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)
Second Quarter Reporting Period: 04/01/2016 – 06/30/2016

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INTRODUCTION:

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

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

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

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

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

- DY 11: January 1, 2016 through June 30, 2016
- DY 12: July 1, 2016 through June 30, 2017
- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020

- DY 16: July 1, 2020 through December 31, 2020

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 24: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Demonstration on the following dates:

- April 11, 2016
- May 9, 2016
- June 13, 2016

The main topics covered were various waiver deliverables, the first uncompensated care report, financial reporting for the waiver, and updates on the pending STCs technical corrections.

STCs Items 178-180: Uncompensated Care Reporting

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

The second report will be due to CMS on June 1, 2017, and it will focus on

uncompensated care, provider payments, and financing across all California hospitals that serve Medi-Cal beneficiaries and the under-insured population, using data from the first report for DPHs. The report will include information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and will enhance the quality of health care services.

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

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

The EQRO will produce and publish an initial draft and a final Access Assessment report that includes a comparison of health plan network adequacy compliance across different lines of business; and recommendations in response to any systemic network adequacy issues, if identified. The initial draft and final report will describe the State's current compliance with the access and network adequacy standards set forth in the Medicaid Managed Care 42 CFR 438 final rule.

Governor Brown signed AB 1568 on July 1, 2016. The STCs require DHCS to complete an amendment to the EQRO contract within 90 days of signature.

Below is the estimated Assessment timeline:

- November 2016: Advisory Committee first meeting – Input into the Assessment Design
- April 2017: Advisory Committee Second Meeting – Review of and Comment on Assessment Design
- April 2017: Assessment Design submission to CMS
- June 2017: Assessment Design approval by CMS
- July 2017: EQRO begins to conduct the Assessment (assumes CMS approval of design in June)
- March 2018: Initial Draft Report posted for public comment and Meeting to Present to Advisory Committee for Review and Comment
- June 2018: Final Report Submission to CMS

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

DHCS created the Access Assessment Advisory Committee Application and posted it on the DHCS website from April 1, 2016 to May 1, 2016.

During April and May, DHCS developed the application scoring criteria and scored all applications, respectively.

DHCS scored the applications in May and announced who had been selected to be on the Access Assessment Advisory Committee on June 30, 2016. The Access Assessment Advisory Committee members roster was posted on the DHCS website: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AccAssessComm.pdf

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

Nothing to report.

Enclosures/Attachments:

None.

CALIFORNIA CHILDREN SERVICES (CCS)

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

The CCS Program is administered as a partnership between local CCS county programs and the Department of Health Care Services (DHCS). Approximately 75 percent of CCS-eligible children are Medi-Cal eligible.

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

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

Aid Codes

Programming for Affordable Care Act (ACA) aid codes was completed in July 2016. The table below includes retroactive updates to the enrollment data back to August 2014.

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

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

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

number 54 requires DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) by September 30, 2016 to include 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.

As of June 30, 2016, revised Protocols are currently being reviewed by DHCS management. DHCS provided CMS with updates during the May 9, 2016 and June 13, 2016 CMS-DHCS monthly waiver monitoring calls.

Health Plan of San Mateo Demonstration Project

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

Contract Amendments
HPSM contract amendment A02 is in process. This amendment is to extend the contract term and to revise rates.

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 to 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. Once the contract has been approved by CMS, RCHSD will contract with MedImpact.

- MEMBER HANDBOOK
  As of December 2015, DHCS Office of Legal Services and RCHSD have come to an agreement 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 June 30, 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 June 30, 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 becoming 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 Federal CMS.

Consumer Issues:

CCS Quarter Grievance Report #12

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[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.

The grievance report had no data to report for Quarter 1 2016 (January through March), which lags by one quarter and is reported in the subsequent quarter.

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 July 1, 2017.

The CCS AG meets quarterly in Sacramento.

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

On April 6, 2016, the CCS AG had its third meeting. The following topics and documentation were presented at the April 6th AG meeting:

- Follow-Up from Previous Meeting, Key Updates, and Future Meetings' Topics/Goals
- CCS Program Improvement and Medical Home Discussion
- Medi-Cal Managed Care Health Plan and CCS Requirements

Attached is the website link for the meeting materials:
http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsApril.aspx

On June 29, 2016, the CCS AG had its fourth meeting. The following topics and documentation were presented at the June 29th AG meeting:

- Implementation Rollout
- Readiness Activities for Health Plans and Counties
- Monitoring for Health Plans and Counties
- Data Update – Regionalization of Inpatient and Outpatient Care Use

Attached is the website link for the meeting materials link:
http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialJune29.aspx

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

In June 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
1/1/2016 – 3/31/2016	1,588	126	35	1,679	4,781

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
Grievance Log/Report (Rpt #12)	4/30/2016	No data to report for Q1 2016		
Provider Manual (Manual #3)	4/30/2016	5/2/2016	X	
DMHC Required Financial Reporting Forms (Forms #3)	5/1/2016	4/19/2016		YES
Financial Audit Report (Rpt #3)	5/1/2016	The Department has requested this information from HPSM, but has not received the reports as of June 30, 2016.		
Provider Network Reports (Rpt #12)	5/15/2016			
Quarterly Financial Statements (Rpt #12)	5/15/2016			
Report of All Denials of Services Requested by Providers (Rpt #11)	5/15/2016			
Annual Forecasts Report (Rpt #3)	6/30/2016			

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) facilitated extensive stakeholder input regarding the continuation of CBAS. DHCS proposed an amendment to the CBAS BTR waiver to continue CBAS as a managed care benefit beyond August 31, 2014. CMS approved amendment to the CBAS BTR waiver extending CBAS for the length of the BTR Waiver, until October 31, 2015.

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

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 where ADHC services had been provided prior to CBAS starting on April 1, 2012.[1] 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) transitioned the CBAS benefit to managed care 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 services (i.e. component parts of CBAS delivered outside of centers with a similar objective of supporting members, allowing them to remain in the community). 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 the Medi-Cal State Plan. If the member is residing in a Coordinated Care Initiative (CCI) county and enrolled in managed care, the Medi-Cal MCP will be responsible for coordinating the care through other avenues.

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 2 (Q2) covers the period of April to June 2016 is shown in Table 1 entitled *"Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 5 entitled *"CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 are based on self-reporting by the MCPs. 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 counties are grouped together. FFS claims data identified in Table 1, which has a lag factor of about two to three months, reflects data for the period of January to March 2016.

[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.

Review Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS

TABLE 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY10 Q4 Apr - June 2015		DY10 Q5 Jul - Sept 2015		DY11 Q1 Oct - Dec 2015		DY11 Q2 Jan - Mar 2016	
County	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used	Unduplicated Participants	Capacity Used
Alameda	466	83%	483	86%	534	96%	507	103%
Butte	*	*	*	*	*	*	*	*
Contra Costa	202	63%	208	65%	227	71%	214	67%
Fresno	622	64%	525	54%	631	65%	548	50%
Humboldt	98	25%	107	28%	164	42%	94	24%
Imperial	177	32%	81	14%	363	65%	344	62%
Kern	96	28%	50	15%	95	28%	77	23%
Los Angeles	18,434	60%	19,084	61%	20,149	64%	19,786	63%
Merced	86	47%	96	52%	92	50%	85	40%
Monterey	86	46%	78	42%	98	53%	89	48%
Orange	2,249	68%	2,248	68%	2,004	60%	2,051	57%
Riverside	397	37%	396	37%	425	39%	428	39%
Sacramento	592	66%	648	72%	697	78%	585	65%
San Bernardino	543	100%	552	102%	610	113%	594	110%
San Diego	1,765	50%	1,781	47%	2,353	62%	1,885	50%
San Francisco	706	48%	720	49%	775	53%	747	51%
San Mateo	155	68%	154	67%	156	68%	157	69%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	549	39%	644	46%	655	47%	660	47%
Santa Cruz	94	62%	96	63%	113	74%	90	59%
Shasta	44	31%	41	28%	12	8%	54	38%
Ventura	901	63%	915	63%	915	63%	920	64%
Yolo	72	19%	81	21%	75	20%	75	20%
Marin, Napa, Solano	179	36%	158	32%	167	33%	68	14%
Total	**28,542**	**57%**	**29,160**	**58%**	**31,348**	**62%**	**30,091**	**59%**

FFS and MCP Enrollment Data 03/2016

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

Table 1 reflects a slightly lower total count of 30,091 participants, approximately 1,000 participants lower from the last quarter due to some CBAS Centers closing or reducing their licensed capacity. There is ample capacity for participant enrollment into almost all of the CBAS Centers except for Alameda and San Bernardino County which are currently operating over center capacity. Alameda County's licensed capacity has been reduced, resulting in an over-extension of the county's maximum capacity used due to the number of participants they were still providing services for. The decrease in the number of participants enrolled in the CBAS Centers has reduced the percentage of capacity used by more than 5% for CBAS Centers in Humboldt, Sacramento, San Diego, Marin,

Napa, and Solano counties. It is important to note that member participation has been reduced which effects overall utilized capacity. Decreased capacity used is not due to Center closures, rather the decrease is due to a lower number of participants. Also, the increase in licensed capacity in Fresno, Merced, and Orange counties has resulted in a decrease in the percentage of capacity used for CBAS Centers in those counties.

It should also be noted that Butte and Imperial counties MCP numbers for DY11 Q1 have been updated in this report to reflect available data. Submission of last quarter's information showed a much lower number for both counties. This report has since been updated to reflect actual data the State has gathered.

CBAS Assessments Determined Eligible and Ineligible

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

Table 2 entitled "*CBAS Assessment Data for MCP and FFS"* list the number 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	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY10 Q1 (7/1-9/30/2014)	2,299	2,251 (98%)	48 (2%)	260	256 (98.5%)	4 (1.5%)
DY10 Q2 (10/1-12/31/2014	2,860	2,812 (98%)	48 (2%)	62	60 (96.8%)	2 (3.2%)
DY10 Q3 (1/1-3/31/2015)	2,497	2,433 (97.4%)	64 (2.6%)	51	49 (96.8%)	2 (3.2%)
DY10 Q4 (4/1-6/30/2015)	2,994	2,941 (98.2%)	53 (1.8%)	43	42 (97.7%)	1 (2.3%)
DY10 Q5 (7/1-9/30/2015)	2,600	2,552 (98.2%)	48 (1.8%)	50	50 (100%)	0 (0%)
DY11 Q1 (10/1-12/31/2015)	2,301	2,258 (98.1%)	43 (1.9%)	26	25 (96.2%)	1 (3.8%)
DY11 Q2 (1/1-3/31/2016)	2,404	2,370 (98.6%)	34 (1.4%)	19	19 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

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

Requests for CBAS services were collected by MCPs and DHCS. For DY11 Q2, approximately 2,404 assessments were completed by the MCPs, 2,370 were determined to be eligible, and 34 were determined ineligible. There were a total of 62 requests for FFS CBAS services submitted to DHCS; 19 of the requests were assessed and determined to be FFS eligible; and 28 requests were referred to managed care for CBAS benefits. There were 15 FFS requests that were not completed due to the beneficiaries deciding not to follow through with the face-to-face assessment. Eligible FFS counts continue to decline due to all CBAS counties being covered by managed care as of December 1, 2014. The number of FFS requests submitted to DHCS has slightly decreased from last quarter. Table 2 only reflects the actual assessments completed by MCPs and DHCS.

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 close decrease the available capacity and enrollment while conversely, new CBAS Center openings increase capacity and enrollment. 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 entitled "*CDA – CBAS Provider Self-Reported Data*." On average, the ADA at the 242 CBAS Centers are 20,900 or 86%.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	242
Non-Profit Centers	59
For-Profit Centers	183
ADA @ 242 Centers	20,900
ADA per Centers	86%

CDA - MSSR Data 03/2016

**Note: 242 CBAS Centers were open for at least one business day in March 2016; therefore, they were required to report data. Information is not available for April to June 2016 due to a delay in the availability of data.*

Outreach/Innovative Activities:

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 Transition Plan (STP). DHCS and CDA hosted three meetings/webinars in February, March, and April 2015 that were focused on developing the CBAS HCBS transition plan. In May 2015, DHCS and CDA released a draft of the CBAS HCBS transition plan for public comment. In July 2015, the comments and CBAS plan revisions were presented for incorporation into the STP. DHCS submitted the amended STP on August 14, 2015.

After reviewing stakeholder input in addition to milestones identified in the CBAS Amendment of BTR Waiver, DHCS and CDA decided to initiate work groups to address the identified concerns. In July 2015, DHCS and CDA convened two work groups to develop a CBAS quality strategy and to revise the current CBAS IPC emphasizing person-centered planning. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that have convened 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 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 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 CBAS inquiries to CBAS@dhcs.ca.gov for assistance from DHCS.

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

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11 - Q 1 (Oct 1 - Dec 31)	1	0	1
DY11 - Q2 (Jan 1 - Mar 31)	1	0	1

CDA Data - Complaints 03/2016

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

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11 - Q 1 (Oct 1 - Dec 31)	4	0	4
DY11 - Q2 (Jan 1 - Mar 31)	6	1	7

Plan data - Phone Center Complaints 03/2016

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

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

In DY11 Q2, there were six grievances filed with MCPs. Two of the grievances were regarding CBAS providers and four were about other CBAS related issues. There were six CBAS appeals filed with MCPs. Four out of the six appeals were related to denial of services or limited services, and two were related to other CBAS issues that were unrelated to denial of services.

The State Fair Hearings / Appeals continue to be facilitated by the California Department of Social Services with Administrative Law Judges' hearing all cases filed. As of DY11 Q2, there were no requests for fair hearing.

Quality Assurance/Monitoring Activities:

DHCS and CDA convened six stakeholder workgroup meetings between July 2015 and June 2016 to develop a quality strategy for CBAS. The CBAS Quality Assurance and Improvement Strategy will be released for comment in August 2016 and implementation is scheduled to begin in October 2016.

DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under the Medi-Cal 2020 Waiver. Table 6 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 6 also illustrates overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal members is 59% statewide.

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	DY11-Q1 Oct Dec 2015	DY11-Q2 Jan-Mar 2016	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	330	330	**330**	290	-12%	103%
Butte	60	60	60	60	60	**60**	60	0%	28%
Contra Costa	190	190	190	190	190	**190**	190	0%	67%
Fresno	590	547	572	572	572	**572**	652	14%	50%
Humboldt	229	229	229	229	229	**229**	229	0%	24%
Imperial	250	315	330	330	330	**330**	330	0%	62%
Kern	200	200	200	200	200	**200**	200	0%	23%
Los Angeles	17,735	17,506	18,184	18,238	18,502	**18,508**	18,536	0%	63%
Merced	109	109	109	109	109	**109**	124	14%	40%
Monterey	290	0	110	110	110	**110**	110	0%	48%
Orange	1,897	1,747	1,910	1,960	1,960	**1,960**	2,120	8%	57%
Riverside	640	640	640	640	640	**640**	640	0%	39%
Sacramento	529	529	529	529	529	**529**	529	0%	65%
San Bernardino	320	320	320	320	320	**320**	320	0%	110%
San Diego	2,132	1,992	1,873	2,068	2,233	**2,233**	2,233	0%	50%
San Francisco	803	803	866	866	866	**866**	866	0%	51%
San Mateo	120	120	135	135	135	**135**	135	0%	69%
Santa Barbara	55	55	55	60	60	**60**	60	0%	5%
Santa Clara	820	750	840	830	830	**830**	830	0%	47%
Santa Cruz	90	90	90	90	90	**90**	90	0%	59%
Shasta	85	85	85	85	85	**85**	85	0%	38%
Ventura	806	806	806	851	851	**851**	851	0%	64%
Yolo	224	224	224	224	224	**224**	224	0%	1%
Marin, Napa, Solano	295	295	295	295	295	**295**	295	0%	14%
SUM =	29,009	27,967	29,007	30,396	30,825	30,831	31,074	24%	59%

CDA Licensed Capacity as of 03/2016

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 April to June 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 a decrease in provider capacity of 5% or more during this quarter for Alameda County since the county's licensed capacity has been reduced from 330 to 290. The decrease was caused by the Berkeley Adult Day Health Care Center closing in December 2015. A total of 25 program participants were impacted by the closure of Berkeley ADHC Center closing. When the center closed, 19 of its 25 participants were transferred to another CBAS Center, three of the participants chose to terminate their participation in CBAS services, two of the participants were placed in a Senior Nursing Facility, and one participant was transferred to an All-Inclusive Program. Of the 25 participants, 19 had received services via a managed care fee-for- service payment model.

While Alameda County decreased its licensed capacity, Fresno, Merced, and Orange counties have increased their licensed capacity over 5% or more. Increased of licensed capacity can be a combination of new CBAS Center opening or request to CDA to increase their licensed capacity. For Orange County, it was a result of a CBAS Center opening in January 2016 (licensed capacity data is updated in this report to reflected actual available data). For Fresno and Merced, it could be due to licensed capacity increase approval from CDA. CBAS Centers self-report utilization data and during the past quarter, the counties identified above provided services to beneficiaries beyond their licensed capacities. While licensed capacity allows for the total number of beneficiaries at any given center, CBAS participants come in and out during the day and week and therefore, the overall services exceeded the license capacity.

Access Monitoring (STC 99.e.)

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

Unbundled Services (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 be 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 participants 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 Q2, CDA had 241 CBAS Center providers operating in California. According to Table 7 entitled "*CBAS Center History*," the number of CBAS Centers operating has decreased by one from the last quarter. On March 31, 2016, Salida Del Sol Adult Day Health Care in Los Angeles County closed.

Table 7:

CBAS Center History

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

Table 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) of the 1115 Waiver, the MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the centers capacity to date and adequate networks remains for this population.

The extension of CBAS, under Medi-Cal 2020 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.

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:

<u>Domain 1 – Increase Preventive Services for Children</u>

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

<u>Domain 2 – Caries Risk Assessment (CRA) and Disease Management</u>

Domain 2 will be available in select pilot counties and is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages 6 and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this domain, a provider must attend training and elect to opt into this domain. If the pilot is successful, then this program may be expanded to

other counties, contingent on available DTI funding. The program year for this domain will capture all activities for 2017 with an anticipated implementation date in January 2017.

Domain 3 – Continuity of Care

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

Domain 4 – Local Dental Pilot Projects (LDPP)

The LDPP will support the aforementioned domains through up to 15 innovative pilot programs to test alternative methods, to increase preventive services, to manage early childhood caries, and to establish and maintain continuity of care. DHCS received 25 non-binding Letters of Intent in May 2016 for entities interested in submitting a formal application for consideration. Formal applications are due September 30, 2016 with a target implementation date of February 15, 2017.

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

Small Stakeholder Workgroup

In March 2016, DHCS convened a small stakeholder workgroup, 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, to discuss policy considerations for DTI implementation. As envisioned, this workgroup has continued to collaborate with the Department on planning and roll-out efforts necessary to ensure the success of the DTI. Their collaboration and input helped to further inform the DTI work and outcomes for each of the domains. The final products have been shared as they are finalized with the larger set of interested dental stakeholders and the provider community via webinars and other communication methods. This workgroup is still active.

DTI Small Stakeholder Subgroups:

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

Caries Risk Assessment Sub-Workgroup
Established in March 2016 and spearheaded by California's State Dental Director, Dr. Jayanth Kumar, this sub-workgroup is tasked with identifying, developing, and finalizing the risk assessment tool(s) and training program that will be used for Domain 2, the 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 development of these risk assessment tools and training programs will enable DHCS to work toward the achievement of CMS' Triple Aim goals by implementing provider incentives, performing a CRA to identify a child's risk level, and developing and completing a beneficiary-specific treatment plan. This sub-workgroup is still active.

Safety Net Clinic Sub-Workgroup
This sub-workgroup is comprised of representatives from DHCS, California Rural Indian Health Board, California Consortium for Urban Indian Health, California Primary Care Association, Dental Managed Care plans and the Dental Fiscal Intermediary (FI). This workgroup was established in May 2016 for the purpose of identifying the best mechanism by which to collect beneficiary and service specific data from the safety net clinics, such as Federally Qualified Health Centers, Rural Health Centers, and Indian Health Centers, for the services rendered to Medi-Cal beneficiaries which will then enable them to participate in the DTI. This sub-workgroup is still active.

Webinars

On April 8, 2016, DHCS held a DTI Stakeholder Webinar and provided the participants an overview of DTI, a high-level overview of the DTI timeline, and answered stakeholder questions.

On May 18, 2016, DHCS held a DTI Stakeholder Webinar, which provided an overview of the Local Dental Pilot Program (LDPP), the application process, and an update on Domains 1-3.

On June 14, 2016, DHCS held a DTI Stakeholder Webinar, which provided general updates on the LDPP application revisions and the revised application due date.

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 was updated regularly during DY11 Q2 and will continue to be updated as new information becomes available.

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

DTI Inbox and Listserv

In March 2016, DHCS created an e-mail address and listserv for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations to direct comments, questions, or suggestions and sign up for our listserv to receive relevant DTI updates.

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

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

DTI FAQs

In March 2016, DHCS released the first iteration of a DTI FAQs document. The document provided responses to stakeholders' frequently asked questions for DTI. The FAQs document is a living document and is continuously updated as new questions are submitted and responded to; these questions are raised and received through the DTI e-mail inbox, DTI webinars, and other venues. The link to the FAQs is:
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver Renewal/FAQs_DTI.xls

Outreach Plans

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

- Dental outreach and education plan - targeted toward the Medi-Cal beneficiaries
- Provider outreach plan – targeted toward the provider community

These plans were updated as part of the 2016 outreach plans to include the DTI efforts. A call center script was also being developed during DY11 Q2 to provide a DTI overview and domain-specific information.

In addition, DHCS presented information on the initiative at several venues. Following is a list of venues at which information on DTI was disseminated:

- April 13, 2016 and June 9, 2016 – Los Angles (LA) Stakeholder Meeting
- April 26, 2016 – Child Health and Disability Prevention (CHDP) Oral Health Subcommittee
- May 2, 2016 – Indian Health Services (IHS) Dental Directors Conference
- May 13, 2016 – California Dental Association (CDA) Presents in Anaheim

- May 16, 2016 – Stakeholder Advisory Committee (SAC) Meeting
- May 26, 2016 – Medi-Cal Dental Advisory Committee (MCDAC)
- June 10, 2016 – California Health Care Foundation (CHCF) & DHCS Quarterly Meeting
- June 21, 2016 – Oral Health Advisory Council Meeting
- June 29, 2016 – Perinatal Infant Oral Health Quality Improvement Project Technical Assistance Meeting

Operational/Policy Developments/Issues:

Domain 1 DY11 Q2 Update

A Safety-Net Clinic sub-workgroup was established in May 2016 and has continued to meet on a weekly basis in an effort to finalize the data collection and reporting mechanisms for the safety net clinics, i.e. Federally Qualified Health Centers, Rural Health Centers, and Indian Health Centers, that will participate in this domain. The workgroup has played a critical role in providing input, insight, and suggestions for data submission alternatives by the safety net clinics because they currently do not bill for dental services via the Dental Fiscal Intermediary (FI).

Discussions to date have included a proposal that safety net clinics submit their encounter data in an 837D format to the Dental FI, in addition to the 837i transaction file they already submit to the medical fiscal intermediary as part of their current processes. The clinic service data is needed to capture specific service information needed at the claim level, beyond an 03 encounter, to calculate the services which qualify for an incentive payment across the DTI domains. This update also applies to Domain 3's quarterly update.

Additionally, the Domain 1 Fact Sheet, was released and posted to the DTI website on June 1, 2016. The fact sheet is located at:
http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain1Final.pdf

Incentive payments under Domain 1 will occur semi-annually. The first payment is anticipated to be disbursed in January 2017, covering the first six months of program year one (January – June 2016).

Domain 2 DY11 Q2 Update

Efforts progressed to select and finalize a CRA tool as well as training materials and resources for implementation. The Caries Risk Assessment Sub-Workgroup that was established at the end of last quarter, March 2016, met several times throughout April,

May, and June this quarter to draft a proposed CRA tool. Based on the group discussions, a tool has been submitted for final review and approval. The next step, post- approval of the tool, in finalizing this domain is to pilot the chosen tool and to evaluate the ease of use and effectiveness.

DHCS in collaboration with the California Dental Association is also developing a training curricula for use under this domain; the provider(s) will be offered continuing education units for the completion of the required training course. The target finalization date of all training and resource materials for the pilot is October 2016 with a January 2017 implementation date.

Domain 3 DY11 Q2 Update

Please see the Domain 1 update related to the establishment of the Safety-Net Clinic sub-workgroup for the purposes of identifying a mechanism to collect specific encounter data from the safety net clinics, such as Federally Qualified Health Centers, Rural Health Centers, and Indian Health Centers. The Domain 3 Fact Sheet and Continuity of Care Baseline Benchmark by County were released and posted to the DTI website on May 26, 2016. The implementation date for this domain is January 2017.

Domain 4 DY11 Q2 Update

Letter of Intent (LOI)
On April 22, 2016, DHCS released its LOI Instructions for LDPPs. The purpose of the LOI was to assess the level of existing interest to participate in an LDPP across the state, obtain preliminary LDPP design information that will assist DHCS with finalizing the LDPP application, and provide an opportunity for potential applicants to submit questions. Submission of an LOI was voluntary and nonbinding. Failure to submit did not preclude an entity from applying to participate in the LDPP. A list of the LOIs received is enclosed as an attachment.

LDPPs Application
On April 22, 2016, DHCS submitted a draft LDPP application and selection criteria to CMS and the DTI Small Stakeholder Workgroup for comment. DHCS received comments in early May 2016. DHCS revised the documents and released drafts for public comment on May 13, 2016. DHCS released and posted to the DTI website the final LDPP pilot application and selection criteria June 01, 2016, with an application due date of August 30, 2016.

In addition to the resources noted throughout this Domain 4 update, a number of other useful Domain 4 and LDPP resources were released and posted on the DTI website throughout DY11 Q2. DHCS intends to have all resources to support the LDPPs finalized in the next reporting quarter.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

As of June 2016, DHCS and CMS were in discussions to finalize the LDPP budget template for Domain 4. A draft budget template and instructions will be provided to CMS for review.

Quality Assurance/Monitoring Activities:

Nothing to report at this time.

Evaluation:

Nothing to report at this time.

Enclosures/Attachments:

Attached is the “Voluntary LDPP Letters of Intent Submissions”, which is also available online at the DTI website.

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

- Bi-monthly technical assistance calls with county leads
- Weekly Harbage Consulting meetings regarding DMC-ODS Wavier
- April 12, 2016 – Quarterly Blue Shield Foundation Meeting
- April 18, 2016 – Fiscal DMC Rates Call
- May 2, 2016 – California Indian Health Service Follow-up Plan/Questions
- May 3, 2016 – Fiscal Provisions Part 2 Webinar
- May 5, 2016 – Director's Stakeholder Advisory Group Meeting
- May 12, 2016 – California Mental Health Advocates for Children and Youth Meeting
- May 16, 2016 – SAC Assembly Budget Subcommittee Meeting Presentation
- May 20, 2016 – Phase 3 Regional Meeting Part 2
- May 23, 2016 – County Behavioral Health Directors Association of California Fiscal Summit
- May 25, 2016 – County Behavioral Health Directors Association of California Small County Conference

- June 2, 2016 – Indian Health Service & Centers for Medicare and Medicaid Services Call regarding Indian Health Services Proposal
- June 3, 2016 – Integration Plan Stakeholder Meeting
- June 7, 2016 – DHCS Academy Presentation
- June 7, 2016 – California Health Care Foundation
- June 10, 2016 – UCLA American Society Addiction Medicine Tool Webinar
- June 13, 2016 – Review of Indian Health Services' Concept Paper

Operational/Policy Developments/Issues:

There was a delay in obtaining approval for the UCLA evaluation design, and CMS approval was received on June 20, 2016.

There was a continuous delay in the counties' implementation plan review process with CMS. DHCS brought the counties' concerns to CMS, and CMS strategized a more efficient review procedure.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

The CPE Protocol was approved on June 17, 2016. The Protocol and CMS approval letter has been posted online at the DHCS website link below:
http://www.dhcs.ca.gov/provgovpart/Pages/Standard-Terms-and-Conditions.aspx

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

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

Enclosures/Attachments:

None.

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/DSRIP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
Designated State Health Program (DSHP)				
(Qtr 1 Jan - March)	$0	$0	DY 11	$0
(Qtr 2 April - June)	$0	$0	DY 11	$0
Total	**$0**	**$0**		**$0**

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

Delivery System Reform Incentive Pool (DSRIP)

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

Payment	FFP	IGT	Service Period	Total Funds Payment
Delivery System Reform Incentive Pool (DSRIP)				
(Qtr 1 Jan - March)	$0	$0	DY 10	$0
(Qtr 2 April – June)	$100,051.88	$100,051.87	DY 10	$200,103.75
Total	**$100,051.88**	**$100,051.87**		**$200,103.75**

DY 11 quarter 2, DSRIP had one payment totaling $200,103.75. This payment was for DSRIP's DY 10 annual payment for achievements occurring between July 1, 2014 – October 31, 2015.

This quarter, Designated Public Hospitals received **$100,051.88** in federal fund payments for DSRIP eligible services.

Low Income Health Program (LIHP)

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

Payment	FFP	IGT	Service Period	Total Funds Payment
Low Income Health Program (LIHP)				
(Qtr 1 Jan - March)	$0	$0	DY 10	$0
(Qtr 2 April – June)	$0	$0	DY 10	$0
Total	**$0**	**$0**		**$0**

This quarter, LIHP received $0 in federal fund payments. DHCS is still collaborating with the LIHP counties to complete final reconciliations for DY3 through DY9.

GLOBAL PAYMENT PROGRAM (GPP)

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

The Department held a webinar on May 26, 2016, to discuss in detail the point valuations of traditional and non-traditional services and their impact on the funding available through the GPP for participating Designated Public Hospital systems.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

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

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
			2015	
(Qtr 2 April-June)	$571,025,147	$744,822,416	July 1, 2015 – June 30, 2016	$1,315,847,563
Total	$828,112,666	$828,112,666		$1,656,225,332

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

DY11 Q1 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 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.

DY11 Q2 reporting is the second GPP payment for services from October 2015 – June 2016. In addition, the Department completed a methodology reconciliation for payment made using the BTR methodology versus the GPP methodology for services between July 2015 – September 2015, as agreed with CMS during the negotiations. A total of $1,315,847,563 was paid out in June 2016.

This quarter, PHCS received $571,025,147 in federal funds payments and $744,822,416 in IGT for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

DHCS and Navigant, as the contractor to conduct the first report, submitted the Evaluation of Uncompensated Care Financing for California Designated Public Hospitals to CMS on May 15, 2016. CMS has 60 days to provide a formal determination of the funding levels for demonstration years two through five.

Enclosures/Attachments:

None.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Per STC Item 83 *Evaluation Requirement,* DHCS must engage the public in the development of its evaluation design. In August, 2016, DHCS plans to engage the public in the development of the design after is has gone through internal vetting.

Operational/Policy Developments/Issues:

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

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

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

Financial/Budget Neutrality Development/Issues:

PRIME 5-year plans were not approved in time to make payments in June 2016. Payments will go out in July 2016 (DY12 Q1).

Payment	FFP	IGT	Service Period	Total Funds Payment
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)				
(Qtr 1 Jan - March)	$0	$0	DY 11	$0
(Qtr 2 April – June)	$0	$0	DY 11	$0
Total	**$0**	**$0**		**$0**

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 Activities:

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

Evaluations:

As of June 1, 2016, DHCS has started the process of development and internal review of the draft evaluation design. The draft design will be posted to the PRIME Webpage under Stakeholder Engagement, and public comments will be submitted through the PRIME Inbox at: PRIME@dhcs.ca.gov.

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 SPD BY COUNTY
April 2016 – June 2016

County	Total Member Months
Alameda	90,583
Contra Costa	53,148
Fresno	70,613
Kern	55,906
Kings	7,576
Los Angeles	560,251
Madera	7,222
Riverside	91,873
San Bernardino	103,254
San Francisco	48,005
San Joaquin	50,728
Santa Clara	62,282
Stanislaus	36,922
Tulare	31,959
Sacramento	112,740
San Diego	109,641
Total	**1,492,703**

TOTAL MEMBER MONTHS FOR EXISTING SPD BY COUNTY
April 2016 – June 2016

County	Total Member Months
Alameda	54,112
Contra Costa	23,772
Fresno	31,783
Kern	20,670
Kings	3,336
Los Angeles	1,083,230
Madera	3,216
Marin	19,239
Mendocino	17,508
Merced	47,709
Monterey	48,036
Napa	13,939
Orange	365,867
Riverside	144,591
Sacramento	53,301
San Bernardino	140,271
San Diego	210,450
San Francisco	36,365
San Joaquin	22,174
San Luis Obispo	24,694
San Mateo	69,864
Santa Barbara	45,479
Santa Clara	146,586
Santa Cruz	31,083
Solano	58,854
Sonoma	52,654
Stanislaus	11,796
Tulare	14,349
Ventura	83,782
Yolo	26,107
Total	**2,904,817**

TOTAL MEMBER MONTHS FOR SPD IN RURAL NON-COHS COUNTIES
April 2016 – June 2016

County	Total Member Months
Alpine	61
Amador	1,100
Butte	19,663
Calaveras	1,846
Colusa	749
El Dorado	5,187
Glenn	1,629
Imperial	9,979
Inyo	594
Mariposa	663
Mono	216
Nevada	3,229
Placer	9,015
Plumas	1,047
San Benito	178
Sierra	145
Sutter	5,754
Tehama	5,238
Tuolumne	2,697
Yuba	6,762
Total	**75,752**

TOTAL MEMBER MONTHS FOR SPD IN RURAL COHS COUNTIES
April 2016 – June 2016

County	Total Member Months
Del Norte	8,098
Humboldt	26,891
Lake	18,891
Lassen	4,283
Modoc	1,801
Shasta	40,859

County	Total Member Months
Siskiyou	10,880
Trinity	2,825
Total	**114,528**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

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:

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

Operational/Policy Issues:

On March 16, 2016, DHCS released Frequently Asked Questions (FAQs) regarding the WPC Pilot Program. The FAQs were subsequently updated on April 11, May 13, June 2 and June 24, 2016, as program development continued in preparation for release of the WPC Application and based upon stakeholder feedback. The FAQs are available on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Documents/RevisedDHCSWPCFAQ6-24-16.pdf.

On April 11, 2016, DHCS released the WPC Pilot Program draft application and selection criteria for stakeholder review. The draft application reflects the requirements described in the Medi-Cal 2020 Special Terms and Conditions (STCs), which include

the identification of the target population, a description of the WPC pilot structure and the needs of the target population, services that will be provided and the interventions that will be applied, and the funding request for the WPC pilot.

On April 25, 2016, DHCS submitted the WPC draft application and selection criteria to Center for Medicare and Medicaid Services (CMS) for approval. CMS approved the WPC Application and Selection Criteria on May 13, 2016.

On April 21, 2016, DHCS released the Letter of Intent (LOI) template. The completed LOI was due to DHCS from eligible lead entities on April 8, 2016. The purpose of the LOI was to assess the level of interest to participate in the WPC pilots across the state, obtain preliminary WPC pilot design information, and provide an opportunity for potential applicants to submit questions. The LOIs were voluntary and non-binding, furthermore absence of LOI submission did not preclude a lead entity from applying to participate in the WPC pilot. Twenty-eight entities submitted LOIs. One entity responded they were unable to provide preliminary details as requested in an LOI but were considering participation in the WPC pilot.

On May 13, 2016, DHCS received approval from CMS on the WPC Pilots Program STC attachments: Whole Person Care (WPC) Reporting and Evaluation (Attachment GG), WPC Pilot Requirements and Application Process (Attachment HH), and WPC Pilot Requirements and Metrics (Attachment MM).

On May 16, 2016, DHCS released the final application and selection criteria for the WPC Pilot Program. The application elements were based on the STCs, Attachment HH, and developed from feedback by CMS, as well as various stakeholders.

On May 19, 2016, DHCS hosted a webinar on the WPC application. The purpose of the webinar was to describe the final WPC application and selection criteria prior to the release of the application and selection criteria. DHCS clarified specific program requirements, as had been requested in public comments and questions received by DHCS.

On June 15, 2016, DHCS submitted a waiver amendment request to CMS to expand the definition of an allowable WPC pilot lead entity to include a federally recognized tribe, a tribal health program operated under a Public Law 93-638 contract with the federal Indian Health Services. A response is expected from CMS within 120 days of submission.

WPC applications are due from the lead entities on July 1, 2016. The application evaluation will be a competitive process that will result in the selection of qualified WPC pilots based on the quality and scope of their application. DHCS will conduct the evaluation process in two phases: (1) Quality and Scope of Application and (2) Funding Decision. WPC pilot applications that do not meet the basic requirements of the STCs and DHCS application guidance will be disqualified.

Consumer Issues:

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

Financial/Budget Neutrality Development/Issues:

On June 3, 2016, DHCS hosted a webinar to review the components of the budget and provide additional guidance to assist WPC pilots in developing their budget model.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

Enclosures/Attachments:

None.