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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Twelve (07/01/2016 – 06/30/2017)
Second Quarter Reporting Period: 10/01/2016 – 12/31/2016

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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.

On December 8, 2016, DHCS received approval from CMS for the DTI and WPC amendments. These amendments will expand the definition of the lead entity for the WPC pilots to include federally recognized Tribes and Tribal Health Programs, and modify the methodology for determining baseline metrics for incentive payments and provide payments for a revised threshold of annual increases in children preventive services under the DTI.

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 November 21, 2016 and December 12, 2016.

The following topics were discussed:

- WPC applications
- Attachment KK/CCS Protocols
- Attachment R/Alternate Payment Methodology (APM) framework
- Progress on Draft Evaluation Designs
- Cal MediConnect
- Health Homes
- Second Uncompensated Care Report Proposal
- Pending waiver amendments for WPC and DTI

STCs Items 178-180: Uncompensated Care Reporting

Please refer to the Evaluation section of GPP's report below for information.

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 (STCs) sections 65-69 require the Department of Health Care Services (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, as well as grievances and appeals, and 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 will include a comparison of health plan network adequacy compliance across different lines of business and recommendations in response to any systemic network adequacy issues, if identified. The initial draft and final report will describe the State's current compliance with the access and network adequacy standards set forth in federal regulations (42 Code of Federal Regulations 438).

Governor Brown signed Assembly Bill (AB) 1568 (Chapter 42, Statutes of 2016) and Senate Bill (SB) 815 (Chapter 111, Statutes of 2016), establishing the Medi-Cal 2020 Demonstration and requirements for implementation of the STCs. DHCS is required to complete an amendment to the EQRO contract within 90 days of signature. SB 815 which provided authority to DHCS pertaining to the Assessment was signed by the Governor on July 25, 2016.

Below is the estimated Assessment timeline:

- November 2016: First Advisory Committee Meeting – Input into the Assessment Design
- April 2017: Second Advisory Committee Meeting – Review of and comment on Assessment Design
- April 2017: Assessment Design submitted to the Centers for Medicare and Medicaid Services (CMS)
- TBD: Assessment Design approved by CMS
- TBD: EQRO begins to conduct the Assessment (assuming CMS approval of Assessment Design in June)
- TBD: Initial draft report posted for public comment and meeting to present to the advisory committee for review and comment
- Ten months following CMS design approval: Final report submission to CMS

DHCS and its EQRO, Health Services Advisory Group (HSAG), finalized and signed the EQRO contract amendment to include the Access Assessment project. On

September 23, 2016, DHCS sent the EQRO contract amendment to CMS for its review and approval.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

The first advisory committee was held on November 18, 2016. Based off of the advisory committee discussions, HSAG is building the Access Assessment design outline. The next advisory committee meeting is scheduled for January 31, 2017. The Assessment webpage is continuously being updated and can be accessed at the following link: http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

Nothing to report.

CALIFORNIA CHILDREN SERVICES (CCS)

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

The CCS Program is administered as a partnership between local CCS county programs and 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 186,000 children enrolled in CCS.

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

The two (2) health care delivery models include:

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

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

Enrollment information:

The table below represents the most current enrollment numbers and the capitation rates for HPSM for the period January 1, 2015 through December 31, 2016. Eligibility

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

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
January 2015	1,527	$1,593.01	$2,432,526
February 2015	1,502	$1,593.01	$2,392,701
March 2015	1,546	$1,593.01	$2,462,793
April 2015	1,552	$1,593.01	$2,472,352
May 2015	1,569	$1,593.01	$2,499,433
June 2015	1,589	$1,593.01	$2,531,293
July 2015	1,591	$1,475.28	$2,347,170
August 2015	1,590	$1,475.28	$2,345,695
September 2015	1,598	$1,475.28	$2,357,497
October 2015	1,581	$1,475.28	$2,332,418
November 2015	1,590	$1,475.28	$2,345,695
December 2015	1,587	$1,475.28	$2,341,269
January 2016	1,580	$1,475.28	$2,330,942
February 2016	1,589	$1,475.28	$2,344,220
March 2016	1,607	$1,475.28	$2,370,775
April 2016	1,624	$1,475.28	$2,395,855
May 2016	1,619	$1,475.28	$2,388,478
June 2016	1,622	$1,475.28	$2,392,904
July 2016	1,651		
August 2016	1,639		
September 2016	1,611		
October 2016	1,645		
November 2016	1,635		
December 2016	1,639		
		TOTAL	**$43,084,018**

*Capitation rates for July 2016 through December 2016 pending review and approval from CMS.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by Federal Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. On September 29, 2016, revised Protocols were submitted to CMS.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

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

Contract Amendments

HPSM contract amendment A02 is in process. This amendment is to extend the contract one year as allowed by Request for Proposal #11-88024; and increase the total budget to compensate the Contractor for continuing to perform services for an additional year. New rates have been added for Fiscal Years 14/15, 15/16, and 16/17. Payments for Hepatitis C and Behavioral Health Therapy (BHT) services have also been included. The contract has also been updated to include the aid codes for eligible beneficiaries, and "R Letter" language approved by CMS to include in managed care contracts. Once A02 has been approved by DHCS management, it will be submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

DHCS met in person with RCHSD on October 4th and November 28th to collaborate with RCHSD on the following: outreach, enrollment, covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model. DHCS is in the process of confirming contractual compliance with the new Medicaid Final Rule.

Demonstration Schedule

It is anticipated the RCHSD Demonstration will not be operational until after July 2018. It should be noted the projected implementation timetable is contingent on a number of factors including development and acceptance of capitated rates, the ability of the contractor to demonstrate compliance with the new Medicaid Final Rule and readiness to begin operations, and approvals by Federal CMS.

Consumer Issues:

CCS Quarter Grievance Report #14

On October 2016, HPSM submitted a "CCS Quarterly Grievance Report" for the second quarter, July – September 2016. During the reporting period, HPMS received and processed 12 member grievances.

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

- 1 grievance was designated as Accessibility:
  - Coded as "Lack of primary care provider availability" and was resolved in favor of Member.

- 1 grievance was designated as Quality of Care/Services:
  - Coded as "Plan denial of treatment"; and was resolved in favor of Plan.

- 10 grievances were labeled as Other:
  - 6 were coded as "Access" and all were resolved in favor of the CCS Member.
  - 3 were coded as "Billing"; 2 were resolved in favor of the CCS Member and 1 was resolved in favor of Plan.
  - 1 was coded as "Availability" and was resolved in favor of the CCS Member.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

HPSM deliverables submitted during this quarter are located in the table below.

Report Name	Date Due	Received
Provider Network Reports (Rpt #14)	10/30/2016	10/27/2016
Grievance Log/Report (Rpt #14)	10/30/2016	11/14/2016
Quarterly Financial Statements (Rpt #14)	11/17/2016	11/7/2016
Report of All Denials of Services Requested by Providers (Rpt #13)	11/17/2016	8/15/2016

Evaluations:

The draft CCS evaluation is located at http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx. The public comment period closed on October 19, 2016 for

the draft CCS evaluation and interested parties' comments were reviewed for possible inclusion into the final design. DHCS is currently waiting to receive CMS' comments for the draft CCS evaluation and has 60 days to respond.

Enclosures/Attachments:

None.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

Initial eligibility for the CBAS benefit is determined through a face-to-face assessment by a Managed Care Plan (MCP) registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. Initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information 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 12 months for individuals

determined by the MCP to be clinically appropriate. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment.

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

Effective April 1, 2012, eligible 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) if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services include local senior centers to engage members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the members with Activities of Daily Living or Instrumental Activities of Daily Living) through the Medi-Cal State Plan. If the member is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Enrollment and Assessment Information:

Per Special Terms and Conditions (STC) 48, the CBAS Enrollment data for both MCP and FFS members per county for Demonstration Year 12 (DY12), Quarter 2 (Q2), represents the period of October 2016 to December 2016. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 7 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the

[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.

MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties. FFS claims data identified in Table 1, reflects data up to the quarter of July 2016 to September 2016 because of the lag factor of about two to three months. Data for DY12, Q2, will be reported in the next quarterly report.

Table 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY11 Q1 Oct - Dec 2015		DY11 Q2 Jan - Mar 2016		DY11 Q3 Apr - Jun 2016		DY12 Q1 Jul - Sept 2016	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	534	96%	507	103%	502	102%	504	76%
Butte	*	*	*	*	35	34%	45	44%
Contra Costa	227	71%	214	67%	208	65%	206	64%
Fresno	631	65%	548	50%	585	53%	619	56%
Humboldt	164	42%	94	24%	95	24%	95	24%
Imperial	363	65%	344	62%	345	62%	426	76%
Kern	95	28%	77	23%	75	22%	81	24%
Los Angeles	20,149	64%	19,786	63%	21,311	69%	21,041	67%
Merced	92	50%	85	40%	91	43%	91	43%
Monterey	98	53%	89	48%	106	57%	102	55%
Orange	2,004	60%	2,051	57%	2,073	55%	2,100	54%
Riverside	425	39%	428	39%	459	42%	453	42%
Sacramento	697	78%	585	65%	563	63%	587	66%
San Bernardino	610	113%	594	110%	574	106%	590	109%
San Diego	2,353	62%	1,885	50%	1,549	38%	1,937	45%
San Francisco	775	53%	747	51%	752	51%	749	51%
San Mateo	156	68%	157	69%	166	73%	172	75%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	655	47%	660	47%	656	47%	655	47%
Santa Cruz	113	74%	90	59%	103	68%	109	72%
Shasta	12	8%	54	38%	*	*	*	*
Ventura	915	63%	920	64%	916	64%	918	64%
Yolo	75	20%	75	20%	74	20%	74	20%
Marin, Napa, Solano	167	33%	68	14%	70	14%	79	16%
Total	**31,348**	**62%**	**30,091**	**59%**	**31,318**	**62%**	**31,648**	**61%**

FFS and MCP Enrollment Data 09/2016

*Note: Information is not available for October 2016 to December 2016 due to a delay in the availability of data. *Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*

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

Bernardino County. San Bernardino County's CBAS centers are currently operating over center capacity, due to steady increase in participant enrollment. In the first quarter of DY 11, which covered the period of October 2015 through December 2015, San Bernardino County had 610 CBAS participants, which overextended their licensed capacity to 113%. However, San Bernardino County experienced a slight decrease in enrollment during the last three quarters, which resulted in a decrease of licensed capacity from 113% to 109%.

Please note that Table 1 illustrates that in the previous two quarters DY11, Q2 and Q3, Alameda County was operating over their maximum licensed capacity. This is in fact an error as according to new data reported by the CBAS Centers for DY12, Q1, Alameda County is operating well within their maximum capacity. This is due to a reporting error by one of Alameda's CBAS Center which failed to previously account for multiple shifts it is approved to operate which increase the census it can serve within its maximum capacity. Under the most recent reporting for DY12, Q1, Alameda County is now operating within their licensed capacity at 76%.

While the closing of a CBAS Center in a county can contribute to the increased utilization of the license capacity in that county, it is important to note the amount of member participation can also play a significant role in the overall amount of licensed capacity used throughout the State. For example, in Butte, Imperial, and San Diego counties, there was more than a 5% increase of licensed capacity used compared to the previous quarter. The increased utilization rate of licensed capacity in these counties was impacted by changes in member enrollment, not the closure of a center. A decrease in utilization can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

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

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

Table 2 entitled "*CBAS Assessment Data for MCP and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Due to delay in availability of data, Table 2 represents data to DY12, Q1. Data for DY12, Q2, will be provided in the next quarterly report.

Table 2:

CBAS Assessments Data for MCPs and FFS:						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
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%)
DY11 Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
DY12 Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	18	11 (61.1%)	7 (38.9%)
5% Negative change between last Quarter		No	No		No	No

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

Requests for CBAS services were collected by MCPs and DHCS. There were 2,600 assessments completed by the MCPs, of which 2,514 were determined to be eligible and 85 were determined to be ineligible. Seventy-two participants submitted requests for CBAS benefits under FFS to DHCS. Fifty-four of the requests qualified for managed care while 18 participants were determined to be FFS eligible by DHCS. Of these 18 participants, only 11 were assessed and approved for FFS. Table 2 reflects that the total number of eligible FFS participants continues to decline due to the CBAS transition to managed care.

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

CBAS enrollment and CBAS Center licensed capacity is impacted by the opening or closing of a CBAS Center. The closing of a CBAS Center decreases licensed capacity and enrollment while conversely, new CBAS Center openings increase capacity and enrollment. CBAS Centers are licensed by the California Department of Public Health and CDA certifies the Centers to provide CBAS benefits and facilitates monitoring and oversight of the Centers. The number of counties with CBAS Centers and the average daily attendance (ADA) of each center are listed in Table 3 entitled "*CDA – CBAS Provider Self-Reported Data*." On average, the ADA at the 240 operating CBAS Centers is approximately 21,622 participants, which corresponds to 71% of total license capacity.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	240
Non-Profit Centers	56
For-Profit Centers	184
ADA @ 240 Centers	21,622
Total Capacity	30,442
ADA per Centers	71%

CDA - MSSR Data 09/2016

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

Outreach/Innovative Activities:

Stakeholder Process

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

After reviewing stakeholder input in addition to the milestones identified in the CBAS STC, in the Medi-Cal 2020 Waiver, DHCS and CDA decided to initiate work groups to address concerns identified during the stakeholder meetings. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that have convened every other month through June 2016. Implementation of the five-year *CBAS Quality Assurance and Improvement Strategy* is scheduled to begin in October 2016. The revised IPC will be implemented in early 2017. 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 engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. To

date, no new CBAS centers have opened, but CDA has received several applications that are currently under review.

Consumer Issues:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 48.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 CBASinfo@dhcs.ca.gov for assistance from DHCS.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, language barriers, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized below in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Table 4 and Table 5 represents data covering to DY12, Q1. Data for DY 12, Q2, will be provided in the next quarterly report.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. Table 4 illustrates there were no complaints received by CDA for DY12, Q1, in comparison to three complaints that were received from the previous quarter. For complaints received by MCPs, Table 5 illustrates there were nine complaints collected by the MCPs for DY12, Q1. Data for DY11, Q3, in Table 5 is updated to reflect current information reported by the MCPs.

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
DY11 - Q3 (Apr 1 - Jun 30)	1	2	3
DY12 - Q1 (Jul 1 - Sept 30)	0	0	0

CDA Data - Complaints 09/2016

Note: Information is not available for October 2016 to December 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
DY11 - Q3 (Apr 1 - Jun 30)	8	0	8
DY12 - Q1 (Jul 1 - Sept 30)	8	1	9

Plan data - Phone Center Complaints 09/2016

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

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

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the lag factor in data reporting, grievances and appeals data from the MCPs are reported up to DY12, Q1. According to Table 6 entitled “Data on CBAS Managed Care Plan Grievances,” four grievances were filed with MCPs for DY12, Q1. All four grievances were regarding CBAS providers.

Table 6:

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY11 - Q 1 (Oct 1 - Dec 31)	0	1	1	5	7
DY11 - Q2 (Jan 1 - Mar 31)	2	0	0	4	6
DY11 - Q3 (Apr 1 - Jun 30)	4	0	0	4	8
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
					Plan data - Grievances 09/2016

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

For DY12, Q1, there were four CBAS appeals filed with MCPs. Table 7 entitled "Data on CBAS Managed Care Plan Appeals", illustrates that all four appeals were related to denial of services or limited services. Due to the delay in information, data for DY12, Q2, will be available in the next quarterly report.

Table 7:

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Grievances
DY11 - Q 1 (Oct 1 - Dec 31)	6	0	0	0	6
DY11 - Q2 (Jan 1 - Mar 31)	4	0	0	2	6
DY11 - Q3 (Apr 1 - Jun 30)	0	0	0	3	3
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
					Plan data - Grievances 09/2016

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

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY12, Q2, there was

no report of any hearing related to denials of CBAS services or limited services.

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to the first quarter of DY12, Q1, because of delay in availability of data. Data for DY12, Q2, will be discussed in the next quarterly report.

Table 8:

County	CBAS Centers Licensed Capacity					
	DY11-Q1 Oct-Dec 2015	DY11-Q2 Jan-Mar 2016	DY11-Q3 Apr-Jun 2016	DY12-Q1 Jul-Sep 2016	Percent Change Between Last Two Quarters	Capacity Used
Alameda	330	290	290	390	34%	76%
Butte	60	60	60	60	0%	44%
Contra Costa	190	190	190	190	0%	64%
Fresno	572	652	652	652	0%	56%
Humboldt	229	229	229	229	0%	24%
Imperial	330	330	330	330	0%	76%
Kern	200	200	200	200	0%	24%
Los Angeles	18,508	18,536	18,291	18,406	1%	67%
Merced	109	124	124	124	0%	43%
Monterey	110	110	110	110	0%	55%
Orange	1,960	2,120	2,240	2,308	3%	54%
Riverside	640	640	640	640	0%	42%
Sacramento	529	529	529	529	0%	66%
San Bernardino	320	320	320	320	0%	109%
San Diego	2,233	2,233	2,408	2,518	5%	45%
San Francisco	866	866	866	866	0%	51%
San Mateo	135	135	135	135	0%	75%
Santa Barbara	60	60	60	60	0%	3%
Santa Clara	830	830	830	830	0%	47%
Santa Cruz	90	90	90	90	0%	72%
Shasta	85	85	85	85	0%	8%
Ventura	851	851	851	851	0%	64%
Yolo	224	224	224	224	0%	20%
Marin, Napa, Solano	295	295	295	295	0%	16%
SUM =	29,756	29,999	30,049	30,442	43%	61%

CDA Licensed Capacity as of 09/2016

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

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

Table 8 reflects the average licensed capacity used by CBAS participants is at 61% statewide since September 2016. Overall, the CBAS Centers have not operated at full capacity with the exception of San Bernardino County. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. With new data available from the CBAS Centers, Alameda County licensed capacity is increased from 290 to 390. This caused a 34% raise in licensed capacity from the last quarter.

STCs 48(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 was no decrease in provider capacity of 5% or more, therefore an analysis is not needed.

Access Monitoring (STC 48.e.)

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

Unbundled Services (STC 44.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY12, Q2, CDA has 240 CBAS Center providers operating in California. Table 9 entitled "CBAS Center History," illustrates the history of openings and closings of centers. Effective December 1, 2016, Salida Del Sol Adult Day Health Care Center in Los Angeles County became operational and Advantage Adult Day Health Care Center in San Diego County closed its Center.

Table 9:

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
December 2016	240	1	1	0	240
November 2016	240	0	0	0	240
October 2016	240	0	0	0	240
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
November 2013	245	1	0	-1	244
October 2013	245	0	0	0	245
September 2013	243	0	2	2	245
August 2013	244	1	0	-1	243
July 2013	243	0	1	1	244
June 2013	244	1	0	-1	243
May 2013	245	1	0	-1	244
April 2013	246	1	0	-1	245
March 2013	247	0	0	0	246
February 2013	247	1	0	-1	246*
January 2013	248	1	0	-1	247
December 2012	249	2	1	-1	248
November 2012	253	4	0	-4	249
October 2012	255	2	0	-2	253
September 2012	256	1	0	-1	255
August 2012	259	3	0	-3	256
July 2102	259	0	0	0	259
June 2012	260	1	0	-1	259
May 2012	259	0	1	1	260
April 2012	260	1	0	-1	259

Table 9 also shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances.

Financial/Budget Neutrality Development/Issues:

Pursuant to STC item 50 (b) of the Medi-Cal 2020 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, 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)

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

Through the DTI, DHCS aims to:

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

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

- Domain 1 – Increase Preventive Services for Children

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

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

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

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

- Domain 3 – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between a beneficiary and dental provider in seventeen (17) select pilot counties. Incentive payments will be made to dental service office locations 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. The first program year for this domain will capture all activity that occurs in 2016.

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

- Domain 4 – Local Dental Pilot Projects (LDPPs)

The LDPPs 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 released the final LDPP application in June 2016 with a due date of September 2016.

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

<u>Small Stakeholder Workgroup</u>

This workgroup is still active; they met on October 19, 2016, November 16, 2016, and December 21, 2016.

<u>DTI Small Stakeholder Subgroups</u>

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

Caries Risk Assessment Sub-Workgroup
This sub-workgroup is still active; they met on November 30, 2016.

Safety Net Clinic Sub-Workgroup
This sub-workgroup is still active; they met on December 21, 2016. The purpose of the meeting was to discuss the DTI data collection process and address any outstanding questions from Safety Net Clinics.

Webinars

On October 13, 2016, DHCS held a webinar titled, *DTI Safety Net Clinics Data Submission Process,* and provided the participants with the following resources:

- Data collection template instructions
    - Domain 1
    - Domain 3
- Naming convention & resubmission instructions

The webinar presentation may be accessed at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/DTIWebinar10-13-16.pdf

On December 19, 2016, DHCS held a webinar on the streamlined provider enrollment application, titled *DHCS 5300 and Bulletin*.

The provider bulletin may be accessed at the following link: http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_32_Number_19.pdf.

DTI Webpage

The DTI webpage was updated regularly during DY12 Q1 and will continue to be updated as new information becomes available. The webpage contains: program information, stakeholder engagement information, webinars, timelines, Frequently Asked Questions (FAQs), Medi-Cal 2020 Special Terms and Conditions (STCs), and an inbox to direct comments, questions, or suggestions.

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

DTI Inbox and Listserv

DHCS continued regularly monitoring of the DTI inbox and listserv during DY12 Q2. The email address continued to be useful for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations to direct comments, questions, or suggestions about the DTI directly to us. The listserv provides another opportunity, for those that sign up, to receive relevant and current 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

Outreach Plans

DHCS presented information on the DTI at several venues during this reporting period.

Below is a list of venues at which information on DTI was disseminated:

- October 17, 2016 – 29th Annual State Health Policy Conference; *Open Wide: Innovations in Oral Health Policy*
- October 27, 2016 – Medi-Cal Dental Advisory Committee (MCDAC)
- November 1, 2016 – State Child Health and Disability Prevention (CHDP) Oral Health Subcommittee
- November 1, 2016 – Annual DHCS Tribal and Designee Meeting
- November 3, 2016 – California Primary Care Association (CPCA) and MDSD Quarterly Meeting
- November 4, 2016 – Los Angeles Stakeholder Meeting
- November 15, 2016 – Medi-Cal Children's Health Advisory Panel (MCHAP)
    - A copy of the meeting minutes are available at: http://www.dhcs.ca.gov/services/Documents/091316_MCHAPSummary.pdf
- November 21, 2016 – Legislative Analyst's Office Briefing on Eligibility and Dental
- December 12, 2016 – California Department of Public Health (CDPH)-DHCS Oral Health Workgroup

Operational/Policy Developments/Issues:

Domain 1

Baseline letters were sent to Medi-Cal Dental Providers on December 20, 2016. Within this reporting period, DHCS posted the following materials on the DTI webpage:

- The Domain 1 Data Collection Instructions were revised and posted online on October 13, 2016. Data was due on October 27, 2016. A copy is available at: http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain1DataReqs.pdf.
- The Domain 1 Data Collection Template was revised and posted online on October 13, 2016. A copy is available at: http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain1DataTemplate.xls.

On December 8, 2016, CMS approved an amendment to the STCs for DTI's Domain 1. The DTI amendment modifies the methodology for determining baseline metrics for incentive payments and provides payments for a revised threshold of annual increases in dental preventive services provided for children. This amendment furthers the goals of the DTI program to increase use of preventive services for children in Medi-Cal. A copy of the approval letter from CMS is available online at: http://www.dhcs.ca.gov/provgovpart/Documents/DTIWPCAmendmentApprovalLetter.pdf

Domain 2

Nothing to report at this time.

Domain 3

Within this reporting period, DHCS posted the following materials on the DTI webpage:

- The Domain 3 Data Collection Instructions were revised on October 13, 2016 and posted online at: http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain3DataInstructions.pdf.
- The Domain 3 Data Collection Template was revised on October 13, 2016 and posted online at: http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain3DataTemplate.xls.

Domain 4

DHCS received 23 LDPP applications and throughout this reporting period. We continued to review, vet, and reach out to individual applicants with questions and clarifications needed to proceed in the selection process. In the next reporting period, DHCS anticipates making LDPP selections and preparing to make payments to LDPPs in accordance with the requirements stipulated.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

Nothing to report at this time.

Quality Assurance/Monitoring Activities:

Nothing to report at this time.

Evaluation:

In anticipation of CMS' response to our draft DTI evaluation design, DHCS met with three organizations that have expressed interest in conducting the DTI evaluation – Health Management Associates, Mathematica Policy Research, and University of California, Los Angeles (UCLA).

The DTI draft evaluation plan can be viewed at the following link:
http://www.dhcs.ca.gov/provgovpart/Documents/DTIDraftEvaluationDesign.pdf

Enclosures/Attachments:

None.

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

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

The state DMC-ODS implementation is occurring in five phases, (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. DHCS is currently assisting phase four and have received a total of eighteen implementation plans from: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, and Imperial. DHCS has approved the following counties' implementations plans: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Los Angeles, Marin, Contra Costa, Monterey, Ventura, and Orange. The remaining seven counties' implementation plans are currently in review by DHCS and CMS.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- October 3, 2016: California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) Conference Call
- October 5, 2016: County Behavioral Health Directors Association of California (CBHDA) Policy Committee Meeting
- October 10, 2016: Provider Enrollment Division (PED) Monthly Conference Call Meeting with Providers
- October 11, 2016: Alcohol and/or Drug Certification (AOD) Standards Meeting
- October 12, 2016: DHCS and UCLA Conference Call
- October 13, 2016: DHCS Meeting for Medication Assisted Treatment in Phase 4 Counties
- October 14, 2016: Collaborative Justice Courts Advisory Committee Meeting

- October 17, 2016: External Quality Review Organization (EQRO), UCLA, and DHCS October Quarterly Meeting
- October 19, 2016: UCLA's Integrated Care Conference 2016
- October 20, 2016: Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup Meeting
- October 21, 2016: DHCS Bi-Weekly Parity Meeting
- October 24, 2016: DHCS Stakeholder Advisory Committee
- October 27, 2016: Innovative Accelerator Program (IAP) SUD call with DHCS regarding EQRO Performance Measures
- October 28, 2016: California Consortium of Addiction Programs and Professionals (CCAPP) Conference
- November 1, 2016: Medicaid Evidence-Based Decision Project Fall Conference
- November 2, 2016: Meeting with Partnership HealthPlan of California for a DMC Financial Model Discussion
- November 4, 2016: Phase 4 Regional Meeting Kick-off
- November 14, 2016: PED Monthly Conference Call Meeting
- November 18, 2016: DHCS Bi-Weekly Parity Meeting
- November 21, 2016: Monthly Waiver Monitoring Call with CMS and DHCS
- December 5, 2016: DHCS Bi-Weekly Parity Meeting
- December 6, 2016: CAADPE Annual Board Meeting
- December 6, 2016: CAADPE and DHCS Quarterly Meeting
- December 7, 2016: CBHDA Medi-Cal Policy Committee Conference Call
- December 7, 2016: IAP National Dissemination: Strategizing Managed Care Contract Language
- December 8, 2016: CBHDA Substance Abuse Prevention and Treatment (SAPT) Committee In-Person Meeting
- December 12, 2016: PED Monthly Conference Call Meeting with Providers
- December 14, 2016: DHCS and UCLA Conference Call
- December 16, 2016: AOD Standards Stakeholder Meeting
- December 28, 2016: CBHDA Medi-Cal Policy Executive Committee Call

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.

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 the 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 evaluation is posted on UCLA's DMC-ODS website at http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf.

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 (CPE) for services to uninsured individuals will be treated as expended for non-emergency care to non-qualified aliens.

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$21,004,142	$42,008,284	DY 11	$21,004,142
(Qtr 2 Oct - Dec)	$18,731,270	$37,462,540	DY 11	$18,731,270
Total	**$39,735,412**	**$79,470,824**		**$39,735,412**

This quarter, the Department claimed **$18,731,270** 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.

On March 1, 2016, DHCS submitted the DSRIP Final Evaluation to CMS for review and approval. On July 18, 2016, CMS provided feedback to the final evaluation, and on September 23, 2016, DHCS provided an updated evaluation and responses to

questions to CMS.

On November 2, 2016, DHCS received additional comments from CMS, and on December 28, 2016, provided a response. CMS is currently reviewing the evaluation revisions and responses to questions.

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr 1 July - Sept)	($97,936.54)	($97,936.55)	DY 10	($195,873.09)
(Qtr 2 Oct – Dec)	$1,883,350	$1,883,350	DY 9	$3,766,700
(Qtr 2 Oct – Dec)	($328,769.74)	($328,769.74)	DY 10	($657,539.48)
Total	**$1,456,643.72**	**$1,456,643.72**		**$2,913,287.43**

DY 12 quarter 2, DSRIP had one payment for the DY 9 annual report for achievements between July 1, 2013 – June 30, 2014 and one recoupment for the DY 10 annual report for achievements between July 1, 2014 – October 31, 2015.

All DSRIP payments and recoupments have been reconciled for DY 6-10, therefore this program will be going through the deactivation phase.

This quarter (Quarter 2 *only*), Designated Public Hospitals received **$1,554,580.26** 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.

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 on July 1, 2015.

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
(Qtr 2 Oct – Dec.)	$249,946,244	$249,946,244	Apr. 1, 2016 – June 2016	$499,892,488
(Qtr 2 Oct – Dec.)	$286,502,138.50	$286,502,138.50	July 1, 2016 – Sept. 2016	$573,004,277
Total	**$536,448,382.50**	**$536,448,382.50**		**$1,072,896,765**

DY12 Q2 reporting is for services from April 2016 through June 2016 and July through September 2016.

This quarter, PHCS received **$536,448,382.50** in federal funds payments and **$536,448,382.50** in IGT for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

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:

On October 18, 2016, the DHCS PRIME team attended the PRIME Reporting DY11 Lessons Learned Summit put on by the California Safety Net Institute. All participating PRIME entities attended, including DPHs and DMPHs, and shared actionable lessons from DY11, data approaches that support the shift to pay-for-performance in DY12, and reporting accomplishments for DY11.

Operational/Policy Developments/Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT		Service Period	Total Funds Payment
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)					
(Qtr 1 July - Sept)	$199,810,000	$199,810,000		DY 11	$399,620,000
(Qtr 2 Oct – Dec)	$598,626,428.57	$598,626,428.57		DY 11	$1,197,252,857.14
Total	**$798,436,428.57**	**$798,436,428.57**			**$1,596,872,857.14**

DY12 Q2, Sonoma West Medical Center was unable to complete the IGT transfer for their DY 11 annual report for achievements between January 1, 2016 – June 30, 2016, due to lack of funds. Their payment will be going out in January 2017.

This quarter, DPHs and DMPHs received **$598,626,428.57** in federal fund payments for PRIME-eligible services.

Consumer Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

DY11 Final Year-End Reports were due to DHCS from all participating PRIME entities on September 30, 2016. DHCS clinical and administrative teams conducted a review of all reports submitted and approved them for payment.

Evaluations:

On August 29, 2016, DHCS submitted a Draft Evaluation Design for the PRIME program to CMS for review. On November 18, 2016, CMS provided feedback to the Draft Design. DHCS has been working to provide a response to CMS feedback that will be due January 17, 2017.

DHCS is in the process of securing an external evaluator for the PRIME program.

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
October 2016 – December 2016

County	Total Member Months
Alameda	89,026
Contra Costa	52,780
Fresno	71,502
Kern	56,116
Kings	7,797
Los Angeles	606,993
Madera	7,314
Riverside	104,328
San Bernardino	111,319
San Francisco	115,415
San Joaquin	121,604
Santa Clara	46,515
Stanislaus	50,686
Tulare	67,643
Sacramento	36,872
San Diego	32,098
Total	**1,578,008**

TOTAL MEMBER MONTHS FOR EXISTING SPD BY COUNTY
October 2016 – December 2016

County	Total Member Months
Alameda	56,400
Contra Costa	25,010
Fresno	34,402
Kern	22,486
Kings	3,505
Los Angeles	1,029,710
Madera	3,505
Marin	19,301
Mendocino	17,289
Merced	48,304
Monterey	48,403
Napa	13,989
Orange	371,722
Riverside	141,781
Sacramento	56,208
San Bernardino	139,456
San Diego	201,305
San Francisco	38,701
San Joaquin	24,022
San Luis Obispo	24,622
San Mateo	69,473
Santa Barbara	45,701
Santa Clara	140,957
Santa Cruz	31,169
Solano	58,928
Sonoma	52,686
Stanislaus	12,752
Tulare	15,153
Ventura	84,833
Yolo	26,026
Total	**2,857,799**

TOTAL MEMBER MONTHS FOR SPD IN RURAL NON-COHS COUNTIES
October 2016 – December 2016

County	Total Member Months
Alpine	69
Amador	1,178
Butte	19,572
Calaveras	1,824
Colusa	792
El Dorado	5,238
Glenn	1,665
Imperial	10,235
Inyo	557
Mariposa	683
Mono	223
Nevada	3,362
Placer	9,295
Plumas	1,034
San Benito	232
Sierra	129
Sutter	5,928
Tehama	5,200
Tuolumne	2,639
Yuba	6,783
Total	**76,638**

TOTAL MEMBER MONTHS FOR SPD IN RURAL COHS COUNTIES
October 2016 – December 2016

County	Total Member Months
Del Norte	8,105
Humboldt	27,148
Lake	19,073
Lassen	4,406
Modoc	1,854
Shasta	40,628
Siskiyou	11,020

County	Total Member Months
Trinity	2,817
Total	**115,051**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Enclosures/Attachments:

None.

WHOLE PERSON CARE (WPC)

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

During the second quarter, DHCS continued to provide technical assistance to WPC applicants through emails, multiple teleconferences, and numerous individual discussions regarding application changes/finalization process and the agreement execution process. DHCS held frequent teleconferences and email communications to discuss the WPC applications, approvals and WPC implementation planning.

October 6, 2016, through October 19, 2016, DHCS held a series of teleconference with CMS and their contractor, National Opinion Research Center (NORC) at the University of Chicago, to review the WPC applications. The series began with a kickoff meeting to provide background on the 18 applications, application review

process, application summaries and the proposed schedule for the review process. DHCS submitted the applications, summaries, budgets and additional miscellaneous documents pertaining to the eighteen applications to CMS/NORC through their SharePoint for review of the applications.

On October 17, 2016, DHCS announced opening a second round of WPC pilot applications. The second round of applications will be due on March 1, 2017. The general requirements for the second round of applications will remain the same, but DHCS plans to update the application based upon lessons learned from the first round and the use of available resources. During the second application period, DHCS anticipates new pilots and expansion of applicants approved in the first round to add new target populations and/or services and interventions to applications already approved in the first round.

On October 18, 2016, CMS approved the variant metrics menu and DHCS received approval from CMS for the updated Attachment MM that incorporates the final menu of variant metrics for the WPC on October 21.

On October 21, 2016, after DHCS submitted the final fourteen updated pilot applications recommended for approval by DHCS, CMS found that these fourteen applications complied with the Special Terms and Conditions and approved protocols for the demonstration. Four pilots (Riverside, San Bernardino, San Francisco, and San Mateo) continued to work on updates to their applications. DHCS expected to submit these four pilot applications to CMS for review and approval within a few weeks.

On October 24, 2016, DHCS approved 14 of the 18 WPC applications received for the WPC pilot with CMS approval. DHCS released approval notices to these fourteen applicants with the amount of their annual total funds allocation they are eligible to receive for each of the five program years. Additionally, these applicants received the WCP agreement for their signature and formal acceptance to DHCS.

On November 23, 2016, DHCS submitted the final four updated pilot applications (Riverside, San Bernardino, San Francisco and San Mateo) to CMS for approval. CMS found these four applications complied with the Special Terms and Conditions and approved protocols for the demonstration by CMS.

On November 30, 2016, DHCS held a second webinar for tribes and tribal organizations on proposed changes to the Medi-Cal program including WPC and a second round of applications for WPC. Upon CMS approval of the STCs, tribes and tribal organizations will be welcome to apply as lead entities who must provide a source of non-federal share (50% of the program funding) to support the program.

By December 5, 2016, all eighteen pilots had formally accepted and executed agreements with DHCS for their WPC pilot programs including but not limited to, allocations, intergovernmental transfer payment process, attestations, Business Associate Addendum, and terms of the agreement. The total 5-year budget for the

eighteen pilots is approximately $2.4 billion dollars in total computable funds.

On December 8, 2016, CMS approved the WPC amendment to the Special Terms and Conditions of California's Medi-Cal 2020 Waiver. This amendment expanded the WPC pilots to allow federally recognized tribes and tribal health programs operated under Public Law 93-638 contract with the federal Indian Health Services to submit WPC applications. Additionally, the WPC amendment allowed federally recognized tribes and tribal health programs to act in a lead entity role in the design, application, and operation of a WPC pilot program. The addition of these entities promotes the intent and goals of the WPC program to coordinate health, behavioral health, and social services in a patient-centered manner to improve beneficiary health and well-being. Upon CMS approval, DHCS notified tribes and tribal organizations that they are eligible to apply as lead entities to submit applications in the second round of applications. As a lead entity, they must provide the non-federal share of payment through an intergovernmental transfer (IGT).

On December 11, 2016, DHCS submitted the revised WPC application for the second round of applications to CMS for approval. On December 12, DHCS discussed the changes with CMS during a teleconference. On December 23, 2016, CMS approved the selection criteria and the revised second round application. DHCS intends to release the application in January 2017 with a due date of March 1, 2017 for the second round of WPC applications.

DHCS has contracted with a consultant to develop the Learning Collaborative. DHCS continues to develop the purpose, goals, structure, and potential key topics for the Learning Collaborative. The Learning Collaborative will begin in January 2017.

Consumer Issues:

DHCS continued to work with stakeholders in the development and implementation of the WPC pilot program.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

DHCS continued to development the WPC baseline, mid-year, and annual report templates.

On December 14, 2016, DHCS began the bi-weekly teleconferences with lead entities to discuss issues and administrative topics.

Evaluations:

On November 7, 2016, DHCS submitted the Whole Person Care Draft Evaluation Design to CMS per STC 211 of California's *Medi-Cal 2020 Demonstration* (Project 11-W-00193/9) and invited public comment. DHCS anticipates submitting the final WPC evaluation design within 60 days from receipt of CMS comments and feedback on the Draft Evaluation Design.

Enclosures/Attachments:

None.