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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fourteen (07/01/2018 – 06/30/2019)
First Quarter Reporting Period: 07/01/2018 – 9/30/2018

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted a waiver monitoring conference call on July 9, 2018, and August 13, 2018, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration.

The following topics were discussed: CCS Protocols, CMS Substance Use Disorder Demonstration Evaluation Program, GPP Evaluation, Access Assessment, and Financial Reporting Activities.

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

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

On August 30, 2018, the EQRO provided DHCS with a crosswalk of the Access Assessment requirements and the corresponding text in the draft California Access Assessment Design (CA Access Assessment Design) to use as a discussion with CMS.

CMS approved DHCS' CA Access Assessment Design on September 12, 2018, and sent the formal approval letter to DHCS on September 19, 2018. DHCS posted the approval letter on its website at https://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx and updated the Access Assessment Advisory Committee via email.

On September 26, 2018, DHCS and the EQRO began determining dates for a kick-off meeting as well as twice monthly meetings to complete the final access assessment report. DHCS' goal is to submit the report to CMS in July 2019.

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

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

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

In addition to Health Plan San Mateo, DHCS contracted with Rady Children’s Hospital of San Diego (RCHSD), an ACO beginning FY 2018

Enrollment Information:

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

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
18-Feb	1,573	$1,645.68	$2,588,655
18-Mar	1,570	$1,645.68	$2,583,718
18-Apr	1,572	$1,645.68	$2,587,009
18-May	1,548	$1,645.68	$2,547,513
18-Jun[1]	1,537	$1,645.68	$2,529,410
		Total	**$105,117,157**

[1]All CCS Demonstration members in HPSM were transitioned into HPSM's managed care plan effective July 1, 2018.

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

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-Jul	0	$2,733.54	$0.00
18-Aug	45	$2,733.54	$123,009.30
18-Sep	129	$2,733.54	$352,626.66
Total			**$475,635.96**

Member Months:

RCHSD

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	0	45	129	1	174

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

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

November 17, 2017 for the CCS evaluation design.

Health Plan of San Mateo Demonstration Project

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 technical details of the transition.

Contract Amendments

HPMS had no contract amendments updates during DY14-Q1.

HPSM contract amendment A03 is in process. This amendment will extend the contract for to December 31, 2018 as allowed by Request for Proposal #11-88024.
No rates are included. A03 has been approved by DHCS management and was submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

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

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In October 2018, HPSM submitted their "CCS Quarterly Grievance Report" for the reporting period, July-September 2018. During the reporting period, HPMS received and processed 19 member grievances. These grievances sorted by type: Accessibility, Benefits/Coverage, Referral, Quality of Care/Service and Other.

- Accessibility: Two (2) grievance were reported
    - Both grievances were regarding excessive long wait time/appointment schedule time. Both were resolved in the plan's favor.
- Benefits/Coverage: One (1) grievance was reported
    - This grievance was related to a dispute over covered services and was resolved in the plan's favor.

- Quality of Care/Service: Nine (9) grievances were reported
    - All grievances were regarding the plan's denial of treatment. Six were resolved in the member's favor and three were resolved in the plan's favor.
- Other: Seven (7) grievances were reported
    - One (1) was for "access" and was resolved in the member's favor
    - Four (4) were for "customer service" of which one (1) was resolved in the member's favor and three (3) was resolved in the plan's favor
    - Two (2) were for "billing" and both were resolved in the member's favor

In August 2018, members began enrolling in RCHSD. During the reporting period, RCHSD notified DHCS that there were zero member grievances to report for the quarter.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

There is no new activity to report for this quarter.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

CBAS continues as a CMS-approved benefit for the next five years through December 31, 2020, under the Medi-Cal 2020 Demonstration.

Program Requirements:

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

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

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

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both MCP and FFS members per county for DY14-Q1 represents the period of July 2018 to September 2018. CBAS enrollment data is shown in the table, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.* The table, titled "*CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

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

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

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY13-Q2		DY13-Q3		DY13-Q4		DY14-Q1	
	Oct - Dec 2017		Jan -Mar 2018		Apr - Jun 2018		Jul - Sep 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	522	79%	518	78%	510	77%	539	82%
Butte	45	44%	43	42%	34	33%	37	36%
Contra Costa	224	70%	223	69%	232	72%	240	73%
Fresno	632	57%	634	57%	676	61%	602	46%
Humboldt	86	22%	86	22%	100	26%	95	24%
Imperial	318	57%	338	56%	307	51%	308	51%
Kern	76	22%	79	23%	83	25%	72	21%
Los Angeles	21,775	67%	21,381	65%	21,983	67%	21,414	63%
Merced	94	45%	88	42%	94	45%	94	45%
Monterey	107	57%	109	59%	107	57%	106	57%
Orange	2,243	54%	2,268	54%	2,329	53%	2,369	54%
Riverside	488	45%	449	41%	450	42%	470	43%
Sacramento	461	74%	437	70%	440	70%	367	59%
San Bernardino	624	84%	640	86%	650	87%	677	91%
San Diego	2,036	55%	2,068	56%	2,138	57%	2,238	60%
San Francisco	702	45%	693	44%	672	43%	684	44%
San Mateo	57	25%	56	27%	65	28%	65	28%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	590	42%	617	45%	224	16%	611	43%
Santa Cruz	109	72%	103	68%	110	72%	108	71%
Shasta	*	*	*	*	*	*	*	*
Ventura	903	63%	892	62%	905	63%	898	62%
****Yolo**	295	78%	290	76%	282	74%	287	76%
Marin, Napa, Solano	75	15%	80	16%	80	16%	83	17%
Total	**32,471**	**61%**	**32,104**	**62%**	**32,489**	**61%**	**32,364**	**59%**
								FFS and MCP Enrollment Data 09/2018

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

The data provided in the previous table shows that while enrollment has slightly decreased between DY13-Q4 and DY14-Q1, 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.

While the closing of a CBAS Center in a county can contribute to increased utilization of the license capacity in a county, it is important to note the amount of participation can also play a significant role in the overall amount of licensed capacity used throughout the State. In Fresno County, there was a more than 5% increase in licensed capacity utilized compared to their previous quarter. This increase is likely due to an error where data was under-reported during DY13-Q4. No other counties reported increases between the two previous quarters. In Fresno and Sacramento, there was more than a 5% decrease of licensed capacity compared to the previous quarter. The opening of a new CBAS Center in Fresno during the last reporting period may have caused the decrease in licensed capacity utilization. A decrease in utilization of licensed capacity can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

<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 next table, titled *CBAS Assessments Data for MCPs and FFS*, reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the table below 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-Q2 (10/1-12/31/2017)	2,342	2,315 (98.8%)	27 (1.2%)	7	7 (100%)	0 (0%)

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

Requests for CBAS services are collected and assessed by the MCPs and DHCS. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. According to the table, for DY14-Q1, there were (2,369) assessments completed by the MCPs, of which (2,305) were determined to be eligible and (64) were determined to be ineligible. The table identifies that 4 participants were assessed for CBAS benefits under FFS, and all were determined eligible by DHCS.

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

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

The next table, titled *CDA – CBAS Provider Self-Reported Data*, identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY14-Q1. The ADA at the 247 operating CBAS Centers is approximately 22,499 participants, which corresponds to 70% Statewide ADA per center. As the result of a decrease in the total unduplicated participants in DY14-Q1, a drop in ADA was seen compared to the previous quarter. Additionally, three new CBAS Centers in Los Angeles County (one of these was a re-open) and one new CBAS Center in Fresno County opened during DY14-Q1 that resulted in an overall increase in total statewide license capacity at 32,180 compared to the previous quarter.

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	247
Non-Profit Centers	56
For-Profit Centers	191
ADA @ 247 Centers	22,499
Total Licensed Capacity	32,180
Statewide ADA per Center	70%

CDA - MSSR
Data 09/2018

Outreach/Innovative Activities:

Stakeholder Process

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

After reviewing stakeholder input in addition to the milestones identified in the CBAS STC, in the Medi-Cal 2020 Waiver, DHCS and CDA initiated work groups to address concerns identified during the stakeholder meetings. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that convened every other month through June 2016. Implementation of the five-year *CBAS Quality Assurance and Improvement Strategy* began in October 2016. The revised IPC is currently under review and projected to be implemented during the spring of 2019. Updates and progress on stakeholder activities for CBAS can be found at:

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

Operational/Policy Developments/Issues:

DHCS and CDA continue to work with CBAS providers and MCPs to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. Three new CBAS Centers in Los Angeles County (one of which was a re-opening) and

one new CBAS Center in Fresno County opened during DY14-Q1. CDA also has several applications that are currently under review.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY14-Q1. DHCS delayed 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 updates.

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

Consumer Issues:

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

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

Issues that generate CBAS complaints are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in the table, titled *Data on CBAS Complaints*, and the table titled, *Data on CBAS Managed Care Plan Complaints*.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY14-Q1, as illustrated in the table, titled *Data on CBAS Complaints*. The table, titled *Data on CBAS Managed Care Plan Complaints*, shows that MCPs received two beneficiary complaints and eight provider complaints in DY14-Q1. Overall, complaints have increased between the last two quarters, as reported by the managed care plans.

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

CDA Data - Complaints 09/2018

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
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
DY14-Q1 (Jul 1 - Sep 30)	2	8	10

Plan data - Phone Center Complaints 09/2018

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

Grievance and appeals data is provided to DHCS by the MCPs. According to the table, titled *Data on CBAS Managed Care Plan Grievances*, six grievances were filed with the MCPs for DY14-Q1; one grievance was related to “CBAS Providers,” and the remaining five grievances were related to “other CBAS grievances.”

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 - 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
DY14-Q1 (Jul 1 - Sep 30)	1	0	0	5	6

Plan data - Grievances 09/2018

For DY14-Q1, sixteen CBAS appeals were filed with the MCPs. The table, titled *Data on CBAS Managed Care Plan Appeals*, illustrates that thirteen appeals were related to "denial of services or limited services" and the other two were categorized as "other CBAS appeals".

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY13 – 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
DY14 – Q1 (Jul 1 – Sep 30)	13	1	0	2	16

Plan data - Grievances 09/2018

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY14-Q1 (July 2018 to September 2018), there were 4 requests for hearings related to CBAS services filed. Of these, one was granted, one was dismissed, and two are still pending as of this report.

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.

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. The table, titled *CBAS Centers Licensed Capacity,* indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY14-Q1. Quality Assurance/Monitoring Activity reflects data through October 2017 to September 2018.

County	CBAS Centers Licensed Capacity					
	DY13-Q2 Oct-Dec 2017	DY13-Q3 Jan-Mar 2018	DY13-Q4 Apr-Jun 2018	DY14-Q1 Jul-Sep 2018	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	390	0%	82%
Butte	60	60	60	60	0%	36%
Contra Costa	190	190	190	195	3%	73%
Fresno	652	652	652	772	+16%	46%
Humboldt	229	229	229	229	0%	24%
Imperial	330	355	355	355	0%	51%

County	CBAS Centers Licensed Capacity					
	DY13-Q2 Oct-Dec 2017	DY13-Q3 Jan-Mar 2018	DY13-Q4 Apr-Jun 2018	DY14-Q1 Jul-Sep 2018	Percent Change Between Last Two Quarters	Capacity Used
Kern	200	200	200	200	0%	21%
Los Angeles	19,315	19,365	19,380	19,974	+3%	63%
Merced	124	124	124	124	0%	45%
Monterey	110	110	110	110	0%	57%
Orange	2,458	2,458	2,608	2608	0%	54%
Riverside	640	640	640	640	0%	43%
Sacramento	369	369	369	369	0%	59%
San Bernardino	440	440	440	440	0%	91%
San Diego	2,198	2,198	2,198	2198	0%	60%
San Francisco	926	926	926	926	0%	44%
San Mateo	135	135	135	135	0%	28%
Santa Barbara	60	60	60	60	0%	*
Santa Clara	830	830	830	830	0%	43%
Santa Cruz	90	90	90	90	0%	71%
Shasta	85	85	85	85	0%	*
Ventura	851	851	851	851	0%	62%
Yolo	224	224	224	224	0%	76%
Marin, Napa, Solano	295	295	295	295	0%	17%
SUM	31,201	31,276	31,441	32,160	+2%	59%

CDA Licensed Capacity as of 09/2018

**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 the average licensed capacity used by CBAS participants at 59% statewide as of September 30, 2018. Overall, most of the CBAS Centers have not operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STC 52(e) (v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was no decrease in provider capacity of five percent or more throughout the participating counties in DY14-Q1 compared to the prior quarter, therefor no analysis is needed to addresses such variances. In the table, titled

CBAS Centers Licensed Capacity, Fresno County saw an increase of sixteen percent in their license capacity in DY14-Q1 compared to DY13-Q4, and resulted in an overall increase of in the total licensed capacity statewide.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS* and *CBAS Centers Licensed Capacity*, CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to beneficiaries. There are other centers in nearby counties that can assist should the need arise for ongoing care of CBAS participants.

Unbundled Services (STC 48.b.iii.)

CDA certifies and provides oversight of CBAS Centers. CDA and DHCS continue to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participant's if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for each of the CBAS participants they provide services for CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. The table, titled *CBAS Center History*, illustrates the history of openings and closings of the centers. According to the table below for DY14-Q1 (July 2018 to September 2018), CDA currently has 247 CBAS Center providers operating in California. In DY14-Q1, no centers closed, and as previously mentioned above, three centers opened in Los Angeles County while one center opened in Fresno County. The table below shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

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

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

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

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

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

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

Domain 3 – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between a beneficiary and

dental provider in seventeen (17) select pilot counties. Incentive payments will be made to dental service office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods. If the pilots are successful, this domain may be expanded to other counties, contingent on available DTI funding.

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

Domain 4 – Local Dental Pilot Projects (LDPPs)

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

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

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

Enrollment Information:

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

	July 2018	August 2018	September 2018
Measure Period	08/2017-07/2018	09/2017-08/2018	10/2017-09/2018
Denominator[2]	5,591,279	5,575,959	5,558,844
Numerator[3]	2,529,352	2,520,026[4]	N/A[5]
Preventive Dental Service Utilization	45.24%	45.19%[4]	N/A[5]

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

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

Delivery System	Provider Type	Quarter 1		
		July 2018	August 2018	September 2018
FFS	**Service Offices**	5,780	5,781	5,800
	Rendering	10,270	10,347	10,439
GMC[2]	**Service Offices**	118	113	118
	Rendering	268	376	394
PHP[2]	**Service Offices**	874	933	885
	Rendering	1,930	1,955	1,997
Safety Net Clinics		565	564	N/A[3]

[1] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008A, PS-

O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of Safety Net Clinics is based on encounter data from the DHCS data warehouse as of October 2018. Only Safety Net Clinics who submitted at least one dental encounter within a year were included.
[2] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty. DHCS updated the address deduplication methodology, therefore, numbers of GMC and PHP service offices are lower than previous reports.
[3] Count of SNCs for the third month of each quarter is not available due to claim submission time lag.

Outreach/Innovative Activities:

DTI Small Workgroup

This workgroup now meets on a bi-monthly basis, the third Wednesday of the month. This workgroup did not convene during this quarter, and in lieu of meeting, DHCS sent updates via email. The objective of these meetings is to review monthly updates regarding all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. In addition to the DTI small stakeholder workgroup, DHCS has continued its efforts to target specific groups with the assistance of stakeholders.

Domain 2 Caries Risk Assessment Workgroup

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

Domain 2 Subgroup

This subgroup did not convene this reporting period; however, it is scheduled to convene in October. 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 in the next quarter to discuss continued outreach efforts.

DTI Clinic Workgroup

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

Domain 3 Subgroup

This subgroup did not convene this quarter. 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.

DTI Data Subgroup

DHCS established a new DTI data subgroup to garner stakeholder feedback on the usefulness of data reported in the DTI PY 1 Annual Report. The subgroup met in the

previous quarter and on September 2018. This subgroup will convene as needed for discussion of data reported in future DTI reports.

Domain 4 Subgroup

This subgroup is still active. DHCS holds bi-monthly calls with the LDPPs to address any outstanding questions. During this reporting period, a LDPP conference call was held on August 22, 2018.

DTI Webpage

The DTI webpage was updated as information became available during DY14-Q1 and will continue to be updated regularly. This quarter's updates included claims submission deadlines for Domains 1 and 3, Domain 4 updates to reflect the reduced number of active LDPPs, and LDPP state contacts.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY14-Q1. The inbox is useful for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations, to direct comments, questions, or suggestions about the DTI to DHCS directly. The listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

In this quarter, there were a total of 185 inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to the following categories: encounter data submission, payment status and calculations, resource documents, dispute inquiries for Domain 1 PY 1 and 2, Domain 2 billing and opt-in questions, and Domain 4 budget changes and reimbursement inquiries. All requests were researched and responded to within seven business days.

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

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

Outreach Plans

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

- August 2, 2018: Medi-Cal Dental Advisory Committee (agenda)
- August 16, 2018: LA Stakeholder Meeting (agenda)
- August 17, 2018: National Academy for State Health Policy – Jacksonville, FL (agenda)

- September 5, 2018: CDA Presents-San Francisco (agenda)

Operational/Policy Developments/Issues:

Domain 1

During DY14-Q1, DHCS issued its second PY 2 incentive payment. A breakdown of this payment is included below.

Second PY 2 Payment:
FFS - $3,637,027.50
DMC - $812,285.25
SNC - $1,351,821.00
Total - $5,801,133.75

In total, DHCS has made over $98.9 million in Domain 1 incentive payments.

DHCS mailed letters to providers in September to inform them of new rebaseline and benchmark goals effective for PY 3.

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 DY14-Q1 reporting period. During this time, the total incentive claims paid equaled $1,265,392.49, and 14 providers opted into the domain.

	FFS	DMC	SNC
Sacramento	$149,798.50	$396,713	-
Tulare	$489,018.99	-	-
Kings	$2,394	-	-
Glenn	$756	-	-
Mendocino	-	-	$226,712
Total Incentive Claims Paid - $1,265,392.49			

The second table represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program (February 2017) until the end of DY14-Q1. The total incentive claims paid for this period equals $4,653,598.84, and 187 providers have opted into the domain.

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

Domain 2 Outreach Efforts

DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation which includes follow-up with recently visited providers. DHCS intends to gather feedback from providers who are not interested in enrolling as a Medi-Cal dental provider and their reasons why. DHCS has also continued to work closely with its Dental Administrative Services Organization (ASO) to target and focus Domain 2 outreach efforts. The ASO has emphasized outreach in underutilized counties, based on the ratio of beneficiaries to providers. Specifically, the ASO has begun researching providers in all eleven counties that have opted in but are not billing for CRA procedures. Based on preliminary reports, the ASO determined that approximately 50 providers that are opted-in have not billed for Domain 2. The ASO has been meeting with the identified providers on an individual basis to determine the root cause. In some cases, the ASO found that services have been provided but no claims have been submitted.

Domain 3

Domain 3 Outreach Efforts

The ASO shares Domain 3 information with providers during outreach events that may occur in Domain 3 counties. In this quarter, the ASO visited nine of the 17 counties (Alameda, Fresno, Kern, Marin, Riverside, San Luis Obispo, Shasta, Stanislaus, and Yolo). Upon review of the June and July 2018 payment data, DHCS identified 15 SNCs enrolled in Domain 1 that are also eligible for Domain 3. DHCS emailed an outreach letter and the Domain 3 opt-in form to the eligible SNCs on August 28, 2018, to encourage them to participate in PY3. Results from this effort will be determined following the PY3 opt-in deadline on October 31, 2018.

Domain 4

The LDPPs have utilized the email inbox, LDPPinvoices@dhcs.ca.gov, to submit invoices electronically. The majority of invoices have been submitted via the inbox.

Invoices are still submitted on a quarterly basis. DHCS has received 16 invoices from the LDPPs in this quarter. Nine invoices have been paid during DY14-Q1 for a total of $3,384,939.38, inclusive of invoices submitted during the previous quarter. Four invoices are awaiting payment totaling $1,654,362.57, and five invoices are under review with DHCS. Some invoices may require additional follow up regarding backup documentation from the LDPP. Once approved by DHCS, invoices are paid within a 3-4 week period. DHCS is expecting additional invoices from the LDPPs that currently have executed agreements.

At the end of DY14-Q1, the final pending LDPP agreement for First 5 Kern was withdrawn as shown in the table below. On July 20, 2018, after multiple extensions to submit a complete application that corrected the issues previously identified and demonstrated an ability to operationalize, DHCS decided not to move forward with First 5 Kern's LDPP proposal.

The LDPPs continued to submit budget revisions to roll over unused funds from PY 2017 to PY 2018, which are being reviewed and approved on a flow basis. Additionally, DHCS allowed requests for additional funding for dollars that were originally allocated to the two LDPPs that are no longer participating in Domain 4. DHCS received nine requests for additional funds, and are currently under review.

DHCS continues to schedule bi-monthly calls with the LDPPs to address any outstanding concerns. During this reporting period, one LDPP conference call was held on August 22, 2018.

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

Lead Entity	Status
Alameda County	Executed April 15, 2017
California Rural Indian Health Board, Inc.	Executed June 21, 2017
California State University, Los Angeles	Executed April 15, 2017
First 5 Kern	Application Withdrawn
First 5 San Joaquin	Executed May 31, 2017
First 5 Riverside	Executed November 28, 2017
Fresno County	Executed June 27, 2017
Humboldt County	Executed June 21, 2017
Northern Valley Sierra Consortium	Application Withdrawn
Orange County	Executed June 30, 2017
Sacramento County	Executed June 28, 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

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

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

Quality Assurance/Monitoring Activities:

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

Evaluation:

DHCS received CMS approval of the DTI Evaluation Design on September 12, 2017. The final DTI Evaluation Design and the CMS Approval Letter have been posted on the DTI webpage. DHCS executed the contract with its DTI Evaluator, Mathematica Policy Research, Inc. on August 23, 2018. DHCS anticipates the contractor to begin evaluation work in November 2018.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of 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.

Enrollment Information:

Prior quarters have been updated based on new claims data. For DY13-Q4 and DY14-Q1, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY13-Q2	14,639	8,617	22,950
DY13-Q3	15,439	8,312	23,474
DY13-Q4	14,600	8,043	22,388
DY14-Q1	7,153	4,159	11,245

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	11,270	11,178	10,571	DY13-Q2	14,639
	11,551	11,170	11,531	DY13-Q3	15,439
	10,946	10,701	10,439	DY13-Q4	14,600
	6,245	3,202	1,479	DY14-Q1	7,153
Non-ACA	7,326	7,311	6,892	DY13-Q2	8,617
	6,944	6,824	6,852	DY13-Q3	8,312
	6,691	6,508	6,317	DY13-Q4	8,043
	3,873	2,347	641	DY14-Q1	4,159

Outreach/Innovative Activities:

- Monthly Technical Assistance (TA) Calls with Counties’ Leads
- Monthly Harbage Consulting Meetings regarding DMC-ODS Waiver
- July 3, 2018: Conference Call with California Department of Public Health (CDPH) to discuss expanding MAT
- July 18, 2018: Stakeholder Advisory Committee (SAC) Meeting
- July 20, 2018: Indian Health Program Organized Delivery System (IHP-ODS) Conference Call
- July 26, 2018: CMS Innovative Accelerator Program (IAP) Opioid Data Analytics Cohort MAT Closeout Webinar
- July 30, 2018: Maternal/Neonatal Task Force Meeting
- August 6, 2018: California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) Bi-Monthly Call
- August 9, 2018: IAP SUD – Opioid Data Analytics Cohort – Neonatal Abstinence Syndrome (NAS) Overview Webinar
- August 13, 2018: Bi-Monthly SUD Waiver States Conference Call Meeting
- August 15, 2018: DMC-ODS Evaluation 2017-2018 report
- August 21-23, 2018: SUD Statewide Annual Conference
- August 24, 2018: California Department of Corrections and Rehabilitation (CDCR) Substance Use Disorder Treatment Meeting
- August 27, 2018: Institutions for Mental Diseases (IMDs) Project Conference Call with Technical Assistance Collaborative Inc. (TAC)
- August 29, 2018: Conference Call with California Health Care Foundation (CHCF)

- August 30, 2018: CHCF Meeting for Opioid Measures Discussion
- September 5, 2018: Speak at the State Capitol for “Recovery Happens”
- September 6, 2018: DHCS and CHCF Conference Call
- September 10, 2018: IHP-ODS Conference Call
- September 28, 2018: Coalition of Alcohol & Drug Associations (CADA) and DHCS SUD Workgroup

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

County	County/Provider Staff Training Dates	County/Provider Staff Training Attendees
San Francisco	July 11-12, 2018	22
San Mateo	September 10-11, 2018	10

Additional technical assistance meetings and trainings for DMC-ODS Waiver services include:

- Technical assistance to 24 quality assurance and compliance staff from southern California counties;
- A DMC-ODS Waiver overview and status update at the California Quality Improvement Coordinators Annual Conference with approximately 300 in attendance;
- Technical assistance to 15 quality assurance and compliance staff from central California counties; and
- Network Adequacy Webinar to county substance use disorder and mental health staff on March 5, 2018.

Operational/Policy Developments/Issues:

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

Consumer Issues:

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.

Grievance	Access to Care	Quality of Care	Program Requirements	Service Denials	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Total
Alameda		3						**3**
Contra Costa		1	1					**2**
Imperial	1				1			**2**
Los Angeles	2	2	3		1		2	**10**
Marin		2				1		**3**
Monterey								**0**
Napa								**0**
Nevada		1						**1**
Orange		3						**3**
Riverside	3							**3**
San Bernardino	3		1		1			**5**
San Diego		34			1		1	**36**
San Francisco			1			1	1	**3**
San Joaquin		1						**1**
San Luis Obispo	1	3				2	6	**12**
San Mateo		2			2			**4**
Santa Clara			1		1			**2**
Santa Cruz								**0**
Yolo		1						**1**

Resolution	Grievances	Appeal
Alameda	3	1
Contra Costa	0	0
Imperial	2	0
Los Angeles	8	0
Marin	1	0
Monterey	0	0
Napa	0	0
Nevada	0	0
Orange	3	2
Riverside	1	0
San Bernardino	4	0
San Diego	1	0
San Francisco	4	0
San Joaquin	0	0
San Luis Obispo	6	4
San Mateo	4	0
Santa Clara	2	0
Santa Cruz	0	7
Yolo	0	0

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.

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY13-Q2					
ACA	1,312,639	$31,742,618.20	$28,216,497.24	$2,403,698.20	$1,122,422.76
Non-ACA	858,596	$15,263,635.86	$7,694,385.51	$2,346,808.24	$5,222,442.11
DY13-Q3					
ACA	1,048,428	$28,778,375.25	$25,246,965.68	$2,388,868.75	$1,142,540.82
Non-ACA	617,051	$12,149,103.00	$6,100,446.41	$2,013,562.05	$4,035,094.54

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY13-Q4					
ACA	696,324	$23,182,462.62	$20,177,319.64	$1,951,333.87	$1,053,809.11
Non-ACA	454,488	$10,126,802.79	$5,131,205.74	$1,225,211.32	$3,770,385.73
DY14-Q1					
ACA	280,596	$7,475,952.13	$6,486,460.88	$593,921.22	$395,570.03
Non-ACA	212,949	$3,822,925.56	$1,949,471.28	$280,425.41	$1,593,028.87

ACA and Non-ACA Expenditures by Level of Care

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

While there are now twenty counties participating in the DMC-ODS waiver as of July 1, 2018, an increase in expenses is anticipated in DY14-Q3 due the lag in claim submission.

Quality Assurance/Monitoring Activities:

On-site Readiness Reviews are conducted to ensure counties are prepared to go live with 1115 Waiver services and provide technical assistance with policy development. On-site Readiness Reviews were conducted in Ventura County on October 7, 2018.

Evaluation:

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

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

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

UCLA continues to hold monthly conference calls with updates, activities, and

meetings. The evaluation design and surveys are posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/ca-policy/html/evaluation.html

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July - Sept)	$18,718,589	$37,437,178	DY 13	$18,718,589
Total	**$18,718,589**	**$37,437,178**		**$18,718,589**

This quarter, the Department claimed $18,718,589 in federal fund payments for DSHP eligible services.

Low Income Health Program (LIHP)

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

This quarter, LIHP received $0 in federal fund payments. DHCS is still collaborating with the LIHP counties to complete final reconciliation for DY 3 through DY 9.

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 2 Final Rec. (July – June)	$25,178,285.00	$25,178,285.00	DY 12	$50,356,570.00

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 2 (July – June) Overpayment collection	*($7,816,852.50)*	*($7,816,852.50)*	DY 12	*($15,633,705.00)*
Total	**$17,361,432.50**	**$17,361,432.50**		**$ 34,722,865.00**

DY14-Q1 reporting includes a GPP for payment made on August 13, 2018. The payment made during this time period was for PY 2, Final Reconciliation (July 1, 2016 - June 30, 2017).

In PY 2 Final Reconciliation, the PHCS received $25,178,285.00 in federal fund payments and $25,178,285.00 in IGT for GPP.

DHCS recouped $15,633,705.00 in total funds. The recoupment process is a result of four PHCS that submitted final year-end reports with revisions to the interim report. The percent of GPP threshold met table below shows the PHCS PY 2 Interim and Final reporting differences.

Public Health Care System	Interim Report % of threshold met	Final Report % of threshold met
Los Angeles County Health System	104%	99%
Natividad Medical Center	101%	96%
San Mateo Medical Center	100%	98%
Ventura County Medical Center	71%	65%

The four PHCS received interim quarterly GPP payments based on their percent of threshold met as reported in the interim report. Their final report indicates a decrease in percent of threshold met. The payments previously received by the PHCS exceeded the amounts earned as reported in the final report. DHCS adjusted the payments previously made to the PHCS for GPP PY 2 and recouped the difference in the amount of $15,633,705.00. The final year-end report served as the basis for the final reconciliation of GPP payments and recoupments for GPP PY 2.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

The STCs require the State to conduct two evaluations of provider expenditures and activities under the global payment methodology. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of GPP PY 4. The two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstration.

Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by PHCS and patients' experience, with a focus on understanding the benefits and challenges of the program.

The PHCS must submit two PY 3 Final Reports: (1) aggregate Report and (2) encounter data. In order to meet the GPP Final Evaluation report deadline due to CMS, the PY 3 final reporting due dates have been moved two months earlier to January 30, 2019 from March 31, 2019. The additional time will allow the RAND Corporation (RAND) to incorporate PY 3 encounter data and assess changes over time to show a more complete picture of the success of the GPP.

The GPP Midpoint Evaluation Report was submitted to CMS on June 30, 2018. This report is the first of the two evaluations required for GPP and is also available on the DHCS GPP webpage. The midpoint report uses utilization data from program years one and two and is designed to assess early trends and describe the infrastructure investments California's public health care systems have made.

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

1. Was the GPP successful in driving a shift in provision of services from inpatient to outpatient settings (including non-traditional services) over the course of the GPP?

2. Did GPP allow PHCS to leverage investments in primary care, behavioral health, data collection and integration, and care coordination to deliver care to the remaining uninsured?

3. Did the percentage of dollars earned based on non-inpatient, non-emergency services increase across PHCS?

The GPP Final Evaluation Report is being prepared and will consist of a survey and an interview. During DY14-Q1, RAND analyzed the PHCS interviews that took place throughout June 2018. The interview analysis and RAND's findings will be incorporated into the final report.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

In DY14-Q1, DHCS continued its 2018 PRIME Learning Collaborative activities with 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 supported PRIME entities in their efforts to begin or continue a Quality Improvement (QI) project.

Additionally, DHCS coordinated and led Topic-Specific Learning Collaboratives (TLCs), a variety of workgroups offered to help PRIME entities meet their project goals and improve care delivery through peer-to-peer learning, hearing from national and statewide subject matter experts, an exchange of ideas, and the dissemination of best practices on common topics. TLC workgroups are currently underway in the areas of Health Homes for Foster Children, Mental Health, Non-opioid Management of Chronic Pain, Obesity Prevention, Maternal Health, Tobacco Cessation, Care Transitions, and Disparities Reduction.

DHCS also began to plan for the annual PRIME Learning Collaborative in-person conference that was held in Sacramento on October 29-30, 2018. Participating PRIME entities convened to hear from quality improvement experts, collaborate on shared improvement projects, and chart collective progress on PRIME implementation. This year's conference featured nationally recognized speakers that reflect the PRIME program mission of healthcare delivery system transformation and clinical quality improvement. The official conference took place on Tuesday, October 30, with optional topic and hospital specific activities taking place Monday, October 29, including "Office hours" with Jane Taylor of the Fundamentals of Quality Improvement webinar series. A limited number of entities were able to sign-up for one-on-one meetings with Dr. Taylor to discuss issues related to their individual QI projects and TLC workgroups had the opportunity to convene face-to-face.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$9,471,663.13	$9,471,663.13	DY 13	$18,943,326.26
Total	**$9,471,663.13**	**$9,471,663.13**		**$18,943,326.26**

In DY14 Q1, one DPH and four DMPHs received payments.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received $9,471,663.13 in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

Coalinga Regional Medical Center (CRMC) closed effective June 12, 2018, and was therefore unable to meet the participation requirements of the PRIME program. Due to this closure, it was precluded from submitting a complete DY 12 Year-End report. Furthermore, CRMC did not make the intergovernmental transfer of funds to DHCS for DY 13 mid-year as required by the STCs, and was therefore ineligible for DY 13 mid-year PRIME incentive payments and was terminated from the PRIME program.

Of the remaining 52 PRIME entities, 46 submitted their DY 13 Year-End reports to DHCS on or before September 30, 2018. There were 8 PRIME entities which requested a reporting due date extension into DY14-Q2, and as of November 15, 2018, 7 entities have submitted their report.

Evaluation:

The UCLA Center for Health Policy Research (UCLA CHPR) is the PRIME external evaluator. UCLA CHPR received inpatient discharge data from the Office of Statewide Health Planning and Development in early 2018 and is currently conducting data analysis for applicable PRIME measures. UCLA CHPR also piloted a comprehensive survey regarding the planned and ongoing activities of PRIME entities among select PRIME entities and made revisions to the final survey based on their feedback.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

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

Total Member Months for Mandatory SPDs by County

County	Total Member Months
Alameda	84,885
Contra Costa	52,032
Fresno	71,324
Kern	57,383
Kings	7,858
Los Angeles	585,577
Madera	7,000
Riverside	106,020
San Bernardino	107,724
San Francisco	114,648
San Joaquin	120,181
Santa Clara	42,526
Stanislaus	49,142
Tulare	66,496
Sacramento	35,667
San Diego	31,621
Total	**1,540,084**

Total Member Months for Existing SPDs by County

County	Total Member Months
Alameda	64,723
Contra Costa	30,459
Fresno	40,578
Kern	27,732
Kings	4,152
Los Angeles	1,037,392
Madera	4,152
Marin	19,357
Mendocino	17,760
Merced	48,741
Monterey	49,602
Napa	14,703
Orange	332,511
Riverside	115,944
Sacramento	64,656
San Bernardino	112,361
San Diego	191,428
San Francisco	43,062
San Joaquin	27,956
San Luis Obispo	25,119
San Mateo	41,406
Santa Barbara	46,612
Santa Clara	123,313
Santa Cruz	31,726
Solano	60,387
Sonoma	53,116
Stanislaus	16,401
Tulare	18,725
Ventura	86,913
Yolo	26,085
Total	**2,777,072**

Total Member Months for SPDs in Rural Non-COHS Counties

County	Total Member Months
Alpine	57
Amador	1,079
Butte	18,871
Calaveras	1,705
Colusa	847
El Dorado	5,119
Glenn	1,640
Imperial	10,539
Inyo	515
Mariposa	654
Mono	191
Nevada	3,124
Placer	9,719
Plumas	1,065
San Benito	274
Sierra	109
Sutter	5,943
Tehama	5,276
Tuolumne	2,613
Yuba	6,329
Total	**75,669**

Total Member Months for SPDs in Rural COHS Counties

County	Total Member Months
Del Norte	8,138
Humboldt	26,269
Lake	19,643
Lassen	4,325
Modoc	2,110
Shasta	40,373
Siskiyou	11,085
Trinity	2,775
Total	**114,718**

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WHOLE PERSON CARE PILOT

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

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

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

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

- Eight existing LEs were approved to expand their WPC pilots, including Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura counties.
- Seven new entities were approved to implement WPC pilots, including the counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma; the City of Sacramento; and the Small County Whole Person Care Collaborative (SCWPCC), which is a consortium of San Benito, Mariposa, and Plumas Counties.

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

Enrollment Information:

Quarterly enrollment counts are the cumulative number of unique new members enrolled for the reported quarter with year-to-year totals reflected in the table below. The total-to-date column includes 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 26, 2018. Since enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status, it 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-Q1 (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
San Bernardino	107	216	193	21	544
San Diego	0	0	11	82	93
San Francisco	1,509	1,283	184	957	9,352
San Joaquin	39	104	135	39	317
San Mateo	114	97	235	261	2,950
Santa Clara	13	35	81	140	2,986
Santa Cruz*	179	23	64	95	361
SCWPCC*	0	3	21	17	41

Lead Entity	DY13-Q1 (July-Sept 2017) Unduplicated	DY13-Q1 (Oct-Dec 2017) Unduplicated	DY13-Q3 (Jan-March 2018) Unduplicated	DY13-Q4 (April-June 2018) Unduplicated	Jan 2017 – June 2018 Total to Date Unduplicated
Shasta	52	16	39	36	177
Solano	9	39	30	18	127
Sonoma*	0	0	0	4	4
Ventura	132	318	244	135	829
Total	**15,416**	**9,586**	**11,941**	**12,535**	**75,452**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in availability of data, DY14-Q1 data will be reported in the next quarterly report.*

Member Months:

Quarterly and cumulative year-to-date member months are reflected in the table below. The cumulative year-to-date column includes 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 26, 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-Q1 (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
Kings*	2	57	133	216	408
LA	17,881	22,133	23,448	27,386	116,974
Marin*	0	20	131	151	302
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	184	199
San	17,791	20,655	22,333	21,971	105,207

Lead Entity	DY13-Q1 (July-Sept 2017)	DY13-Q1 (Oct-Dec 2017)	DY13-Q3 (Jan-March 2018)	DY13-Q4 (April-June 2018)	Jan 2017 – June 2018 Cumulative Year-to-Date
Francisco					
San Joaquin	79	319	690	734	1,822
San Mateo	6,000	6,000	6,000	6,000	35,948
Santa Clara	7,915	7,546	7,530	7666	35,561
Santa Cruz*	535	567	738	890	2,730
SCWPCC*	0	3	46	91	140
Shasta	172	159	162	228	763
Solano	110	202	290	343	1,020
Sonoma*	0	0	0	5	5
Ventura	194	998	1,768	2,149	5,109
Total	**94,093**	**116,206**	**128,969**	**144,214**	**567,782**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in availability of data, DY14-Q1 data will be reported in the next quarterly report.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

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

Beginning in 2018, the LC launched five topic-specific affinity groups focused on the following areas: data, care coordination, sustainability, housing, and reentry. Each affinity group is led by a LC staff member who is responsible for working with the group to understand the challenges pilots are facing in each area, helping the pilots to share best practices, and working towards finding solutions. Pilots were encouraged to have frontline staff and pilot partners participate in groups relevant to their role in WPC. Below is a schedule of the affinity group meetings and topics for this quarter.

Combined Data and Care Coordination meeting	8/7/18	Shared Care Planning
Housing	7/17/18	Getting WPC Members into Housing: Sharing Processes and Policies
	8/30/18	Working with Housing Partners, Part I

Reentry	7/12/18	University of California, San Francisco Transitions Clinic
	8/9/18	Reentry Workflows, Case Management, & Medication Management
Sustainability	8/17/18	Sustainability Guide Discussion

This quarter, the LC advisory board met on July 19 and August 16, 2018. The meetings focused on finalizing the agenda for the October 1, 2018, WPC LC convening and on soliciting feedback regarding the effectiveness of topic-specific affinity groups.

DHCS held monthly administrative teleconferences with LEs on July 3, August 1, and September 5, 2018. These teleconferences focused on administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various contract issues such as reporting, reporting templates, timeliness, and expectations. The calls during this quarter included the following topics: Health Homes Program & WPC interaction guidance, PY 3 mid-year reports, invoices, baseline data, and program spotlights on San Bernardino and Sacramento.

On July 3, 2018, DHCS submitted to CMS a series of documents which CMS subsequently approved on July 31, 2018:

- *Metric adjustments by LE.* Due to a combination of factors such as slow program implementation and second round implementation beginning mid-year, some LEs expressed concerns on whether they would be able to meet continuous enrollment requirements and metric objectives. To help mitigate these issues, LEs were allowed to adjust their selected metrics.
- *Plumas county withdrawal documents.* Plumas withdrew from the SCWPCC due to a number of challenges since implementing WPC, including significant staffing issues as well as a loss of key leadership. DHCS continues to provide TA to the remaining members of this collaborative (San Benito and Mariposa), to provide support needed for the remaining years of the pilot.
- *Budget adjustment and rollover changes for CMS approval*. 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.

On July 20 and 27, 2018, DHCS held teleconferences on the revised WPC Universal and Variant Metrics Technical Specification to respond to LE questions and provide guidance on the revisions being made in response to LE concerns meeting continuous enrollment requirements and metric objectives.

On August 7, 2018, DHCS released the revised WPC Universal and Variant Metrics Technical Specifications, which allow for changes to the length of enrollment and enrollment data type for several of the metrics. It is anticipated that these changes will facilitate successful LE report outcomes based on actual program experience.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

On August 31, 2018, LEs submitted their PY 3 mid-year invoices. DHCS anticipates approval of mid-year invoices and payment in the next quarter.

During this quarter, no WPC payments were made. This is in accordance with the WPC payment schedule. PY 3 mid-year payments are scheduled for October 2018.

Quality Assurance/Monitoring Activities:

During the first quarter, all twenty-five LEs submitted the reports listed below:

- Second quarter PY 3 Quarterly Enrollment and Utilization,
- PY 3 Mid-year Narrative and Plan Do Study Act,
- Baseline Variant and Universal Metric,
- PY 2 Annual Variant and Universal Metric, and
- PY 3 Mid-year Variant and Universal Metric.

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

Several LEs that required more time to enroll beneficiaries and fully develop their programs have met in-person with DHCS management to develop improvement plans. DHCS continues to monitor these LEs closely and provide TA. Follow-up teleconferences were held during the quarter, and several LEs have completed their improvement plans. Additional in-person meetings are planned for the next quarter.

Evaluation:

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

costs through reductions in avoidable utilization.

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

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

- Developed a preliminary algorithm to identify the appropriate control group from Medi-Cal data, which included creating and verifying variables that will be included in the propensity score model and beginning the process of determining the proper model specifications.
- Analyzed 2017 enrollment and utilization report data. This work included data cleaning, identifying and developing strategies to address data quality concerns, and developing measures to understand program enrollment, enrollment patterns, target populations, and utilization.
- Began work on developing a shadow pricing strategy. This included assessing the feasibility of using the Medi-Cal fee schedule to assign a price to each Current Procedural Terminology code.
- Finalized and fielded a questionnaire to collect systematic data from WPC lead entities and partner organizations around the following key domains: motivation for participation in WPC, communication and decision-making processes, performance monitoring, and inter-agency collaboration with partner organizations. Initial analysis of the LE questionnaire is underway.
- Conducted a local, three-day site visit with the Los Angeles LE, which helped to fine-tune site visit protocols and procedures for the UCLA evaluation team.

On September 11, 2018, DHCS requested that the WPC evaluation report date be changed from June 30, 2021, to align with the December 31, 2021, final evaluation of the Demonstration due date. The WPC STC 127 and Attachment GG state "The final WPC evaluation will be completed no later than six months following the expiration of the demonstration" while STC 216 requires DHCS to submit the final evaluation report of the Demonstration by December 31, 2021.

On September 12, 2018, CMS approved the date change to December 31, 2021, for the WPC evaluation report to support a more mature and robust evaluation report.