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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Eleven (01/01/2016-06/30/2016)
First Quarter Reporting Period: 01/01/2016-03/31/2016
Waiver Extension Period: 11/01/2015-12/31/2015

Table of Contents

Introduction 3
Waiver Deliverables 5
STCs Item 17: Post Award Forum 5
STCs Items 65-69: Access Assessment Document 5
STCs Items 178-180: Uncompensated Care Reporting 6
STCs Item 201: Budget Neutrality Monitoring Tool 6
California Children Services (CCS) 7
Community-Based Adult Services (CBAS) 14
Dental Transformation Initiative (DTI) 26
Drug Medi-Cal Organized Delivery System (DMC-ODS) 31
Financial/Budget Neutrality: SNCP/DSRIP/DSHP 34
Global Payment Program (GPP) 36
Low-Income Health Program (LIHP) 38
Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 40
Seniors and Persons with Disabilities(SPD) 43
Whole Person Care (WPC) 51

INTRODUCTION:

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

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

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

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

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

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

- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020
- DY 16: July 1, 2020 through December 31, 2020

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 17: Post Award Forum

On February 25, 2016, DHCS presented an update on the new Medi-Cal 2020 waiver to members of the Stakeholder Advisory Committee (SAC). The meeting highlighted the key components of the waiver and provided an overview of programs and implementation timelines for each component. The four main programs were discussed: Public Hospital Redesign and Incentives in Medi-Cal (PRIME); Global Payment Program (GPP); Dental Transformation Initiative (DTI); and Whole Person Care (WPC). Additionally, the Blue Shield of California Foundation announced Navigant as the contractor that they selected for the first Uncompensated Care Assessment, due to CMS on May 15, 2016.

DHCS intends to use SAC as a platform for further discussions regarding waiver developments. SAC presentation slides and other meeting materials are available online at: http://www.dhcs.ca.gov/Pages/February25MeetingMaterials.aspx

STCs Items 65-69: Access Assessment Document

DHCS is required to contract with its external quality review organization (EQRO) to conduct an Independent Access Assessment (Assessment). The Assessment will evaluate primary, core specialty, and facility access to care for Medi-Cal managed care beneficiaries based upon requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 and Department of Health Care Services, Medi-Cal managed care health plan contracts. An Advisory Committee must be established to provide input into the structure, draft report, and recommendations of the Assessment. At a minimum, the Assessment will consider State Fair Hearing, Independent Medical Reviews (IMR), grievances and appeals, and complaints data.

The EQRO will produce and publish an initial draft and a final Assessment report that includes a comparison of health plan network adequacy compliance across different lines of business and provides recommendations for identified systemic issues. The initial draft and final report will describe the state's current compliance with access and network adequacy standards set forth in the Medicaid Managed Care proposed rule at 80 FR 31097 or the finalized 42 CFR 438 if published prior to submission of the Assessment design to CMS.

In February of 2016, DHCS created:

a. The Access Assessment website located at: http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx
b. The Access Assessment email inbox for questions and inquiries. The email address is Access.assessment@dhcs.ca.gov.

DHCS posted the Access Assessment Advisory Committee Application to its website on April 1, 2016 with an application deadline of May 1, 2016. DHCS received 87 applications. DHCS developed scoring criteria and is in the process of scoring all applications. DHCS has not yet received legislative authority to move forward with the Assessment; it is currently moving through the legislative process and DHCS is hopeful the legislature will act before the end of June.

STCs Items 178-180: Uncompensated Care Reporting

The State must commission two reports from an independent entity on uncompensated care in the state. The first independent report will focus on Designated Public Hospitals (DPHs) and is due to CMS on May 15, 2016. The objective of the report is to support a determination of the appropriate level of the Uncompensated Care Pool component of the total Global Payment Program (GPP) funding for participating DPHs in Demonstration Years Two through Five of Medi-Cal 2020. Within sixty days of receipt of the report, CMS will provide a formal determination of the funding levels.

During the first quarter, the State selected Navigant as the contractor to conduct the first report. The Blue Shield of California Foundation is funding the completion of this report. Per CMS's request, a Request for Proposal (RFP) that provides the scope and deliverables of the study was shared with them on March 4, 2016. Although it occurred after the close of this reporting period, DHCS does note that the report was submitted as required on May 15, 2016 which will be reflected in the next quarterly report.

The second report will be due to CMS on June 1, 2017, and it will focus on uncompensated care, provider payments, and financing across all California hospitals that serve Medi-Cal beneficiaries and the underinsured, using data from the first report for DPHs. The report will include information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and will enhance the quality of health care services.

STCs Item 201: Budget Neutrality Monitoring Tool

The State and CMS are still jointly developing a budget neutrality monitoring tool for the State to use for quarterly budget neutrality status updates and for other situations when an analysis of budget neutrality is required. The current Budget Neutrality, titled "Medi-Cal 2020 Budget Neutrality", is provided as an attachment with this quarterly progress report.

CALIFORNIA CHILDREN SERVICES (CCS)

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

The CCS Program is administered as a partnership between local CCS county programs and the Department of Health Care Services (DHCS). Approximately 80 percent of CCS-eligible children are Medi-Cal eligible.

The pilot project under the 1115 Waiver titled Medi-Cal 2020 is focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction, and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improvement of care for all 182,000 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 their CCS condition. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the demonstration period decisions can be made on permanent restructuring of the CCS Program design and delivery systems.

The two (2) health care delivery models include:

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

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

Enrollment information:

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

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

Aid Codes

Programming for Affordable Care Act (ACA) aid codes was not completed to be included in the below enrollment data. Retroactive updates to the enrollment data are expected to be completed by May 2016.

Month	HPSM Enrollment Numbers	Difference Prior Month	Month	HPSM Enrollment Numbers	Difference Prior Month
July 2014	1,472		June 2015	1,199	-51
August 2014	1,457	-15	July 2015	1,158	-41
September 2014	1,435	-22	August 2015	1,125	-33
October 2014	1,413	-22	September 2015	1,086	-39
November 2014	1,405	-8	October 2015	1,050	-36
December 2014	1,421	16	November 2015	1,015	-35
January 2015	1,364	-57	December 2015	980	-35
February 2015	1,303	-61	January 2016	933	-47
March 2015	1,302	-1	February 2016	901	-32
April 2015	1,276	-26	March 2016	874	-27
May 2014	1,250	-26			

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by the Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration.

STCs number 54 requires DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) by September 30, 2016, including the addition of performance measures, to be implemented in 2017. DHCS is required to propose:

- One (1) provider satisfaction measure,
- One (1) patient satisfaction measure,
- Whole person average cost of care, and
- Two (2) measures of participant health outcomes.

The revised Protocols are currently being reviewed by DHCS management. In addition, DHCS provided CMS with updates during the CMS-DHCS monthly waiver monitoring calls on February 17 and March 14, 2016.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM
The Systems of Care Division (SCD) and HPSM conduct bi-weekly scheduled conference calls to discuss various issues, inclusive of those related to financial, information technology, and deliverable reporting.

Contract Amendment
HPSM contract amendment A02 is in process. This amendment is to extend the contract one year as allowed by Request for Proposal #11-88024; and to increase the total budget to compensate the Contractor for continuing to perform services for an additional year.

Rady Children's Hospital of San Diego Demonstration Project

DHCS has been collaborating with Rady Children's Hospital San Diego (RCHSD) and the local CCS Program regarding implementing the RCHSD CCS DP. Discussions have taken place around contract documents (Scope of Work, reporting requirements, etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model.

Capitated Rates
DHCS's Capitated Rates Development Division (CRDD) continued to work with actuaries on rate development and risk corridor contract language. Concerns that affect rate derivation regarding drug pricing and pharmacy access have been resolved, and data discrepancies have been validated.

DHCS Communications with RCHSD
DHCS participated in weekly conference calls with RCHSD to discuss and resolve various issues such as:

- PHARMACEUTICALS / PBM

On September 21, 2015, RCHSD provided to DHCS a Letter of Intent between MedImpact Healthcare Systems, Inc. (MedImpact) and RCHSD, demonstrating the mutual intention to negotiate an agreement for Pharmaceuticals Benefit Manger (PBM) services.

- MEMBER HANDBOOK

As of December 2015, DHCS and RCHSD agreed on the grievance and appeals component of the member handbook. The pharmacy/pharmaceutical component has been resolved and will incorporate RCHSD's proposed split for blood factor 340B drug pricing. RCHSD is finalizing the member handbook as of March 31, 2016.

- PROVIDER MANUAL

DHCS reviewed and provided feedback to RCHSD's provider manual to satisfy a Readiness Review component. RCHSD is finalizing the provider manual as of March 31, 2016.

- RCHSD READINESS REVIEW DELIVERABLES

DHCS developed a Readiness Review Matrix to operationalize the RCHSD Demonstration. The readiness review lists deliverables RCHSD will need to submit to DHCS prior to enrolling members into the plan. These policies and procedures (P&Ps) ensure RCHSD has safeguards in place for access to care and family centered care practices. As of January 2016, DHCS had reviewed all 67 P&P drafts. The 67 P&Ps need to be submitted to DHCS in a finalized format.[1]

- CONTRACT ITEMS

As of March 31, 2016, the contract is pending discussions for the following:
Risk corridor language and rate finalization. Once the contract is approved by CMS, RCHSD has requested a 90-day lead time prior to going operational.

Demonstration Schedule

It is anticipated the RCHSD Demonstration will become operational in Winter 2016. It should be noted the projected implementation timetable is contingent on a number of factors including development and acceptance of capitated rates by RCHSD, the ability of the contractor to demonstrate readiness to begin operations, and approvals by CMS.

Complaints, Grievances, and Appeals

CCS Quarterly Grievance Report #11

---

[1] SCD gave RCHSD a Readiness Review document indicating required deliverables P&Ps in Summer/Fall 2013. Since December 2015, DHCS has been waiting for RCHSD to submit finalized P&Ps.

On February 2, 2016, HPSM submitted a "CCS Quarterly Grievance Report" for the fourth quarter, October - December 2015. During the reporting period, HPMS received and processed 15 member grievances. The grievance rate per enrollee is 0.02. The Grievances Report includes type of grievance, accessibility, benefits/coverage, referral, and quality of care/service.

- 1 grievance was labeled as Accessibility:
  - It was coded as "Lack of primary care provider availability" and was resolved in favor of the plan.

- 10 grievances were designated as Quality of Care/Service:
  - 8 were coded as "Plan denial of treatment"; 4 were resolved in favor of the CCS Member and 4 were resolved in favor of Plan.
  - 2 were coded as "Poor provider/staff attitude"; 1 was resolved in favor of the CCS Member and 1 was resolved in favor of Plan.

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

Consumer Issues:

CCS Advisory Group (AG)

DHCS continued stakeholder discussions on the CCS Program improvements to an ongoing CCS Advisory Group (AG). The CCS AG was formed to continue with DHCS's commitment to engage stakeholders in program changes and specifically improve the delivery of health care to CCS children and their families through an organized health care delivery model. DHCS has developed a "Whole-Child Model" to be implemented in specified counties, no sooner than January 2017.

The CCS AG meets quarterly in Sacramento; in addition to the AG, three topic-specific technical workgroups (TWG) meet either on bi-monthly or quarterly.

The CCS AG website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

On January 6, 2016, the CCS AG had its second meeting. The following topics and documentation was presented at the January 6th AG meeting:

- Follow-Up from Previous Meeting, Key Updates, and Future Meetings' Topics/Goals
- Medi-Cal Managed Care Health Plan, CCS, and Whole-Child Requirements
- Medi-Cal Managed Care Health Plan Readiness

Attached is the meeting materials link:

http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsJan16.aspx

TWG webinars were held during this quarter and meeting material links follow:

- Data and Quality Measures TWG – December 4, 2015 and February 3, 2016
http://www.dhcs.ca.gov/services/ccs/Pages/DataQualityMeasuresTech.aspx

- Care Coordination / Medical Home / Provider Access TWG – December 11, 2015 and January 28, 2016
http://www.dhcs.ca.gov/services/ccs/Pages/ProviderAcessTechWorkgroup.aspx

Financial/Budget Neutrality Development/Issues:

Financial Review
DHCS completed a financial review on HPSM's DP quarterly reports; consisting of Administrative Costs, Profit Margin, and Medical Loss Ratio. Please refer to Attachment, Health Plan of San Mateo: Plan Analysis.

Quality Assurance/Monitoring Activities:

On February 12, 2016, HPSM submitted contractual report, "Enrollment and Utilization Table". Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
10/1/2015 – 12/31/2015	1,604	143	152	1,595	4,784

HPSM deliverables submitted during this quarter are located in the table below, along with DHCS's internal review and approval for each deliverable.

Report Name	Date Due	Received	Pending Review	DHCS Approved
Provider Network Reports (Rpt #10)	10/30/2015	12/8/2015		YES
Grievance Log/Report (Rpt #10)	10/30/2015	12/1/2015		YES
Quarterly Financial Statements (Rpt #10)	11/17/2015	11/16/2015		YES
Report of All Denials of Services Requested by Providers (Rpt #9)	11/17/2015	11/20/2015		YES
Grievance Log/Report (Rpt #11)	1/30/2016	1/29/2016		YES
Member Services Guide / Evidence of Coverage (Rpt #3)	1/30/2016	1/30/2016		YES
Formulary Report (Rpt #3)	1/30/2016	2/1/2016	✓	
Provider Network Reports (Rpt #11)	2/16/2016	3/2/2016	✓	

Report Name	Date Due	Received	Pending Review	DHCS Approved
Quarterly Financial Statements (Rpt #11)	2/16/2016	2/12/2016		YES
Report of All Denials of Services Requested by Providers (Rpt #10)	2/16/2016	3/2/2016	✓	

Evaluations:

Nothing to report.

Enclosures/Attachments:

Attached enclosure "California Children Services (CCS) Member Months and Expenditures" consisting of *Number of Member Months in a Quarter, Number of Unique Eligibles Based on the First Month of Eligibility in the Quarter,* and *Expenditures Based on Payment 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. The Department of Health Care Services (DHCS) amended the “California Bridge to Reform” 1115 Demonstration Waiver (BTR waiver) to include CBAS, which was approved by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2012. CBAS was operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

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

In October 2015, CBAS was authorized a temporary extension by CMS until December 31, 2015, under the BTR waiver extension. The new DHCS 1115 waiver, called “California Medi-Cal 2020 Demonstration” (Medi-Cal 2020) was approved by CMS on December 30, 2015. CBAS continues as a CMS approved benefit for the next five years through December 31, 2020, under the Medi-Cal 2020 waiver.

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 State Plan members that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing, Medicaid, and waiver program standards; 2) provide services in accordance with the participants’ physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements identified in the CMS approved Medi-Cal 2020 waiver; and 4) demonstrate ongoing compliance with above requirements.

Initial eligibility for the CBAS benefit is determined through a face-to-face review by a managed care plan (MCP) registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. Initial face-to-face review is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve 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 review.

The State must assure CBAS access/capacity in every county in which ADHC services

had been provided prior to CBAS starting on April 1, 2012.[2] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans (available in two counties), along with the final COHS county (Ventura) also transitioning at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for those CBAS eligible members who have an approved medical exemption from enrolling in Managed Care. The final four rural counties (Shasta, Humboldt, Butte and Imperial) were transitioned to managed care with the CBAS benefit available as of December 2014.

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

Enrollment and Assessment Information:

The CBAS Enrollment data (per STC. 99) for both MCP and FFS members per county for Demonstration Year 11 (DY11), Quarter 1 (Q1) is shown in Table 1, *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS*. Table 5, *CBAS Centers Licensed Capacity,* provides the CBAS capacity available per county, which is also incorporated into Table 1. Table 1 data also reflect that CBAS participation has increased to more than 30,000 participants from approximately 28,000 participants statewide.

The CBAS enrollment data as described in Table 1, *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS,* are based on self-reporting by the MCPs, which is reported quarterly, along with claims data for CBAS individuals remaining in FFS. Some MCPs report enrollment data based on their covered geographical areas, which may include multiple counties. For example, Marin, Napa, and Solano are smaller counties, therefore; data from these smaller counties are grouped together. FFS claims data, which has a lag factor of about two to three months, was used for the FFS enrollment data in Table 1 which reflects data through

[2] 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.

December 2015.

Review County Enrollment for CBAS vs. Capacity per County

TABLE 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY10 Q3 Jan - Mar 2015		DY10 Q4 Apr - June 2015		DY10 Q5 Jul - Sept 2015		DY11 Q1 Oct - Dec 2015	
County	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used
Alameda	459	76%	466	83%	483	86%	534	96%
Butte	*	*	*	*	*	*	*	*
Contra Costa	197	61%	202	63%	208	65%	227	71%
Fresno	569	59%	622	64%	525	54%	631	65%
Humboldt	206	53%	98	25%	107	28%	164	42%
Imperial	340	61%	177	32%	81	14%	363	65%
Kern	91	27%	96	28%	50	15%	95	28%
Los Angeles	18,549	60%	18,434	60%	19,084	61%	20,149	64%
Merced	90	49%	86	47%	96	52%	92	50%
Monterey	87	47%	86	46%	78	42%	98	53%
Orange	2,197	66%	2,249	68%	2,248	68%	2,004	60%
Riverside	401	37%	397	37%	396	37%	425	39%
Sacramento	570	64%	592	66%	648	72%	697	78%
San Bernardino	532	98%	543	100%	552	102%	610	113%
San Diego	1,464	41%	1,765	50%	1,781	47%	2,353	62%
San Francisco	712	49%	706	48%	720	49%	775	53%
San Mateo	127	56%	155	68%	154	67%	156	68%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	502	36%	549	39%	644	46%	655	47%
Santa Cruz	107	70%	94	62%	96	63%	113	74%
Shasta	46	32%	44	31%	41	28%	12	8%
Ventura	905	63%	901	63%	915	63%	915	63%
Yolo	289	76%	72	19%	81	21%	75	20%
Marin, Napa, Solano	141	28%	179	36%	158	32%	167	33%
Total	**28,615**	**58%**	**28,542**	**52%**	**29,160**	**58%**	**31,042**	**62%**

FFS and MCP Enrollment Data 12/2015

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

Table 1, entitled *Preliminary CBAS Unduplicated Participant Data for FFS and MCP Enrollment Data with County Capacity of CBAS*, reflects a slightly higher total count of 31,042 participants, approximately 2,000 participants higher from the last quarter due to some CBAS Centers opening and/or increasing their capacity. There is ample capacity for participant enrollment into almost all of the CBAS Centers except for San Bernardino County which is currently operating over center capacity. The decrease in number of

participants enrolled in the CBAS Centers has reduced the percentage of capacity used by more than 5% in CBAS Centers in Orange and Shasta counties. It is important to note that participant counts have reduced to increase available capacity but capacity size has not reduced in these counties. Alameda and Butte county MCP numbers for DY10 Q5 have been updated in this report to reflect data availability. Submission of last quarter's information showed a much lower number for both counties and has since been updated to reflect data the state has gathered.

CBAS Assessments Determined Eligible and Ineligibility:

Individuals requesting to receive CBAS services will go through an initial face-to-face assessment by a registered nurse with qualifying experience to determine eligibility. An individual is not required to go through the face-to-face assessment if an MCP determines that individual is eligible based on medical information or history that the plan possesses. Table 2, *CBAS Assessment Data for MCP and FFS,* list the numbers of new assessments reported by the MCPs. The FFS data for new assessments in Table 2 are reported by DHCS.

Table 2:

CBAS Assessment Data for MCP and FFS						
Demonstration Year	MCP			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 10, Q 1 (7/1-9/30/2014)	2,299	2,251 (98%)	48 (2%)	260	256 (98.5%)	4 (1.5%)
DY 10, Q 2 (10/1-12/31/2014)	2,860	2,812 (98%)	48 (2%)	62	60 (96.8%)	2 (3.2%)
DY 10, Q 3 (1/1-3/31/2015)	2,497	2,433 (97.4%)	64 (2.6%)	51	49 (96.8%)	2 (3.2%)
DY 10, Q 4 (4/1-6/30/2015)	2,994	2,941 (98.2%)	53 (1.8%)	43	42 (97.7%)	1 (2.3%)
DY 10, Q 5 (7/1-9/31/2015	2,600	2,552 (98.2%)	48 (1.8%)	50	50 (100%)	0 (0%)
DY 11, Q 1 (10/1-12/31/2015)	2,301	2,258 (98.1%)	43 (1.9%)	26	25 (96.2%)	1 (3.8%)
5% Negative Change between last Quarter		No	No		No	No

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

During DY10, Q5, there were a total of 99 requests for CBAS services submitted to DHCS; 50 of the requests were assessed and determined to be FFS eligible and 29 were referred to managed care for CBAS benefits. There were 20 requests that did not follow through with the face-to-face assessment.

For DY11, Q1, there were a total of 77 requests for CBAS services submitted to DHCS; 25 of the requests were assessed and determined to be FFS eligible, one request was denied, and 36 requests were referred to managed care for CBAS benefits. Eligible FFS counts continue to change due to all CBAS counties being covered by managed care as of December 1, 2014. The decreased number of requests submitted to DHCS this quarter had a significant reduction on the number of new assessments. There were 15 FFS requests that did not follow through with the face-to-face assessment.

CBAS provider-reported data (per CDA) (STC 99.b):

CBAS enrollment and capacity correlates between the number of CBAS Centers opening and closing. CBAS Centers that closed will decrease the number of enrollment and capacity for participants while new CBAS Center openings will increase the number of enrollment and capacity. CBAS Centers are certified and monitored by CDA. The number of counties with CBAS Centers and the average daily attendance (ADA) of each center are listed below in Table 3, *CDA – CBAS Provider Self-Reported Data*. Eighty-five percent reflects the ADA of CBAS participants at each Center statewide.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	243
Non-Profit Centers	62
For-Profit Centers	181
ADA @ 243 Centers	20,588
ADA per Centers	85%
CDA - MSSR Data 12/2015	

**Note: 243 CBAS Centers were open for at least one business day in December 2015; therefore they were required to report data. Information is not available for January to March 2016 due to a delay in the availability of data.*

Outreach/Innovative Activities:

CMS' approval of the CBAS amendment to the BTR Waiver occurred on November 28, 2014. DHCS and CDA completed a new stakeholder process to develop a Home and Community-Based Settings (HCBS) transition plan for the CBAS program which was included in California's Statewide HCBS Transition Plan. DHCS and CDA hosted three meetings/webinars in February, March, and April 2015 focused on developing the CBAS HCBS transition plan, released a draft CBAS HCBS Transition Plan for public comment in May 2015 and presented the comments and CBAS Plan revisions in July 2015 for incorporation into California's Statewide Transition Plan. DHCS submitted the amended

Statewide Transition Plan on August 14, 2015.

Based on stakeholder input and milestones identified in the CBAS amendment of the BTR Waiver, DHCS and CDA convened two workgroups beginning in July 2015 to develop a CBAS quality strategy and to revise the current CBAS Individual Plan of Care (IPC) emphasizing person-centered planning. The workgroups are comprised of MCPs, CBAS providers, advocates, and state staff, which will meet every other month through June 2016. Updates and progress on stakeholder activities for CBAS can be found at:

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

Operational/Policy Development/Issues:

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

Consumer Issues:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 99.e.iv)

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

Issues that generate CBAS complaints are minimal from both members and providers. Complaints are collected via telephone or emails and are directed to CDA. Complaints were primarily related to cost/billing issues and dissatisfaction with services from CBAS providers. Complaint data received by the MCPs and from CBAS members and providers are also summarized below in Table 4, *Data on CBAS Complaints*, and Table 5, *Data on CBAS Managed Care Plan Complaints*:

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q 1 (Oct 1 - Dec 31)	1	0	1

CDA Data - Complaints 12/2015

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

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q 1 (Oct 1 - Dec 31)	4	0	4

Plan data - Phone Center Complaints 12/2015

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

CBAS Grievances / Appeals (FFS / MCP) (STC 99.e.iii)

CBAS grievances were submitted to the MCPs, and in DY11, Q1, there were seven grievances filed. The grievances were related to requests for assessment or reassessment, excessive travel time to access CBAS, and other CBAS related issues. There were six CBAS appeals filed with MCPs. All six appeals were related to denial of services or limited services. Four out of the six appeals were denied and two of the appeals were approved.

The State Fair Hearings / Appeals continue to be facilitated by the California Department of Social Services (CDSS) with Administrative Law Judges' hearing all cases filed. As of DY11, Q1, there were three requests for fair hearing recorded from approximately 30,000 CBAS participants, but all three requests were verbally withdrawn before the hearing date. All three hearing requests were regarding level of care.

Quality Assurance/Monitoring Activity:

DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under the Medi-Cal 2020 Waiver. Table 6, *CBAS Centers Licensed Capacity*, indicates the consistency of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 6 also illustrates

overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal members is 62% statewide. There is sufficient capacity in almost all counties where CBAS is available to allow access for Medi-Cal members.

Table 6:

County	CBAS Centers Licensed Capacity							
	DY7-Q4 Apr- Jun 2012	DY8-Q4 Apr-Jun 2013	DY9-Q4 Apr Jun 2014	DY10-Q4 Apr-Jun 2015	DY10-Q5 Jul-Sept 2015	DY1-Q1 Oct Dec 2015	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	330	330	**330**	0%	96%
Butte	60	60	60	60	60	**60**	0%	9%
Contra Costa	190	190	190	190	190	**190**	0%	71%
Fresno	590	547	572	572	572	**572**	0%	65%
Humboldt	229	229	229	229	229	**229**	0%	42%
Imperial	250	315	330	330	330	**330**	0%	14%
Kern	200	200	200	200	200	**200**	0%	28%
Los Angeles	17,735	17,506	18,184	18,238	18,502	**18,508**	0%	64%
Merced	109	109	109	109	109	**109**	0%	50%
Monterey	290	0	110	110	110	**110**	0%	53%
Orange	1,897	1,747	1,910	1,960	1,960	**1,960**	0%	60%
Riverside	640	640	640	640	640	**640**	0%	39%
Sacramento	529	529	529	529	529	**529**	0%	78%
San Bernardino	320	320	320	320	320	**320**	0%	113%
San Diego	2,132	1,992	1,873	2,068	2,233	**2,233**	0%	62%
San Francisco	803	803	866	866	866	**866**	0%	53%
San Mateo	120	120	135	135	135	**135**	0%	68%
Santa Barbara	55	55	55	60	60	**60**	0%	8%
Santa Clara	820	750	840	830	830	**830**	0%	47%
Santa Cruz	90	90	90	90	90	**90**	0%	74%
Shasta	85	85	85	85	85	**85**	0%	8%
Ventura	806	806	806	851	851	**851**	0%	63%
Yolo	224	224	224	224	224	**224**	0%	20%
Marin, Napa, Solano	295	295	295	295	295	**295**	0%	33%
SUM =	29,009	27,967	29,007	30,396	30,825	30,831	0%	62%

CDA Licensed Capacity as of 12/2015

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

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

STCs 99(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There has been no decrease in provider capacity of 5% or more during this Quarter.

Access Monitoring (STC 99.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Table 1, *Preliminary CBAS Unduplicated Participant - FSS and MCP Enrollment Data with County Capacity of CBAS,* CBAS capacity is adequate to serve Medi-Cal members in almost all of the counties with CBAS Centers with the exception of San Bernardino County. Overserving of the CBAS population in

San Bernardino County does not negatively impact the program or the members served. There are other centers in nearby counties that can assist should the need arises to allow for ongoing care of the CBAS participants.

Unbundled Services (95.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, the managed care plans will work with the nearest available CBAS Center to provide the necessary services. This may include but not limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the members 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 members traveling to and from a CBAS Center. Prior to any closure, the CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for all of their CBAS participants. 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 the participant's local area. The large, statewide volume of IHSS providers is a key characteristic of California's HCBS that help substitute institutional care for seniors and persons with disabilities. Participants can employ IHSS providers of their choice and can self-direct their own care in their home and community-based setting(s).

CBAS Center Utilization (Newly Opened/Closed Centers)

For DY11, Q1, CDA had 242 CBAS Center providers open and operating in California. According to Table 7, *CBAS Center History*, the number of CBAS Centers opened and operating has stayed consistent from the last quarter. In December 2015, there were two CBAS Center closures (Berkeley ADHC in Alameda County and Casa Del Sol ADHC in Los Angeles County) and one CBAS Center opening (Santa Clarita ADHC in Los Angeles). Regent West ADHC in Orange County began providing CBAS services in January 2016, which increased the total number of CBAS Centers to 242.

Table 7:

CBAS Center History

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

Table 7 shows there was no negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

Financial/Budget Neutrality Development/Issues:

Pursuant to Special Terms and Conditions (STC's) item 101 (b), the MCP payments

must be sufficient to enlist enough providers so that care and services are available under the MCP at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the centers capacity to date and adequate networks remains for this population.

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

Enclosures/Attachments:

None.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Within the Medi-Cal 2020 Waiver, the Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this strategy 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. Given the importance of oral health to the overall physical wellbeing of an individual, California views improvements in dental care as a critical component to achieving overall better health outcomes for Medi-Cal beneficiaries, particularly children.

The Dental Transformation Initiative covers four areas or domains:

Domain 1

In alignment with the CMS Oral Health Initiative, this program aims to increase the statewide proportion of children under the age of 20 enrolled in Medi-Cal who receive preventive dental services in a given year. The goal is to increase statewide proportion of children ages 20 and under enrolled in Medi-Cal who receive a preventive dental service by at least ten percentage points over a five-year period.

Domain 2

Providers in selected pilot counties will be eligible to receive incentives for performing pre-defined treatment plans for children based upon the beneficiaries risk assessment. If the pilot is successful, then this program will be expanded to other counties, contingent on available DTI funding. The goal is to:

- Diagnose early childhood caries by utilizing Caries Risk Assessments (CRA) to treat it as a chronic disease.
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventive services, in lieu of more invasive and costly procedures (restorative services).
- Identify the effectiveness of CRA and treatment plans for children ages 6 and under.

Domain 3

This pilot program is aimed to improve the continuity of care. Incentive payments will be awarded to dental service office locations who have maintained continuity of care through providing examinations for their enrolled children under the age of 20. If the pilots are successful, it will be expanded to other counties, contingent on available DTI funding. The goal is to increase continuity of care for beneficiaries ages 20 and under for 2, 3, 4, 5, and 6 continuous periods.

Domain 4

The Local Dental Pilot Projects (LDPP) will address the above described domains through pilot programs aimed at increasing preventive services, CRAs and disease management, and continuity of care. DHCS will invite applicants to submit proposals for pilots. The goal is to:

- Address one or more of the three domains through alternative programs, potentially using strategies focused on rural areas, including local case management initiatives and education partnerships.
- DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments for LDPPs in accordance with the requirements stipulated in the Medi-Cal 2020 Waiver.
- A maximum of 15 LDPPs shall be approved.

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; to implement effective, efficient, and sustainable health care delivery systems; to maintain effective, open communication and engagement with our stakeholders; and to hold DHCS and our providers, plans, and partners accountable for performance and health outcomes.

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

Small Stakeholder Workgroup

In March 2016, DHCS convened a small stakeholder workgroup to discuss policy considerations for DTI implementation. As envisioned, this workgroup will collaborate with the Department on planning and rollout efforts necessary to ensure the success of the dental component of the waiver. Their collaboration and input will help to further inform DTI work, and the outcomes will be broadly shared with the larger set of

interested dental stakeholders and the provider community. These forums are comprised of legislative staff, children's health advocates, dental providers (across delivery systems and academia), dental managed care plans, local agencies (First 5, etc.), and safety net clinics.

DTI Small Stakeholder Subgroups:

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

1. Dental Clinicians for Caries Risk Assessment

Guided by California's state dental director, Dr. Jayanth Kumar, this subgroup is tasked with identifying the risk assessment tools and training programs that will be used in DTI Domain 2, the Caries Risk Assessment (CRA) and Disease Management Pilot. The CRA incorporates an evidence-based philosophy which focuses on preventive and intervention therapy based on an individual patient's caries risk through prevention, intervention, education, and identification. The use of these risk assessment tools and training programs will enable DHCS to work toward the achievement of the CMS Triple Aim goals by implementing provider incentives, based on performing a CRA to identify a child's risk level, and developing and completing a beneficiary-specific treatment plan.

This subgroup will meet in May 2016 and will continue to meet until an approved CRA tool and training curricula are selected for use under this domain.

2. Clinic Representatives for Data Reporting

This subgroup is comprised of representatives from DHCS, California Rural Indian Health Board, California Consortium for Urban Indian Health, California Primary Care Association, and dental plans. They are tasked with determining enrollment and the reporting requirements for clinics under the DTI.

This subgroup will meet in early May 2016, and they will continue to meet weekly for the foreseeable future.

Webinars

On April 8, 2016, DHCS will hold a DTI Stakeholder Webinar. DHCS will provide a DTI overview, a high level DTI timeline, and answer stakeholder questions. DHCS will offer an update on the planning and implementation efforts.

On May 18, 2016 DHCS will hold an additional DTI stakeholder webinar. This convening will offer an overview of the Local Dental Pilot Program (LDPP) application. An update on Domains 1-3 will be provided as well.

Letter of Intent (LOI)

By late April 2016, DHCS will release its LOI Instructions for LDPPs. The LDPP is a component of the DTI program. The purpose of the LOI is to assess the level of interest to participate in the LDPPs across the state, to obtain preliminary LDPP design information that will assist DHCS with finalizing the LDPP application, and to provide an opportunity for potential applicants to submit questions. Submission of the LOI is voluntary and nonbinding. Failure to submit will not preclude an entity from applying to participate in the LDPP.

LDPPs Application

In late April 2016, DHCS will submit a draft LDPP application and selection criteria to CMS and the DTI Small Stakeholder Workgroup for comment. DHCS will receive comments in early May 2016. DHCS will revise the documents and release drafts for public comment. DHCS anticipates releasing the final LDPP pilot application and selection criteria June 1, 2016, with applications due 60 calendar days after release.

The LDPP applicants will be expected to detail a pilot project's specific goals, anticipated outcomes, data that will be used to measure whether the project is having the intended impact, and the frequency of performance metric measurements.

DTI Webpage

In March 2016, DHCS set up a webpage dedicated to the DTI. The webpage contains program information, stakeholder engagement information, webinars, timelines, Frequently Asked Questions (FAQs), Medi-Cal 2020 Special Terms and Conditions (STCs), and an inbox to direct comments, questions, or suggestions. The webpage will be updated as new information becomes available.

DTI Webpage:
http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx

DTI Inbox:
DTI@dhcs.ca.gov

DTI Listserv

In March 2016, DHCS created an e-mail service for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations to register to receive relevant updates on the DTI. The sign up link can be found below.

Listserv:
http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DTIStakeholders

DTI FAQs

In March 2016, DHCS released a DTI FAQs document. The document provides responses to stakeholders frequently asked DTI questions. The FAQs document will be continuously updated as new questions arise.

FAQs:
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver Renewal/FAQs_DTI.xls

Outreach

As a part of the Denti-Cal program, our fiscal intermediary Delta Dental is required to provide outreach activities. To enable these activities, three plans are developed:

i. Dental outreach and education plan - targeted towards the beneficiaries
ii. Provider outreach plan – targeted towards the provider community
iii. Provider survey – to obtain feedback on the effectiveness of our outreach activities

These plans will be updated to include the DTI program in general and various domains-specific information. This information would include items, such as overview of the program, eligibility, baseline data, target goals, payment of incentives, etc.

Operational/Policy Issues:

Nothing to report at this time.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

Nothing to report at this time.

Quality Assurance/Monitoring Activities:

Nothing to report at this time.

Evaluations:

Nothing to report at this time.

Enclosures/Attachments:

None.

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

DMC-ODS will provide an evidence-based benefit design covering the full continuum of care, requiring providers to meet industry standards of care, a strategy to coordinate and integrate across systems of care, create 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 will allow 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 waiver 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 and Northern California, (4) Northern California and (5) Tribal Partners. The Department of Health Care Services is currently assisting phase three and have received a total of seven implementation plans from: San Francisco, San Mateo, Riverside, and Santa Cruz, Santa Clara, Marin, and Los Angeles. San Mateo County's implementation plan is DHCS Approved. The other six counties' implementation plans are in concurrent review by DHCS and CMS.

Enrollment Information:

- San Francisco – SFHN-BHS estimates that 24,293 Medi-Cal beneficiaries would meet DSM 5 SUD diagnosis/medical necessity criteria for DMC-ODS Pilot treatment services.

- San Mateo – BHRS projects between 16,756 to 12,154 Medi-Cal beneficiaries have a SUD and could benefit from treatment.

- Riverside – The estimated utilization of services by SMC beneficiaries is 7,000 non-duplicated clients across treatment modalities.

- Santa Cruz – The number of Medi-Cal beneficiaries who will seek DMC-ODS services is estimated to range between 1,588 and 2,602, based on two estimation methods, including 1) extrapolating from a 2013 Mercer study on DMC prevalence and penetration rates that was used by the Department of Finance to estimate DMC expansion costs under AB1X; and 2) extrapolating from the DHCS California Mental Health and Substance Abuse Needs Assessment (2012) and the National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2013).

- Santa Clara

Table 7. Projected total admissions by modality and percent Medi-Cal-2016-17

	Projected admissions	Medi-Cal Expansion	Medi-Cal Traditional	Other payors
Withdrawal management ASAM 3.2	**927**	304	130	494
Residential treatment ASAM 3.1, 3.3, 3.5	**1863**	494	262	1106
Outpatient ASAM 1, 2.1, 2.5	**6643**	1493	1308	3481
OTS (MAT)	**655**	210	260	184
(Subtotal)				
Recovery Services	**2657**	597	523	747
Total (all services)				

- Marin – Based on an analysis of current Marin County Medi-Cal beneficiaries, estimated substance use prevalence rates among the Medi-Cal Expansion population and national penetration rates, it is projected that there will be 315 adult (18+ years) and 27 (14-17 years) unduplicated Medi-Cal beneficiaries accessing substance use services in FY 2016-17.

- Los Angeles – Using medium-level estimates (readmission variable 1.3), Los Angeles County anticipates total utilization of at least 16,696 duplicated youth served annually, with another 60,627 youth in need of SUD services. Using medium-level estimates (readmission multiplier 1.4), Los Angeles County anticipates total utilization of at least 88,698 duplicated adults served annually, with another 186,002 adults in need of SUD services.

Outreach/Innovative Activities:

- Bi-monthly technical assistance calls with County leads
- DHCS participates in CMS's Innovation Accelerator Program Targeted Learning Opportunities which focuses on primary care and SUD integration.
- November 11, 2015 – DMC-ODS Implementation Plan Webinar
- December 8, 2015 – Follow up Region 2 implementation Meeting.
- December 10, 2015 – Quarterly Blue Shield Foundation Meeting
- December 18, 2015 – County Plan Meeting with CMS
- January 28, 2016 – Santa Cruz Technical Assistance Meeting
- February 4, 2016 – California Alliance of Child and Family Services (CACFS) Winter Conference at Monterey
- February 10, 2016 – Fiscal Webinar Part 1 to the Counties
- February 19, 2016 – EQRO Implementation Plan Meeting
- March 7-9, 2016 – Tarzana Site Visit and San Diego Tribal Conference
- March 10, 2016 – Beneficiary Protections Webinar
- March 29, 2016 – EQRO and UCLA Implementation Plan Meeting

- March 30, 2016 – Phase 3 Regional Meeting

Operational/Policy Development/Issues:

On February 24, 2016, CMS approved the amended County Implementation Plan, and the revised document replaces Attachment Z *County Implementation Plan* in the Waiver STCs. With this approval, CMS authorizes the state to move forward and to assist counties in the implementation of the DMC-ODS program. This has also helped the review process run more efficiently.

Consumer Issues:

Nothing new to report.

Financial/Budget Neutrality Development/Issues:

The Certified Public Expenditures (CPE) Protocols continue to be developed between DHCS and CMS.

Quality Assurance/Monitoring Activity:

Nothing new to report.

Evaluation:

Through an existing contract with DHCS, the University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, integration, and coordination of care.

UCLA holds monthly conference call with updates, activities, and meetings.

On April 1, 2016, DHCS anticipates sending CMS a response from UCLA regarding CMS comments and questions about the draft report.

Enclosures/Attachments:

None.

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Bridge to Reform Demonstration Extension Period Reporting
November 1, 2015 - December 31, 2015

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr6 Ext)	$19,666,669		$19,666,669	DY 10	$39,333,338
Total	**$19,666,669**		**$19,666,669**		**$39,333,338**
DSRIP					
(Qtr6 Ext)*	$18,087,790		$18,087,790		$36,175,580
Total	**$18,087,790**		**$18,087,790**		**$36,175,580**
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr6 Ext)	$51,760		$51,760	DY 10 (June)	$103,520
(Qtr6 Ext)	$364,082		$364,082	DY 10 (Oct)	$728,164
(Qtr6 Ext)	$54,568		$54,568	DY 10 (Jul-Sept)	$109,136
Total	**$470,410**		**$470,410**		**$940,820**

Designated State Health Program (DSHP) Update

Program costs for each of the Designated State Health Programs (DSHP) are expenditures made through the Safety Net Care Pool (SNCP) 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.

During the BTR Waiver Extension Period, DSHPs claimed **$ 470,410.00** in federal fund payments for SNCP eligible services.

Safety Net Care Pool Uncompensated Care Update

Expenditures may be made through the SNCP for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received, furnished by the hospitals or other providers identified by the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, designated public hospitals received **$19,666,669.00** in federal fund payments for SNCP eligible services.

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 is meant to focus on value, rather than volume, of care provided. The purpose is to support PHCS for 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 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.

Operational/Policy Issues:

On March 21, 2016, DHCS received CMS approvals of Attachment EE, *GPP Funding and Mechanics Protocol,* and Attachment GG, *GPP Valuation Methodology Protocol*.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
(Qtr 1 Jan-March)	$257,087,519	$83,290,250	July-September 2015	$340,377,769
Total	$257,087,519	$83,290,250		$340,377,769

The GPP will assist PHCS that provide health care for the uninsured. Expenditures are claimed in accordance with CMS-approved claiming protocols.

DY 11 QTR 1 reporting is the first GPP payment for services from July – September

2015 in which $173,797,269 was paid out in December 2015 and $166,580,500 was paid out in January 2016. The GPP program year began July 1, 2015. The first GPP payment was paid using the Bridge to Reform (BTR) Waiver Disproportionate Share Hospital and Safety Net Care Pool payment methodology and was reported in the BTR Waiver CMS forms since the Department was finalizing Waiver 2020 and the Waiver 2020 CMS forms were not yet available. As agreed with CMS during the negotiations, the Department will be completing a reconciliation in June 2016 to reconcile the funding paid under the BTR methodology to the approved GPP methodology.

In December 2015, PHCS received $173,797,269 in federal funds payments for GPP. In January thru March 2016, Public Health Care Systems received $83,290,250 in federal fund payments and $83,290,250 in IGT for GPP. All of these payments are based on the BTR methodology.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Per STC Items 178-180 *Uncompensated Care Reporting*, the State must commission two reports from an independent entity on uncompensated care in the state. The first independent report will focus on Designated Public Hospitals and will be due to CMS on May 15, 2016. More information about the report can be found in the beginning of this quarterly progress report.

Enclosures/Attachments:

None.

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.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

In November and December 2015, DHCS began the process of gathering cost information from the LIHP counties for completion of final reconciliations.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

LIHP PAYMENTS					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
CDCR (Qtr 6 Ext)	$0.00	$0.00	$0.00		$0.00
Health Care (Qtr 6 Ext)	$579,389	$0.00	$579,389	DY 7	$1,158,778
	$2,112,644	$0.00	$2,112,644	DY 8	$4,225,288
	$1,563,715		$1,563,715	DY 9	$3,127,430
IGT (Qtr 6 Ext)	$0.00	$0.00	$0.00		$0.00
Admin (Qtr 6 Ext)*	$9,742,649	$0.00	$9,742,649	DY7	$19,485,298
	$19,243,228	$0.00	$19,243,228	DY8	$38,486,456
	$13,107,011	$0.00	$13,107,011	DY9	$26,214,022
Total (Qtr 6 Ext)	**$46,348,636**	**$0.00**	**$46,348,636**		**$92,697,272**

Quality Assurance/Monitoring Activities:

Nothing to report.

Enclosures/Attachments:

None.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

<u>The PRIME Program aims to:</u>

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

On March 9, DHCS launched a PRIME Webpage with program information and updates, including stakeholder events and an inbox for public questions and comments.

As required by the Waiver's Special Terms and Conditions (STCs) Item 79 *PRIME Transparency* DHCS will conduct two stakeholder engagement sessions during the 60-day application review process of the PRIME 5-year plans. These sessions will inform the public of DHCS's 5-year plan approval process and enabled DHCS to respond to questions that were raised. A webinar is scheduled for April 11, 2016 while an In-Person Meeting and Webinar is scheduled for April 19, 2016. Meeting agendas and materials will be available on the PRIME Webpage.

Operational/Policy Developments/Issues:

On March 3, CMS approved the PRIME Operational Protocols (Attachments D, Q and II). Following these approvals on March 4, 2016, DHCS released the PRIME 5-Year Plan Template to the 60 participating PRIME entities, and the project applications will be due back to DHCS on April 4, 2016. Eligible PRIME entities, which include Designated Public Hospitals and District/Municipal Public Hospitals as identified in Attachment D, *Participating Prime Entities*, will use a standardized template in submitting their applications. DHCS will review the 5-year plan applications to assess each entity's ability to meet the requirements specified in the STCs and to ensure that each institution has the capacity to successfully participate in the PRIME program.

Each 5-year plan application will be scored on a "Pass/Fail" basis. The state will evaluate the responses to each section and to determine if the response is sufficient to demonstrate that the applicant will be able to effectively implement the selected PRIME Projects while simultaneously conducting the regular business of operating the hospital system.

In the event that a response to a Plan section is not sufficient and fails to meet review criteria, the applicant will have an opportunity to revise the response(s) to meet the state's satisfaction.

Per STC Item 75(a) *Application Process and Five-Year PRIME Project Plan*, DHCS must take action on the 5-year plan applications by either approving or providing

feedback to the hospitals by June 3, 2016. Per STC Item 100(a) *Monitoring and Review of Metric Target Achievement* these 5-year plan applications will be submitted in place of the Interim Mid-Year Report for PRIME DY11 only. The first PRIME payment to participating entities will be contingent on the approval of each hospital's PRIME 5-year plan.

Financial/Budget Neutrality Developments/Issues:

Participating entities in the PRIME program will receive incentive payments, which are funded through federal funds and intergovernmental transfers (IGT). Expenditures are claimed in accordance with CMS-approved claiming protocols.

Payment	FFP			Service Period	Total Funds Payment
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)					
(Qtr 1 Jan - March)	$0	$0		DY 11	$0
Total	**$0**	**$0**			**$0**
Payment	**FFP**		**CPE**	**Service Period**	**Total Claim**
Designated State Health Program (DSHP)					
(Qtr 1 Jan - March)	$0		$0	DY 11	$0
Total	**$0**		**$0**		**$0**

This quarter, the Department claimed **$0** in federal fund payments for DSHP eligible services.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$0** in federal fund payments for PRIME eligible services.

Consumer Issues:

Nothing to report.

Quality Assurance/Monitoring Activity:

Nothing to report.

Enclosures/Attachments:

None.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

Seniors and Persons with Disabilities (SPD) 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
November 2015 – December 2015

County	Total Member Months
Alameda	61,222
Contra Costa	35,372
Fresno	47,544
Kern	37,910
Kings	5,205
Los Angeles	377,848
Madera	5,010
Riverside	62,019
San Bernardino	70,888
San Francisco	33,371
San Joaquin	34,499
Santa Clara	42,443
Stanislaus	25,293
Tulare	21,987
Sacramento	76,647
San Diego	75,739
Total	**1,012,997**

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
January 2016 – March 2016

County	Total Member Months
Alameda	91,198
Contra Costa	53,179
Fresno	70,953
Kern	56,148
Kings	7,682
Los Angeles	563,151
Madera	7,359
Riverside	92,138
San Bernardino	104,633
San Francisco	49,200
San Joaquin	51,375
Santa Clara	63,097
Stanislaus	37,349
Tulare	32,413
Sacramento	114,307
San Diego	111,483
Total	**1,505,665**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
November 2015 – December 2015

County	Total Member Months
Alameda	35,282
Contra Costa	15,411
Fresno	19,811
Kern	13,124
Kings	2,111
Los Angeles	742,194
Madera	2,069
Marin	12,885
Mendocino	11,849
Merced	32,109
Monterey	32,186
Napa	9,388

County	Total Member Months
Orange	242,151
Riverside	99,279
Sacramento	34,154
San Bernardino	97,361
San Diego	146,814
San Francisco	23,442
San Joaquin	14,057
San Luis Obispo	16,634
San Mateo	47,220
Santa Barbara	30,545
Santa Clara	98,362
Santa Cruz	20,755
Solano	39,365
Sonoma	35,404
Stanislaus	7,463
Tulare	9,307
Ventura	56,514
Yolo	17,515
Total	**1,964,761**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
January 2016 – March 2016

County	Total Member Months
Alameda	53,218
Contra Costa	23,322
Fresno	30,642
Kern	19,906
Kings	3,233
Los Angeles	1,100,913
Madera	3,153
Marin	19,300
Mendocino	17,624
Merced	47,877
Monterey	48,189
Napa	14,021

County	Total Member Months
Orange	363,362
Riverside	146,673
Sacramento	52,033
San Bernardino	143,095
San Diego	214,923
San Francisco	35,781
San Joaquin	21,548
San Luis Obispo	24,784
San Mateo	70,486
Santa Barbara	45,610
Santa Clara	148,896
Santa Cruz	31,018
Solano	58,959
Sonoma	52,840
Stanislaus	11,411
Tulare	14,151
Ventura	84,075
Yolo	26,189
Total	**2,927,232**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
November 2015 – December 2015

County	Total Member Months
Alpine	46
Amador	753
Butte	13,463
Calaveras	1,251
Colusa	507
El Dorado	3,539
Glenn	1,141
Imperial	6,880
Inyo	388
Mariposa	469
Mono	139
Nevada	2,211

County	Total Member Months
Placer	6,016
Plumas	714
San Benito	117
Sierra	99
Sutter	3,941
Tehama	3,587
Tuolumne	1,856
Yuba	4,523
Total	**51,640**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
January 2016 – March 2016

County	Total Member Months
Alpine	67
Amador	1,107
Butte	19,996
Calaveras	1,834
Colusa	758
El Dorado	5,217
Glenn	1,681
Imperial	10,120
Inyo	587
Mariposa	686
Mono	217
Nevada	3,251
Placer	9,007
Plumas	1,061
San Benito	173
Sierra	150
Sutter	5,823
Tehama	5,311
Tuolumne	2,763
Yuba	6,781
Total	**76,590**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
November 2015 – December 2015

County	Total Member Months
Del Norte	5,466
Humboldt	18,232
Lake	12,700
Lassen	2,861
Modoc	1,225
Shasta	27,677
Siskiyou	7,338
Trinity	2,037
Total	**77,536**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
January 2016 – March 2016

County	Total Member Months
Del Norte	8,101
Humboldt	27,152
Lake	19,036
Lassen	4,301
Modoc	1,780
Shasta	41,218
Siskiyou	10,951
Trinity	2,890
Total	**115,429**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Enclosures/Attachments:

None.

WHOLE PERSON CARE (WPC)

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

On January 27, 2016, DHCS submitted *Attachment MM WPC Pilot Requirements and Metrics* to CMS for review and approval.

On February 1, 2016, DHCS submitted *Attachment GG WPC Reporting and Evaluation* and *Attachment HH WPC Pilot Requirements and Application Process* to CMS for review and approval.

DHCS continues to collaborate with CMS to finalized edits for Attachments GG, HH, and MM in anticipation of approval within the next quarter.

On March 16, 2016, DHCS released Frequently Asked Questions (FAQs) regarding the Whole Person Care pilots and crosswalk that describes the WPC pilot in comparison to other major programs, including the Health Home Program, Public Hospital Redesign and Incentives in Medi-Cal, and Coordinated Care Initiative. The FAQs will continue to be updated as the program is developed and operated.

On March 16, 2016, DHCS launched the WPC webpage located at http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

On March 22, 2016, DHCS hosted a webinar on the WPC pilot program. The purpose of the webinar was to present responses to FAQs regarding the WPC pilot, as well as to provide an opportunity for stakeholders and interested participants to clarify requirements and expectations of the program. DHCS anticipates hosting a webinar next quarter on the WPC pilot application.

With funding from The California Endowment, DHCS contracted with a vendor, to collaborate on the development of the WPC pilot, the WPC pilot application and selection criteria. DHCS continues to prepare for the release of the draft WPC pilot application and selection criteria for stakeholder review in April, submission of selection criteria to CMS for approval, and then the anticipated release of the final WPC pilot application in May.

Consumer Issues:

DHCS has been working with key stakeholders in the development of the WPC pilot program.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

Enclosures/Attachments:

None.