delivery Systems (DMC-ODS); and iv) Dental Managed Care (DMC) plans.

Going forward, the Department will combine both the Quality Strategy and the Medi-Cal Managed Care Quality Strategy into a single report and issue an update in November 2019.

- **Item 31 of the STCs – External Quality Review**

Medical Managed Care

Every April, DHCS releases an annual External Quality Review (EQR) technical report to CMS and the public. These reports are compliant with federal regulations (Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E) and are viewable on DHCS' Medi-Cal Managed Care – Quality Improvement & Performance Measurement webpage at:
http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.

DMC-ODS

Behavioral Health Concepts External Quality Review Organization (EQRO) has completed reviews for the following counties:

- San Mateo County on April 17-18, 2018
- Riverside County on May 16-18, 2018

- Marin County on June 5-6, 2018

Twelve performance measures will be reviewed during the first year reviews. Reviews focused on access, timeliness, and quality. The DMC-ODS EQRO reports are made available here: https://calegro.com/dmc-egro#!dmc-reports_and_summaries/Fiscal

- **Item 33 of the STCs – Certified Public Expenditures (CPE)**

CMS approved DHCS' updates to the DMC-ODS' CPE Protocol/Attachment AA of the STCs in October of 2017.

- **Item 34 of the STCs – Designated State Health Programs**

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

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

The STCs allow the State to claim Federal Financial Participation (FFP) using the CPE of approved DSHP. The annual FFP limit the State may claim for DSHPs during each demonstration year is $75 million for a five-year total of $350 million.

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July - Sep)	$18,679,15	$37,358,316	DY 12	$18,679,158
(Qtr. 2 Oct - Dec)	$21,977,68	$43,955,371	DY 12	$21,977,686
(Qtr. 3 Jan - Mar)	$19,819,69	$39,639,391	DY 12	$19,819,695
(Qtr. 4 Apr – Jun)	$14,523,46	$29,046,922	DY 12	$14,523,461
Total	**$75,000,00**	**$150,000,000**		**$75,000,000**

In DY13-Q4, the Department claimed $14,523,461 in federal fund payments for DSHP-eligible services.

- **Item 37 of the STCs – Managed Care Expansions**

The Department awarded contracts to two plans, UnitedHealthcare of CA (United), and Aetna, both of which are operating in Sacramento and San Diego Counties. United began operation on October 1, 2017. Aetna began operation on January 1, 2018. On June 29, 2018, United notified the Department of their decision to terminate their contract in Sacramento County.

- **Item 38 of the STCs – Encounter Data Validation Study for New Health Plans**

DHCS' Encounter Data Quality Unit annually performs an Encounter Data Validation (EDV) study with its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. During each study, DHCS obtains encounter data from a sample of medical records from newly established MCPs within 18 months of the effective date of the MCP's contract. DHCS sends this data to the EQRO to be reviewed for completeness and accuracy by comparing it with encounter data from DHCS' Medi-Cal Management Information System/Decision Support System (MMIS/DSS).

The DY 13 EDV study began examining the completeness and accuracy of professional encounter data submitted to DHCS by MCPs and Specialty Health Plans. DHCS' contracted EQRO completed the Study Plan; Data Collection and Sampling; Medical Record Procurement; and Review. Analysis of the medical record review results is in process and written reports are scheduled to be published in early DY 14.

- **Item 39 of the STCs – Submission of Encounter Data**

In May 2017, CMS approved DHCS to move into production for data transmission to the Transformed Medicaid Statistical Information System (T-MSIS), which replaced the Medicaid Statistical Information System. During DY 13, DHCS continued to work with CMS to identify and resolve any concerns with its production encounter data transmissions through T-MSIS.

- **Item 41 of the STCs – Contracts**

Nothing to report.

- **Item 43 of the STCs – Network Adequacy**

DHCS performs extensive ongoing and scheduled periodic monitoring activities as well as network certification and network readiness reviews when expansion occurs or there is a significant change. DHCS reports quarterly and annually to CMS on the status of MCP network adequacy.

MCPs must gain written approval from DHCS prior to making significant changes in their networks that would impact the availability or location of covered services or before they begin enrollment of new populations. MCPs are also required to submit provider data to DHCS monthly so that DHCS and MCPs can actively work together to resolve any network adequacy issues as they arise.

DHCS conducts comprehensive ongoing reviews of the MCPs' networks and sends data analysis and inquiries to the MCPs for responses and necessary resolutions. DHCS then evaluates the MCPs' responses to identified deficiencies during the next review. Network adequacy indicators, include, but are not limited to:

- Primary Care Provider (PCP) Capacity (PCPs accepting new members)
- PCP-to-member ratios
- Physician-to-member ratios
- Termination of contracts
- PCP time and distance standards
- Specialist time and distance standards
- Timely access to PCPs and specialists
- MCP alternate access standards
- Out of network requests/approvals/denials
- Hospital geographical access
- State Fair Hearings
- Independent Medical Reviews

Starting in DY 14, MCPs will be required to annually submit comprehensive data to DHCS that reflects the MCP's entire contracted provider network for each service area. DHCS will evaluate this data to confirm that each MCP's network is sufficient to meet the anticipated needs of its members with adequate availability and accessibility of services including an appropriate range of providers.

- **Item 44 of the STCs – Network Requirements**

In DY 13, DHCS implemented new network adequacy standards, in addition to the existing network requirements. These standards consider elements specified in 42 CFR Section 438.68, 438.206 and 438.207, Welfare and Institutions Code Section 14197 (codified pursuant to AB 205 (Chapter 738, Statutes of 2017)), and the Knox-

Keene Act. The Medicaid Managed Care Final Rule Network Adequacy standards were initially released on July 19, 2017; however, they were subsequently revised to account for changes pursuant to state law. These revised network adequacy standards were released and are available on DHCS' website (see link below).

On February 16, 2018, DHCS issued All Plan Letter (APL) 18-005 to provide guidance to MCPs regarding Annual Network Certification, other network reporting requirements, associated network adequacy standards, and alternative access standards and requirements. This APL is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

On June 28, 2018, DHCS submitted the Compliance Assurance Report: 2018 Network Certification to CMS in accordance with 42 CFR 438.207(d). The report confirmed that MCPs contracting with DHCS are compliant with the network certification requirements set forth in 42 CFR Sections 438.206, 438.207, and 438.68. The compliance assurance report was published on DHCS' website (see link below).

In July 2018, DHCS published the 2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Alternative Access Standards Report. MCPs that submitted an Alternative Access Standard (AAS) request that was approved are included in the report. This report is available on DHCS' website (see link below).

Lastly, in accordance with AB 205, DHCS published the 2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report. This report details any MCPs noncompliance with time and distance standards. It also identifies the MCPs that are subject to a corrective action plan (CAP) due to noncompliance with the Annual Network Certification requirements, as well as each MCP's response to the CAP. This report is available on DHCS' website (see link below).

The following reports: Medicaid Managed Care Final Rule: Network Adequacy; Compliance Assurance Report: 2018 Network Certification; 2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Alternative Access Standards Report; and the 2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report can be accessed at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx.

- **Item 45 of the STCs – Certification (Related to Health Plans)**

DHCS developed and published statewide provider network adequacy standards in APL 18-005 to guide the Annual Network Certification process, which is available on

DHCS' website at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

DHCS continues to work with plans to improve and automate the submission process. However, any changes to the submission process will not detract from the requirements placed on DHCS to report documentation to CMS that demonstrates each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number of members for the service area in compliance with CFR Section 438.68 (network adequacy standards) and Section 438.206 (c)(1) (availability of services).
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.
- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services.

- **Item 58 of the STCs – 2016 CCS Pilot Update**

As of June 2018, DHCS is working with CMS to finalize the CCS protocols. The report will meet the STCs' requirements and includes:

- Brief description of the pilot program
- Description of HPSM as a MCP
- HPSM DP status update
- Description of RCHSD as an ACO
- RCHSD DP status update
- Number of children enrolled and cost of care

- **Items 69-73 of the STCs – Access Assessment**

In 2016, DHCS established an access assessment advisory committee that includes representatives from consumer advocacy organizations, providers, provider associations, MCPs, health plan associations, and legislative staff. With participation from the advisory committee, DHCS submitted a draft design to CMS for review on April 21, 2017. There was no further activity on this matter during DY 13.

- **Items 201-202 of the STCs – Budget Neutrality**

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

- **Items 211-216 of the STCs – Evaluation of the Demonstration**

Detailed information about the CCS, DTI, GPP, SPD, PRIME, and WPC evaluations are available in their respective program updates provided below. Copies of the program evaluation designs are available on the DHCS website at: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S 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 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 189,312 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 (HPSM), DHCS contracted with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning in FY 2018.

Accomplishments:

Date	Pilot Accomplishment Items
September 19, 2016	The draft CCS evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at: http://www.dhcs.ca.gov/provgovpart/Pages/MediCal2020Evaluations.aspx.
November 2017	DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and received the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.
Date	**HPSM Pilot Accomplishment Items**
October 2017 – November 2017	Submitted and received CMS approval of contract amendment A02.
October 2017 - Present	Preparing contract amendment A03 for signature.
June 2018	Transitioned CCS beneficiaries from demonstration pilot plan to managed care plan.
Date	**RCHSD Pilot Accomplishment Items**
July 1, 2018	RCHSD was implemented as a full risk plan. RCHSD began enrolling members into their plan.

Program Highlights:

HPSM

CCS Pilot Protocols
California's 1115 Waiver Renewal, Medi-Cal 2020 Demonstration, was approved by CMS on December 30, 2015. The Waiver contains STCs for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. DHCS received the formal approval package from CMS on November 17, 2017 for the CCS evaluation design.

DHCS Communications with HPSM
Recurring conference calls between DHCS and HPSM were conducted on a regular basis to discuss the transitioning of the demonstration project to a regular managed

care plan benefit that began July 1, 2018. Extra meetings were scheduled as necessary to sort out the technical details of the transition.

RCHSD CCS DP

DHCS and RCHSD have begun meeting regularly to facilitate the Rady Children's Hospital – San Diego pilot demonstration. RCHSD will be brought up as a full-risk Medi-Cal managed care health plan servicing CCS beneficiaries in San Diego County that have been diagnosed with one of five eligible medical conditions. The meetings have focused on the onboarding activities that will occur prior to implementation, including, but not limited to, the deliverable review process, contract development process, and provider network adequacy review.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

The monthly enrollment for HPSM CCS DP is reflected in the table below. Eligibility data is extracted from the Children's Medical Services Network (CMS Net) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to HPSM. HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference Prior Month
July 2017	1,610	-
August 2017	1,618	8
September 2017	1,621	3
October 2017	1,608	-13
November 2017	1,581	-27
December 2017	1,600	19
January 2018	1,599	-1
February 2018	1,577	-22
March 2018	1,576	-1
April 2018	1,572	-4
May 2018	1,548	-24
June 2018	1,534	-14

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

The draft evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

DHCS submitted a revised evaluation design to CMS on May 15, 2017. DHCS received CMS' draft evaluation comments on June 19, 2017, and DHCS responded to CMS on July 14, 2017. DHCS received additional CMS comments on September 12, 2017, which DHCS responded to CMS on October 10, 2017. DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

COMMUNITY-BASED ADULT SERVICES (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services as a 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, and was replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. DHCS amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR waiver) to include CBAS, which was approved by the CMS on March 30, 2012. CBAS was operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

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

CBAS will continue as a CMS-approved benefit through December 31, 2020, under Medi-Cal 2020.

Program Requirements

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

Initial eligibility for the CBAS benefit is determined through a face-to-face assessment by a 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 an 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 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 members, allowing them to remain in the community) if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services include local senior centers to engage members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the members with Activities of Daily Living or Instrumental Activities of Daily Living) through the Medi-Cal State Plan. If the member is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Program Highlights:

As a result of stakeholder processes during 2015 and 2016, the California Department of Aging (CDA) and Department of Health Care Services (DHCS) in collaboration with CBAS providers, managed care plans and other interested stakeholders developed the following documents which impacted CBAS program activities during DY 13 (July 2017 through June 2018): (1) New CBAS Individual Plan of Care (IPC); (2) New standardized ADHC/CBAS Participation Agreement; (3) CBAS Quality Assurance and Improvement Strategy: A Five-Year Plan (dated October 2016); and (4) Revised CBAS Home and Community-Based (HCB) Settings Transition Plan (dated January 11, 2018)

These documents were developed in response to the following directives by CMS in the CBAS provisions of the 1115 Demonstration Waiver: (1) STC 48(c) and STC 49(c)

[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.

requiring all CBAS settings to comply with the federal Home and Community-Based (HCB) Settings requirements (42 CFR 441.301(4)) and Person-Centered Planning requirements (42 CFR 441.301(c)(1)(2)(3)); and (2) STC 53 requiring the State to develop a quality strategy to assure the health and safety of Medi-Cal beneficiaries receiving CBAS. The following is an update on CBAS program activities related to each of these documents:

IPC

The target date for implementation of the new IPC was initially projected for March/April 2017; however, implementation is now targeted for March 2019 as DHCS works with CDA to finalize the new IPC and the CBAS section of the Medi-Cal Provider Manual which includes the IPC instructions. CBAS providers are required to continue using the current IPC until the new IPC is approved which includes implementing person-centered planning principles in its care planning processes.

ADHC/CBAS Participation Agreement Update

CBAS providers began using the new Participation Agreement (CDA Form 7000) for new and continuing CBAS participants as of March 1, 2017, and are required to replace all non-standardized participation agreements in participants' health records with the new form on a rolling basis as participants' IPCs are developed and reauthorized. CBAS providers are required to have assessment and care planning policies and procedures in place prior to implementing the new Participation Agreement.

CBAS Quality Assurance and Improvement Strategy

The CBAS Quality Assurance and Improvement Strategy is a five-year plan to assure CBAS participant health and safety by addressing the following: (1) the quality and implementation of the CBAS beneficiary's person-centered IPC, (2) provider adherence to state and licensure and certification requirements, (3) quality metrics for person-centered care/continuity of care, (4) clinical and program outcome measures/indicators, (5) CBAS center staff training on best practices and quality improvement, and (6) improved use of existing enforcement provisions for CBAS centers that do not meet licensing or certification standards. The *CBAS Quality and Improvement Strategy* is designed to assure federal partners, beneficiaries and the public that CBAS providers meet program standards while they continue to develop new approaches to improving service delivery.

CDA and DHCS are implementing the goals and objectives of this report within specific timeframes in partnership with an Advisory Committee comprised of CBAS providers, managed care plans, and advocates. The short-term objectives identified in Goals I and II guided CBAS program activities for DY 13.

CBAS Home and Community-Based (HCB) Settings Transition Plan Update

All CBAS centers must comply with the federal HCB settings and person-centered planning requirements by March 17, 2022, and thereafter, or risk losing their CBAS Medi-Cal certification. The State submitted *California's Statewide Transition Plan (STP)* to the CMS on November 23, 2016, which includes an attachment the *Revised Draft CBAS HCB Settings Transition Plan* (dated November 23, 2016). CMS requested additional information from the State, which DHCS submitted on September 1, 2017. Although CMS has not yet provided initial approval for California's *STP* or *CBAS Transition Plan*, the State is implementing the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA is evaluating each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Qualitative and Quantitative Findings:

Enrollment and Assessment Information

Per STC 52, the CBAS Enrollment data for both MCP and FFS members per county for DY 13 represents the period of July 2017 to June 2018 as shown in the table entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* The table entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into the table. Per the data presented, enrollment for CBAS has been consistent in DY 13.

The CBAS enrollment data as described in the table below is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. Enrollment with County Capacity data identified in the table below, reflects data through July 2017 to June 2018.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY13-Q1		DY13-Q2		DY13-Q3		DY13-Q4	
	Jul - Sept 2017		Oct - Dec 2017		Jan -Mar 2018		Apr - Jun 2018	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	512	78%	522	79%	518	78%	510	77%
Butte	43	42%	45	44%	43	42%	34	33%
Contra Costa	212	66%	224	70%	223	69%	232	72%
Fresno	611	55%	632	57%	634	57%	676	61%
Humboldt	95	24%	86	22%	86	22%	100	26%
Imperial	352	63%	318	57%	338	56%	307	51%
Kern	66	19%	76	22%	79	23%	83	25%
Los Angeles	22,176	69%	21,775	67%	21,381	65%	21,983	67%
Merced	95	45%	94	45%	88	42%	94	45%
Monterey	107	57%	107	57%	109	59%	107	57%
Orange	2,166	52%	2,243	54%	2,268	54%	2,329	53%
Riverside	463	43%	488	45%	449	41%	450	42%
Sacramento	501	80%	461	74%	437	70%	440	70%
San Bernardino	522	70%	624	84%	640	86%	650	87%
San Diego	1,951	52%	2,036	55%	2,068	56%	2,138	57%
San Francisco	716	46%	702	45%	693	44%	672	43%
San Mateo	168	27%	57	25%	56	27%	65	28%
Santa Barbara	*		*	*	*		*	
Santa Clara	758	45%	590	42%	617	45%	224	16%
Santa Cruz	95	62%	109	72%	103	68%	110	72%
Shasta	*		*	*	*		*	
Ventura	914	63%	903	63%	892	62%	905	63%
**Yolo	299	79%	295	78%	290	76%	282	74%
Marin, Napa, Solano	86	17%	75	15%	80	16%	80	16%
Total	**32,921**	**62%**	**32,471**	**61%**	**32,104**	**62%**	**32,489**	**61%**
								FFS and MCP Enrollment Data 06/2018

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

*** DY13-Q1 & Q2 Yolo county MCP data has been updated to reflect correct data.*

The data provided in the previous table shows that while enrollment has slightly decreased throughout DY 13 it has remained 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 close to its center capacity due to a steady increase in participant enrollment. However, a majority of CBAS participants are able to choose an alternate CBAS Center in nearby counties should the need arise for ongoing CBAS services.

Unduplicated Participant Data for Yolo County was entered incorrectly for DY 13 Quarters 1 & 2. The updated numbers have been added to Table 1. The original unduplicated participant data for Yolo County was lower than the actual data, causing an overall increase in Total MCP data for DY 13 Quarters 1 & 2.

Unduplicated Participant Data for Santa Clara County reveals a substantial decrease between DY 13 Quarters 3 & 4. DHCS believes this to be a reporting error due to the substantive size of the decrease and is working with Santa Clara County health plans to confirm and correct this discrepancy.

It is important to note the amount of member participation also plays a significant role in the percentage of overall licensed capacity used throughout the State. From July 2017 to June 2018 there was a one percent (1.3%) decrease in the total number of participants enrolled in CBAS centers. As a result, Butte, Imperial, Sacramento, and Santa Clara Counties experienced a decrease of more than five percent (5%) in their licensed capacity used throughout DY 13. However, Contra Costa, Fresno, Kern, San Bernardino, and Santa Cruz Counties experienced an overall increase in participation, which resulted in an increase of more than five percent (5%) of licensed capacity used.

<u>CBAS Assessments for MCPs and FFS Participants</u>

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

The table entitled "*CBAS Assessment Data for MCP and FFS"* lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the table is reported by DHCS.

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY13-Q1 (7/1-09/30/2017)	2,168	2,134 (98.4%)	34 (1.6%)	3	3 (100%)	0 (0%)
DY13-Q2 (10/1-12/31/2017)	2,342	2,315 (98.8%)	27 (1.2%)	7	7 (100%)	0 (0%)
DY13-Q3 (1/1-3/31/2018)	2,213	2,188 (98.8%)	25 (1.1%)	8	7 (87.5%)	1 (12.5%)
DY13-Q4 (4/1-6/30/18)	2,446	2,386 (97.5%)	60 (2.4%)	5	5 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous table, for DY 13, 9,169 assessments were completed by the MCPs, of which 9,023 were determined to be eligible, and 146 were determined to be ineligible. For DHCS, it was reported that 23 participants were assessed for CBAS benefits under FFS and of these, 22 were determined to be eligible and 1 was determined to be ineligible. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. The table entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY 13. As of DY 13, the number of counties with CBAS Centers and the ADA of each center are listed below in the table. On average, the ADA at the 243 operating CBAS Centers is approximately 22,735 participants which corresponds to 72 percent of total capacity. Provider-reported data identified in the table below, reflects data through July 2017 to June 2018.

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	243
Non-Profit Centers	56
For-Profit Centers	187
ADA @ 243 Centers	22,735
Total Licensed Capacity	31,581
Statewide ADA per Center	72%

CDA - MSSR
Data 06/2018

Outreach/Innovative Activities: Stakeholder Process

There are no updates in outreach activities over DY 13.

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 CBAS@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 were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in the table entitled "*Data on CBAS Complaints"* and the table entitled "*Data on CBAS Managed Care Plan Complaints*." According to the table below, no complaints were submitted to CDA for DY 13.

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

CDA Data - Complaints 06/2018

For complaints received by MCPs, the table below illustrates there were eight beneficiary complaints submitted for DY 13. The data reflects that for DY 13, complaints received by MCPs have decreased by a total of six complaints from DY 12.

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY13-Q1 (Jul 1 - Sep 30)	0	0	0
DY13-Q2 (Oct 1 - Dec 31)	4	0	4
DY13-Q3 (Jan 1 - Mar 31)	2	0	2
DY13-Q4 (Apr 1 - Jun 30)	2	0	2

Plan data - Phone Center Complaints 06/2018

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in the entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 79 grievances were filed with MCPs during DY 13. Six of the grievances were solely regarding CBAS providers. 73 grievances were related to other grievance issues. Alameda County reported 33 "other" grievances for DY13-Q3 & Q4. Due to surge in grievances reported for 2 quarters (3 & 4), DHCS is working with the reporting plan to

verify cause and accuracy of the data. Grievances/Appeals data identified in the tables below reflects data through July 2017 to June 2018.

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	Grievances				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY13 - Q1 (Jul 1 - Sep 30)	2	0	0	1	3
DY13 - Q2 (Oct 1 - Dec 31)	1	0	0	3	4
DY13 – Q3 (Jan 1 - Mar 31)*	0	0	0	33	33
DY13 – Q4 (Apr 1 - Jun 30)	3	0	0	36	39

Plan data - Grievances 06/2018

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 CBAS	Other CBAS Appeals	Total Appeals
DY13 - Q1 (Jul 1 - Sep 30)	1	0	0	0	1
DY13 – Q2 (Oct 1 - Dec 31)	1	0	0	1	2
DY13-Q3 (Jan 1-Mar 31)	11	0	0	0	11
DY13-Q4 (Apr 1-Jun 30)	8	0	0	0	8

Plan data- Appeals 6/2018

During DY 13, the table entitled "*Data on CBAS Managed Care Plan Appeals*", shows there were 21 CBAS appeals filed with the MCPs. The table illustrates that 20 of the appeals were related to "denial of services or limited services" and the other was categorized as "other CBAS appeals".

The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 13, there were six requests for hearings related to CBAS services filed. Of these, five were from Los Angeles County and one was from Orange County.

Quality Assurance/Monitoring Activity

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. The table 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. The table below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 13. Quality Assurance/Monitoring Activity reflects data through July 2017 to June 2018.

County	CBAS Centers Licensed Capacity							
	DY13-Q1 Jul-Sep 2017	DY13-Q2 Oct-Dec 2017	Percent Change Between Last Two Quarters	Capacity Used	DY13-Q3 Jan-Mar 2018	DY13-Q4 Apr-Jun 2018	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	0%	79%	390	390	0%	77%
Butte	60	60	0%	44%	60	60	0%	33%
Contra Costa	190	190	0%	70%	190	190	0%	72%
Fresno	652	652	0%	57%	652	652	0%	61%
Humboldt	229	229	0%	22%	229	229	0%	26%
Imperial	330	330	0%	57%	355	355	0%	51%
Kern	200	200	0%	22%	200	200	0%	25%
Los Angeles	19,088	19,315	+1.2%	67%	19,365	19,380	+0.08%	67%

Merced	124	124	0%	45%	124	124	0%	45%
Monterey	110	110	0%	57%	110	110	0%	57%
Orange	2,458	2,458	+0%	54%	2,458	2,608	+6.1%	53%
Riverside	640	640	0%	45%	640	640	0%	42%
Sacramento	369	369	0%	74%	369	369	0%	70%
San Bernardino	440	440	0%	84%	440	440	0%	87%
San Diego	2,198	2,198	0%	55%	2,198	2,198	0%	57%
San Francisco	926	926	0%	45%	926	926	0%	43%
San Mateo	135	135	0%	25%	135	135	0%	28%
Santa Barbara	60	60	0%		60	60	0%	*
Santa Clara	830	830	0%	42%	830	830	0%	16%
Santa Cruz	90	90	0%	72%	90	90	0%	72%
Shasta	85	85	0%		85	85	0%	*
Ventura	851	851	0%	63%	851	851	0%	63%
Yolo	224	224	0%	22%	224	224	0%	74%
Marin, Napa, Solano	295	295	0%	15%	295	295	0%	16%
SUM	30,974	31,201	+1.2%	61%	31,276	31,441	+6.2%	61%

CDA Licensed Capacity as of 06/2018

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

The previous table reflects that the average licensed capacity used by CBAS participants is 61% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of San Bernardino County. This allows for the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

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

that addresses such variance. There were no decreases in CBAS provider capacity in any county across DY 13. Throughout DY 13, Los Angeles County experienced an increase of 2% and Orange County experienced an increase of 6.1% in capacity used.

Access Monitoring (STC 48.e.)

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

Unbundled Services (STC 44.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, the managed care plans will work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct 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 continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 13, CDA had 243 CBAS Center providers operating in California. According to the table entitled “*CBAS Center History*,” a total of two CBAS Centers were closed and five new centers were opened in DY 13. Rancho Cordova ADHC Center in Sacramento County and ABC Therapy Center in Los Angeles County closed in DY 13. The five CBAS center openings in DY 13 took place in Los Angeles, Fresno, Orange, San Bernardino, and San Joaquin Counties.

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
June 2018	243	0	0	0	243
May 2018	242	0	1	1	243
April 2018	242	0	0	0	242
March 2018	242	0	0	0	242
February 2018	241	0	1	1	242
January 2018	241	0	0	0	241
December 2017	241	0	0	0	241
November 2017	240	0	1	1	241
October 2017	240	0	0	0	240
September 2017	241	1	0	-1	240
August 2017	240	1	2	1	241
July 2017	240	0	0	0	240

The previous table shows there was no negative change of more than five percent in DY 13, from July 2017 to June 2018, so no analysis is needed to address such variances.

Financial/Budget Neutrality Development/Issues

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

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

Policy/Administrative Issues and Challenges:

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY 13. As previously identified in the Program Highlights section, DHCS did delay implementation of the revised CBAS IPC from April 2017 to March 2019. This delay was determined necessary by DHCS and CDA to align the IPC changes with existing IPC instructions in the CBAS Provider Manual. Moving forward, DHCS and CDA have updated the CBAS form/template revision process to include identification of all related forms/templates/publications that will require corresponding update.

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

Progress on the Evaluation and Findings:

Not applicable.

COORDINATED CARE INITIATIVE (CCI)

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), including beneficiaries who are dually-eligible for Medi-Cal and Medicare (Duals). The CCI's aim is to achieve substantial savings by rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015), and SB 97 (Chapter 52, Statutes of 2017).

The three major components of the CCI are:

1. A Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs). Originally this was a three-year demonstration that has been extended to the end of 2019;
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of LTSS, with the exception of In-Home Supportive Services (IHSS), which has transitioned back to counties, as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal MediConnect (CMC).

The seven CCI counties participating in Cal MediConnect are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Four counties implemented CCI in April 2014 (San Bernardino, San Diego, San Mateo, and Riverside). Los Angeles County launched CCI in July 2014. Santa Clara County began in January 2015, and Orange County implemented in July 2015.

Accomplishments:

Date	Pilot Accomplishments
Implementation of Streamlined Enrollment	
2017	Since DHCS implemented streamlined enrollment in August 2016, MMPs have been able to submit enrollment changes to DHCS on behalf of their members. This provides a simpler method for members to enroll in CMC and has continued through DY 13 to contribute to a modest increase in enrollment for all demonstration MMPs.

Date	Pilot Accomplishments
Bi-monthly Conference Calls	
2017	DHCS and CMS continue to support MMPs in simplifying enrollment for all services, including Managed Long Term Services and Supports (MLTSS), by holding bimonthly conference calls.
Dual Plan Letters Released	
July 11, 2017	Dual Plan Letter (DPL) 17-001 "Health Risk Assessment and Risk Stratification Requirements for Cal Mediconnect."
July 21, 2017	DPL 17-002 "Reporting Requirements Related to Provider Preventable Conditions."
April 26, 2018	DPL 18-001 "Non-Emergency Medical and Non-Medical Transportation Services."

Program Highlights:

DHCS, in collaboration with MMPs, and CMS, formed a data sharing workgroup in late April 2018 to provide recommendations to DHCS leadership regarding MMP capabilities in sharing data between CMC plans. The goal of this data sharing workgroup was to allow MMPs to share member data between MMPs when members transition between counties. This will promote a smoother transition and continuity of care for members between CMC counties, and will allow MMPs to utilize the information as a baseline to assist new members and understand their level of need.

Qualitative and Quantitative Findings:

Enrollment

As of July 1, 2018, approximately 111,403 members were enrolled in MMPs across the seven participating CCI counties. Detailed enrollment information for each CCI county can be found below:

County	Number of Members
Los Angeles	35,091
Orange	14,535
Riverside	14,674
San Bernardino	14,319
San Diego	14,053
Santa Clara	9,805
San Mateo	8,926

DHCS updates the CMC dashboard quarterly to include updated enrollment numbers and tables on key aspects of the CMC program that assist MMPs in improving their

performance and quality standards. Enrollment information for 2018 and other quality metrics can be found at the following link: http://www.dhcs.ca.gov/Documents/CMCDashboard6.18.pdf.

CMC Ombudsman Call Volume

From July 1, 2017, to June 30, 2018, the CMC Ombudsman received approximately 4,386 calls from members. Below is a breakdown of the CMC Ombudsman call data by each county's corresponding Ombudsman Service Provider:

- Legal Aid Society of San Diego (San Diego): 916
- Neighborhood Legal Services (Los Angeles): 1,062
- Inland Counties Legal Services (San Bernardino and Riverside): 652
- Bay Area Legal Aid: 463
- Legal Aid Society of Orange County: 231
- Legal Aid Society of San Mateo: 55
- Other Health Consumer Alliance programs: 807
- Abandoned calls: 200

Continuity of Care Data

DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. From Quarter 3 of 2017 to Quarter 2 of 2018, there was a total of 75 continuity of care requests. Overall, 88 percent of the requests were approved, 9.3 percent were denied, and 2.7 percent were in process. The continuity of care request denials were due to reasons such as providers refusing to work with managed care, providers and plans not agreeing to a rate, and other reasons such as the provider being out on a sabbatical.

Policy/Administrative Issues and Challenges:

The CMC demonstration has encountered the following difficulties during DY 13:

- The "unable to reach" reporting metric reached an all-time high for several MMPs,
- The resistance from providers to participate in the CMC program, and
- The unknown future of the program.

MMPs have encountered a high level of "unable to reach" percentages for members within the CMC demonstration due to several external factors. There are many possible reasons for this, such as members moving, phones being disconnected, and members not responding to attempted contacts. MMPs have attempted multiple workarounds to reach their members for Health Risk Assessments and Individual Care Plan completion.

However, negative reporting metrics remain high, and efforts have not been as beneficial as the MMPs had hoped. To respond, CMS and DHCS partnered with MMPs to first understand the extent of this issue and second, to conduct short-term focused quality improvement efforts.

Some providers continue to misunderstand CMC and discourage enrollment in the program. This resistance has created difficulties maintaining enrollment in a few counties; however, most counties have been able to create positive CMC relationships that assist members in accessing services in a collaborative manner.

Lastly, the unknown future and longevity of the CMC program has created difficulties with gaining support and garnering enrollment growth for the demonstration. DHCS has arranged for the ongoing education of MMPs and providers to allow them to understand CMC and the benefits that it provides to their patients.

Progress on the Evaluation and Findings:

Research Triangle Institute (RTI) International

CMS contracted with RTI to monitor the implementation of demonstrations, including CMC, under the federal Medicare-Medicaid Financial Alignment Initiative and to evaluate their impact on member experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide.

The goals of the evaluation are to monitor demonstration implementation, the impact of the demonstration on member experience, unintended consequences, and the impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International collects qualitative and quantitative data from DHCS each quarter; analyzes Medicare and Medi-Cal enrollment and claims data; conducts site visits, conducts member focus groups and key informant interviews; and incorporates relevant findings from any member surveys conducted by other entities.

MMPs are required to annually conduct a Medicare Advantage – Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is designed to measure important aspects of an individual's health care experience, including the accessibility to and quality of services. MMPs are also required to include supplemental questions as part of their annual survey in order to assist with RTI's independent evaluation. In January 2018, RTI added supplemental questions to the 2017 CAHPS survey and released the additional questions to the MMPs ahead of time to allow them to prepare appropriately. RTI assesses their questions as necessary to

ensure they are gathering pertinent information to the demonstration. The annual report that will be provided by RTI is under revision and is expected to be released in the second half of 2018.

The SCAN Foundation

The SCAN Foundation (TSF) funded two evaluations of the CMC program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of CMC, as described below. While TSF funded these evaluations, DHCS has been working collaboratively with TSF and stakeholders to develop and update the content of both evaluations.

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of CMC on California's Duals population in as close to real time as possible. FRC completed several waves of the project and continued to conduct additional waves until polling ended in October 2017. The study compared the levels of confidence and satisfaction of CMC members with Duals who are eligible for CMC but are not participating, or live in a non-CMC county within California.

The poll was released on December 14, 2017, and showed an increase in CMC members' confidence in navigating their health care system. A large majority of CMC members expressed confidence in managing their health conditions as well as reporting that they knew where to get answers regarding their health care needs. Member satisfaction with their health care increased. Even though satisfaction increased, there were problems reported pertaining to members' health care. Problems that were reported included member misunderstanding around health care services or coverage and providers no longer being available. Lastly, members reported on their LTSS and IHSS needs and utilization. The trends continued to improve based on the data collected and improved the experience for members due to the services delivered by CMC. A list of improvements and TSF's presentation can be found at: http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration.

TSF, along with The Commonwealth Fund, American Association of Retired Persons (AARP) Foundation, and AARP Public Policy Institute maintain a state scorecard on LTSS for older adults, people with physical disabilities, and family caregivers. The scorecard showcases measures of state performance for creating a high-quality system of care in order to drive progress toward improvement in services for older adults and people with physical disabilities, and their family caregivers. The focus is on state-level data because the U.S. does not have a single national system to address LTSS needs. Per the July 2017 Policy Brief, California maintained its ranking of 9th among all 50 states, and is in the top 10 for Choice of Setting and Provider, and Support for Caregivers. More scorecard information can be found at:

http://www.thescanfoundation.org/sites/default/files/picking_up_the_pace_of_change_ltss_scorecard_policy_brief_july_2017_updated.pdf.

In 2014, an evaluation team comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health was formed. The evaluation team engaged stakeholder input and built upon the national evaluation conducted in 2014, by the University of California San Francisco Community Living Policy and the University of California Berkeley Health Research for Action Center to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects. The following evaluations, which often include data from previous years, were conducted for DY 13. These are outlined below.

In August 2017, TSF released an evaluation conducted by researchers from the University of California on the impact of the CMC program on members and health systems. The results from the in-depth examination included the perspectives of various health system stakeholders regarding the efforts of CMC plans to coordinate behavioral health services for their members. Data for this research was collected through 27 online survey responses and telephone interviews with key stakeholders, including CMC plans, county behavioral health departments, and community behavioral health providers who serve Dual members. Key findings include:

- Great variety across CMC plans and counties in how they approached coordination of behavioral health services for CMC members.
- Interdisciplinary care team meetings were one of the most successful approaches to behavioral health care coordination.
- CMC plans connected members to behavioral health services through intensive outreach.
- Although the level of integration differed, several CMC plans took additional steps to integrate care for "mild-to-moderate" behavioral health services.
- The CMC program encouraged CMC plans to coordinate more closely with county behavioral health departments as they continued to provide "carved out" specialty behavioral health care to members.
- Communication between CMC plans and county behavioral health departments improved through promising practices such as formal and informal meetings and the co-location of providers. Data sharing remained a major challenge.
- County behavioral health departments and CMC plans remained unclear about their division of service and financial responsibility for some behavioral health services due to imprecise definitions and delineation.

The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/coordination_of_behavioral_health_care_through_cal_mediconnect_brief_ucb-_august_2017.pdf.

In November 2017, TSF released an evaluation of the impact of the CMC program on members and health systems that was conducted by researchers from the University of California, San Francisco and Berkeley. The following research brief includes results from an in-depth examination of the efforts of CMC plans to administer HCBS through their MLTSS programs. Data collected for this research brief built on the results of phase I and included an online survey with CMC plans as well as 20 in-depth interviews with representatives from HCBS agencies that served CMC members. Key findings included:

- The CCI has improved coordination and collaboration between CMC plans and agencies that provide Medi-Cal-reimbursed HCBS such as IHSS and Community-Based Adult Services, resulting in better access for many members.
- A lack of clarity about the scope of CMC plans' responsibility for HCBS has led to unmet expectations regarding referral and payment for non-Medi-Cal HCBS.
- Local HCBS providers offer critical support services to Duals that are not covered by Medi-Cal, but some CMC plans experience barriers to working with these agencies.
- The brokerage model, in which CMC plans work with one large HCBS agency to coordinate an array of HCBS for their members, is a promising practice that has the potential to increase access to HCBS.
- Multipurpose Senior Services Program staff have extensive expertise providing intensive care management for older adults at risk for nursing home placement, but CMC plans varied in the extent to which they leveraged the program.
- Although there have been many improvements with HCBS agencies sharing data with CMC plans, data sharing from CMC plans to HCBS agencies still needs improvement.

The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/ucb_researchbrief_hcbs_final.pdf.

In January 2018, TSF released an evaluation conducted by researchers from the University of California on the impact of the CMC program for members and health systems. Data collected for this research brief built on phase I results and included 19 additional interviews with provider stakeholders, including physician providers, provider groups, CMC plan directors of provider networks, Federally Qualified Health Centers, hospitals, management services organizations, and Long-Term Care providers. Key findings included:

- Providers perceived CMC to be part of a general trend toward more integrated systems of care.
- CMC's additional benefits added value, though awareness of them could be improved, and access more consistent.

- For some providers, CMC introduced more complexity into their client population, presenting challenges with time and resource management.
- Many providers experienced challenges navigating member eligibility data, as well as the CMC referral and authorization processes.
- Providers struggled with care transitions without assistance from CMC plans.
- Data collection and reporting processes created challenges for some providers.
- Low CMC plan reimbursement rates led some providers to decline participation.
- Provider contracting arrangements with CMC plans varied, sometimes including risk-sharing agreements.
- Some barriers remained in aligning financial incentives between and across CMC plans and providers.
- CMC has facilitated data sharing, though progress varies among CMC plans and providers.

The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/provider_perspectives_final_010818.pdf.

In May 2018, TSF released an evaluation from researchers at the University of California, San Francisco and Berkeley, that focused on the implementation and impact of the CMC program on health systems and members. The evaluation was done through informant interviews with health system stakeholders to determine the progress made and challenges that remain in coordinated care for Duals. Key findings included:

- State and federal policies recognize that care coordination is an essential part of integrating care for Duals.
- There is great variation in how CMC plans are organizing and delivering care coordination benefits.
- The CMC care coordination benefit encourages collaboration across health system stakeholders.
- The CMC care coordination requirement could improve care transitions across health care settings.
- The CMC care coordination benefit could improve access to HCBS.
- The CMC care coordination benefit has affected California's health care workforce.
- Awareness about the CMC care coordination benefit varies among CMC plans, providers, and members.
- Data sharing barriers remain a significant challenge to successful, non-duplicative care coordination efforts.

The presentation for these findings and additional information can be found at: http://www.thescanfoundation.org/sites/default/files/uc_coordinating_care_for_duals_through_cal_mediconnect_may_2018.pdf.

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.

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

Domain 2 is available in 11 pilot counties and is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages 6 and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this domain, a provider must take a training and elect to opt into this domain via an attestation form and provide confirmation of completed CRA training specifically created for this domain. If the pilot is successful, then this program may be expanded to other counties, contingent on available DTI funding.

The following 11 pilot counties were selected as pilot counties and are currently participating in this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba.

Domain 3 – Continuity of Care

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

The following 17 pilot counties were selected as pilot counties and are currently participating in this domain: Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus, and Yolo.

Domain 4 – Local Dental Pilot Projects (LDPPs)

The LDPPs support the aforementioned domains through 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 were: 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.

Accomplishments:

Program Timeline

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

Date	DTI Outreach Presentations (Venue)
October 25, 2017	National Academy for State Health Policy – Portland, OR (agenda)
November 2, 2017	DHCS Medi-Cal Tribal and Indian Health Program Designee Bi-Annual Follow-Up Meeting (presentation)
November 7, 2017	State CHDP Oral Health Subcommittee Virtual Meeting (agenda)
December 1, 2017	Los Angeles Dental Stakeholders Meeting (agenda)
December 7, 2017	MCDAC (agenda)
February 1, 2018	MCDAC (agenda)
February 16, 2018	Los Angeles Dental Stakeholders Meeting (agenda)
March 5, 2018	Healthy Smiles for Kids Orange County (information)
March 20, 2018	California Oral Health Network 2018 Regional Convening (agenda)
May 17-19, 2018	CDA Presents, Anaheim, CA (program)
May 21, 2018	UCLA-led Dental Transformation Initiative in Los Angeles
June 3-5, 2018	Medicaid, Medicare, CHIP Services Dental Association (MSDA) Symposium in Washington DC (information)
June 7, 2018	MCDAC (agenda)
June 19-20, 2018	CA Department of Public Health Oral Health Summit (information)
June 22, 2018	Los Angeles Dental Stakeholders Meeting (agenda)

Program Highlights:

DTI Small Stakeholder Workgroup

The objective of these meetings is to review monthly updates regarding all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a monthly basis, each third Wednesday of the month. During this reporting period, the workgroup met on the following dates:

- July 20, 2017
- August 17, 2017
- September 20, 2017
- October 18, 2017
- December's meeting was rescheduled to January 17, 2018.

In 2018, the workgroup was rescheduled to a bi-monthly basis. The group convened on the following dates:

- January 17, 2018
- March 29, 2018 - in lieu of this meeting, DHCS sent updates via email
- May 15, 2018

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

Other Small Stakeholder Sub-workgroups

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

Domain 2 Caries Risk Assessment Workgroup
This sub-workgroup is still active; however, it did not convene during this reporting period. A different sub-workgroup with the same members was created and named Domain 2 Subgroup. This subgroup convened for the first time during this reporting period on August 8, 2017.

Domain 2 Subgroup
This sub-workgroup is active. The group convened on August 8, 2017 and on February 20, 2018 where Domain 2 updates and outreach efforts from DHCS, the dental Administrative Services Organization (Delta Dental), and the California Dental Association were discussed. The subsequent meetings have been cancelled and will reconvene in October 2018.

The purpose of the subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis to discuss continued outreach efforts.

DTI Clinic Workgroup
This sub-workgroup is still active and it convened on May 7, 2018. The group discussed Domain 1 over and under incentive payments. The group will continue to meet as needed.

Domain 3 Subgroup
This sub-workgroup is still active and it convened on August 8, 2017. The subsequent meetings have been cancelled. The subgroup will reconvene in November 2018.

The purpose of this subgroup is to report on the domain's current activity and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

Domain 4 Subgroup
This sub-workgroup is still active. DHCS holds monthly calls with the LDPPs to address any outstanding questions. During this reporting period, LDPP conference calls were held on the following dates:

- January 24, 2018
- February 28, 2018
- March 28, 2018
- April 25, 2018
- June 27, 2018

Beginning June 2018, DHCS reduced the frequency of LDPP conference calls to a bi-monthly basis.

Domain 1

On July 31, 2017, DHCS disbursed $2.2 million in incentive payments to 2,646 providers (2,426 FFS providers, 156 DMC providers, and 64 SNCs) for the remainder of 2016 claims. The total disbursed for Program Year (PY) 1/Calendar Year (CY) 2016 in this domain was $85,945,101 across 5,020 unique providers (providers with multiple office locations have been removed). An explanation of payment was mailed separately, which included a breakdown by the procedure code that was paid and the program year it was allocated to.

DHCS identified due dates for accepting Domain 1 claims applicable to PY 1. The EDI testing cutoff date was November 17, 2017 and all EDI providers had to be EDI-tested by this deadline. This deadline was necessary to enable complete testing prior to the assumption of operations by the new dental FI; we do not anticipate any additional testing cutoff dates in the future. Providers had until December 23, 2017 to complete their electronic claim submission. The paper submission deadline was December 8, 2017.

During DY 13, DHCS responded to provider inquiries regarding the payments they received and have not received, the payment amounts, and how they can confirm they were paid the correct amount.

The SNC Frequently Asked Questions and Answers document was updated during this reporting period: http://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain 1/DTISNCFAQUpdated 07132017.pdf.

During DY 13, DHCS met with Delta Dental and DXC Technology Services, Inc., on a weekly basis to prepare for the January 31, 2018 payment. The payment timeline shifted from January 31, 2018 to February 5, 2018, due to the revised payment methodology and the new payment process with DXC Technology Services, Inc., the

Fiscal Intermediary (FI) contractor effective January 29, 2018.

DHCS issued its third and final PY 1 incentive payment and its first PY 2 incentive payment on February 5, 2018. By implementing the revised payment methodology, some providers were found to have been over or under paid and reconciliation began in the February 5th payment. A breakdown of payment data is included in the Quantitative Findings section of this report.

In late March 2018, DHCS mailed letters to providers that were identified as being overpaid as a result of the revised payment methodology for PY 1, notifying them that any incentive payments due to them in the February payment was not disbursed as a result of their overpayment. Alternatively, providers who were underpaid as a result of the revised payment methodology received a subsequent payment for the difference owed to them in May 2018.

Domain 2

Domain 2 incentive payment data is listed under the Quantitative Findings section in this report.

Domain 2 Outreach Efforts
DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation. DHCS has been working closely with Delta Dental to target outreach efforts in low-participating Domain 2 counties. Delta Dental conducted in-person visits and telephone calls to providers in all 11 counties during this reporting period. The majority of the outreach efforts to these counties have been successful. Most notably, outreach efforts to Tulare and Glenn counties have proven to be very fruitful. Most of the providers visited in Tulare County including Federal Qualified Health Centers and private practice providers showed interest and noted they would enroll in the Medi-Cal Dental program and participate in this domain. In Glenn County, some of the larger size providers, Ampla Health Dental Clinic and North Valley Indian Health Clinic, agreed to encourage their providers to take the TYKE training and opt-in to participate in the domain. The Domain 2 Toolkits for DMC, SNC, and FFS providers were posted to the DTI webpage, as well as an update to the Opt-in form that states providers will receive a notification letter once they are successfully opted in to the program.

The following Domain 2 documents were updated or added to the Domain 2 webpage during this reporting period:

- FFS, SNC and DMC Claims Examples (November 2017) – https://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain%202/FFS_DMC_How_to_Bill.zip

- FFS and DMC Toolkits (February 2018) – https://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain%202/FFS_DMC_Toolkit.zip
- SNC Toolkit (February 2018) - https://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain%202/SNC_Toolkit.zip
- Provider Opt-In Attestation Update (March 2018) – http://www.dhcs.ca.gov/provgovpart/Documents/DTI/Domain 2/Domain_2_Provider_Opt-In_Attestation.pdf

Domain 3

Domain 3 incentive payment data is listed under the Quantitative Findings Section in this report.

Domain 3 Outreach Efforts
DHCS identified 17 SNCs enrolled in Domain 1 that were also eligible for Domain 3. DHCS emailed an outreach letter and the Domain 3 opt-in form to the eligible SNCs on September 22, 2017, to encourage them to opt into PY 2. Subsequently, six opted into Domain 3 (35% outreach success rate) and 10 additional SNCs not included in this outreach effort opted into Domain 3 in PY 2, totaling to 16 new opt-ins. The total number of SNC providers opted into Domain 3 in PY 2 was 66 service office locations – an increase of 16 locations compared to PY 1.

In October 2017, DHCS also identified and sent acknowledgement letters with recognition awards to the top performing providers for Domain 3 in PY 1, and subsequently held a conference call with these providers to discuss continuity of care best practices. The providers shared feedback on how they increased continuity of care, some examples included implementing frequent appointment follow-up with patients by telephone and text messages; additionally they used various methods to disseminate additional educational materials to members, such as showing preventive dental videos in their waiting rooms.

Additionally, on January 12, 2018, DHCS emailed a survey to the 38 providers who were not able to participate on the conference call to obtain qualitative data. For consistency, the survey questions were comparable to those discussed on the conference call. Ten of the 38 providers completed the survey (26% participation). The results indicated that Domain 3 providers consistently implemented strategies or processes that supported increased patient outreach and communication, appointment follow-ups, and patient education.

Domain 4

In July 2017, there were 15 LDPP applications selected to participate in this domain. However, Northern Valley Sierra Consortium (NVSC) notified DHCS on November 6,

2017, that it would not proceed with the grant opportunity. The final approved applications and budgets are posted on the Domain 4 webpage as they become available.

Additional Funding Request Process
DHCS requested CMS guidance for the ability to reallocate unused NVSC funds to other LDPP projects. DHCS received CMS' approval to reallocate Domain 4 funds from the LDPPs that do not proceed with their DTI project. DHCS will allow the executed LDPPs to apply for additional funding to expand on their projects. DHCS will review each LDPP submission, determine which LDPPs warrant an increased budget allocation, and work with the LDPP(s) for any necessary budget augmentations.

At the end of DY13, 13 of 14 LDPP contracts have been executed. The final LDPP, First 5 Kern County, is still pending final revisions.

The Domain 4 Summary of LDPP Applications is available on the Domain 4 webpage.

Lead Entity	Contract Status
Alameda County	Executed April 15, 2017
California Rural Indian Health Board, Inc.	Executed June 21, 2017
California State University, Los Angeles	Executed April 15, 2017
First 5 San Joaquin	Executed May 31, 2017
First 5 Kern County	Pending
First 5 Riverside	Executed November 28, 2017
Fresno County	Executed June 27, 2017
Humboldt County	Executed June 21, 2017
Orange County	Executed June 30, 2017
Sacramento County	Executed June 30, 2017
San Luis Obispo County	Executed January 12, 2018
San Francisco City and County Department of Public Health	Executed June 27, 2017
Sonoma County	Executed May 15, 2017
University of California, Los Angeles	Executed May 15, 2017

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Statewide Eligible Medi-Cal Beneficiaries Age 1-20 and the Preventive Dental Service Utilization [1]

Month	Measure Period	Numerator[3]	Denominator[2]	Utilization
Jul 17	08/2016-07/2017	2,508,513	5,771,052	43.47%
Aug 17	09/2016-08/2017	2,508,477	5,737,281	43.72%
Sep 17	10/2016-09/2017	2,529,196	5,724,184	44.18%
Oct 17	11/2016-10/2017	2,551,144	5,717,888	44.62%
Nov 17	12/2016-11/2017	2,560,391	5,715,874	44.79%
Dec 17	01/2017-12/2017	2,569,338	5,690,870	45.15%
Jan 18	02/2017-01/2018	2,566,824	5,671,120	45.26%
Feb 18	02/2017-03/2018	2,566,188	5,657,839	45.36%
Mar 18	04/2017-03/2018	2,559,597	5,653,218	45.28%
Apr 18	05/2017-04/2018	2,546,353	5,635,708	45.18%
May 18	06/2017-05/2018	2,544,455	5,618,121	45.29%
Jun 18	07/2017-06/2018	2,535,017	5,609,019	45.20%

[1] Data Source – DHCS Data Warehouse MIS/DS Dental Dashboard September 2018 Update. Utilization does not include one-year full run-out allowed for claim submission.
[2] Denominator: Eligible Children Age 1-20 - beneficiaries who were enrolled in the same dental plan for at least three continuous months; not reflective of potential retroactive eligibility.
[3] Numerator: Eligible Children age 1-20 - beneficiaries who were enrolled in the same dental plan for at least three continuous months who received at least one preventive dental service during the measure period; not reflective of potential retroactive eligibility.

The numbers of active FFS service offices increased by 187 from 5,543 to 5,730; rendering providers increased by 582 from 9,626 to 10,208. The numbers of active DMC service offices slightly increased. GMC rendering providers remained the same with a peak during the DY, and PHP rendering providers slightly decreased. These numbers do not indicate whether a provider provided dental services during the reporting month. The numbers of Safety Net Clinics who provided at least one dental service in recent one year increased by 30 from 532 to 562.

Statewide Active Dental Service Offices, Rendering Providers and Safety Net Clinics [1]

Measure Month	FFS		GMC[2]		PHP[2]		Safety Net Clinics
	Offices	Rendering	Offices	Rendering	Offices	Rendering	
Jul 17	5,543	9,626	136	354	1,103	2,004	532
Aug 17	5,558	9,710	137	350	1,119	2,009	529
Sep 17	5,585	9,801	140	355	1,123	2,011	530
Oct 17	5,602	9,847	141	350	1,129	1,984	561
Nov 17	5,579	9,907	143	355	1,113	1,947	549
Dec 17	5,588	9,865	145	350	1,101	1,922	553
Jan 18	5,593	9,857	144	352	1,107	1,958	552

Measure Month	FFS		GMC[2]		PHP[2]		Safety Net Clinics
	Offices	Rendering	Offices	Rendering	Offices	Rendering	
Feb 18	5,610	9,914	143	350	1,108	1,950	556
Mar 18	5,648	9,986	143	352	1,108	1,963	561
Apr 18	5,674	10,067	171	391	1,146	1,929	554
May 18	5,697	10,128	156	356	1,154	1,918	555
Jun 18	5,730	10,208	153	354	1,152	1,922	562

[1] Active service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of Safety Net Clinics is based on encounter data from the DHCS Data Warehouse MIS/DSS as of September 2018. Only Safety Net Clinics who submitted at least one dental encounter within one year were included.
[2] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net and LIBERTY.

DTI Payments

Domain 1

The second payment was issued July 31, 2017, this covered services rendered in CY 2016 that were not paid in the first payment, please refer to the table below for totals. Prior to the third payment in January 2018, DHCS identified a calculation error in the payment methodology used to calculate the incentive payments. Upon correcting this error, DHCS identified providers with overpayments and underpayments. Providers with identified overpayments were not issued earned incentives in the third payment. The third payment was issued January 31, 2018, which covered services rendered in CY 2016 that were not paid in previous payments for that period and for services rendered in CY 2017. After allowing a 60-day period for recovery of overpayments, DHCS released an interim payment in May 2018 to pay underpaid providers any remaining withheld balances from the third payment in January 2018.

	FFS	DMC	SNC	Total
July 2017	$561,887.25	$608,666.25	$1,032,588.00	$2,203,141.50
January 2018	$33,273,819.00	$1,591,663.50	$408,249.00	$35,273,731.50
May 2018	$10,792,414.50	$198,940.50	-	$10,991,355.00
Total DY 13				**$48,468,227.00**
Participants	**4,265**	**524**	**231**	**5,020**

Domain 2

FFS providers are paid weekly and SNC and DMC providers are paid on a monthly basis. The top table represents incentive claims paid for FFS, SNC and DMC providers during the DY13 reporting period. During this time, the total incentive claims paid equaled $2,876,668.85. The second table represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program until the end of DY13. The total incentive claims paid for this period equals $3,171,912.35.

During the DY13 reporting period:

County	FFS	DMC	SNC
Sacramento	$478,456	$694,490	$0
Tulare	$1,591,576.35	$0	$0
Kings	$9292.50	$0	$0
Glenn	$3,741	$0	$0
Mendocino	$0	$0	$91,679
Inyo	$0	$0	$7,434
Total	**$2,083,065.85**	**$694,490**	**$99,113**
Total Incentive Claims Paid: $2,876,668.85			

- 81 providers opted into the Domain 2.
- 319 providers completed the TYKE training.

From the start of Domain 2 in February 2017 through the end of DY13:

County	FFS	DMC	SNC
Sacramento	$489,166	$695,876	$0
Tulare	$1,874,723.85	$0	$0
Kings	$9,292.50	$0	$0
Mendocino	$0	$0	$91,679
Inyo	$0	$0	$7,434
Glenn	$3,741	$0	$0
Total	**$2,376,923.35**	**$695,876**	**$99,113**
Total Incentive Payments: $3,171,912.35			

- 168 providers opted into the Domain 2
- In addition, 520 providers completed the TYKE training.

Domain 3

Domain 3 Incentive Payments

	FFS	SNC	Total
Program Year 1	$9,384,640	$426,960	$9,811,600
Program Year 2	$11,495,810	$437,050	$11,932,860
Totals	$20,880,450	$864,010	$21,744,460

Total DTI Domain 3 Payments by County and Program Year (PY)

	PY 1			PY 2		
County	**FFS**	**SNC**	**Total**	**FFS**	**SNC**	**Total**
Alameda	$951,880	$32,880	$984,760	$1,080,290	$7,160	$1,087,450
Del Norte	$280	$0	$280	$390	$0	$390
El Dorado	$71,880	$0	$71,880	$97,690	$0	$97,690
Fresno	$1,627,040	$27,560	$1,654,600	$1,989,070	$31,010	$2,020,080
Kern	$1,781,600	$73,120	$1,854,720	$2,189,700	$78,350	$2,268,050
Madera	$284,880	$0	$284,880	$342,070	$0	$342,070
Marin	$5,480	$0	$5,480	$6,860	$0	$6,860
Modoc	$680	$7,560	$8,240	$830	$7,600	$8,430
Nevada	$1,080	$0	$1,080	$2,070	$0	$2,070
Placer	$177,120	$0	$177,120	$208,930	$0	$208,930
Riverside	$2,921,800	$0	$2,921,800	$3,572,730	$0	$3,572,730
San Luis Obispo	$213,080	$0	$213,080	$270,650	$0	$270,650
Santa Cruz	$230,920	$125,400	$356,320	$280,180	$147,420	$427,600
Shasta	$49,880	$0	$49,880	$72,870	$0	$72,870
Sonoma	$265,160	$160,440	$425,600	$284,610	$139,990	$424,600
Stanislaus	$756,120	$0	$756,120	$1,041,710	$0	$1,041,710
Yolo	$45,760	$0	$45,760	$55,160	$25,520	$80,680
Total	**$9,384,640**	**$426,960**	**$9,811,600**	**$11,495,810**	**$437,050**	**$11,932,860**

Domain 4 LDPP Invoicing
DHCS set up an email inbox LDPPinvoices@dhcs.ca.gov to allow for electronic submission invoices. Invoices are submitted on a quarterly basis. DHCS has received 35 invoices from the LDPPs in during this reporting period, 31 of which have been paid for a total of $7,490,355. As of the end of DY 13 reporting period, three of the invoices are awaiting payment totaling $1,317,461, and one invoice was pending review with DHCS. DHCS is expecting additional invoices from the LDPPs that currently have executed agreements.

Policy/Administrative Issues and Challenges:

Domain Expansion

With the availability of unused funds and funding flexibility, DHCS is currently assessing to expand Domains 2 and 3 to more counties in an effort to increase preventive service utilization.

In May 2018, DHCS directed its contractors to initiate baseline and benchmark recalculations for Domain 1, beginning in PY 3, based on historical provider encounter

or claims data. Providers with no encounter or claim data, or with encounter or claim data that would equate to a benchmark below the county average, will be assigned the county average benchmark until the following year, at which point the provider will be recalculated using the same performance (claims) based methodology.

Eligible Domain 1 providers in FFS, DMC, and SNC delivery systems will receive letters in early October notifying them of their PY 3 (CY 2018) baseline and benchmarks. Eligible Domain 1 providers must have been active at any time in 2018.

Progress on the Evaluation and Findings:

DHCS received CMS approval of the DTI Evaluation Design on September 12, 2017. The final DTI Evaluation Design and the CMS Approval Letter have been posted on the DTI webpage. DHCS has been working with the evaluation contractor in an effort to bring the contract to a final phase for submission. DHCS anticipates the evaluation contract will be executed within the first quarter of the next DY.

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

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

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

Accomplishments:

The following counties have begun providing DMC-ODS services during this period:

- Los Angeles County on July 1, 2017
- San Francisco County on July 1, 2017
- Santa Cruz County on November 1, 2017
- San Louis Obispo County on January 1, 2018
- San Bernardino County on March 1, 2018
- Imperial County on June 18, 2018
- Monterey County on June 18, 2018
- Orange County on June 18, 2018
- San Diego County on June 18, 2018
- Nevada County on June 28, 2018
- San Joaquin County on June 29, 2018

- Alameda County on June 30, 2018
- Yolo County on June 30, 2018

Program Highlights:

Please refer to previous quarterly reports to find additional activities that occurred during DY 13.

- Monthly Technical Assistance (TA) Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- April 2, 2018: CAADPE Conference Call
- April 4, 2018: IHP-ODS Conference Call
- April 5, 2018: CMS IAP Opioid Data Analytics Cohort – Opioid Use Disorder (OUD) Overview Webinar
- April 6, 2018: DHCS and UCLA Conference Call: DMC-ODS Evaluation Status
- April 11, 2018: DHCS and UCLA Conference Call: Tribal MAT evaluation
- April 12, 2018: Opioid Process Mapping Meeting & Matrix
- April 17, 2018: CHCF, DHCS, and Harbage Consulting Conference Call: Medication Assisted Treatment (MAT) Toolkit for Residential Providers
- April 18, 2018: CMS and DHCS Annual Meeting
- April 20, 2018: IHP-ODS Conference Call
- April 24, 2018: CCAPP Conference
- April 25, 2018: CMS IAP SUD: Opioid Data Use Group- Meeting #4
- April 25, 2018: IHP-ODS Conference Call
- May 4, 2018: DHCS and UCLA Conference Call: Level of Care Tool
- May 9, 2018: DHCS and CMS Site Visit to Los Angeles County
- May 11, 2018: DHCS, EQRO, and UCLA Quarterly Meeting
- May 14, 2018: Mathematica Policy Research Meeting: National Evaluation of Section 1115 Demonstrations - Physical and Behavioral Health Integration
- May 15, 2018: DHCS Opioid Workgroup Meeting
- May 16, 2018: DHCS and California Department of Public Health (CDPH) Presentation regarding MAT and National Prevention Week "Out of Reach" Film
- May 18, 2018: CMS & DHCS Conference Call: IHP-ODS
- May 21, 2018: California Medical Association Conference Call: Opioid Discussion
- May 23-24, 2018: CADTP Spring Forum
- May 24, 2018: DHCS Present at the Pain Management Workgroup
- May 25, 2018: DHCS and Harbage Meeting: MAT Toolkits for Residential Treatment Facilities
- June 6, 2018: CMS IAP Opioid Data Analytics Cohort MAT Overview Webinar
- June 7, 2018: DHCS, Harbage Consulting, and CHCF Meeting: DMC-ODS TA Needs
- June 7, 2018: CDPH Maternal/Neonatal Task Force Meeting
- June 12, 2018: Judge Tigar: State's Prison System Integration and Addressing SUD Treatment

- June 13, 2018: Collaborative Justice Courts Advisory Committee Meeting
- June 14, 2018: DHCS and Harbage Meeting: MAT Toolkits for Residential Treatment Facilities
- June 18, 2018: The American Association of Health and Human Services Attorneys (AAHHSA) Conference: The Opioid Crisis: An Update on Methods Used by States to Combat the Crisis
- June 19, 2018: DHCS Opioid Workgroup Meeting
- June 21, 2018: IAP OUD Analytics MAT Cohort: Call with California
- June 25, 2018: CAADPE and DHCS Quarterly Meeting
- June 26, 2018: Statewide Opioid Safety Workgroup (SOS) Workgroup Meeting

Qualitative Findings:

Outreach/Innovative Activities

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

County	Technical Assistance Date	County/Provider Staff Training Dates	County/Provider Staff Training Attendees
Alameda	March 28, 2018	March 29, 2018	24
Los Angeles	March 8, 2018	March 9, 2018	45-50
Marin	January 22, 2018	January 23-24, 2018	73
Napa		May 30-31, 2018	19
San Diego	May 9, 2018	May 10, 2018	50
San Francisco	July 11, 2018	July 12, 2018	30
Santa Clara	February 1, 2018	January 30-31, 2018	75-80
Yolo		April 16 & 18, 2018	50

DHCS conducted mock utilization reviews which included shadowing county compliance monitoring staff and providing comprehensive technical assistance to county staff. The mock utilization reviews occurred in the following counties:

County	Mock Review Date
Marin	November 11-16, 2017
Riverside	September 12-15, 2017
San Mateo	December 12-13, 2017

Additional technical assistance meetings and trainings for DMC-ODS services in DY 13 include:

- A workshop addressing documentation requirements for State Plan DMC and DMC-ODS - contract providers at the Substance Use Disorders Statewide Conference on August 22, 2017;
- Technical assistance to 24 quality assurance and compliance staff from southern California counties on February 23, 2018;
- A DMC-ODS overview and status update at the California Quality Improvement Coordinators (CALQIC) Annual Conference with approximately 300 people in attendance on March 4, 2018;
- Technical assistance to 15 quality assurance and compliance staff from central California counties on March 29, 2018; and
- A Network Adequacy Webinar to county substance use disorder and mental health staff on March 5, 2018.

Quality Assurance/Monitoring Activities

On-site Readiness Reviews were conducted in the following counties:

County	Date
Alameda	March 6, 2018
El Dorado	March 19, 2018
Fresno	June 19, 2018
Imperial	November 14, 2017
Kern	January 30, 2018
Kings	May 22, 2018
Los Angeles	August 8, 2017
Merced	March 26, 2018
Monterey	November 7, 2017
Napa	August 15, 2017
Nevada	February 20, 2018
Orange	December 5, 2017
Placer	March 27, 2018
San Benito	February 20, 2018
San Bernardino	December 5, 2017
San Diego	March 20, 2018
San Joaquin	March 13, 2018
San Luis Obispo	September 5, 2017
Santa Barbara	April 20, 2018

County	Date
Santa Cruz	September 5, 2017
Sonoma	August 17, 2017
Stanislaus	April 16, 2018
Tulare	June 12, 2018
Yolo	April 24, 2018

Annual On-site Monitoring Reviews:

County	Date
Contra Costa	June 12, 2018
Marin	June 26-28, 2018
Riverside	May 9-11, 2018
San Francisco	May 29-31, 2018
San Mateo	May 23-25, 2018
Santa Clara	June 4-6, 2018

Consumer Issues

All counties that are actively participating in the DMC-ODS Waiver track grievance and appeal claims. An appeal is defined as a request for review of an action (e.g. adverse benefit determination) while a grievance is a report of dissatisfaction with anything other than an adverse benefit determination. Grievance and appeal data is as follows. Contra Costa has previously reported grievances and appeals for its entire behavioral health system in error, below are the accurate statistics for Contra Costa's DMC-ODS Waiver services for DY 13.

Appeal: Defined as a review of a beneficiary adverse benefit determination.

Grievance: Defined as a report of beneficiary dissatisfaction with any matter other than an adverse benefit determination. Grievances are reported by type of dissatisfaction.

Grievance	Contra Costa	Los Angeles	Marin	Napa	Riverside	San Bernardino	San Francisco	San Luis Obispo	San Mateo	Santa Clara	Santa Cruz
Access to Care		1	2		1	1			1	1	
Quality of Care		1	1		5		2	1		3	
Program Requirements			2				3			6	
Service Denials										2	
Failure to Respect Enrollee's Rights			1							3	
Interpersonal Relationship Issues		2	4		2				4	4	
Other		1	4				5	6	4	7	
Total	**0**	**4**	**14**	**0**	**8**	**1**	**10**	**7**	**9**	**26**	**0**

Resolution	Contra Costa	Los Angeles	Marin	Napa	Riverside	San Bernardino	San Francisco	San Luis Obispo	San Mateo	Santa Clara	Santa Cruz
Grievances	0		13		4		10	3	9	20	
Appeals	1	2						1			
Total	**1**	**2**	**13**	**0**	**4**	**0**	**10**	**4**	**9**	**20**	**0**

Quantitative Findings:

Enrollment Information

Prior quarters have been updated based on new claims data. For DY13-Q3 and Q4, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non ACA	Total
DY13-Q1	14,075	8,645	22,420
DY13-Q2	14,571	8,583	22,859
DY13-Q3	15,119	8,228	23,079
DY13-Q4	14,150	7,882	21,798

Member Months

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. “Current Enrollees (to date)” represents the total number of unique clients for the quarter. Prior quarters’ statistics have been updated, and for DY13-Q3 and Q4, there is only partial data available at this time since counties have up to six months to submit claims after the month of service.

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	10306	10798	10853	DY13-Q1	14,075
	11216	11121	10522	DY13-Q2	14,571
	11454	11050	10806	DY13-Q3	15,119
	10689	9950	9627	DY13-Q4	14,150
Non ACA	7090	7260	7222	DY13-Q1	8,645
	7296	7278	6873	DY13-Q2	8,583
	6910	6779	6592	DY13-Q3	8,228
	6571	6181	5952	DY13-Q4	7,882

Payments

Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY13-Q1					
ACA	1,344,108	$29,617,283.36	$26,356,994.67	$2,217,694.46	$1,042,594.23
Non-ACA	1,049,916	$14,964,375.97	$7,512,833.23	$2,101,701.01	$5,349,841.73
DY13-Q2					
ACA	1,336,891	$31,007,939.86	$27,567,646.39	$2,334,617.07	$1,105,676.40
Non-ACA	1,013,479	$14,934,852.88	$7,536,992.99	$2,227,223.10	$5,170,636.79
DY13-Q3					
ACA	1,111,519	$26,706,997.13	$23,423,288.03	$2,185,940.75	$1,097,768.35
Non-ACA	750,662	$11,703,250.74	$5,879,993.65	$1,853,328.86	$3,969,928.23
DY13-Q4					
ACA	714,348	$16,397,504.20	$14,208,617.30	$1,219,314.87	$969,572.03
Non-ACA	497,304	$8,747,645.28	$4,437,970.00	$713,522.40	$3,596,152.88

Due to the six-month lag in claim submission, DY13-Q4 is understated at this time. DY13-Q1 through Q3 are more representative of actual quarterly claiming in DY 13.

ACA and Non-ACA Expenditures for DY13-Q4
Total expenditures for both ACA and non-ACA for four quarters as of September 2018 is approximately $161 million. Over the last four quarters, the top three services provided are Narcotic Treatment Program services (ODS/NTPM, NTPI, & NTPG) at 28.71% of approved claims, Residential 3.1 (Res 3.1) at 18.48%, and Residential 3.5 (Res 3.5) at 14.43%. Approved claims for these services are $46,274,719; $29,790,417; and $23,255,266, respectively.

For the detail of approved claim amounts by level of care, please refer to the Excel file titled, “DY 13 DMC-ODS Expenditures.”

Policy/Administrative Issues and Challenges:

DHCS and CMS worked through many methodology challenges regarding the revised SUD Cost Report Settlement Forms. During this reporting period, CMS continued to assist DHCS with program and fiscal questions on Attachment BB for the IHP-ODS.

Progress on the Evaluation and Findings:

On June 20, 2016, CMS approved the evaluation design for the DMC-ODS component of California’s Medi-Cal 2020 Demonstration. The University of California, Los Angeles,

Integrated Substance Abuse Programs (UCLA ISAP) will conduct an evaluation to measure and monitor outcomes of the DMC-ODS demonstration project.

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

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

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

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) assists 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 receive GPP payments that are 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 is valued relatively higher than care given in inappropriate care settings for the type of illness.

The total amount of funds 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.

Accomplishments:

On September 15, 2017, DHCS announced the Notice of Intent to Award the RAND Corporation with a contract to conduct two evaluations of the GPP to assess the degree to which the program achieved the intended goals and improved care for uninsured patients accessing care in California's PHCS. The RAND Corporation will conduct the independent evaluation of the GPP that includes a Midpoint Evaluation Report and a Final Evaluation Report.

The Midpoint Evaluation Report examines early trends and describes the infrastructure investments the PHCS have made; in contrast, the Final Evaluation Report will determine whether, and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Furthermore, STC 173 (b) and (c) state the evaluation "will examine the purpose and aggregate impact of the GPP, care provided by the PHCS, and patients' experience, with a focus on understanding the benefits and challenges of this innovative payment approach." On June 29, 2018, DHCS submitted the GPP Midpoint Evaluation Report to CMS.

DHCS successfully utilized the GPP Encounter Data Collection SharePoint Extranet site as a method of data transmission. Each PHCS submitted encounter level data on their uninsured services using excel templates provided, in accordance with the STCs' Attachment EE and FF. The encounter level data documents for PY 2 were submitted to DHCS on March 31, 2018.

Program Highlights:

DHCS successfully completed the PY 2: 2016-17 Final Reconciliation and Redistribution process. PHCS were notified of the payment amount and IGT Notification on June 11, 2018. The Midpoint Evaluation Report was submitted to CMS on June 29, 2018.

Qualitative Findings:

The GPP Midpoint Evaluation concluded the following:

- Since the beginning of GPP, PHCS have built and strengthened primary care, data collection and integration, and care coordination to deliver care to the remaining uninsured.
- The majority of PHCS improved the utilization of non-inpatient, non-emergent services.
- PHCS are putting a strong foundation in place to deliver care for the remaining uninsured.

Quantitative Findings:

Two DY 13 final reports, (1) final year-end summary aggregate report and (2) PY 2 encounter level data reports, were due to DHCS from all participating GPP PHCS on March 31, 2018. DHCS received all reports on time, conducted thorough evaluations of the reports, and completed the final reconciliation and redistribution process for PY 2.

On June 6, 2018, Los Angeles County Health System (LACHS) submitted a revised FY 2015-16 PY 1 final year-end summary report. The threshold points earned for LACHS decreased by 2%, from 107% to 105%. The GPP points earned decreased from 108,937,543 GPP points to 107,006,011 GPP points. The decrease in GPP points places LACHS in a position of repayment because they were initially paid based on meeting 107% of their GPP threshold. LACHS originally received $1,142,739,933 in federal fund payments, however with the correction, the revised PY 1 final year-end summary report reflects LACHS earned $1,142,428,158. The difference creates a situation where DHCS overpaid LACHS in the amount of $311,775 and LACHS overpaid in IGT in the amount of $73,103.

DHCS will recoup $311,775 from LACHS in October 2018. DHCS will return the associated IGT funds to LACHS in the amount of $78,103 in November 2018.

The payments table below shows the GPP payments made to the PHCS in DY 13. In PY 2, Ventura County Medical Center earned 65.56% of GPP thresholds. The 65.56% is less than 75% of its total annual budget; therefore, DHCS recouped $8,510,890 in

total funds from Ventura County Medical Center. In DY 13, the PHCS received a total of $1,136,850,801 in federal fund payments.

Payment	FFP	IGT	Service Period	Total Funds Payment
PY 1 Final Rec. (July - June)	$26,091,312.50	$26,091,312.50	DY 11	$52,182,625.00
(Qtr. 4: April - June)	$235,602,039.50	$235,602,039.50	DY 12	$ 471,204,079.00
(Qtr. 1: July - Sept) (includes DSH reduction)	$262,275,752.00	$262,275,752.00	DY 13	$ 524,551,504.00
(Qtr. 2: Oct - Dec) (includes DSH reduction)	$262,275,752.00	$262,275,752.00	DY 13	$ 524,551,504.00
(Qtr. 3: Jan - March) (post-reduction)	$354,861,390.00	$354,861,390.00	DY 13	$709,722,780.00
PY 2 (July-June) Over-payment collection	*($4,255,445.00)*	*($4,255,445.00)*	DY 12	*($8,510,890.00)*
Total	**$1,136,850,801.00**	**$1,136,850,801.00**		**$2,273,701,602.00**

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

On July 26, 2017, CMS approved the final evaluation design for the GPP, authorized under California's Section 1115(a) Demonstration, entitled "Medi-Cal 2020."

Per STC 177, DHCS is required to conduct two evaluations of the GPP to assess the degree to which the program achieved the intended goals and improved care for uninsured patients accessing care in the PHCS.
The two evaluations seek to assess whether changing the payment methodology results in more cost-effective and higher-value care as measured by:

- Delivering more services at lower level of care as measured by diagnosis codes
- Expansion of the use of non-traditional services
- Reorganization of care teams to include primary care and mental health providers

- Better use of data collection
- Improved coordination between mental health and primary care
- Costs that could have been avoided
- Additional investments in infrastructure to improve ambulatory care

The RAND Corporation surveyed PHCS leaders and their GPP teams about their most important priorities for changing their health systems to meet GPP goals, the health system strategies for change that they adopted, and the services they provide for patient care. The RAND Corporation used 24 months of utilization data from PY 1 and 2 to examine early trends in service use in both high- and low-intensity care settings. On March 1, 2018, all PHCS submitted their completed Midpoint Evaluation Survey to DHCS and the RAND Corporation.

On June 29, 2018, DHCS submitted the GPP Midpoint Evaluation Report to CMS. The report assessed the degree to which the program achieved the intended goals and improved care for uninsured patients accessing care in California's PHCS.

The GPP Midpoint Evaluation Report addressed two research questions:

1. Did the GPP allow PHCS to build or strengthen primary care, data collection and integration, and care coordination to deliver care to the remaining uninsured?

   Findings from the Midpoint Report: Since the beginning of the GPP, PHCS built and strengthened primary care, data collection and integration, and care coordination to deliver care to the remaining uninsured. There is evidence that health systems have incorporated strategies to support the goals of the GPP.

2. Across the majority of the PHCS, did the utilization of non-inpatient, non-emergent services increase?

   Findings from the Midpoint Report: The majority of the PHCS improved the utilization of non-inpatient and non-emergent services. Trends during the first two years of the GPP suggest changes in utilization of non-behavioral health services in the hypothesized direction.

In addition, the findings from the Midpoint Evaluation Report discuss the activities the PHCS have undertaken through GPP regarding reorganization of care teams, better use of data collection, improved coordination between mental health and primary care, the expansion of non-traditional services use, and additional investments in infrastructure to support improvements in care delivery.

DHCS is preparing for the GPP Final Evaluation Report that is due to CMS on June 30, 2019. The final evaluation will determine whether, and to what extent,

changing the payment methodology resulted in a more patient-centered system of care. Throughout June 2018, the RAND Corporation conducted teleconference interviews with each PHCS. Each interview took one hour to complete. The PHCS-specific midpoint narratives provided a qualitative description that addressed whether the GPP payment strengthened primary care, data collection, integration, and care coordination. The findings from the interviews will be in the Final Evaluation Report.

OUT-OF-STATE FORMER FOSTER CARE YOUTH (OOS FFCY)

On August 18, 2017, CMS approved an amendment to the Medi-Cal 2020 Demonstration to allow DHCS to continue providing Medicaid coverage for former foster care youth (FFCY) under age 26, consistent with federal requirements for coverage of this population. Given the waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category. The amendment authorized an effective date of November 1, 2017. The Medi-Cal data provided for DY 13 is based on 2016 Medi-Cal data since Medi-Cal data for 2017 will not be settled until DY 14.

Accomplishments:

California was the first state approved by CMS to provide Medi-Cal eligibility to FFCY who were in foster care in a state other than California. Under the FFCY Program, the OOS FFCY under age 26 who qualify consistent with the federal requirements, receive full scope benefits in Medi-Cal until they turn 26. These youths do not have to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

Program Highlights:

California successfully enrolled over 10,764 FFCY in Medi-Cal in 2016, enabling these youths ready access to full-scope Medi-Cal benefits. Of the 10,764 FFCY, 44 OOS FFCY were enrolled in Medi-Cal, and remained enrolled for 11 months of the 12 month period (See attachment titled, “DY 13 FFCY Enrollment, Utilization, and Health Outcomes Evaluation”).

Qualitative Findings:

Nothing to report.

Quantitative Findings:

According to the 2016 Enrollment, Utilization, and Health Outcomes Evaluation, the FFCY population shows greater use of emergency room visits and behavioral health visits when compared to the 18 to 25 year old Medi-Cal population. Quality measures for Chlamydia Screening in Women (CHL) and Cervical Cancer Screening (CCS) were also accessed more by the FFCY group than the 18 to 25 year old Medi-Cal population.

Policy/Administrative Issues and Challenges:

FFCY are a group of individuals who move often, and are accustomed to having their health care needs taken care of by the foster care system and/or caretakers. A youth new to California will have limited knowledge on where to access health care resources.

They may also be unaware that California offers Medi-Cal for the former foster youth from age 18 to 26 until they are in need of the services.

Administratively, California lacks the ability to track OOS FFCY entering or exiting the state or transitioning to other programs, potentially having a negative impact on the comparison to the Medi-Cal population. Engagement with FFCY stakeholders to convey information on access to services is conducted bi-monthly.

Many FFCY are also eligible for other programs that offer cash aid in addition to Medi-Cal. When these youths lose their eligibility for the cash aid programs, they may not return to the FFCY program potentially creating a loss in their Medi-Cal coverage. DHCS is currently working on a system alert to the counties to correct this situation.

Progress on the Evaluation and Findings:

On December 22, 2017, CMS approved and accepted the evaluation design for the amendment to the Medi-Cal 2020 Demonstration for the FFCY population. The evaluation design used the most current data representing 2015. This year's submission represents the first full year evaluation, using the most current data from 2016 as instructed by CMS.

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 Designated Public Hospitals (DPH)/District/Municipal Public Hospitals (DMPH) 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 three domains. Participating DPH systems will implement at least nine 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: populations in need of perinatal care, individuals in need of post-acute care or complex care planning, foster children, individuals who are reintegrating into

society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

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.

Accomplishments:

The following are highlighted accomplishments based on entity reporting up to DY 13 Mid-Year:

Domain 1

- Tobacco Assessment and Counseling: Based on the DY 13 Mid-Year report, 11 participating entities achieved the 90th percentile benchmark or above.
- Colorectal Cancer Screening: Nine entities achieved the 90th percentile benchmark or above.
- Health Disparities: Each public health care system designed an individual disparity reduction plan based on the trends that emerged from its own data, and the unique needs of each community focusing on one of the “Ambulatory Care Redesign: Primary Care” project metrics, i.e. blood pressure control, colorectal cancer screening, comprehensive diabetes care, use of aspirin for heart disease, and tobacco screening and cessation. A few examples of the reduction plans include San Francisco Health Network’s implementation of Food Pharmacies to address hypertension in their African American population and Alameda Health System’s Patient Photo Voice Project to delve deeper understanding on the needs of patients with cardiovascular disease. Alameda Health system is focusing their efforts on Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) in the African American population.

Domain 2

- Prenatal Care: Five participating entities achieved the 90th percentile or above.
- Postpartum Care: Seven entities achieved the 90th percentile or above.

Domain 3

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: nine entities achieved the 90th percentile or above.
- Appropriate Emergency Department Utilization of CT for Pulmonary Embolism: Seven entities achieved the 90th percentile or above.

DHCS continues to update and maintain the PRIME Reporting Information System to serve as the basis for entity reporting activities throughout the duration of PRIME. The platform contains data entry fields for more than 100 PRIME metrics across the 18 PRIME projects. Data fields include numerators, denominators, qualitative narratives, and radio buttons. With a few exceptions, the platform automatically calculates metric achievement rates, achievement values, and next DY target rates.

DHCS continues to maintain a secure shared learning website via Microsoft SharePoint called PRIMEone. The shared learning website contains PRIME project discussion boards, libraries for documents and learning collaboratives materials, metric policies, and helpful links. Entities collaborate with each other on best practices, strategies for using their respective electronic health record systems and leveraging resources. DHCS monitors the site and provides administrative oversight when needed.

DHCS collaborated with Safety Net Institute (SNI) and the District Hospital Leadership Forum (DHLF) on the release of the DY 12 Year-End Reporting Manual, of which the most updated version was released on August 29, 2018. DHCS, SNI, and DHLF also collaborated on the DY 13 Mid-Year Reporting Manual, released on January 8, 2018.

DHCS released the DY 13 benchmarks on August 8, 2018, and also established procedures to allow DPHs to reclaim unearned funds as outlined in Attachment II of the STCs.

Program Highlights:

General Program Webinars

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

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

PRIMEd Annual Conference 2017

On November 15, 2017, DHCS hosted the DY 12 in-person PRIME Learning Collaborative (called the PRIMEd Annual Conference) in Sacramento at the Sheraton Grand Hotel with 52 PRIME entities in attendance. The event focused on two major themes for improving the quality of health care delivery – Patient and Community Engagement and Collaboration and Integration.

For the theme of Patient and Community Engagement, Contra Costa Regional Medical Center showcased its work in actively engaging patients in design of improvements to care. Their presentation included a patient panel discussion. Kaweah Delta Health Care District and DHCS provided other presentations regarding patient engagement and community engagement. In addition, the University of California, Davis Medical Center and San Francisco Health Network presented on work achieved within their entities for two required PRIME projects – Integration of Behavioral Health and Engaging Patients in Exclusive Breastfeeding Efforts (as part of the Perinatal Project), respectively.

For the theme of Collaboration and Integration of Care, the Los Angeles County Department of Health Services (LACDHS) presented its journey in integrating its system of care over the past decade, including successful quality improvement interventions, which eliminated fragmented care. LACDHS' presentation was followed by a panel discussion with two other PRIME entities, San Mateo Medical Center and Salinas Valley Memorial Healthcare System, who have worked to achieve integration under a fee-for-service business model. The panel discussion provided all PRIME entities with ideas for collaboration and integration, regardless of their individual reimbursement model.

The conference featured a poster session where each PRIME entity submitted a storyboard poster showcasing its vision for the sustainable changes that will be made within its system following the end of PRIME in 2020. The entities' posters were both informative and beautifully creative. All in attendance were inspired by the thought and effort that went into creating the entities' posters, and written feedback was positive. Conference attendees were able to vote on their top three DPH and DMPH posters, and DHCS presented the respective entities with awards.

DHCS hosted a networking session the night before the event on November 14, 2017. PRIME entities were able to meet contacts within other PRIME entities for help collaborating on similar PRIME projects.

Additional Ongoing Learning Collaborative Activities

On August 11, 2017, DHCS hosted a webinar on the topic of Tobacco Assessment and Counseling. The webinar provided an overview of tobacco cessation evidence, including an overview of current smoking in California and associated health and economic costs.

It also provided information to help PRIME entities capture the tobacco status and counseling elements of the PRIME metric, which is a metric included in four different PRIME projects.

In DY13-Q3, DHCS launched the 2018 PRIME Learning Collaborative activities with the first webinar of a three-part webinar series entitled, *Fundamentals of Quality Improvement*. The series was facilitated by nationally renowned quality improvement expert, Jane Taylor, EdD. These webinars support PRIME entities in their efforts to begin or continue a Quality Improvement (QI) project. The first webinar, "Getting Started," occurred on February 27, 2018, and the next two webinars occurred in the following quarter.

In March 2018, DHCS coordinated and finalized plans for Topic-Specific Learning Collaboratives (TLCs), a variety of workgroups offered to help PRIME entities meet their project goals and improve care delivery through peer-to-peer learning, an exchange of ideas, and the dissemination of best practices on common topics. The TLC workgroups launched kickoff meetings in DY13-Q4 and will continue through the remainder of 2018.

There are approximately 90 individuals from 40 PRIME entities participating in the 12 TLCs, with many individuals participating in more than one group. The TLC topics include:

- Health Homes for Foster Children
- Reducing Health Disparities
- Patient Safety
- Care Transitions
- Mental Health
- Patient Engagement
- Obesity Prevention/Healthier Foods
- Diabetes Management
- Substance Use Disorders/Pain Management
- Maternal and Infant Health
- Cancer Screening
- Tobacco Cessation (facilitated by the CA Quits Team)

Below are several examples of the types of activities occurring across the TLCs to date:

Reducing Health Disparities – This TLC focuses on topics/challenges entities encounter using Race, Ethnicity and Language (REAL) or Sexual Orientation and Gender Identity (SO/GI) data collection to identify health disparities. Participants of this TLC discussed entities' specific health disparity plans, best practices, and lessons learned. The June 19th meeting was a webinar on REAL SO/GI data collection and translations of REAL

SO/GI questions in different languages. The June 19th session also featured demonstration videos on strategies for communicating effectively with Lesbian, Gay, Bisexual, and Transgender population and training tools for clinical and non-clinical frontline staff to collect REAL SO/GI data in a culturally sensitive manner.

Integrated Health Homes for Foster Children – This TLC group had a session on data sharing and Electronic Health Record (EHR) integration across various county entities that serve the foster care population. DHCS' Chief Medical Information Officer, Dr. Linette Scott, joined the session to present a quality improvement project undertaken to improve the use of psychotropic medication among children and youth in foster care. Dr. Scott also shared with the group opportunities available to them via the state's Medi-Cal EHR Incentive Program.

Opioid and Pain Management – During the May meeting of this TLC, guest speaker, Marlies Perez, Chief of the Substance Use Disorder Compliance Division at DHCS, outlined the Emergency Department (ED) Medication Assisted Treatment (MAT) Bridge Program structure, workflows and outcomes. After the presentation, each TLC member spoke about PRIME Project 2.6 operations at his or her entity. Topics covered as part of this discussion included multi-modal therapies, prescribing guidelines, Controlled Substance Utilization Review and Evaluation System (CURES), tapering protocols, and participation in Project ECHO (Extension for Community Healthcare Outcomes).

Maternal and Infant Health – The May TLC session featured Lekisha Daniel-Robinson from the Institute for Medicaid Innovation, and formerly the coordinator of CMS' Maternal and Infant Health Initiative. She led the group in a discussion about the challenges related to the Perinatal Care project in PRIME, as well as possible strategies and resources available to help address these challenges. In the most recent session, the TLC participants specifically discussed challenges and strategies related to reducing the C-section rates at their hospitals or health systems, including quality improvement activities, leadership support, and provider and patient education.

DHCS also began to plan for the annual PRIME Learning Collaborative in-person conference that will be held in Sacramento on October 29-30, 2018. Dr. Taylor will provide in-person technical assistance, and TLC workgroups will have the opportunity to convene face-to-face.

Qualitative Findings:

DY 12 Final Year-End Reports were due to DHCS from all participating PRIME entities on September 30, 2017. DHCS received all reports, conducted its administrative reviews of all reports, and approved them for payment. An administrative issue with Tulare Regional Medical Center (TRMC) is detailed in the "Policy/Administrative Issues and Challenges" section.

In DY13-Q3, DHCS requested and received documentation from DPHs regarding the APM requirement as specified in STC 76(b).

DY 13 Interim Mid-Year Reports were due to DHCS from all participating PRIME entities on March 31, 2018. DHCS received all reports, conducted its administrative reviews of all reports for mid-year payments and approved them for payment.

Quantitative Findings:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$0	$0	DY 12	$0
(Qtr. 2 Oct - Dec)	$460,140,476.00	$460,140,475.99	DY 12	$920,280,951.99
(Qtr. 3 Jan - Mar)	$9,194,936.17	$9,194,936.17	DY 12	$18,389,872.34
(Qtr. 4 April - June)	$322,580,826.63	$322,580,826.62	DY 13	$645,161,653.25
Total	**$791,916,238.80**	**$791,916,238.78**		**$1,583,832,477.58**

In DY13-Q4, PRIME DY 13 semi-annual payments were issued beginning May 11, 2018. Sixteen DPHs and twenty-seven DMPHs received payments. During the quarter, DPHs and DMPHs received **$322,580,826.63** in federal fund payments for PRIME-eligible achievements.

Policy/Administrative Issues and Challenges:

DY13-Q3 started with 54 active PRIME entities; however, TRMC's participation in PRIME was terminated due to the closure of their hospital following serious patient safety concerns and reorganizational needs. TRMC was terminated from PRIME on March 8, 2018 with an effective date of October 29, 2017. As such, TRMC is ineligible to consistently measure and submit DY 13 data reports as part of the 5-year program. In addition, TRMC failed to submit a complete and timely DY 12 Year-End Report, and was therefore ineligible to receive DY 12 Year-End funding.

Additionally, due to the closure of Coalinga Regional Medical Center (CRMC), and the inability to meet PRIME requirements, DHCS terminated CRMC from the PRIME program, effective June 12, 2018.

Any remaining funding due to the above entities will be made available to the remaining DMPHs via the high performance pool.

Progress on the Evaluation and Findings:

PRIME Evaluation Conceptual Framework

UCLA developed a plan to evaluate PRIME's impact across the three domains targeting specific aspects of care delivery. Domain 1 Projects are designed to develop/enhance the infrastructure and change the process of care delivery overall as well as reduce the prevalence of specific chronic conditions. Domain 2 Projects are designed to target specific high-risk or high-cost populations that require changes in care delivery that is focused on their needs. Domain 3 Projects are designed to target inappropriate use of specific services. PRIME Projects generally include objectives that can be classified as process or outcome indicators. Process objectives indicate achievement of changes in processes demonstrating successful implementation of Project objectives. Outcome objectives demonstrate (1) improvements in patient health that have implications for efficiency and cost reduction and (2) improvements in efficiencies and cost reduction directly.

Qualitative and Quantitative Data Collection

The PRIME evaluation will include qualitative and quantitative data. Data sources include DPH and DMPH self-reported data on performance of PRIME-required metrics, challenges faced, and successful strategies employed in achievement of PRIME objectives. These data are supplemented with detailed and structured surveys of DPHs and DMPHs and semi-structured interviews with key PRIME personnel of a representative sample of these hospitals. The structured surveys gather further information on Projects implemented by each hospital, using the Consolidated Framework for Implementation Research (CFIR)[2] domains as appropriate. Qualitative analyses methods will include thematic analyses of challenges and successful approaches to deal with challenges. DPHs and DMPHs have flexibility to choose different approaches to implement each Project leading to difficulty in attributing the outcomes achieved by each hospital to specific types of interventions. As such, this information will be most useful in interpreting the quantitative findings and how they were achieved.

Quantitative data sources include individual level data from confidential discharge data from the California Office of Statewide Health Planning and Development (OSHPD) and Medi-Cal fee-for-service claims and managed care encounter data when available. Medi-Cal data will allow for assessment of the impact of PRIME on Medi-Cal enrollees' inpatient and outpatient service use and expenditures. OSHPD data will allow for assessment of impact of PRIME on all California inpatient discharges.

[2] https://cfirguide.org/

UCLA will use a quasi-experimental pre-post, intervention-comparison group analytic design and difference-in-difference (DD) methodology for analyses of quantitative data, when possible. The selection of comparison hospitals will follow a similar process as that employed in the DSRIP evaluation by UCLA. Comparison hospitals will be identified using hospital and patient characteristics available in OSHPD financial and patient discharge data. The table below shows the current status and next steps for the evaluation.

Status of PRIME Evaluation Data and Analysis

Data Source	Status
Office of Statewide Health Planning and Development (OSHPD)	OSHPD confidential data will allow UCLA to conduct a pre/post and intervention/control assessment of the impact of PRIME on selected metrics such as All-Cause Readmission. UCLA utilized OSHPD public data in a statistical matching program to identify a set of comparison hospitals to the PRIME hospitals (included as attachment). In DY 13, UCLA obtained 2014-2017 OSHPD confidential data and is in the process of conducting analysis for selected metrics. In the next quarter, we anticipate creating the statistical model comparing the match-hospital data to the PRIME hospital data. UCLA's analysis will subset the data by DPH, DMPH, and their respective matched hospitals.
Medi-Cal Claims and Enrollment	Medi-Cal data will allow for assessment of the impact of PRIME on Medi-Cal enrollees' inpatient and outpatient service use and expenditures (in a pre/post and intervention/control analysis, as described above). The evaluation will compare data from PRIME hospitals control (matched) hospitals. UCLA and DHCS implemented an amendment in April 2018 to add a Business Associate Agreement to the contract in order to share data. UCLA obtained preliminary Medi-Cal data from DHCS in April 2018 and has been validating the data and applying code to create the PRIME metrics. In the next quarter, DHCS and UCLA will continue collaborating to ensure UCLA has complete Medi-Cal data for the PRIME and control populations.
Entity Self-Reported Metrics Data	UCLA will utilize the self-reported metrics to assess progress within PRIME entities and comparisons between types of entities (such as DPH, DMPH, and Critical Access). UCLA is evaluating the benchmarks identified by DHCS as well as other applicable benchmarks to compare with self-reported data and the patient-level analysis using OSHPD and Medi-Cal data. National benchmarks are likely to be available for broadly-used metrics, such as those developed by NCQA, AHRQ, and CMS. In the following year, UCLA will finish identifying such benchmarks, assess comparability with PRIME metrics, and compare the PRIME metrics with these benchmarks in the evaluation.

Data Source	Status
Qualitative: Survey, Interviews, Applications, Entity Reports	In DY 13, UCLA implemented a survey and interview to assess the planned and ongoing activities of the PRIME Entities, including the level of effort, challenges, and lessons learned implementing the core components. UCLA pilot-tested it with selected hospitals and made edits incorporating their feedback. The survey and interviews are complete; in the next year, UCLA will continue analysis of the responses. PRIME entities' applications and reports are being used to gain a better understanding of the infrastructure, processes, and characteristics of PRIME participating hospitals at baseline and progress since starting PRIME. UCLA is using qualitative coding of the applications and reports to identify (1) project selection logic, (2) the challenges and progress implementing PRIME, and (3) contextualizing the data reported for PRIME projects. UCLA is categorizing this information into overarching constructs (e.g. workflows, staff training/capacity, patient outreach, etc.). In the next quarter, UCLA will receive additional report data and continue this analysis.

SENIORS AND PERSONS WITH DISABILITIES (SPDs)

The “mandatory SPD population” consists of Medi-Cal only members with certain aid codes who reside in all counties operating under the Two-Plan and Geographic Managed Care (GMC) models of managed care. The “existing SPD population” consists of members with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Duals 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 members 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 members with certain aid codes who reside in all COHS counties that were included in the 2013 rural expansion of managed care. The Rural counties are presented separately due to aid code differences between COHS and non-COHS models.

Total Member Months for Mandatory SPDs by County

County	DY13-Q1 (July – Sept. 2017)	DY13-Q2 (Oct. – Dec. 2017)	DY13-Q3 (Jan. – March 2018)	DY13-Q4 (April – June 2018)	DY 13 Total Member Months
Alameda	88,294	87,453	85,975	85,184	346,906
Contra Costa	52,878	52,758	52,568	52,317	210,521
Fresno	71,846	72,119	71,558	71,353	286,876
Kern	56,645	56,667	56,803	57,316	227,431
Kings	7,877	7,912	7,841	7,846	31,476
Los Angeles	600,056	596,579	590,081	588,291	2,375,007
Madera	7,162	7,249	7,003	6,953	28,367
Riverside	105,012	104,866	105,051	105,519	420,448
San Bernardino	110,064	109,384	108,122	106,835	434,405
San Francisco	115,756	115,613	114,828	114,852	460,779
San Joaquin	122,082	121,893	120,902	121,057	485,934
Santa Clara	45,211	44,652	43,626	43,193	176,682
Stanislaus	50,157	49,850	49,313	49,277	198,597
Tulare	67,582	67,434	66,933	66,793	268,742
Sacramento	36,325	36,205	35,957	35,867	144,354
San Diego	31,934	31,924	31,903	31,858	127,619
Total	**1,568,881**	**1,562,558**	**1,548,464**	**1,544,241**	**6,224,144**

Total Member Months for Existing SPDs by County

County	DY13-Q1 (July – Sept. 2017)	DY13-Q2 (Oct. – Dec. 2017)	DY13-Q3 (Jan. – March 2018)	DY13-Q4 (April – July 2018)	DY 13 Total Member Months
Alameda	60,598	62,603	62,847	63,463	249,511
Contra Costa	27,725	28,734	28,936	30,005	115,400
Fresno	37,557	38,697	38,943	39,652	154,849
Kern	24,869	25,971	26,422	26,996	104,258
Kings	3,879	4,004	4,018	4,069	15,970
Los Angeles	1,147,732	1,160,475	1,027,978	1,031,585	4,367,770
Madera	3,876	3,972	3,975	4,044	15,867
Marin	19,499	19,529	19,549	19,277	77,854
Mendocino	17,463	17,627	17,684	17,670	70,444
Merced	48,240	48,357	48,748	48,489	193,834
Monterey	48,212	48,299	49,182	49,358	195,051
Napa	14,328	14,328	14,598	14,651	57,905
Orange	370,871	372,843	330,885	331,336	1,405,935
Riverside	160,266	161,283	114,294	115,007	550,850
Sacramento	60,762	62,592	62,588	63,317	249,259
San Bernardino	155,976	157,622	111,699	111,659	536,956
San Diego	226,393	228,610	187,453	189,431	831,887
San Francisco	42,096	43,233	41,263	41,965	168,557
San Joaquin	25,849	25,849	26,826	27,222	105,746
San Luis Obispo	24,844	25,125	25,065	25,008	100,042
San Mateo	68,071	66,820	41,379	41,181	217,451
Santa Barbara	46,052	46,456	46,882	46,328	185,718
Santa Clara	151,207	151,799	124,205	123,380	550,591
Santa Cruz	31,612	31,840	31,607	31,602	126,661
Solano	59,356	59,279	59,970	60,123	238,728
Sonoma	53,329	53,218	53,206	52,868	212,621
Stanislaus	14,612	15,593	15,811	16,032	62,048
Tulare	16,810	17,653	18,064	18,411	70,938
Ventura	85,953	86,499	86,752	86,548	345,752
Yolo	26,210	26,151	26,131	25,955	104,447
Total	**3,074,247**	**3,105,061**	**2,746,960**	**2,756,632**	**11,682,900**

Total Member Months for SPDs in Rural Non-COHS Counties

County	DY13-Q1 (July – Sept. 2017)	DY13-Q2 (Oct. – Dec. 2017)	DY13-Q3 (Jan. – March 2018)	DY13-Q4 (April – July 2018)	DY 13 Total Member Months
Alpine	80	79	57	56	272
Amador	1,128	1,114	1,106	1,076	4,424
Butte	19,333	19,369	19,255	19,247	77,204
Calaveras	1,760	1,754	1,695	1,695	6,904
Colusa	824	846	836	857	3,363
El Dorado	5,254	5,253	5,164	5,104	20,775
Glenn	1,671	1,652	1,659	1,629	6,611
Imperial	10,336	10,258	10,478	10,494	41,566
Inyo	517	515	516	511	2,059
Mariposa	689	665	657	651	2,662
Mono	201	208	207	198	814
Nevada	3,297	3,343	3,203	3,161	13,004
Placer	9,384	9,366	9,402	9,607	37,759
Plumas	1,025	1,016	1,047	1,066	4,154
San Benito	279	273	241	259	1,052
Sierra	116	116	115	118	465
Sutter	5,906	5,895	5,896	5,963	23,660
Tehama	5,173	5,170	5,438	5,378	21,159
Tuolumne	2,645	2,654	2,630	2,664	10,593
Yuba	6,589	6,484	6,367	6,385	25,825
Total	**76,207**	**76,030**	**75,969**	**76,119**	**304,325**

Total Member Months for SPDs in Rural COHS Counties

County	DY13-Q1 (July – Sept. 2017)	DY13-Q2 (Oct. – Dec. 2017)	DY13-Q3 (Jan. – March 2018)	DY13-Q4 (April – July 2018)	DY 13 Total Member Months
Del Norte	8,060	8,086	8,050	8,031	32,227
Humboldt	26,810	26,729	26,310	26,360	106,209
Lake	19,198	19,324	19,536	19,494	77,552
Lassen	4,494	4,490	4,436	4,346	17,766
Modoc	1,865	1,888	2,072	2,082	7,907
Shasta	40,777	40,857	40,528	40,527	162,689

County	DY13-Q1 (July – Sept. 2017)	DY13-Q2 (Oct. – Dec. 2017)	DY13-Q3 (Jan. – March 2018)	DY13-Q4 (April – July 2018)	DY 13 Total Member Months
Siskiyou	11,169	11,197	11,179	11,098	44,643
Trinity	2,797	2,818	2,806	2,791	11,212
Total	**115,170**	**115,389**	**114,917**	**114,729**	**460,205**

WHOLE PERSON CARE (WPC)

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

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

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

WPC pilot payments support infrastructure to integrate services among local entities that serve the target population; provide 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 and enrolling WPC members on January 1, 2017. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. DHCS received and approved fifteen WPC pilot applications the second round.

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

The midpoint report, due to CMS in 2019, will include an assessment of population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, though only preliminary outcome data will be available. The final report, due to CMS in 2021, will provide the complete assessment of care and outcome improvements, including an assessment of the impact of the various packages of interventions for specific target populations. The final report will also include assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

Accomplishments:

Date	Pilot Accomplishments
STC 115 WPC Target Populations	
July 2017	Multiple LEs have selected target populations including homeless/at-risk for homelessness, high-utilizers, individuals with mental health and/or substance use disorders, and individuals recently released from institutions.
STC 117 & 130 WPC Payments	
August 25, 2017	The seven new LEs received WPC payments totaling $19,461,301 for the July 1 - September 30, 2017 service period.
November 17, 2017	Eighteen legacy LEs received mid-year payments totaling $126,619,305.36.
May 2018	All twenty-five LEs received WPC payments totaling $233,148,489.56 for the July 1 - December 31, 2017 service period.
STC 118 Housing and Supportive Services	
July 2017	Sixteen LEs are targeting homeless members or members at risk of homelessness with interventions including but not limited to, enhanced care coordination, wrap-around services (recuperative care services, sobering centers, and mobile outreach teams), and a range of housing and tenancy sustaining services and housing transition services. They are also conducting tenant screening, housing assessments and individualized housing support plans, and they work with landlords, identify community resources, and train tenants to maintain housing once it is established.
STC 119 Lead and Participating Entities	
July 2017	LEs consist of one city, one consortium of three counties, and twenty-three separate counties.
	Over 350 participating entities were identified in the twenty-five LE applications.
STC 123 Learning Collaborative	
July 2017-June 2018	The Learning Collaborative (LC) provides information and assists with WPC pilot implementation and closeout, shares best practices and lessons learned across WPC pilots, and provides a forum for the State to provide information, discuss requirements, and report data about the WPC pilots. During DY 13, the LC held four webinars and moved away from a schedule of quarterly webinars to instead begin hosting webinars on an as-needed basis, or at the request of the LEs.
	DHCS and the LC held two in-person convenings for the LEs and their staff.
January 2018	In response to LE needs and suggestions, the WPC LC has evolved and convened an advisory board of eight LEs. The advisory board meets on a monthly basis to discuss LC strategy, provide general feedback, and help develop agendas for WPC in-person meetings. Advisory board members were selected based on past participation in the bi-weekly technical assistance calls and on their willingness to commit to monthly meetings for the 2018 calendar year. Membership reflects rural/urban and small/large pilots, and includes LEs from Alameda, Los Angeles, Napa, Placer, San Bernardino, San Francisco, San Mateo, as well as the Small County Whole Person Care Collaborative (SCWPCC).

Date	Pilot Accomplishments
March 2018	The LC launched five topic-specific affinity groups based on LE feedback and discussions with the LC advisory board. These affinity groups focus on the following areas: data, care coordination, sustainability, housing, and re-entry. Each affinity group is led by LC staff who are responsible for working with their group to understand the challenges LEs are facing in each area, and then helping the LEs share best practices, lessons learned, and work toward finding solutions.
STC 125 Progress Reports	
September 30, 2017	All eighteen legacy LEs submitted first mid-year report for 2017.
April 2, 2018	All twenty-five LEs submitted first annual report for 2017.
STC 126 Universal and Variant Metrics	
September 30, 2017	All eighteen legacy LEs submitted their first mid-year variant and universal metric report.
April 2, 2018	Baseline and the PY 2 annual variant and universal metric reports were postponed until August 2018 due to technical specification revisions needed to allow for metric reporting by new LEs with smaller enrollment due to July 1, 2017 WPC implementation.
April 24, 2018	DHCS held a webinar on Metric Revisions to the Technical Specifications.
STC 127 Mid-Point and Final Evaluations	
October 16, 2017	DHCS executed a contract with the University of California at Los Angeles, effective November 1, 2017, to provide evaluation services for the WPC.
December 8, 2017	DHCS submitted the WPC Final Evaluation Design to CMS in response to CMS' comments and suggestions provided on September 21, 2017, and November 22, 2017.
April 5, 2018	CMS approved the WPC evaluation design, which is available at: http://www.dhcs.ca.gov/provgovpart/Documents/CAWPCFinalEvaluationDesign.pdf

Program Highlights:

After two rounds of applications, the WPC program consists of twenty-five LEs with eighteen legacy LEs that implemented on January 1, 2017 and seven new LEs (counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma, the City of Sacramento, and a consortium of small counties SCWPCC including San Benito, Mariposa, and Plumas) that implemented on July 1, 2017. Eight of the legacy LEs (Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura) continued their original programs and were approved to expand their programs with additional or expanded target populations, services, and administrative/delivery infrastructure to support the expansions in the second round. By June 30, 2018, WPC touched more than 73,000 unique lives with more than 535,000 member months.

During April – June 2018, DHCS held two webinars and two administrative teleconferences with LEs. The administrative teleconferences focused on administrative topics and technical assistance, allowing the LEs to ask questions about DHCS'

guidance and various contract issues such as deliverable reporting, reporting templates, timelines, and expectations.

Qualitative and Quantitative Findings:

DHCS uses the mid-year and annual narrative reports, quarterly enrollment and utilization reports, and invoices to monitor and evaluate the programs and to verify invoices for payment. Several LEs that required more time to enroll beneficiaries and fully develop their programs have met in-person with DHCS' management and developed action plans as needed. Program implementation for several LEs, Solano in particular, was impacted by the devastating effects of multiple fires during the year. DHCS continues to monitor these LEs closely and provide technical assistance.

Enrollment Information

Quarterly enrollment counts are the cumulative number of unique new members enrolled for the reported quarter with year-to-year totals reflected in the table below. The total-to-date column includes data from DY 12 submitted previously. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization Reports. The data reported is point-in-time as of October 3, 2018. Enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY13-Q1 (July - Sept. 2017) Unduplicated	DY13-Q2 (Oct. – Dec. 2017) Unduplicated	DY13-Q3 (Jan. - March 2018) Unduplicated	DY13-Q4 (April - June 2018) Unduplicated	Jan. 2017 – June 2018 Total to Date Unduplicated
Alameda	739	503	798	603	3,273
Contra Costa	7,942	1,338	4,457	3,885	24,943
Kern	32	56	45	60	193
Kings*	2	27	36	52	117
LA	3,256	4,086	3,474	4,301	21,527
Marin*	0	14	41	2	57
Mendocino*	0	21	104	70	195
Monterey	8	4	33	13	90
Napa	79	37	27	83	226
Orange	1,147	940	1,289	1,203	5,645
Placer	57	37	42	28	228
Riverside	0	153	228	318	699
Sacramento*	0	236	130	112	478

Lead Entity	DY13-Q1 (July - Sept. 2017) Unduplicated	DY13-Q2 (Oct. – Dec. 2017) Unduplicated	DY13-Q3 (Jan. - March 2018) Unduplicated	DY13-Q4 (April - June 2018) Unduplicated	Jan. 2017 – June 2018 Total to Date Unduplicated
San Bernardino	107	216	193	21	544
San Diego	0	0	11	81	92
San Francisco	1,509	1,283	184	957	9,352
San Joaquin	39	104	134	39	316
San Mateo	114	97	235	261	2,950
Santa Clara	13	35	81	**	2,846
Santa Cruz*	179	23	64	95	361
SCWPCC*	0	3	21	17	41
Shasta	52	16	39	36	177
Solano	9	39	**	**	79
Sonoma*	0	0	0	4	4
Ventura	132	318	244	129	823
Total	**15,416**	**9,586**	**11,910**	**12,370**	**75,256**

**Indicates one of seven new LEs that implemented on July 1, 2017.*
***Data is not available at this time but will be updated in the next quarterly report.*

The data provided in the table above shows the count of unduplicated members has increased steadily throughout DY 13.

Member Months

Quarterly and cumulative year-to-date member months are reflected in the table below. The cumulative year-to-date column includes data from DY 12 submitted previously. Member months are extracted from the LE's self-reported Quarterly Enrollment and Utilization Reports. The data reported is point-in-time as of October 3, 2018. Member months are updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY13-Q1 (July - Sept. 2017)	DY13-Q2 (Oct. - Dec 2017)	DY13-Q3 (Jan. - March 2018)	DY13-Q4 (April - June 2018)	Jan. 2017 – June 2018 Cumulative Year-to-Date
Alameda	3,206	4,772	6,578	8,263	25,124
Contra Costa	34,012	43,368	45,979	49,351	188,970
Kern	51	214	305	454	1,024

Lead Entity	DY13-Q1 (July - Sept. 2017)	DY13-Q2 (Oct. - Dec 2017)	DY13-Q3 (Jan. - March 2018)	DY13-Q4 (April - June 2018)	Jan. 2017 – June 2018 Cumulative Year-to-Date
Kings*	2	57	127	216	402
LA	17,881	22,133	23,448	27,386	116,974
Marin*	0	20	130	151	301
Mendocino*	0	21	230	519	770
Monterey	112	98	158	199	642
Napa	204	286	310	354	1,154
Orange	5,311	7,090	9,015	10,165	34,513
Placer	281	341	374	395	1,560
Riverside	0	248	295	888	1,431
Sacramento*	0	368	1,011	1,083	2,462
San Bernardino	237	741	1,430	1,529	3,944
San Diego	0	0	15	183	198
San Francisco	17,791	20,655	22,333	21,971	105,207
San Joaquin	79	319	688	730	1,816
San Mateo[3]	6,000	6,000	6,000	6,000	35,948
Santa Clara	7,915	7,546	7,530	**	27,895
Santa Cruz*	535	567	738	890	2,730
SCWPCC*	0	3	46	91	140
Shasta	172	159	162	228	763
Solano	110	202	**	**	387
Sonoma*	0	0	0	5	5
Ventura	194	998	1,768	2,154	5,114
Total	**94,093**	**116,206**	**128,670**	**133,205**	**559,474**

**Indicates one of seven new LEs that implemented on July 1, 2017.*
***Data is not available at this time but will be updated in the next quarterly report.*

The data provided in the table above shows the count of member months has consistently increased throughout DY 13 as the unduplicated members and enrollment increased.

Payments

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 3 (Jan - March)	$216,787,499.88	$216,787,499.88	DY 11 (PY 1)	$433,594,999.75
Qtr. 4 (April - June)	$22,206,521.50	$22,206,521.50	DY 11 (PY 1)	$44,413,043.00

[3] San Mateo has reached and continues to maintain the enrollment target.

DY 13 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 1 (July - Sept)	$9,730,650.50	$9,730,650.50	DY 12 (PY 2)	$19,461,301.00
Qtr. 2 (Oct - Dec)	$63,309,652.68	$63,309,652.68	DY 12 (PY 2)	$126,619,305.36
Qtr. 3 (Jan – March)	$0	$0	DY 12 (PY 2)	$0
Qtr. 4 (April – June)	$116,574,244.78	$116,574,244.78	DY 12 (PY 2)	$233,148,489.56
Total	**$428,608,569.34**	**$428,608,569.34**		**$857,217,138.67**

During the fourth quarter, all 25 LEs received WPC payments totaling $233,148,489.56.

In DY 13, WPC received $189,614,547.96 in federal fund payments (FFP) with a total of $379,229,095.92 in payments to LEs. This results in a total-to-date for the program of $857,217,138.67 in payments to the twenty-five LEs including DY 12 payments of $478,008,042.75.

Policy/Administrative Issues and Challenges:

Due to a combination of factors, such as slow program implementation ramp-up and second round implementation beginning mid-year, some LEs expressed concerns regarding meeting continuous enrollment requirements and metric objectives. To help mitigate these issues and concerns, DHCS revised the WPC Universal and Variant Metrics Technical Specifications to allow for changes to the length of enrollment and enrollment data type for several of the metrics. These changes will facilitate successful LE report outcomes based on actual program experience during PY 2.

During the third and fourth quarters, DHCS completed approval of both the optional Budget Adjustment and Rollover requests from LEs. The Budget Adjustment process allowed adjustments to future PY budgets within each LE budget, while the Rollover process allowed an LE to move budgeted funds from the current year to the next year's budget. The changes were made to assist the LE to overcome identified barriers during ramp-up and early implementation efforts. Furthermore, these processes allow LEs the flexibility to more fully maximize funding integral to the success of the WPC and support the activities aligned with WPC goals and objectives, including the expansion of services and enrollment.

According to narrative reports, LEs have experienced a few common early challenges to implementing WPC, such as:

- Difficulty identifying and enrolling eligible Medi-Cal beneficiaries
- Concerns regarding data-sharing
- Development of inter-organizational collaboration
- Hiring staff

DHCS has held discussions on these challenges during bi-weekly technical assistance calls, encouraged sharing of tools developed by LEs, and worked with the LC to hold webinars on these topics to assist LEs in dealing with these challenges. Additionally, LEs developed their knowledge, collaborated with partners and with all levels of LE leadership, and developed guidelines and processes. Subsequently, LEs have had more success developing:

- Use of shared data to identify target population
- Data sharing agreements and consent forms
- Purchase and development of technology
- Leadership and governance structure

Common successes have included:

- Strengthening of relationships between community partners
- Development of policy, practices, or other infrastructure
- Provision of enrollee services
- Improved outcomes of care

Progress on the Evaluation and Findings:

During DY 13, UCLA:

- Received approval for conducting the evaluation from the UCLA Office of the Human Research Protection Program and the California Health and Human Services Agency (which includes DHCS) Committee for the Protection of Human Subjects;
- Completed qualitative analysis of the WPC applications and narrative sections of mid-year reports;
- Continued to develop preliminary instruments and questionnaires for structured and semi-structured interviews to collect initial qualitative data from WPC LEs; this data will be used to discuss how each LE implemented their program, challenges they encountered, and strategies they used to overcome those challenges; and
- Began development of the control/comparison group selection methodology.

In May 2018, DHCS revised the quarterly enrollment and utilization report template. The updated template tracks beneficiaries disenrolled from WPC due to a successful graduation or having achieved the desired goals of the services. This data highlights the

positive outcomes for a target population because these beneficiaries disenrolled from WPC no longer needed the services due to the enrollee achieving a positive health outcome. On June 28, 2018, UCLA received the first data delivery from DHCS to obtain Medi-Cal data for evaluation purposes.