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October 28, 2016

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**ANNUAL PROGRESS REPORT FOR THE REPORTING PERIOD OF 11/01/2015
THROUGH 06/30/2016 FOR CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00193/9)**

Dear Mr. Fishman, Ms. Hossain, and Ms. Sam-Louie:

Enclosed is the Annual Progress Report as required by Section 26 of the Special Terms and Conditions of California's Section 1115 Waiver *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the annual progress report submission to the Centers for Medicare and Medicaid Services (CMS) for Demonstration Year Eleven, which covers the reporting period from November 1, 2015 through June 30, 2016. The 1115 waiver renewal extension period from November 1, 2015 through December 31, 2015 is also included in this report.

Mr. Eliot Fishman, Ms. Mehreen Hossain, and Ms. Henrietta Sam-Louie
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If you or your staff have any questions or need additional information regarding this report,
please contact Angeli Lee by phone at (916) 324-0184 or by email
Angeli.Lee@dhcs.ca.gov. Thank you!

Sincerely,

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Enclosure:
Medi-Cal 2020 Demonstration Year 11 Annual Report

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



Section 1115 Waiver Annual Report

Demonstration Reporting Period:

Demonstration Year: Eleven (01/01/2016 – 06/30/2016) and
1115 Waiver Renewal Extension Period of 11/01/2015 – 12/31/2015

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INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 11 to the Centers for Medicare & Medicaid Services (CMS) in accordance with Item 26 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 11:

- Accomplishments
- Project Status
- Quantitative Findings
- Qualitative and Case Study Findings
- Utilization Data
- Policy and Administrative Issues

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

On October 31, 2015, DHCS and CMS announced a conceptual agreement that outlines the major components of the waiver renewal, along with a temporary extension period until December 31, 2015 of the past 1115 waiver to finalize the 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.

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 June 15, 2016, DHCS submitted an amendment request to CMS to expand the definition of a WPC pilot entity to include Federally Recognized Tribes and Tribal Health Programs. As of June 2016, DHCS is also pursuing to amend the STCs to revise the payment criteria methodology for DTI’s Domain 1.

TIME PERIODS:

Demonstration Year

The periods for each Demonstration Year (DY) of the Waiver will consist of 12 months, with the exception of DY 11 and DY 16, which will be 6 months respectively. The periods are:

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

- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020
- DY 16: July 1, 2020 through December 31, 2020

Annual Report

This report covers the period from November 1, 2015 through June 30, 2016. The Demonstration's extension period, November 1, 2015 through December 31, 2015, is also included in this report.

GENERAL REPORTING REQUIREMENTS:

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

Whole Person Care Tribal Entity Amendment

On June 15, 2016, DHCS submitted an amendment to the STCs to expand the definition of an allowable Whole Person Care (WPC) Pilot lead entity to include Federally Recognized Tribes and Tribal Health Programs operating under a Public Law (PL) 93-638 contract with the Federal Indian Health Services (IHS).

The proposed amendment will allow Federally Recognized Tribes and Tribal Health Programs operating under a PL 93-638 contract with the Federal IHS to act in a lead entity role in the design, application, and operation of a WPC Pilot.

Dental Transformation Initiative Domain 1 Amendment

On May 31, 2016, DHCS revised its methodology to determine the baseline metrics that will be used by new and existing dental service office locations for purposes of receiving incentive payments for the DTI program. The metrics proposed that the calculation of baseline metrics be calculated at the individual service office level, rather than county average. New service office locations would receive a county pre-determined benchmark and be reassessed at the end of their first program participation year.

Additionally, DHCS sought authority to provide partial incentive payments to provider service office locations that partially meet annual increases in the preventive services provided to children above the pre-determined baseline. This modification would allow benchmark increases from 1.00 to 1.99 to receive an incentive payment of 37.5 for each qualified service above the current Schedule of Maximum Allowances. The Medi-Cal 2020 Demonstration STCs modifications require an

amendment submission to CMS. This amendment is necessary to ensure new and existing dental provider service office locations are not disadvantaged by having to reach unrealistic increases in the number of children provided preventive services, based on their current capabilities, in order to receive the applicable incentive payment under this domain.

- **Item 16 of the STCs – Public Notice, Tribal Consultation, and Consultation with Interested Parties**

Whole Person Care Tribal Entity Amendment

On May 10, 2016, DHCS submitted a tribal notice related to the amendment to the Medi-Cal 2020 Demonstration Waiver STCs to expand the definition of an allowable WPC Pilot lead entity to include Federally Recognized Tribes and Tribal Health Programs operating under a PL 93-638 contract with the Federal IHS. DHCS presented on this amendment at the quarterly tribal webinar on May 31, 2016. No questions were received. Additional information can be found on the DHCS Indian Health Program's website:

http://www.dhcs.ca.gov/services/rural/Documents/Web_WPC-Medi-Cal_2020_Waiver_Amendment.pdf

Dental Transformation Initiative Domain 1 Amendment

Public Notice:

This amendment was shared publically as follows:

- The amendment was discussed during all DTI sub-workgroup meetings.
- On June 1, 2016, the DTI Domain 1 fact sheet, which includes a description of the amended process, was posted on the DTI website
- DHCS advised meeting participants of the amendment during the June 14, 2016 webinar. The webinar presentation is available at:
<http://www.dhcs.ca.gov/provgovpart/Documents/FinalDTIWebinar06.14.16v2.0.pdf>

Tribal Notice:

- DHCS Primary, Rural, and Indian Health Division will issue a tribal notice regarding the State's intention to request the Demonstration Waiver amendment and post it for thirty days on the DHCS website at:
<http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx>

- **Item 17 of the STCs – Post Award Forum**

DHCS hosted a stakeholder webinar on January 25, 2016 to provide an introduction and overview of the Medi-Cal 2020 waiver programs and requirements. Some of the topics discussed were: key programmatic elements of PRIME, GPP, DTI, and WPC;

Designated State Health Programs; Budget Neutrality; and Reporting and Evaluation Requirements. At the end of the webinar, time was also allotted for a question and answer session from the attendees. A copy of the presentation is available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020IntroWebinar.aspx>.

On February 25, 2016, DHCS presented an update on the Medi-Cal 2020 Demonstration to members of the Stakeholder Advisory Committee (SAC) and other stakeholders. The meeting highlighted the key components of the waiver and provided an overview of programs and implementation timelines. PRIME, GPP, DTI, and WPC were the four main waiver programs discussed. In addition, the Blue Shield of California Foundation announced Navigant as the contractor that they selected to conduct the first Uncompensated Care Assessment. The agenda and meeting materials for the February 25 meeting are available at: <http://www.dhcs.ca.gov/Pages/February25MeetingMaterials.aspx>.

SAC members and other stakeholders convened again on May 16, 2016. A summary was provided regarding CCI enrollment and policy decisions, and a Principal Investigator from University of California, San Francisco presented the preliminary results of the Cal MediConnect evaluation. There was another presentation on the non-designated hospital participation in PRIME.

In addition, DHCS Substance Use Disorder Services Division provided an update on the roll-out of the Drug Medi-Cal Organized Delivery System and shared that the state is giving support to other states interested in developing a similar waiver. DHCS also shared status updates on the access assessment, WPC, GPP, and DTI implementation efforts. The agenda and meeting materials for the May 16 meeting are available at: <http://www.dhcs.ca.gov/Pages/May16MeetingMaterials.aspx>.

DHCS intends to use SAC as a platform for further discussions regarding waiver activities and developments. SAC meeting schedule, presentation slides, past meeting archives, and other information are available online at: <http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx>.

- **Item 23 of the STCs – Contractor Reviews**

Nothing to report.

- **Item 24 of the STCs – Monthly Calls**

CMS and DHCS schedules monthly conference calls to discuss any significant or actual anticipated developments affecting the Demonstration. During DY 11, the conference calls were held on the following dates:

- February 8, 2016
- March 14, 2016
- April 11, 2016
- May 9, 2016
- June 13, 2016

The main discussion topics include: the first uncompensated care report, financial reporting for the waiver, updates on pending STCs technical corrections, various waiver program implementation updates, completion of several waiver attachments, and the completion of other waiver deliverables.

- **Item 25 of the STCs – Demonstration Quarterly Reports**

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. Two reports for DY 11 were submitted to CMS electronically on the following dates:

- Quarter 1 (01/01/16 – 03/31/16) – Submitted May 31, 2016
- Quarter 2 (04/01/16 – 06/30/16) – Submitted August 29, 2016

- **Item 28 of the STCs – Revision of the State Quality Strategy**

On behalf of DHCS, the Office of the Medical Director (OMD) is overseeing the annual revision to the DHCS Strategy for Quality Improvement in Health Care (Quality Strategy)

http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2016.pdf. All Divisions and Offices throughout DHCS have been invited to update their respective quality improvement projects and report on their progress to date. In addition, the OMD team is reaching out across the Department to invite new participation. The Quality Strategy serves as a blueprint, outlining specific programs and policies the Department is undertaking and prioritizing to improve clinical quality and advance population health among the members, patients, and families we serve. The 2016/2017 update of the Quality Strategy will be released this winter. It will be the fifth version of the blueprint to be distributed by the Department.

- **Item 29 of the STCs – External Quality Review**

DHCS meets all of the requirements found in Title 42 Code of Federal Regulations Part 438, Subpart E. DHCS is scheduled to release its annual External Quality Review technical report to CMS and to the public by April of each year.

- **Item 30 of the STCs – Certified Public Expenditures**

Drug Medi-Cal Organized Delivery System

The Certified Public Expenditures (CPE) protocol for DMC-ODS was approved on June 17, 2016. The protocol and approval letter from CMS are posted online at the DHCS website: <http://www.dhcs.ca.gov/provgovpart/Pages/Standard-Terms-and-Conditions.aspx>.

- **Item 31 of the STCs – Designated State Health Programs**

Program costs for each of the Designated State Health Programs (DSHP) are expenditures for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols under the Medi-Cal 2020 Demonstration.

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

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

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. Due to the delay in the implementation of the DTI, the \$75 million was not claimed in DY 11 and is expected to be claimed in DY 12.

Payment	FFP	CPE	Service Period	Total Claim
Designated State Health Program (DSHP)				
(Ext Nov - Dec)	\$571,760	\$51,760	DY 10 (June)	\$103,520
(Ext Nov - Dec)	\$54,568	\$54,568	DY 10 (Jul-Sept)	\$109,136
(Ext Nov - Dec)	\$364,082	\$364,082	DY 10 (Oct)	\$728,164

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 Jan - March)	\$0	\$0	DY 11	\$0
(Qtr 2 April - June)	\$0	\$0	DY 11	\$0
Total	\$470,410	\$470,410		\$940,820

In DY 11, Designated State Health Programs received \$470,410 in federal fund payments.

- **Item 34 of the STCs – Managed Care Expansions**

The Department has released an intent to award to two Plans that will operate in Sacramento and San Diego counties. During this reporting period, Plans began the readiness activities that are required prior to going live. Plans are scheduled to go live no sooner than July 1, 2017.

- **Item 35 of the STCs – Encounter Data Validation Study for New Health Plans**

The Encounter Data Quality Unit annually performs an Encounter Data Validation study with its External Quality Review Organization (EQRO). Encounter data is validated during this study for completeness and accuracy. This study pulls from a sample of medical records as required by this STC. New health plans are subject to this study 18-months after their effective date.

- **Item 36 of the STCs – Submission of Encounter Data**

The State has submitted encounter data to the Medicaid Statistical Information System (MSIS) and State reporting is in alignment with current Federal laws, policy, and regulations. Encounter data file submissions are received and checked for completeness and accuracy, which includes eligibility verification checks upon receipt of the data to the State from the managed care entities. The State is working diligently with CMS to test data transmission for the Transformed MSIS process with anticipated move into production in first quarter Federal Fiscal Year 2017.

- **Item 38 of the STCs – Contracts**

Nothing to report.

- **Item 40 of the STCs – Network Adequacy**

To ensure that each Medi-Cal managed care health plan (MCP) has a provider network that is sufficient to provide access to all services covered in the contract, DHCS performs a network certification and network readiness review when expansion occurs or there is a significant benefit change.

DHCS requires all MCPs to submit quarterly reports that include network adequacy data and notice of significant changes. Data summaries are included with quarterly waiver reports to CMS. DHCS actively works with MCPs to resolve any issues and concerns identified.

Data analysis and inquiries are incorporated in the Department of Managed Health Care (DMHC)/DHCS joint review letters and sent to the MCPs quarterly for responses and necessary resolutions. MCPs then provide responses to the identified deficiencies, which DMHC/DHCS evaluates during the next quarterly review. Network adequacy indicators that are monitored include, but are not limited to, the following:

- Primary Care Provider (PCP) Capacity (PCPs accepting new enrollees);
- PCP-to-member ratios;
- Physician-to-member ratios;
- DMHC Help Center data of complaints;
- Termination of contracts;
- Material modification;
- PCP time and distance standards;
- Reasonable geographical access to specialists;
- Availability of PCPs and specialists;
- Timely access to PCPs and specialists;
- MCP alternate access standards;
- Out of network requests/approvals/denials;
- MCP grievances regarding geographical and timely access to PCPs, specialists, and hospitals, mental health services, transportation services, PCPs and physicians not accepting new patients, PCPs and physicians not accepting enrollee's health plan coverage, and other categories such as interpreter service, disabled accessibility like wheelchair availability, etc.;
- Hospital admitting privileges; and
- Hospital geographical access.

During DY 11, in collaboration with DMHC, DHCS closely monitored all MCP provider networks and reviewed and analyzed the quarterly and monthly network adequacy data. These monitoring activities are conducted on an ongoing quarterly basis.

- **Item 42 of the STCs – Certification [of Health Plans]**

DHCS has developed statewide specialty provider standards and will apply them to its network certification tool. The tool will be used to review and produce documentation that supports assurance of provider network adequacy for each contracted MCP. Documentation will be included in the DHCS's submission of assurance of compliance and certification report to CMS. Annually, DHCS must submit documentation to demonstrate each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area in compliance with Code of Federal Regulations Section 438.68 (network adequacy standards) and Section 438.206 (c)(1) (availability of services);
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to the needs of the anticipated number of enrollees in the service area; and
- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services, such as changes in services, benefits, geographic service area, composition of payments to its provider network, or enrollment of a new population.

- **Item 52 of the STCs – CCS Demonstration Project Approval**

The CCS Demonstration Project (DP) is testing two health care delivery models for children enrolled in the CCS Program. The CCS DP approval is contingent on provisions being met for the two demonstration models: 1) ensuring adequate protections for the population served, 2) sufficient network of appropriate providers, and 3) timely access to out of network care when necessary. The pilot programs are limited to HPSM and RCHSD and will include specific criteria for evaluation of the models.

- **Item 53 of the STCs – CCS Demonstration Project Protocol**

DHCS was required to update the Protocols to include proposed updated goals and objectives and the addition of required performance measures.

Goal

The goal of the DPs is to identify the model or models of health care delivery for children and youth enrolled in the CCS Program; result in improving timely access to care, improved coordination of care, promotion of increased use of community-based services, improved satisfaction with care, and improved health outcomes. Both HPSM and RCHSD will design and implement a Member satisfaction survey (Member Survey) with input and review from DHCS and meet the four objectives below.

Objectives

- Objective 1

By December 31, 2020, there will be a reduction in the annual rate of growth of expenditures for children and youth enrolled in a DP.

- Objective 2

By December 31, 2020, there will be an increase in satisfaction with the delivery of health care services among children and youth enrolled in the CCS Program and their families. Measurement of the changes in satisfaction will be accomplished through surveys of the Members and their families.

- Objective 3

By December 31, 2020, there will be an increase in satisfaction with the delivery of health care services among providers serving children and youth enrolled in the CCS Program. Measurement of the changes in satisfaction will be accomplished through surveys of providers participating in the DPs' networks.

- Objective 4

By December 31, 2020, there will be improved health outcomes among the children and youth enrolled in a DP.

Measures

DHCS will propose one (1) provider satisfaction measure, one (1) patient satisfaction measure, one (1) whole person average cost of care measure, and two (2) measures of participant health outcomes. Proposed Protocol measures include the following:

- Enrollment Measures

Measure 1: Percent of new enrollment

Measure 2: Average length of enrollment

- Access to Care Measures

Measure 1: The percentage of children and young adults 12 months – 20 years of age who had a visit with a PCP

Measure 2: Referral of a Child to Special Care Center (SCC)
Measure 3: Screening for Clinical Depression and Follow-Up Plan

- Clients' Satisfaction Measures

Measure 1: Surveys of families related to satisfaction with participation CCS Pilot including both primary care and subspecialty care access and quality of services
Measure 2: Grievance and Appeals

- Providers' Satisfaction Measure

Measure 1: Surveys of physicians, hospitals/clinics, in-home pharmacy and Durable Medical Equipment (DME) providers for satisfaction, including changes in reimbursement under the CCS Pilot

- Quality of Care Measures

Measure 1: Childhood Immunization Status

Measure 2: Subspecialty care for Diabetes - HbA1c Testing

Measure 3: Lung Function for Cystic Fibrosis patients

- Care Coordination Measures

Measure 1: Family Experiences with Care Coordination (FECC) Survey

Measure 2: Medi-Cal Managed Care Performance Dashboard Indicators for all unique children, with CCS-eligible medical condition

- Total Cost of Care Measure

Measure 1: Total cost of care

- **Item 54 of the STCs – 2016 CCS Pilot Update**

DHCS is developing the required report to be submitted to CMS by September 30, 2016. The report meets the STCs' requirements and includes:

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

- **Items 65-69 of the STCs – Access Assessment**

In order to communicate with stakeholders, DHCS developed a website and a mailbox for its Access Assessment Project. DHCS created and scored the Access Assessment Advisory Committee Applications and posted the selected committee

members on the website. DHCS amended the contract with its EQRO with an effective date of October 23, 2016, contingent on CMS approval.

The Access Assessment webpage is located at:

<http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx>

- **Items 178-180 of the STCs – 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.

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

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

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

DY 11 updates on the CCS, DMC-ODS, and WPC evaluation designs are provided in the program reports within this annual report. The SPD draft evaluation design is currently in the planning phase. DHCS is in the process of completing the various program evaluation designs for submission to CMS in DY 12.

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S SERVICES (CCS)

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

The CCS Program is administered as a partnership between local CCS county programs and the 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 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) (MCP)

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

Accomplishments:

Date	Pilot Action Items
January 2016 – June 2016	CCS Pilot Protocols (Protocols) were updated with the required addition of performance measures. Protocols will be submitted by the specified due date of September 30, 2016.
January 2016 – June 2016	Draft evaluation design will be submitted by the due date of September 19, 2016. Comments from the public on the development of the evaluation design will be open through October 19, 2016.
Date	HPSM Pilot Action Items
July 2015 – Pending	Contract Amendment A02 is currently in process to extend the contract term and to revise rates
Date	RCHSD Pilot Action Items
November 1, 2015 – January 2016	DHCS reviewed 67 RCHSD draft deliverables [Policies and Procedures (P&Ps)]
July 2015 – Pending	Financial – Rates for RCHSD CCS DP are in development by DHCS's Capitated Rates Development Division (CRDD)
Anticipated FY 2017/18	Proposed start date pending approval from CMS for rates and contract and RCHSD's readiness

Program Highlights:

Protocols

As of June 30, 2016, the Protocols were revised and are currently being reviewed by DHCS management. Protocols will be submitted by the specified due date of September 30, 2016. For more information, please refer to the section on Progress on the Evaluation and Findings and STC 53: CCS Demonstration Project Protocol.

RCHSD CCS DP

During DY 11, DHCS continued 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.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

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

Aid Codes

Programming for Affordable Care Act (ACA) aid codes will be 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		July 2015	1,592	3
August 2014	1,477	5	August 2015	1,591	-1
September 2014	1,535	58	September 2015	1,600	9
October 2014	1,502	-33	October 2015	1,583	-17
November 2014	1,505	3	November 2015	1,591	8
December 2014	1,560	55	December 2015	1,588	-3
January 2015	1,527	-33	January 2016	1,581	-7
February 2015	1,502	-25	February 2016	1,591	10
March 2015	1,546	44	March 2016	1,609	18
April 2015	1,552	6	April 2016	1,626	17
May 2014	1,569	17	May 2016	1,621	-5
June 2015	1,589	20	June 2016	1,622	1

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

DHCS continued to collaborate with CCS DP entities relative to issues and challenges specific to each of the model locations. Challenges include determination of the target population, determination of disease specific groups, general organizational structure, reporting requirements, and rate development, etc.

Progress on the Evaluation and Findings:

Evaluation

The evaluation will demonstrate the effectiveness of an integrated delivery model for the CCS population by:

1. Ensuring that the CCS population has access to timely and appropriate, high quality, and well-coordinated medical and supportive services that are available to maintain and enhance health and functioning and developmental needs.
2. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
3. Increasing provider satisfaction with both the delivery of and the reimbursement of services.
4. The State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
5. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
6. Reducing the annual rate of growth of expenditures for the CCS population.

Design

The CCS pilot evaluation design incorporates both quantitative and/or qualitative processes and/or outcome measures that adequately assess the effectiveness of the demonstration in terms of cost of services and total cost of care, improved health outcomes and system transformation including better care, better quality, and enhanced value, change in delivery of care from inpatient to outpatient, and quality improvement under managed care.

The evaluation will meet the standards of leading academic institutions and academic journals. Data will be reported at the beneficiary, provider, health plan, and statewide levels. Significant attention will be given to ensuring use of the best available data and the cleanliness of it when utilized. When necessary, the data will be adjusted and/or controls will be put into place to maximize the use of it. Should there be data limitations, the data will be modified as needed and only used appropriately so as not to

misinterpret it. Any modifications and changes will be reported in the final evaluation report. The final evaluation report will also consider how the findings from the evaluation may or may not be generalized.

COMMUNITY BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant’s multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020; and 4) exhibit ongoing compliance with 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, 2012¹. 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.

Program Highlights:

Outreach/Innovative Activities

Stakeholder Process

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

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.

plan revisions were presented for incorporation into the STP. DHCS submitted the amended STP on August 14, 2015 in response to questions and concerns raised by CMS during its review of the STP. DHCS released a revised STP for public comment, including a revised CBAS plan, on August 29, 2016. Following the public comment period, DHCS anticipates submitting the revised STP to CMS for review in October 2016.

After reviewing stakeholder input in addition to milestones identified in the CBAS STCs of the Medi-Cal 2020 Waiver, DHCS and CDA decided to initiate work groups to address concerns identified during the stakeholder meetings. 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. 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/

Qualitative and Quantitative Findings:

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 11 (DY11) represents the period of October 2015 to June 2016 and 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. Per the data presented in Table 1, enrollment for CBAS has been consistent in DY11.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined as these are small counties.

TABLE 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS									
County	DY11 Q1 Oct - Dec 2015			DY11 Q2 Jan - Mar 2016			DY11 Q3 Apr - Jun 2016		
	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used
Alameda	1	533	96%	0	507	103%	0	502	102%
Butte	1	29	30%	1	27	28%	1	34	34%
Contra Costa	2	225	71%	2	212	67%	2	206	65%
Fresno	4	627	65%	4	544	50%	2	583	53%
Humboldt	1	163	42%	0	94	24%	0	95	24%
Imperial	0	363	65%	0	344	62%	1	344	62%
Kern	0	95	28%	0	77	23%	0	75	22%
Los Angeles	457	19,692	64%	447	19,339	63%	443	20,868	69%
Merced	0	92	50%	0	85	40%	0	91	43%
Monterey	0	98	53%	0	89	48%	0	106	57%
Orange	0	2,004	60%	0	2,051	57%	5	2,068	55%
Riverside	6	419	39%	9	419	39%	10	449	42%
Sacramento	39	658	78%	38	547	65%	27	536	63%
San Bernardino	4	606	113%	5	589	110%	3	571	106%
San Diego	6	2,347	62%	6	1,879	50%	5	1,544	38%
San Francisco	56	719	53%	55	692	51%	56	696	51%
San Mateo	0	156	68%	0	157	69%	0	166	73%
Santa Barbara	0	8	8%	0	5	5%	0	0	0%
Santa Clara	1	654	47%	1	659	47%	1	655	47%
Santa Cruz	0	113	74%	0	90	59%	0	103	68%
Shasta	0	12	8%	0	54	38%	0	10	7%
Ventura	0	915	63%	4	916	64%	2	914	64%
Yolo	0	75	20%	2	73	20%	0	74	20%
Marin, Napa, Solano	0	167	33%	0	68	14%	0	70	14%
Total	578	30,770	62%	574	29,517	59%	558	30,760	62%
Combined Totals	31,348			30,091			31,318		

FFS and MCP Enrollment Data 06/2016

Per the data provided in Table 1, there was a slight increase in CBAS enrollment since DY 11, Quarter 2. However, enrollment has remained relatively consistent (at about 30,000 participants) for the past year. There is ample capacity for participant enrollment into most CBAS Centers with the exception of centers located in Alameda and San Bernardino Counties. Both Alameda and San Bernardino Counties' CBAS centers are currently operating over center capacity. Alameda County's licensed capacity was reduced in December 2015 due to the closing of one CBAS Center. This resulted in an over-extension of the county's maximum capacity used due to the number of participants they were providing services for.

In addition, while the closing of a CBAS Center in Alameda County contributed to increased utilization of license capacity in Alameda County it is important to note the amount of member participation also plays a significant role in the amount of overall

license capacity used throughout the State. For example, from April 2016 to June 2016, there was a three percent (3%) increase in the total number of participants enrolled in the CBAS Centers. As a result, Butte, Los Angeles, Monterey, Merced and Santa Cruz experienced a five percent (5%) increase in their total capacity. However, San Diego, Santa Barbara and Shasta Counties experienced an overall decrease in CBAS participation which resulted in a decrease of more than five percent (5%) of capacity used. The utilization 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 Centers licensed capacity.

San Bernardino County's licensed capacity has been impacted by a steady increase in participant enrollment. In addition, no new CBAS Centers have been opened in San Bernardino County so the existing CBAS Centers have been accommodating the needs of new participants. In DY 10, Quarter 5 which included data from July 2015 to September 2015, San Bernardino County CBAS Centers had a total of 549 MCP participants, three FFS participants and was at 102 percent capacity. By the first quarter of DY 11 which covered the period of October 2015 through December 2015, San Bernardino County CBAS Centers had a total of 606 MCP participants, four FFS participants and had a licensed capacity of 113 percent. However, San Bernardino County experienced a slight decrease in enrollment during the last two quarters of DY 11 which resulted in its overall licensed capacity decreasing from 113 percent to 106 percent.

CBAS Assessments for MCPs and FFS Participants

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*” lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS.

Table 2:

CBAS Assessments Data for MCPs 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%)
DY11 Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS services were collected by MCPs and DHCS. For DY11, 7,352 assessments were completed by the MCPs. Of which 7,236 were determined to be eligible and 116 were determined to be ineligible. Sixty-three participants submitted requests and were assessed for CBAS benefits under FFS. A total of 62 participants were determined to be FFS eligible by DHCS. One request for CBAS services was denied by DHCS. Per the data provided in Table 2, the total number of eligible FFS participants continues to decline due to the CBAS transition to managed care. Table 2 only reflects actual assessments completed by MCPs and DHCS.

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

CBAS enrollment and CBAS Center licensed capacity is directly 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 Centers to provide CBAS benefit and facilitates monitoring and oversight of the Centers. As of DY11, 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 241 operating CBAS Centers is approximately 21,347 participants which corresponds to 71 percent of total capacity.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	241
Non-Profit Centers	57
For-Profit Centers	184
ADA @ 241 Centers	21,347
Total Capacity	30,049
ADA per Centers	71%
CDA - MSSR Data 06/2016	

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 CBAS@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, 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.” According to Table 4, a total of five complaints were collected by CDA for DY11. For complaints received by MCPs, Table 5 illustrates that beneficiaries' complaints were between four to six from October 2015 to March 2016. From April 2016 to June 2016, the number of beneficiaries' complaints had increased to 26 which is within the range that was previously reported by the MCPs.

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q1 (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

CDA Data - Complaints 06/2016

Table 5:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY11 - Q1 (Oct 1 - Dec 31)	4	0	4
DY11 - Q2 (Jan 1 - Mar 31)	6	1	7
DY11 - Q3 (Apr 1 - Jun 30)	26	0	26

Plan data - Phone Center Complaints 06/2016

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Table 6 entitled, "Data on CBAS Managed Care Plan Grievances," a total of 21 grievances were filed with MCPs during DY 11. Eight of the grievances were regarding CBAS providers, contractor assessment or reassessment, and excessive travel times to access CBAS. Thirteen of the grievances were related to other CBAS issues.

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 - Q1 (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

Plan data - Grievances 06/2016

During DY11, there were fifteen CBAS appeals filed with MCPs. The appeals were related to denial of services, limited services or were related to other CBAS issues. The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY11, there was a total of four requests for fair hearings but all four were verbally withdrawn by program participants.

Quality Assurance/Monitoring Activity

DHCS and CDA convened six stakeholder work group meetings between July 2015 and June 2016 to develop a quality strategy for CBAS. The CBAS Quality Assurance and Improvement Strategy was released for comment on September 19, 2016 and is scheduled to be implemented in October 2016.

DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 7 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 7 also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY11.

Table 7:

County	CBAS Centers Licensed Capacity						
	DY11-Q1 Oct-Dec 2015	DY11-Q2 Jan-Mar 2016	Percent Change Between Last Two Quarters	Capacity Used	DY11-Q3 Apr-Jun 2016	Percent Change Between Last Two Quarters	Capacity Used
Alameda	330	290	-12%	103%	290	0%	102%
Butte	60	60	0%	28%	60	0%	34%
Contra Costa	190	190	0%	67%	190	0%	65%
Fresno	572	652	14%	50%	652	0%	53%
Humboldt	229	229	0%	24%	229	0%	24%
Imperial	330	330	0%	62%	330	0%	62%
Kern	200	200	0%	23%	200	0%	22%
Los Angeles	18,508	18,536	0%	63%	18,291	-1%	63%
Merced	109	124	14%	40%	124	0%	43%
Monterey	110	110	0%	48%	110	0%	57%
Orange	1,960	2,120	8%	57%	2,240	6%	55%
Riverside	640	640	0%	39%	640	0%	42%
Sacramento	529	529	0%	65%	529	0%	63%
San Bernardino	320	320	0%	110%	320	0%	106%
San Diego	2,233	2,233	0%	50%	2,408	8%	38%
San Francisco	866	866	0%	51%	866	0%	51%
San Mateo	135	135	0%	69%	135	0%	73%
Santa Barbara	60	60	0%	5%	60	0%	0%
Santa Clara	830	830	0%	47%	830	0%	47%
Santa Cruz	90	90	0%	59%	90	0%	68%
Shasta	85	85	0%	38%	85	0%	7%
Ventura	851	851	0%	64%	851	0%	64%
Yolo	224	224	0%	1%	224	0%	20%
Marin, Napa, Solano	295	295	0%	14%	295	0%	14%
SUM =	29,756	29,999	24%	59%	30,049	13%	62%

CDA Licensed Capacity as of 06/2016

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

Table 7 reflects that the average licensed capacity used by CBAS participants is 62 percent statewide. Overall, almost all of the CBAS Centers have not operated at full capacity except for Alameda and San Bernardino Counties. This allows for the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative 5 percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was a decrease in provider capacity of 5 percent

or more for DY11. Alameda County's licensed capacity was reduced from 330 to 290 between January 2016 to March 2016. 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 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 the CBAS program, two of the participants were placed in a Skilled Nursing Facility and one participant was transferred to an All-Inclusive Program. Of the 25 participants, 18 received services via MCPs and one received FFS payment model.

Access Monitoring (STC 48.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 counties with CBAS Centers with the exception of Alameda and San Bernardino Counties. These two counties are serving in excess of their allotted capacities. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to the beneficiaries. There are other centers in nearby counties that can assist should the need arise to allow for ongoing care of CBAS participants.

Unbundled Services (STC 44.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY11, CDA had 241 CBAS Center providers operating in California. According to Table 8 entitled "CBAS Center History," a total of three CBAS Centers were closed and two new Centers were opened in DY11. Berkeley ADHC in Alameda County and Casa Del Sol ADHC in Los Angeles closed their Center in December 2015. In March 2016, Salida Del Sol ADHC in Los Angeles

closed. Santa Clarita ADHC in Los Angeles open in December 2015 and Regent West ADHC in Orange County open in January 2016.

Table 8:

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 8 shows there was no negative change of more than 5 percent in DY11, from October 2015 to June 2016, so no analysis is needed to address such variances.

Financial/Budget Neutrality Development/Issues

Pursuant to STC item 50 (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 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.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

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 in 2015. 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 undergoing review and processing.

Progress on the Evaluation and Findings:

Not applicable.

COORDINATED CARE INITIATIVE (CCI) – DUALS DEMONSTRATION

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disability (SPDs), including beneficiaries who are dually-eligible for Medi-Cal and Medicare (Duals), while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI through Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs);
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of Long Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal Medi-Connect.

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

Accomplishments:

Enrollment Strategies

As of January 2016, passive enrollment efforts ceased and now all members enrolling into Cal MediConnect MMPs do so through voluntary choice.

In May 2016, DHCS announced the final policy decisions for a comprehensive strategy for the CCI. This strategy focused on improving the quality of care and care coordination that beneficiaries receive through Cal MediConnect, ensuring that beneficiary satisfaction remains high and increases; therefore, generating sustainability for the program.

This strategy, which is designed to expand awareness of Cal MediConnect and encourage voluntary enrollment, builds on activities that DHCS and its partners are already conducting. This strategy also incorporates many of the lessons learned about how best to reach and educate beneficiaries and providers about the CCI and Cal MediConnect. These strategies include streamlined enrollment and mandatory Medi-Cal managed care health plan (MCP) enrollment for managed long-term services and supports (MLTSS).

Streamlined Enrollment

The streamlined enrollment process allows Cal MediConnect MMPs to collect enrollment-required information from beneficiaries and directly submit enrollment requests to the DHCS enrollment broker for processing. This provides beneficiaries an additional way to enroll into a Cal MediConnect MMP. DHCS anticipates the streamline enrollment process to be in place in Fall 2016.

MLTSS Enrollment

The new Cal MediConnect and MLTSS Resource Guide and Choice Book have gone through the University of California's beneficiary user testing process and are being finalized. DHCS anticipates ongoing, mandatory enrollment of MLTSS-eligible beneficiaries into MLTSS to begin in Fall 2016.

Continuity of Care

DHCS announced that it would extend the continuity of care period for Medicare services from six months to 12 months to match the Medi-Cal continuity of care period, and modify requirements to just one visit with a specialist within the past 12 months, as is the case with primary care physicians. DHCS is working with its federal partner, CMS, on an updated Dual Plan Letter (DPL) which is due to be published in July 2016.

Cal MediConnect Deemed Continued Eligibility

As part of DHCS's ongoing efforts to improve access to care for beneficiaries enrolled in Cal MediConnect, DHCS allowed the Cal MediConnect MMPs to offer a one- or two-month period of deemed continued eligibility for beneficiaries who lose Medi-Cal eligibility or state-specific eligibility for Cal MediConnect. DHCS is actively working with Cal MediConnect MMPs to offer a two-month period of deemed continued eligibility for beneficiaries. Deemed continued eligibility allows beneficiaries to remain enrolled in their Cal MediConnect MMP for a specified period of time in order to resolve eligibility issues with the county. During the deeming period, Cal MediConnect MMPs are

required to offer the full continuum of Medicare and Medi-Cal benefits as outlined in the three-way contract and the approved benefit package for the affected calendar year.

Qualitative and Quantitative Findings:

Enrollment

As of July 1, 2016, approximately 119,354 beneficiaries were enrolled in Cal MediConnect MMPs across the seven participating counties. The overall opt-out rate across all counties was 50 percent. Detailed enrollment information for each CCI county is found below:

County	Number of Beneficiaries Enrolled	Eligible Population Enrolled (%)	Opt-Out Rate (%)
Los Angeles	38,773	19%	58%
Orange	19,036	35%	52%
Riverside	13,349	45%	37%
San Bernardino	13,025	43%	39%
San Diego	14,667	33%	42%
Santa Clara	11,160	40%	41%
San Mateo	9,344	73%	10%

2016 Enrollment and opt-out statistics can be found at the following link:

<http://www.calduals.org/wp-content/uploads/2016/07/CMC-Enrollment-Dashboard-July-FINAL.pdf>

Utilization

CCI Ombudsman Data

The Cal MediConnect Ombudsman is structured as an umbrella organization that contracts with local entities operating in CCI counties. The purpose of the local contracts is to ensure that the Ombudsman has the ability to provide local, personalized assistance to Cal MediConnect beneficiaries as they navigate the health care system.

The Cal MediConnect Ombudsman was involved with an extensive outreach and education strategy that includes, but is not limited to:

- Ombudsman contact information being included in the 30, 60, and 90-day beneficiary informing materials;

- Requiring the Cal MediConnect MMPs to include the Ombudsman contact information in beneficiary informing materials, such as the Evidence of Coverage, which is received by beneficiaries prior to enrollment;
- Including the Ombudsman contact information on the Cal MediConnect webpage: <http://www.calduals.org/>;
- Having the DHCS enrollment broker, MAXIMUS, refer beneficiaries to the Ombudsman when deemed appropriate;
- DHCS entering into a contract with Harbage Consulting to launch a very aggressive outreach and education campaign; and
- Adding the Ombudsman phone number to the 1-800-Medicare call script.

CCI Ombudsman Call Volume

From November 1, 2015 to June 30, 2016 the Cal MediConnect Ombudsman received approximately 4,985 calls from beneficiaries. Below is a breakdown of the Cal MediConnect Ombudsman call data by each county's corresponding Ombudsman program:

- Legal Aid Society of San Diego (San Diego): 993 calls.
- Neighborhood Legal Services (Los Angeles): 1,256 calls.
- Inland Counties Legal Services (San Bernardino and Riverside): 504 calls.
- Bay Area Legal Aid: 630 calls.
- Legal Aid Society of Orange County: 406 calls.
- Legal Aid Society of San Mateo: 112 calls.
- Other Health Consumer Alliance programs: 708 calls.
- Abandoned calls: 376 calls.

Continuity of Care Data

DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. For the three quarters included in the reporting period of November 1, 2015 through June 30, 2016, the total number of continuity of care requests was 1,010. A majority of the requests were approved; 12.6 percent were denied. Most denials were based on a lack of relationship between member & provider. The rest of the denials were related to providers who declined to work with managed care or difficulties encountered by plans and providers in reaching agreement on rates.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

Establishing Continuity of Care between the Cal MediConnect MMP and Out-of-Network Providers

CCI continuity of care requirements for Cal MediConnect are defined in Welfare and Institutions Code (WIC), Sections 14182.17 and 14132.275. These requirements are also set forth in the three-way contract. The three-way contract establishes the following requirements:

- CMS and DHCS require Cal MediConnect MMPs to ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers;
- DHCS requires each participating Cal MediConnect MMP to follow continuity of care requirements established in current law;
- As part of the process to ensure that continuity of care and coordination of care requirements are met, a Cal MediConnect MMP must perform a Health Risk Assessment (HRA) within the timeframes specified in DPL 15-005. As part of the HRA, Cal MediConnect MMPs must ask the beneficiary if there are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the continuity of care process at that time if the beneficiary chooses to do so;
- Upon the beneficiary's request, the Cal MediConnect MMP must allow the beneficiary to continue receiving services from out-of-network providers for primary and specialty care services and maintain his or her current providers and service authorizations at the time of enrollment for:
 - A period up to 12 months for Medicare services if the criteria are met under WIC Section 14132.275(l)(2)(A); and
 - A period of up to 12 months for Medi-Cal.

When a beneficiary is unable to receive health care services from his or her provider who is not networked with Cal MediConnect, the beneficiary is able to request continuity of care if he or she meets the requirements contained in DPL 15-003.

Throughout CCI, there have been difficulties with certain provider groups not accepting continuity of care with the Cal MediConnect MMPs. As a result, beneficiaries who want to continue seeing their providers are choosing to disenroll from Cal MediConnect. Transition issues with providers have often led to high opt-out rates or early disenrollments from Cal MediConnect.

As stated above, DHCS is working with CMS to release an updated DPL (superseding DPL 15-003) that will extend the continuity of care period for Medicare services from six to 12 months to match the Medi-Cal continuity of care period and will modify

requirements to just one visit with a specialist within the past 12 months, as is the case with primary care physicians.

DPLs 15-003 and 15-005 can be found at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDDualsPlanLetters.aspx>

Marketing Material Review for Calendar Year 2016

In the beginning of 2016, DHCS collaborated with the Department of Managed Health Care and CMS to establish marketing materials and guidance for Cal MediConnect MMPs to use for contract year 2017. Coordination was required between several divisions within each organization to ensure that the materials met state and federal regulations while remaining informative for beneficiaries. The review period required collaboration among all entities to ensure that the materials were finalized in a timely manner by the established deadlines.

Progress on the Evaluation and Findings:

Research Triangle Institute (RTI) International

CMS contracted with RTI to monitor the implementation of demonstrations under the federal Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations.

The goals of the evaluation are to monitor demonstration implementation, impact of the demonstration on beneficiary experience, unintended consequences, and impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International collects qualitative and quantitative data from DHCS each quarter; analyzes Medicare and Medi-Cal enrollment and claims data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. DHCS is expecting to receive the first RTI Annual Evaluation Report in late 2016.

The SCAN Foundation (TSF)

TSF funded two evaluations of the Cal MediConnect program: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of Cal MediConnect, as described below. While TSF has funded these evaluations, DHCS has been working collaboratively with TSF and stakeholders to initially develop and more recently to update the content of both evaluations.

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of Cal MediConnect on California's Dual population in as close to real time as possible. FRC has completed two waves of the project and is planning to conduct additional waves in 2016. The study compares the levels of confidence and satisfaction of Cal MediConnect enrollees with Duals who are eligible for Cal MediConnect but are not participating, or live in a non-Cal MediConnect county within California.

The first three waves of the project have found that large majorities of Cal MediConnect enrollees express satisfaction and confidence with their health care services and are no more likely than other Duals to report problems with their health care services. In terms of the population that has chosen to opt-out of the program, the main reasons given for not participating in Cal MediConnect relate to beneficiaries' resistance to change.

The most recent survey findings were released in June 2016 and were presented at the SCAN Foundation LTSS Summit on September 13, 2016. The presentation can be found at:

http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medi-cal_polling_results_3_june_2016.pdf

In 2014, an evaluation team comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health, designed a three-year evaluation of the CCI. The evaluation team engaged stakeholder input and built upon the national evaluation to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects.

While this evaluation is still underway, the report of the key findings from Phase One was presented at the SCAN Foundation LTSS Summit on September 13, 2016. This report discussed the results from 36 Key Informant interviews, a longitudinal telephone survey of over 2,000 beneficiaries, focus groups (plus interviews) with beneficiaries, and interviews with Cal MediConnect MMPs and stakeholders. This report is available on TSF's website at:

http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf

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 designated 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 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.

DSRIP was implemented from November 1, 2010, or Demonstration Year (DY) 6, and was initially scheduled to end on October 31, 2015, at the end of DY 10. DSRIP was subsequently extended to December 31, 2015. A total of \$3.3 billion in federal funds were available to DPHs to implement projects that developed infrastructure, implemented innovation and redesign, tracked population-focused measures, and implemented urgent improvements in care. Ten DPHs also implemented Category 5 projects, which focused on ensuring that persons diagnosed with HIV have access to high-quality, integrated, and coordinated care in the outpatient setting. Category 5 projects were implemented for a total of 18 months, from the start of DY 8 in July 2012 through the first six months of DY 9, ending in December 2013.

Accomplishments:

DPHs reported achieving at least 90 percent of Category 1 milestones in all demonstration years, including 100 percent in DY 6 (98 of 98), 98 percent in DY 7 (150 of 153), 97 percent in DY 8 (138 of 142), 98 percent in DY 9 (117 of 119), and 90 percent in DY 10 (86 of 96).

The proportion of improvement milestones increased over the course of the program, from just 7 percent of all Category 1 milestones in DY 6 to 69 percent in DY10, as DPHs gradually shifted from measuring implementation processes early in the program to measuring outcomes in the later years of the program as projects matured.

Qualitative Findings:

In the interim period, DPHs reported that 56 percent of all DSRIP projects had the greatest impact on quality improvement, 36 percent had the greatest impact on improving patient outcomes, and 9 percent had the greatest impact on increasing cost containment/efficiency.

Quantitative Findings:

Payment	FFP	IGT	Service Period	Total Funds Payment
Delivery System Reform Incentive Pool (DSRIP)				
(Ext Nov - Dec)	\$18,087,790	\$18,087,790	DY 10	\$36,175,580
(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	\$18,187,841.88	\$18,187,841.88		\$36,375,683.76

In DY 11, DPHs received \$18,187,841.88 in federal fund payments.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

Nothing to report.

Progress on the Evaluation and Findings:

The UCLA Center for Health Policy Research, completed their external evaluation of the DSRIP program and submitted a final evaluation report to CMS on February 1, 2016. On July 18, 2016, CMS responded to the evaluation report with comments and requests for additional information. DHCS sent a response to CMS's requests along with an updated evaluation report on September 23, 2016. CMS is currently reviewing the revised report.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Given the importance of oral health to the overall health of an individual, California recognizes improvements in its dental care program as critical to achieving better health outcomes in totality for Medi-Cal 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.

Domain 1

This domain aims to increase statewide the number of Medi-Cal children ages 1 through 20 that receive preventive dental services by at least 10 percentage points over a five-year period.

Domain 2

Under this domain, dental providers in selected pilot counties will be eligible to receive incentive payments for performing pre-defined caries risk assessments (CRAs), develop treatment plans, provide nutritional and motivational counseling for Medi-Cal children ages 6 and under based upon the child's risk. This domain seeks to prevent and mitigate oral disease through the delivery of preventive services in lieu of more invasive and costly procedures (restorative services).

Domain 3

This domain seeks to make available incentive payments to dental service office locations in select pilot counties who have maintained continuity of care through providing recall examinations to their enrolled Medi-Cal children ages 20 and under. This domain seeks to increase continuity of care for the targeted population over 2, 3, 4, 5, and 6 continuous year periods.

Domain 4

Local Dental Pilot Projects (LDPPs) will address the aforementioned domains through pilot programs aimed at supporting the goals of the first three domains through

innovative strategies and methods. DHCS will solicit proposals and shall review, approve, and make payments to LDPPs in accordance with the requirements stipulated.

Accomplishments:

Program Timeline

Date	DTI Action Items
February 2016 (weekly) – Ongoing	DHCS conducts weekly meetings to discuss DTI work plan tasks and related deliverables.
March 2016	DTI stakeholder listserv is created. http://apps.dhcs.ca.gov/listsubscribe/default.aspx?list=DTIStakeholders .
March 8, 2016	DHCS created the DTI Webpage. http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx
March 16, 2016	DHCS set up the DTI Inbox. DTI@dhcs.ca.gov
March 17, 2016 – Ongoing	DHCS established the DTI Small Workgroup. The DTI Small workgroup meets to collaborate with DHCS on DTI planning and rollout efforts.
March 28, 2016 – Ongoing	DHCS began to circulate DTI FAQs with Stakeholders. 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. http://www.dhcs.ca.gov/provgovpart/Documents/FAQs_DTI08.31.16.pdf
March 30, 2016	DTI Timeline is finalized.
April – June 2016	DTI Domains 1, 3, and 4 fact sheets are finalized and posted on the DTI webpage.
April 14, 2016 (bi-weekly) – Ongoing	DHCS conduct bi-weekly meetings with CMS to discuss the implementation of the DTI.
April 22 – May 10, 2016	DHCS released the LDPP Letter of Intent (LOI) and received 25 in return.
May 9, 2016 – Ongoing	DHCS established the DTI Safety Net Clinic Subgroup. The DTI Safety Net Clinic Subgroup meets to determine enrollment and reporting requirements for clinics under the DTI.
May 10, 2016	DHCS finalized the LDPP Application and Selection Criteria.

May 27, 2016 (weekly) – Ongoing	DHCS and Delta Dental participate in weekly meetings to discuss DTI deliverables.
May 31, 2016	DHCS revised Domain 1 methodology. Waiver amendment discussions began.
June 1, 2016	DHCS released the LDPP Application on its DTI webpage.
June 7, 2016 – Ongoing	DHCS established the DTI CRA Subgroup. The DTI CRA subgroup meets to identify risk assessment tools and training programs that will be used in DTI Domain 2
Date	DTI Outreach Presentations (Venue)
January 28, 2016	Oral Health Advisory Committee
February 25, 2016	DHCS Stakeholder Advisory Committee (SAC) Meeting
March 1, 2016	Medi-Cal Tribal and Indian Health Program Designee Annual Meeting
April 13, 2016	Los Angeles (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	DHCS SAC Meeting
May 26, 2016	Medi-Cal Dental Advisory Committee (MCDAC)
June 9, 2016	LA Stakeholder Meeting
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
Date	DTI Webinars
January 25, 2016	California Medi-Cal 2020 Waiver Overview <ul style="list-style-type: none"> • Meeting Presentation: Meeting Presentation

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. <ul style="list-style-type: none"> • Meeting Presentation • Agenda
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. <ul style="list-style-type: none"> • Meeting Presentation • Agenda
June 14, 2016	DHCS held a DTI Stakeholder Webinar, which provided general updates on the LDPP application revisions and the revised application due date. <ul style="list-style-type: none"> • Meeting Presentation
Date	DTI Stakeholders Meetings
February 25, 2016 and May 16, 2016	DHCS SAC Meetings
April 4, 2016; April 27, 2016; May 18, 2016; and June 15, 2016	DTI Small Workgroup
May 9, 2016 and May 26, 2016	DTI Safety Net Clinic Subgroup
June 7, 2016 and June 28, 2016	DTI CRA Subgroup

Program Highlights:

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 assembled 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's 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 to collect past and prospective claims data for 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.

Domain 1

The Safety-Net Clinic sub-workgroup continues to meet on a weekly basis in an effort to finalize the data collection and reporting mechanisms for the safety net clinics 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 also applies to Domain 3.

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>.

The fact sheet will be finalized upon CMS approval of the proposed DTI Amendment.

Domain 2

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 on March 2016 met several times throughout April, May, and June, 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.

Additionally, the Domain 2 Fact Sheet is being reviewed and finalized.

Domain 3

Please see the Domain 1 highlight 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.

The Domain 3 Fact Sheet was released and posted to the DTI website on May 26, 2016. The fact sheet is located at:

<http://www.dhcs.ca.gov/services/Documents/DTIDomain3.pdf>.

Domain 4

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 can be found in the link below.

<http://www.dhcs.ca.gov/provgovpart/Documents/DTIVoluntaryLOISubmissions.pdf>

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 on June 1, 2016, with an application due date of September 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 webpage. The Domain 4 Fact Sheet is located at:

<http://www.dhcs.ca.gov/provgovpart/Documents/DTIDomain4.pdf>

Qualitative Findings:

As current system infrastructure is being finalized, there are no reporting items for this report.

Quantitative Findings:

As current system infrastructure is being finalized, there are no reporting items for this report.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

DHCS continued to collaborate with DTI stakeholders regarding issues and challenges specific to each of the four domains. Challenges vary among the domains but include the FQHC baseline data and claims submission requirements, utilization of DMC

encounter data, LDPP Application clarity, incentive payment development, IT system changes, and adequate staffing. The administration is closely monitoring all of these issues to ensure success.

Progress on the Evaluation and Findings:

Progress on the evaluation methodology is occurring. This section will be updated in upcoming reports.

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

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

The DMC-ODS's state 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. DHCS has approved the following counties' implementation plans: San Francisco, San Mateo, Santa Cruz, and Santa Clara. The six counties' implementation plans that are concurrently in review by DHCS and CMS are: Marin, Los Angeles, Napa, Contra Costa, Monterey, and Riverside.

Accomplishments:

CMS approved the following deliverables in DY 11:

- January 2016: Integration Plan Review Process
- May 2016: Integration Plan Approach
- June 2016: County Public Expenditure Protocols
- June 2016: Final Evaluation Design by UCLA

Program Highlights:

- Bi-monthly technical assistance calls with County Leads
- DHCS participates in CMS's Innovation Accelerator Program Targeted Learning Opportunities, which focuses on primary care and SUD integration.
- November 10, 2015: DMC-ODS Implementation Plan Webinar
- December 8, 2015: Follow-up Region 2 implementation Meeting.
- December 10, 2015: Quarterly Blue Shield Foundation Meeting

- December 18, 2015: County Plan Meeting with CMS
- January 28, 2016: Santa Cruz Technical Assistance Meeting
- February 4, 2016: [California Alliance of Child and Family Services](#) Winter Conference (Monterey)
- February 10, 2016: Fiscal Provisions Webinar Part 1 to the Counties
- February 19, 2016: External Quality Review Organization Implementation Plan Meeting
- March 7-9 2016: Tarzana Site Visit and San Diego Tribal Conference
- March 10, 2016: Beneficiary Protections Webinar
- March 29, 2016: EQRO & UCLA Implementation Plan Meeting
- March 30, 2016: Phase 3 Regional Meeting Part 1
- April 12, 2016: DHCS and Blue Shield of California Foundation Quarterly Meeting
- April 18, 2016: Fiscal DMC Rates Conference Call
- May 2, 2016: California Indian Health Service Follow-up Plan/Questions
- May 3, 2016: Fiscal Provisions Part 2 Webinar to the Counties
- May 5, 2016: California Department of Corrections and Rehabilitation Director's Stakeholder Advisory Group Meeting
- May 12, 2016: California Mental Health Advocates for Children and Youth Meeting
- May 16, 2016: Stakeholder Advisory Committee 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 & CMS Conference Call regarding Indian Health Services Proposal
- June 3, 2016: Integration Plan Stakeholder Meeting
- June 7, 2016: DHCS Academy Presentation
- June 7, 2016: DHCS and California Health Care Foundation Quarterly Meeting
- June 10, 2016: UCLA American Society Addiction Medicine Tool Webinar
- June 13, 2016: Review of Indian Health Service Concept Paper
- June 23, 2016: EQRO Meeting
- June 27, 2016: Indian Health Program Organized Delivery System Conference Call

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Nothing to report.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

There was a delay in obtaining approval of the CPE Protocol; CMS approved the protocols on June 17, 2016.

There was a delay in obtaining approval for the UCLA draft evaluation design, but CMS approved the final evaluation design on June 20, 2016.

There was a 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.

Progress on the Evaluation and Interim Findings:

On June 20, 2016, CMS approved the evaluation design for the DMC-ODS component of California's Medi-Cal 2020 Demonstration. The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) will conduct the 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 evaluation is posted on the UCLA website at:

<http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf>

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. Receiving care in proper settings, for the type of illness being treated, will be valued relatively higher than the care being given in improper settings. 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.

Accomplishments:

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 PHCS.

Per STCs Items 178-180 Uncompensated Care Reporting, the State commissioned Navigant as the contractor to conduct the first independent report that focused on Designated Public Hospitals uncompensated care. The report was submitted to CMS on May 15, 2016. CMS authorized up to \$472 million in total computable funds for the Uncompensated Care component of the Global Payment Program for demonstration years two through five.

Program Highlights:

Program developed the interim year-end summary report to be completed by the PHCS after the close of the program year.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Payment	FFP	IGT	Service Period	Total Funds Payment
Global Payment Program (GPP)				
(Qtr 1 Jan - March)	\$257,087,519	\$83,290,250	DY 11	\$340,377,769
(Qtr 2 April – June)	\$571,025,147	\$744,822,416	DY 11	\$1,315,847,563
Total	\$828,112,666	\$828,112,666		\$1,656,225,332

In DY 11, Public Health Care Systems received \$828,112,666 in federal fund payments.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

Nothing to report.

Progress on the Evaluation and Findings:

Per STCs Items 178-180 Uncompensated Care Reporting, the second independent report is due June 1, 2017 and will focus on uncompensated care, provider payments, and financing across hospital providers that serve Medicaid beneficiaries and the uninsured under the current demonstration.

The Department is currently drafting and finalizing the request for proposal for the second uncompensated care report.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL (PRIME)

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

The PRIME Program aims to:

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

PRIME Projects are organized into 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: populations in need of perinatal care, individuals in need of post-acute care or complex care planning, foster children, individuals who are reintegrating into society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

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

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

Accomplishments:

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 5-year plans were approved for program participation. One DMPH hospital, Tehachapi Valley Healthcare District removed themselves from the application process as they were beginning the process of being acquired by a private facility.

Per STCs 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 was contingent on the approval of each hospital's PRIME 5-year plan.

Program Highlights:

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

Qualitative Findings:

PRIME participating entities recently reported qualitative data in the PRIME Final Year-End Reports due on September 30, 2016. In these Final Year-End Reports, DPHs and

one DMPH reported baseline data for their selected PRIME projects, and all but one DMPHs reported on the infrastructure building process measures completed. DHCS anticipates some DMPHs will report baseline data for select projects within their PRIME 5-year plans.

Quantitative Findings:

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

In DY 11, DPHs and DMPHs received \$0 in federal fund payments.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

Nothing to report.

Progress on the Evaluation and Findings:

DHCS is in the process of developing a draft evaluation design to submit for CMS review on August 29, 2016.

WHOLE PERSON CARE (WPC)

The Whole Person Care (WPC) Pilot is a five-year program authorized under the 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 and who have poor health outcomes.

Local WPC pilots will identify high-risk, high-utilizer 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, which 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 IHS, 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.

Accomplishments:

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

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

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

On May 13, 2016, DHCS received approval from CMS on the WPC Pilots Program STC Attachments.

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 CMS feedback, as well as various stakeholder feedback.

Program Highlights:

With funding from The California Endowment, DHCS contracted with a vendor to collaborate on the development of the WPC Pilot, the WPC Pilot application, and the selection criteria. DHCS prepared for the release of the draft WPC Pilot application and selection criteria for stakeholder review in April 2016, the submission of selection criteria to CMS for approval, and then the anticipated release of the final WPC Pilot application in May 2016.

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

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

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

On April 11, 2016, DHCS released the WPC Pilot program draft application and selection criteria for stakeholder review. The draft application reflected the requirements described in the 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 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 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 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 PL 93-638 contract with the federal IHS. On June 23, 2016, CMS approved the amendment request and posted the state's request and supporting documents on the CMS website for a thirty-day comment period. A decision is expected from CMS within 120 days of submission.

During May and June 2016, DHCS provided technical assistance to potential applicants on the application and program requirements. 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.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Nothing to report.

Policy and Administrative Difficulties in the Operation of this Demonstration Year:

Nothing to report.

Progress on the Evaluation and Findings:

The draft evaluation design is currently in the planning phase, and DHCS is in the process of completing the evaluation design for submission to CMS.