State of California—Health and Human Services Agency
Department of Health Care Services

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May 24, 2018

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QUARTERLY PROGRESS REPORT FOR THE PERIOD JANUARY 1, 2018, THROUGH MARCH 31, 2018, OF CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION

Dear Ms. Garner, Ms. Ross, and Ms. Lee:

Enclosed is the Quarterly Progress Report as required by Special Terms and Conditions Paragraph 27 and Attachment I of California's Section 1115 Waiver, entitled *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the third and final quarterly progress report for Demonstration Year Thirteen, which covers the period from January 1, 2018, through March 31, 2018.

If you or your staff have any questions or need additional information regarding this report, please contact Angeli Lee by phone at (916) 552-9331, or by email at Angeli.Lee@dhcs.ca.gov.

Sincerely,

[redacted]

Mari Cantwell
Chief Deputy Director
Health Care Programs

Enclosures: Medi-Cal 2020 DY13-Q3 Progress Report
DY13-Q3 DMC-ODS Expenditures

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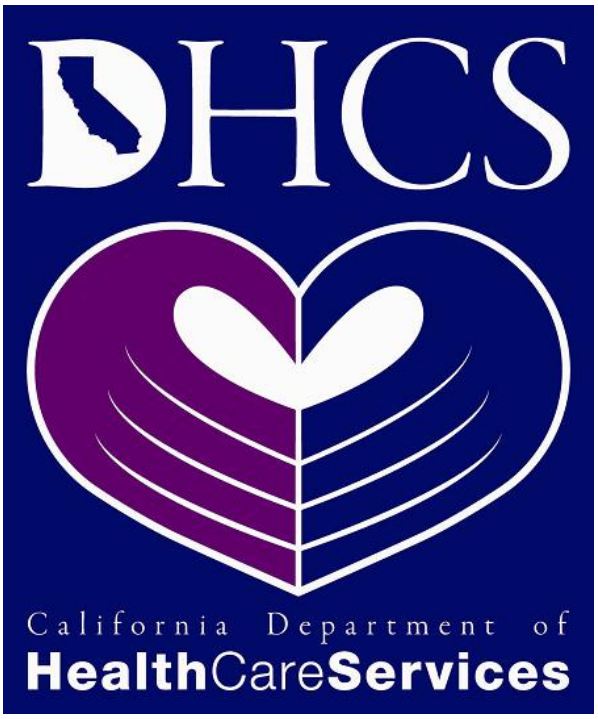
CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)



Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Thirteen (07/01/2017 – 06/30/2018)
Third Quarter Reporting Period: 01/01/2018 – 03/31/2018

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted a waiver monitoring conference call on February 26, 2018 to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration.

The following topics were discussed:

- Whole Person Care/Health Homes Program Interaction
- Redistribution of DTI Domain 4 Funds
- Financial Reporting Activities

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

California's Section 1115(a) Medicaid Waiver Demonstration (Medi-Cal 2020 Waiver Demonstration), STCs paragraphs 69-73 require DHCS to contract with its External Quality Review Organization (EQRO), Health Services Advisory Group, to conduct a one-time access assessment to care (Assessment).

On April 21, 2017, DHCS submitted the Assessment Design to the Centers for Medicare and Medicaid Services (CMS) for review and approval. Once approved by CMS, the EQRO will prepare data requirements, begin data collection, and conduct the analysis. After the analysis is complete, the EQRO will produce and publish an initial draft report and a final report that will include a comparison of health plan network adequacy compliance across different lines of business and recommendations in response to any systemic network adequacy issues, if identified. Throughout the process, the Advisory Committee will be included to provide input and feedback.

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

- Assessment design approval by CMS.
- Assessment conducted by EQRO.
- Initial draft report meeting with Advisory Committee for review and comment.
- Initial draft report posted for public comment.
- Exit Advisory Committee Meeting.
- Final report submission to CMS ten months following CMS' approval of the Assessment Design.

There has been no activity in DY13-Q3.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

The monthly enrollment for Health Plan San Mateo (HPSM) CCS Demonstration Project (DP) is reflected in the table below. Eligibility data is extracted from the Children’s Medical Services Network (CMS Net) utilization management system and is verified by

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

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
15-Jan	1,526	$1,658.05	$2,530,184
15-Feb	1,501	$1,658.05	$2,488,733
15-Mar	1,545	$1,658.05	$2,561,687
15-Apr	1,551	$1,658.05	$2,571,636
15-May	1,568	$1,658.05	$2,599,822
15-Jun	1,588	$1,658.05	$2,632,983
15-Jul	1,590	$1,535.45	$2,441,366
15-Aug	1,589	$1,535.45	$2,439,830
15-Sep	1,597	$1,535.45	$2,452,114
15-Oct	1,580	$1,535.45	$2,426,011
15-Nov	1,587	$1,535.45	$2,436,759
15-Dec	1,584	$1,535.45	$2,432,153
16-Jan	1,577	$1,535.45	$2,421,405
16-Feb	1,587	$1,535.45	$2,436,759
16-Mar	1,605	$1,535.45	$2,464,397
16-Apr	1,622	$1,535.45	$2,490,500
16-May	1,618	$1,535.45	$2,484,358
16-Jun	1,621	$1,535.45	$2,488,964
16-Jul	1,648	$1,481.08	$2,440,820
16-Aug	1,636	$1,481.08	$2,423,047
16-Sep	1,607	$1,481.08	$2,380,096
16-Oct	1,640	$1,481.08	$2,428,971
16-Nov	1,628	$1,481.08	$2,411,198
16-Dec	1,631	$1,481.08	$2,415,641
17-Jan	1,625	$1,481.08	$2,406,755
17-Feb	1,649	$1,481.08	$2,442,301
17-Mar	1,647	$1,481.08	$2,439,339
17-Apr	1,633	$1,481.08	$2,418,604
17-May	1,630	$1,481.08	$2,414,160
17-Jun	1,617	$1,481.08	$2,394,906
17-Jul	1,609	$1,645.68	$2,649,545
17-Aug	1,614	$1,645.68	$2,662,710
17-Sep	1,616	$1,645.68	$2,666,002
17-Oct	1,605	$1,645.68	$2,644,608
17-Nov	1,575	$1,645.68	$2,598,529
17-Dec	1,590	$1,645.68	$2,626,505
18-Jan	1,595	$1,645.68	$2,624,860
18-Feb	1,573	$1,645.68	$2,588,655
18-Mar	1,570	$1,645.68	$2,583,718
		Total	**$97,453,225**

Member Months:

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	1,595	1,573	1,570	3	4,738

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

Recurring conference calls between DHCS and HPSM are conducted on a regular basis to discuss various contract issues, such as financials, information technology, deliverable reporting, and working with HPSM to move to a Whole-Child Model (WCM) with Phase-in beginning July 1, 2018.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

Recurring conference calls between DHCS and HPSM are conducted on a regular basis to discuss various contract issues, such as financials, information technology, deliverable reporting, and working with HPSM to move to a Whole-Child Model (WCM) with Phase-in beginning July 1, 2018.

Contract Amendments

HPMS had no contract amendments updates during DY13-Q3.

HPSM contract amendment A03 is in process. This amendment will extend the contract for 18 months to December 31, 2018 as allowed by Request for Proposal #11-88024. No rates are included. A03 has been approved by DHCS management and was submitted to CMS for federal review and approval.

Rady Children's Hospital of San Diego Demonstration Project

DHCS and RCHSD have been working closely and are committed to the implementation of this pilot demonstration. RCHSD has reviewed and commented on the boilerplate contract used for managed care plans, submitted a majority of their plan readiness deliverables for review, and worked diligently on establishing a provider network to meet the needs of the pilot-eligible population. DHCS is developing the

infrastructure needed for RCHSD to operate as a full-risk provider in the Medi-Cal managed care system; including developing payment systems, rates, and enrollment processes.

Pre-Implementation Contract/Data Use Agreement

DHCS and RCHSD reached out to CCS Demonstration Project pilot-eligible members within San Diego County to gauge their interest in the CCS pilot. A pilot interest letter, a cover sheet and FAQ document was provided. The pre-implementation contract which allows for data-sharing between DHCS and RCHSD has been completed. This contract will allow the Department to provide RCHSD with member information for potentially eligible members currently working with RCHSD.

Demonstration Schedule

The CCS Demonstration Pilot is slated for implementation no sooner than July 1, 2018. It should be noted the projected implementation timetable is contingent on a number of factors including development and acceptance of capitated rates, the ability of the contractor to demonstrate compliance with the new Medicaid Final Rule and readiness to begin operations, and approvals by Federal CMS.

Consumer Issues:

CCS Quarter Grievance Report

In April 2018, HPSM submitted their "CCS Quarterly Grievance Report" for the third quarter, January-March 2018. During the reporting period, HPMS received and processed 17 member grievances. These grievances sorted by type: Accessibility, Benefits/Coverage, Referral, Quality of Care/Service and Other.

- Accessibility: One (1) grievance was reported
    - For "lack of primary care provider availability" and was resolved in the member's favor
- Quality of Care/Service: Seven (7) grievances were reported
    - Six (6) were for "plan denial of treatment" of which four (4) were resolved in the member's favor and two (2) were resolved in the Plan's favor
    - One (1) was for "provider denial of treatment" and was resolved in the member's favor
- Other: Nine (9) grievances were reported
    - Four (4) were for "access" and all were resolved in the member's favor
    - Two (2) were for "customer service" of which one (1) was resolved in the member's favor and one (1) was resolved in the Plan's favor
    - One (1) was for "enrollment/disenrollment" and was resolved in the member's favor

    Two (2) were for "billing" and both were resolved in the member's favor

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and received the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx

There is no new activity to report for this quarter.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

services were provided prior to CBAS starting on April 1, 2012[1]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal 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 participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both MCP and FFS members per county for Demonstration Year 13 (DY13), Quarter 3 (Q3), represents the period of January 2018 to March 2018. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 8 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. FFS claims data identified in Table 1, reflects data through the quarter of October 2017 to December 2017 (DY13-Q2) because of the lag factor of about two to three months. Data for DY13-Q3, will be reported in the next quarterly report.

[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.

Table 1

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY12-Q3		DY12-Q4		DY13-Q1		DY13-Q2	
	Jan - Mar 2017		Apr - June 2017		Jul - Sept 2017		Oct - Dec 2017	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	530	80%	541	82%	512	78%	522	79%
Butte	42	41%	40	39%	43	42%	45	44%
Contra Costa	210	65%	213	66%	212	66%	224	70%
Fresno	615	56%	639	58%	611	55%	632	57%
Humboldt	97	25%	95	24%	95	24%	86	22%
Imperial	330	59%	357	64%	352	63%	318	57%
Kern	73	22%	67	20%	66	19%	76	22%
Los Angeles	21,299	67%	21,720	68%	22,176	69%	21,775	67%
Merced	94	45%	91	43%	95	45%	94	45%
Monterey	116	62%	122	65%	107	57%	107	57%
Orange	2,256	54%	2,103	51%	2,166	52%	2,243	54%
Riverside	459	42%	483	45%	463	43%	488	45%
Sacramento	561	63%	520	58%	501	80%	461	74%
San Bernardino	601	111%	564	104%	522	70%	624	84%
San Diego	1,990	54%	1,995	54%	1,951	52%	2,036	55%
San Francisco	722	49%	730	50%	716	46%	702	45%
****San Mateo**	175	77%	174	76%	62	27%	57	25%
Santa Barbara	*	*	*	*	*	*	*	*
****Santa Clara**	674	48%	643	46%	632	45%	590	42%
Santa Cruz	98	64%	119	78%	95	62%	109	72%
Shasta	*	*	*	*	*	*	*	*
Ventura	943	65%	937	65%	914	63%	903	63%
Yolo	79	21%	80	21%	82	22%	82	22%
Marin, Napa, Solano	74	15%	81	16%	86	17%	75	15%
Total	**32,044**	**62%**	**32,295**	**62%**	***32,472**	***62%**	**32,258**	**61%**
FFS and MCP Enrollment Data 12/2017								

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.
**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***Data for these counties are updated by the MCPs to reflect accurate information for DY13-Q1.*
****Data for total statewide unduplicated participants in DY13-Q1 are updated due to a miscalculation*

Table 1 reflects that enrollment has remained relatively consistent with over 30,000 CBAS participants. The data reflects ample capacity for participant enrollment into most CBAS Centers. Due to reporting errors identified by the MCPs, DY13-Q1 participation data for Santa Clara and San Mateo County was modified from last quarter's report to reflect accurate data. Additionally, please note, the total figure reported for statewide unduplicated participants in DY13-Q1 under Table 1 identifies an amended figure. Due to an error in calculating and tabulating the total unduplicated count, DHCS reported 31,756 enrolled members services during DY13-Q1 which represents an under reported count. The error has been corrected and updated under Table 1, which resulted in an increase in 32,472 unduplicated participants for DY13-Q1. The corrections in participation data for Santa Clara, San Mateo, and statewide unduplicated participant counts resulted in an increase to statewide participation and center capacity usage of CBAS services in DY13-Q1.

While the closing of a CBAS Center in a county can contribute to increased utilization of the license capacity in a county, it is important to note the amount of participation can also play a significant role in the overall amount of licensed capacity used throughout the State. In counties such as San Bernardino and Santa Cruz, there was a more than 5% increase in licensed capacity utilized compared to their previous quarter. The increase in licensed capacity utilized in San Bernardino and Santa Cruz was the result of an increase in unduplicated participants during the quarter. In Imperial and Sacramento, there was more than a 5% decrease of licensed capacity compared to the previous quarter. This decrease was due to the decline in CBAS participant enrollment, not the closure of a center. A decrease in utilization of licensed capacity can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

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

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

Table 2 entitled "*CBAS Assessments Data for MCPs and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Due to a delay in the availability of data, Table 2 represents data from DY11-Q3 (April 2016 – June 2016) through DY13-Q2 (October 2017 to December 2017). Data for DY13-Q3 (January 2018 – March 2018) will be provided in the next quarterly report.

Table 2

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY11-Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
DY12-Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	11	11 (100%)	0 (0%)
DY12-Q2 (10/1-12/31/2016)	2,741	2,689 (98.1%)	52 (0.02%)	2	2 (100%)	0 (0%)
DY12-Q3 (1/1-3/31/2017)	2,476	2,439 (98.5%)	37 (0.01%)	5	5 (100%)	0 (0%)
DY12-Q4 (4/1-6/30/2017)	2,449	2,408 (98.3%)	41 (0.01%)	8	7 (100%)	1 (0%)
**DY13-Q1 (7/1-09/30/2017)	2,168	2,134 (98.4%)	34 (0.02%)	3	3 (100%)	0 (0%)
DY13-Q2 (10/1-12/31/2017)	2,342	2,315 (98.8%)	27 (0.01%)	7	7 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.
***Assessment data submitted by the MCPs has been updated to reflect accurate information for DY13-Q1.*

Due to an error in reporting in DY13-Q1, assessment data for Santa Clara is modified from last quarter's report to reflect accurate information. The correction in assessment data for Santa Clara County resulted in an overall increase to CBAS assessments under the MCPs in DY13-Q1.

As indicated in Table 2, the number of CBAS FFS participants has remained relatively low due to the transition of CBAS into managed care. In addition, there was an increase in the number of new assessments completed by MCPs in DY13-Q2. Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to Table 2 for DY13-Q2, there were 2,342 assessments completed by the MCPs, of which 2,315 were determined to be eligible and 27 were determined to be ineligible. For DHCS, it was reported that 7 participants submitted their requests for CBAS benefits

under FFS. No requests were deferred to the managed care plans as all seven of the requests were determined to be FFS-eligible. Table 2 identifies seven requests were assessed and approved for CBAS FFS by DHCS.

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

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

Table 3 entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY13-Q2. Due to a delay in availability of data, DY13-Q3 data will be reported in the next quarterly report. The ADA at the 241 operating CBAS Centers is approximately 22,239 participants, which corresponds to 71% Statewide ADA per center. As the result of a decrease in the total unduplicated participants in DY13-Q2, a drop in ADA was seen compared to the previous quarter. Additionally, one new CBAS center in Los Angeles County opened during DY13-Q2 that resulted in an overall increase in total statewide license capacity at 31,201 compared to the previous quarter.

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	56
For-Profit Centers	185
ADA @ 241 Centers	22,239
Total Licensed Capacity	31,201
Statewide ADA per Center	71%

CDA - MSSR Data 12/2017

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.

Outreach/Innovative Activities:

Stakeholder Process

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

After reviewing stakeholder input in addition to the milestones identified in the CBAS STC, in the Medi-Cal 2020 Waiver, DHCS and CDA initiated work groups to address concerns identified during the stakeholder meetings. The workgroups were comprised of MCPs, CBAS providers, advocates, and state staff that convened every other month through June 2016. Implementation of the five-year *CBAS Quality Assurance and Improvement Strategy* began in October 2016. The revised IPC is currently under review and projected to be implemented during the summer of 2018. Updates and progress on stakeholder activities for CBAS can be found at:

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

Operational/Policy Developments/Issues:

DHCS and CDA continue to work with CBAS providers and MCPs to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. One new CBAS Center in Los Angeles County opened during DY13-Q2, and CDA has several applications that are currently under review.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY13-Q2. DHCS delayed implementation of the revised CBAS IPC from April 2017 to April 2018. This delay was determined necessary by DHCS and CDA to align the IPC changes with existing IPC instructions in the CBAS Provider Manual. Moving forward, DHCS and CDA have updated the CBAS form/template revision process to include identification of all related forms/templates/publications that will require corresponding updates.

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

Consumer Issues:

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

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

Issues that generate CBAS complaints are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Tables 4 and 5 represent data covering October 2017 to December 2017 (DY13-Q2). Data for January 2018 to March 2018 (DY13-Q3), will be provided in the next quarterly report.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY13-Q1, as illustrated in Table 4. Table 5 shows that MCPs received 4 beneficiary complaints in DY13-Q2.

Table 4

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11-Q3 (Apr 1 - Jun 30)	1	2	3
DY12-Q1 (Jul 1 - Sept 30)	0	0	0
DY12-Q2 (Oct 1 - Dec 31)	0	0	0
DY12-Q3 (Jan 1 - Mar 31)	0	0	0
DY12-Q4 (Apr 1 - Jun 30)	0	0	0
DY13-Q1 (Jul 1 - Sep 30)	0	0	0
DY13-Q2 (Oct 1 – Dec 31)	0	0	0

CDA Data - Complaints 12/2017

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.

Table 5

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY12-Q1 (Jul 1 - Sept 30)	8	1	9
DY12-Q2 (Oct 1 - Dec 31)	2	0	2
DY12-Q3 (Jan 1 - Mar 31)	3	0	3
DY12-Q4 (Apr 1 - Jun 30)	1	0	0
DY13-Q1 (Jul 1 - Sep 30)	0	0	0
DY13-Q2 (Oct 1 - Dec 31)	4	0	0

Plan data - Phone Center Complaints 12/2017

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.

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

Grievance and appeals data is provided to DHCS by the MCPs. Because of the delay in data reporting, grievances and appeals data from the MCPs are reported up to DY13-Q2. According to Table 6 entitled "*Data on CBAS Managed Care Plan Grievances*," four grievances were filed with the MCPs for DY13-Q2; one grievance was related to "CBAS Providers," and the remaining three grievances were related to "other CBAS grievances."

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**
DY12 - Q1 (Jul 1 - Sep30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	1	0	0	0	1
DY12 - Q3 (Jan 1 - Mar 31)	1	0	0	1	2
DY12 - Q4 (Apr 1 - Jun 30)	4	0	0	3	7
DY13 - Q1 (Jul 1 - Sep 30)	2	0	0	1	3
DY13 - Q2 (Oct 1 - Dec 31)	1	0	0	3	4

Plan data - Grievances 12/2017

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.

For DY13-Q2, two CBAS appeals were filed with the MCPs. Table 7 entitled "*Data on CBAS Managed Care Plan Appeals*", illustrates that the appeal was related to "denial of services or limited services" and the other was categorized as "other CBAS appeals". Due to a delay in information, data for DY13-Q3, will be available in the next quarterly report.

Table 7

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	5	0	0	0	5
DY11 - Q3 (Apr 1 - Jun 30)	0	0	0	3	3
DY12 - Q4 April 1 - Jun 31)	1	0	0	0	1
DY13 - Q1 (Jul 1 - Sep 30)	1	0	0	0	1
DY13 – Q2 (Oct 1 - Dec 31)	1	0	0	1	2

Plan data - Grievances 12/2017

Note: Information is not available for January 2018 to March 2018 due to a delay in the availability of data.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY13-Q2 (October 2017 to December 2017), there were no requests for hearings related to CBAS services filed.

Financial/Budget Neutrality Development/Issues:

Pursuant to STC item 54(b) of the Medi-Cal 2020 Demonstration, MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP, to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the center's capacity to date and adequate networks remain for this population.

The extension of CBAS, under the Medi-Cal 2020 Demonstration will have no effect on budget neutrality as it is currently a pass-through, meaning that the cost of CBAS remains the same with the Waiver as it would be without the waiver. As such, the program cannot quantify savings and the extension of the program will have no effect on overall Waiver budget neutrality.

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under the Medi-Cal 2020 Waiver. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to DY13-Q2, due to a delay in availability of data. Data for DY13-Q3 will be discussed in the next quarterly report.

Table 8

County	CBAS Centers Licensed Capacity					
	DY12-Q3 Jan-Mar 2017	DY12-Q4 Jan-Mar 2017	DY13-Q1 Jul-Sep 2017	DY13-Q2 Oct-Dec 2017	Percent Change Between Last Two Quarters	Capacity Used for DY13-Q2 Oct-Dec 2017
Alameda	390	390	390	390	0%	79%
Butte	60	60	60	60	0%	44%
Contra Costa	190	190	190	190	0%	70%
Fresno	652	652	652	652	0%	57%
Humboldt	229	229	229	229	0%	22%
Imperial	330	330	330	330	0%	57%
Kern	200	200	200	200	0%	22%
Los Angeles	18,996	19,088	19,088	19,315	1%	67%
Merced	124	124	124	124	0%	45%
Monterey	110	110	110	110	0%	57%
Orange	2,458	2,458	2,458	2,458	0%	54%
Riverside	640	640	640	640	0%	45%
Sacramento	529	369	369	369	0%	74%
San Bernardino	320	440	440	440	0%	84%
San Diego	2,188	2,198	2,198	2,198	0%	55%
San Francisco	866	926	926	926	0%	45%
San Mateo	135	135	135	135	0%	25%
Santa Barbara	60	60	60	60	0%	*
Santa Clara	830	830	830	830	0%	42%
Santa Cruz	90	90	90	90	0%	72%
Shasta	85	85	85	85	0%	*
Ventura	851	851	851	851	0%	63%

County	CBAS Centers Licensed Capacity					
	DY12-Q3 Jan-Mar 2017	DY12-Q4 Jan-Mar 2017	DY13-Q1 Jul-Sep 2017	DY13-Q2 Oct-Dec 2017	Percent Change Between Last Two Quarters	Capacity Used for DY13-Q2 Oct-Dec 2017
Yolo	224	224	224	224	0%	22%
Marin, Napa, Solano	295	295	295	295	0%	15%
SUM	30,652	30,852	30,974	31,201	1%	61%

CDA Licensed Capacity as of 12/2017

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
Note: Information is not available for October 2017 to December 2017 due to a delay in the availability of data.

Table 8 reflects the average licensed capacity used by CBAS participants at 61% statewide as of December 31, 2017. Overall, most of the CBAS Centers have not operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STC 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was no decrease in provider capacity of five percent or more throughout the participating counties in DY13-Q2 compared to the prior quarter, therefor no analysis is needed to addresses such variances. In Table 8, Los Angeles County saw an increase of one percent in their license capacity in DY13-Q2 compared to DY13-Q1, and resulted in an overall increase of in the total licensed capacity statewide.

Access Monitoring (STC 52.e.)

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

Unbundled Services (STC 48.b.iii.)

CDA certifies and provides oversight of CBAS Centers. CDA and DHCS continue to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans work with the nearest available

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. Table 9 entitled "*CBAS Center History*," illustrates the history of openings and closings of the centers. According to Table 9 for DY13-Q2 (October 2017 to December 2017), CDA currently has 241 CBAS Center providers operating in California. In DY13-Q2, no centers closed, and as previously mentioned above, one center opened in Los Angeles County. Table 9 shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances. Data for DY13-Q3 will be discussed in the next quarterly report due to a delay in availability of data.

Table 9

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
December 2017	241	0	0	0	241
November 2017	240	0	1	1	241
October 2017	240	0	0	0	240
September 2017	241	1	0	-1	240
August 2017	240	1	2	1	241
July 2017	240	0	0	0	240
June 2017	240	0	0	0	240
May 2017	240	0	0	0	240
April 2017	240	0	0	0	240
March 2017	239	0	1	1	240
February 2017	240	1	0	0	239
January 2017	240	0	0	0	240
December 2016	240	1	1	0	240
November 2016	240	0	0	0	240
October 2016	240	0	0	0	240
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
November 2013	245	1	0	-1	244
October 2013	245	0	0	0	245
September 2013	243	0	2	2	245
August 2013	244	1	0	-1	243
July 2013	243	0	1	1	244
June 2013	244	1	0	-1	243
May 2013	245	1	0	-1	244
April 2013	246	1	0	-1	245
March 2013	247	0	0	0	246
February 2013	247	1	0	-1	246*

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
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

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

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

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

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

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

Domain 3 – Continuity of Care

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between a beneficiary and dental provider in seventeen (17) select pilot counties. Incentive payments will be made

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

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

Domain 4 – Local Dental Pilot Projects (LDPPs)

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

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

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

Enrollment Information:

Statewide Eligible Children Age 1-20 and Preventive Service Utilization [1]

Statewide Preventive Service Utilization for Children Age 1-20	December 2017	January 2018	February 2018	March 2018
Measure Period	01/2017-12/2017	12/2017-01/2018	01/2017-02/2018	02/2017-03/2018
Denominator[2]	5,675,834	5,668,298	5,656,225	5,643,604
Numerator[3]	2,565,162	2,555,669	2,538,851	N/A[4]
Preventive Service Utilization	45.19%	45.09%	44.91%	N/A

[1] Data Source - Dental Dashboard DM3 March 2018 MIS/DSS Data. Utilization does not include one-year full run-out allowed for claim submission.
[2] Denominator: Eligible Children ages 1-20 - beneficiaries who are enrolled in the same dental plan for at least three continuous months; not reflective of potential retroactive eligibility.
[3] Numerator: Eligible Children ages 1-20 who received Preventive Services during the measure period; not reflective of potential retroactive eligibility.
[4] Performance for the third month of each quarter is not available due to claim submission time lag.

State Fiscal Year 2017-2018 Statewide Active Service Offices, Rendering Providers and Safety Net Clinics [1]

State Fiscal Year 2017-2018 Statewide Active Billing & Rendering Providers & Safety Net Clinics							
Delivery System	**Provider Type**	**Quarter 1**			**Quarter 2**		
		July 2017	**August 2017**	**September 2017**	**October 2017**	**November 2017**	**December 2017**
FFS	**Service Offices**	5,543	5,558	5,585	5,602	5,579	5,588
	Rendering	9,626	9,710	9,801	9,847	9,907	9,865
GMC[2]	**Service Offices**	136	137	140	141	143	145
	Rendering	354	350	355	350	355	350
PHP[2]	**Service Offices**	1,103	1,119	1,123	1,129	1,113	1,101
	Rendering	2,004	2,009	2,011	1,984	1,947	1,922
Safety Net Clinics		532	529	530	547	549	553

Delivery System	Provider Type	Quarter 3			Quarter 4		
		January 2018	February 2018	March 2018	April 2018	May 2018	June 2018
FFS	Service Offices	5,593	5,610	5,648	-	-	-
	Rendering	9,857	9,914	9,986	-	-	-
GMC[2]	Service Offices	144	143	143	-	-	-
	Rendering	352	350	352	-	-	-
PHP[2]	Service Offices	1,107	1,108	1,108	-	-	-
	Rendering	1,958	1,950	1,963	-	-	-
Safety Net Clinics		552	556	N/A	-	-	-

[1] Active service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of Safety Net Clinics is based on encounter data from the DHCS data warehouse as of March 2018. Only Safety Net Clinics who submitted at least one dental encounter were included.
[2] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.

Outreach/Innovative Activities:

DTI Small Workgroup

The objective of these meetings is to review monthly updates regarding all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup now meets on a bi-monthly basis, the third Wednesday of the month. This quarter, the workgroup met on January 17, 2018, and in lieu of the March 29, 2018 meeting, DHCS sent updates regarding outreach efforts and the results of the January 12, 2018, provider survey to the group (see Operational/Policy Developments/Issues section). In addition to the DTI small stakeholder workgroup, DHCS has continued its efforts to target specific groups with the assistance of stakeholders.

Domain 2 Caries Risk Assessment Workgroup

This sub-workgroup is still active; however, it did not convene this quarter. As reported in the DY13-Q2 report, a Domain 2 Subgroup was created in August 2017.

Domain 2 Subgroup

A meeting was held on February 20, 2018 where Domain 2 updates and outreach efforts from DHCS, Delta, and California Dental Association were discussed. The

subgroup will reconvene in June 2018. The purpose of the subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

DTI Clinic Workgroup

This sub-workgroup is still active; however, it did not convene this quarter. As reported in quarter one, a Domain 3 Subgroup was created in August 2017.

Domain 3 Subgroup

This subgroup did not convene this quarter. The subgroup will reconvene in May 2018. The purpose of this subgroup is to report on the domain's current activity and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

DTI Webpage

The DTI webpage was updated as information became available during DY13-Q3 and will continue to be updated regularly. This quarter's updates were primarily for Domain 2. The updates included updating the opt-in form to state that providers will receive a confirmation letter once they have successfully opted into the program. The Domain 2 Toolkits for SNC, DMC, and FFS providers was also posted to the site.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY13-Q3. The inbox is useful for interested stakeholders, such as advocates, consumers, counties, legislative staff, providers, and state associations, to direct comments, questions, or suggestions about the DTI to DHCS directly. The listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

In this quarter, there were a total of 196 inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to the following categories:, Encounter data submission, payment status, incentive payment calculations and dispute inquiries for Domain 1 Program Year (PY) 1 and 2, Domain 2 billing questions; Domain 3 opt-in and claim receipt verifications; and Domain 4 budget changes and reimbursement inquiries. All requests were researched and responded to within seven business days.

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

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

Outreach Plans

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

- October 25, 2017: National Academy for State Health Policy – Portland, OR (agenda)
- November 2, 2017: DHCS Medi-Cal Tribal and Indian Health Program Designee Bi-Annual Follow-Up Meeting (presentation)
- November 7, 2017: State CHDP Oral health Subcommittee Virtual Meeting (agenda)
- December 1, 2017: LA Stakeholder Meeting (agenda)
- December 7, 2017: Medi-Cal Dental Advisory Committee (agenda)

Operational/Policy Developments/Issues:

Domain 1

During DY13-Q3, DHCS mailed out updated baseline/benchmark letters to providers who previously participated in PY 1 and new providers who participated in PY 2. DHCS issued its third and final PY 1 incentive payment and its first PY 2 incentive payment. A breakdown of this payment is included below.

Third PY 1 Payment:
FFS - $20,349,773.25
DMC - $1,591,663.50
SNC - $408,249.00
Total - $22,349,685.75

First PY 2 Payment:
FFS - $33,273,819.00
DMC - $2,166,875.25
SNC - $365,448.00
Total - $35,806,142.25

In total, DHCS has made over $82.3 million in Domain 1 incentive payments.

In late March 2018, DHCS also mailed letters to providers impacted by the revised payment methodology for PY 1. For providers who were underpaid, DHCS sent subsequent payment for the difference owed to the providers. For providers who were overpaid, DHCS sent a letter to confirm the overpaid amount and options for repayment.

DHCS continued to respond to provider inquiries regarding the payments they received and have not received, the payment amounts, and how they can confirm they were paid the correct amount.

Domain 2

During this reporting period:

- The total incentive claims paid was $710,824.60, of this total:
    - FFS: Sacramento $117,391; Tulare $425,509.60; Kings $3,276; and Glenn $825
    - DMC: Sacramento $157,397
    - SNC: $6,426
- 16 providers opted into Domain 2.
- 105 providers completed the TYKE training.

From the start of Domain 2 in February 2017 through DY13-Q3:

- The total incentive payments were $2,208,810.60. This total includes:
    - $516,916 DMC incentive payments (Sacramento)
    - $1,662,788.60 FFS incentive payments to four counties (Tulare, Sacramento, Kings, and Glenn)
    - $29,106 SNC incentive payments (Inyo and Mendocino)
- 154 providers opted into Domain 2
- 550 providers completed the TYKE training; however, this number is inclusive on providers in non-Domain 2 counties.

Domain 2 Outreach Efforts

DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation. DHCS has been working closely with Delta Dental to target outreach efforts in low-participating Domain 2 counties, including in-person visits and telephone calls to providers. Delta Dental has contacted providers via phone and had in-person visits with providers in Glenn, Lassen, Plumas, and Sierra Counties during this quarter. Delta Dental has also been following up with providers who want to opt-in and with those with billing concerns. The Domain 2 Toolkits for DMC, SNC and FFS providers were posted to the DTI webpage, as well as an update to the Opt-in form that states providers will receive a notification letter once they are successfully opted in to the program.

The following Domain 2 documents were updated or added to the Domain 2 webpage during this reporting period:

- Domain 2 Provider Summary (Weekly)
- FFS and DMC Toolkit (February 2018) SNC Toolkit February 2018)
- Provider Opt-In Attestation update (March 2018)

Domain 3

Domain 3 Outreach Efforts

On October 24, 2017, DHCS held a conference call with the top paid providers in the 17 pilot counties for Domain 3. The goal of the conference call was to obtain feedback on the providers' best practices that helped them achieve an increase in continuity of care and become top performing providers. On January 12, 2018, DHCS emailed a survey to the 38 remaining top performing providers who were not able to participate on the conference call to obtain qualitative data. For consistency, the survey questions were comparable to those discussed on the conference call. Ten of the 38 providers completed the survey (26% participation).

The survey included 5 total questions, 3 of which were multiple choice that allowed providers to choose more than one answer, while the last 2 were short answer questions. DHCS measured the data from the multiple-choice questions by the number of answers chosen, rather than the number of participating providers.

The results indicated that Domain 3 providers consistently increased patient outreach and communication, appointment follow-ups, and patient education.

Domain 4

There were 15 LDPP applications selected to participate in this domain. However, Northern Valley Sierra Consortium (NVSC) notified the department on November 6, 2017, that it will not proceed with the grant opportunity. DHCS requested the Centers for Medicare and Medicaid Services (CMS) guidance for the ability to reallocate unused NVSC funds to other LDPP projects. The final approved applications and budgets are being posted on the Domain 4 webpage as they become available.

DHCS set up an email inbox LDPPinvoices@dhcs.ca.gov to allow for electronic submission invoices. Invoices are to be submitted on a quarterly basis. DHCS has received 11 invoices from the LDPPs in this quarter, and 23 invoices YTD, 12 of which have been paid during DY13-Q3 for a total of $2,687,453.80. Two of the invoices have been sent to Accounting awaiting payment totaling $778,359.56, and two invoices were under review with DHCS. DHCS is expecting additional invoices from the LDPPs that currently have executed agreements.

At the end of DY13-Q3, the final pending agreement was still in progress as shown in the table below. DHCS has been working with the final applicant regarding their budget

calculations and providing technical assistance/feedback on a regular basis. In addition, DHCS scheduled monthly calls with the LDPPs including those that have not finalized their contracts with DHCS. During this reporting period, LDPP conference calls were held on January 24, February 28, and March 28, 2018.

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

Lead Entity	Status
Alameda County	Executed April 15, 2017
California Rural Indian Health Board, Inc.	Executed June 21, 2017
California State University, Los Angeles	Executed April 15, 2017
First 5 Kern	Revisions Pending
First 5 San Joaquin	Executed May 31, 2017
First 5 Riverside	Executed November 28, 2017
Fresno County	Executed June 27, 2017
Humboldt County	Executed June 21, 2017
Northern Valley Sierra Consortium	Application Withdrawn
Orange County	Executed June 30, 2017
Sacramento County	Executed June 28, 2017
San Luis Obispo County	Executed January 12, 2018
San Francisco City and County Department of Public Health	Executed June 27, 2017
Sonoma County	Executed May 15, 2017
University of California, Los Angeles	Executed May 15, 2017

DTI Annual Report

The Medi-Cal 2020 Waiver's STCs require DHCS to provide an annual report on DTI to CMS. The annual report includes analyses of data and quality measures for the applicable PY, which is also the calendar year. A preliminary annual report is due to CMS only for internal review six months following the end of the applicable PY. An updated annual report is due to CMS and published publicly 12 months following the end of the applicable PY. DHCS submitted the DTI Final Annual Report for PY 1 to CMS on December 22, 2017 and is pending CMS' final review and approval.

Highlights from the annual report include:

Domain 1

- The preventive service utilization rate for children (ages 1-20) increased by 4.64 percentage points from CY 2014 to CY 2016.
- The number of Medi-Cal dentists providing preventive dental services to at least ten children increased by 6.07 percent from CY 2014 to CY 2016.

- DHCS provided a total of $24.19 million in Domain 1 incentive payments in January and July 2017.

Domain 3

- From CY 2015 to CY 2016, across the 17 pilot counties, the percentage of children receiving continuity of care from the same service office location increased by 2.6 percentage points.
- DHCS sent $9.5 million in Domain 3 incentive payments to 695 dental service office locations in 17 counties in June 2017.

Domains 1 and 3: two positive results

- Preventive Services Utilization rates are higher in Domain 3 counties. From CY 2014 to CY 2016, utilization of preventive services increased 7.46 percent in Domain 3 counties, and 3.74 percent in non-Domain 3 counties.
- Correlation between Continuity of Care and Preventive Services Utilization. Among the 17 counties in Domain 3, those counties with higher continuity of care between CY 2015 and CY 2016 also had higher utilization of preventive services in CY 2016.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

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

Quality Assurance/Monitoring Activities:

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

Evaluation:

DHCS received CMS approval of the DTI Evaluation Design on September 12, 2017. The final DTI Evaluation Design and the CMS Approval Letter have been posted on the DTI webpage. DHCS has been working with the evaluation contractor in an effort to finalize and implement the contract. DHCS anticipates the contractor to begin evaluation work by July 2018.

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 state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of forty implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings, and Partnership Health Plan of California. As of January 18, 2018, DHCS has approved all counties' implementation plans. With the forty submitted implementation plans, 97.54% of California's population will be covered under the DMC-ODS. Eleven counties are currently providing DMC-ODS services.

Enrollment Information:

Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY12-Q3	2,360	935	3,258
DY12-Q4	3,840	1,401	5,174
DY13-Q1	13,910	8,539	22,160
DY13-Q2	14,315	8,465	22,505
DY13-Q3	11,141	6,747	17,771

Prior quarters have been updated based on new claims data. For DY13-Q3, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Member Months:

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	0	1,821	2,061	DY12-Q3	2,360
	2,258	2,319	2,993	DY12-Q4	3,840
	10,165	10,688	10,670	DY13-Q1	13,910
	11,057	10,934	9,725	DY13-Q2	14,315
	9,567	7,835	2,686	DY13-Q3	11,141
Non-ACA	0	753	808	DY12-Q3	935
	889	876	1,077	DY12-Q4	1,401
	7,000	7,190	7,145	DY13-Q1	8,539
	7,232	7,199	6,340	DY13-Q2	8,465
	6,107	5,190	2,361	DY13-Q3	6,747

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. “Current Enrollees (to date)” represents the total number of unique clients for the quarter. Prior quarters’ statistics have been updated, and for DY13-Q3, there is only partial data available at this time since counties have up to six months to submit claims after the month of service.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties’ Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- January 5, 2018: Phase 5 Conference Call for the Indian Health Program Organized Delivery System (IHP-ODS)
- January 8, 2018: DHCS and University of California, Los Angeles (UCLA) Conference Call
- January 10, 2018: Phase 5 Conference Call for the IHP-ODS
- January 10, 2018: CA Opioid Safety Network Advisory Body Meeting
- January 12, 2018: Plenary Panel Call for Insure the Uninsured Project (ITUP) Conference
- January 16, 2018: DHCS Opioid Workgroup Meeting
- January 17, 2018: Medical Director’s Meeting
- January 17, 2018: Phase 5 Conference Call for the IHP-ODS
- January 18, 2018: Meeting with Senator McGuire and DHCS
- January 23, 2018: Executive Leadership Call with Parker and Dennison Consultants for IHP-ODS
- January 29, 2018: Executive Leadership Call with Parker and Dennison Consultants for IHP-ODS
- January 31, 2018: CMS Innovative Accelerator Program (IAP) SUD: Opioid Data

Use Group Meeting #1
- February 1, 2018: DHCS and California Behavioral Health Directors Association of California (CBHDA) Executive Call
- February 1, 2018: Quarterly Meeting with California Health Care Foundation (CHCF)
- February 5, 2018: California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) Conference Call
- February 6, 2018: Speaker at the 2018 ITUP Conference
- February 7, 2018: CHCF Meeting on DMC-ODS Communications Strategy
- February 7, 2018: Opioid Process Mapping Meeting
- February 8, 2018: Phase 5 Conference Call for the IHP-ODS
- February 8, 2018: Assembly Budget Sub 1 Pre-Hearing
- February 12, 2018: Bi-Monthly SUD Waiver States Conference Call Meeting
- February 16, 2018: Phase 5 Conference Call for the IHP-ODS
- February 20, 2018: DHCS Opioid Workgroup Meeting
- February 21, 2018: DHCS and CAADPE Quarterly Meeting
- February 27, 2018: Statewide Opioid Safety Workgroup Meeting
- February 28, 2018: CMS IAP SUD: Opioid Data Use Group Meeting #2
- March 1, 2018: Phase 5 Conference Call for the IHP-ODS
- March 1, 2018: Meeting with Harbage Consulting regarding the Provider Training Plan
- March 2, 2018: Interview with California Health Report
- March 12, 2018: DHCS and UCLA Conference Call DMC-ODS Evaluation Status
- March 15, 2018: CBHDA Meeting
- March 16, 2018: Opioid Process Mapping Meeting
- March 19, 2018: Cross-Agency Leaders Roundtable to Address Substance Use Disorder Prevention and Treatment
- March 20, 2018: Blue Shield of California Foundation's Advancing Behavioral Health Integration Convening: Charting Our Progress toward Policy and Practice Transformation
- March 21, 2018: Phase 5 Conference Call for the IHP-ODS
- March 21, 2018: Tribal Leaders Meeting

DHCS staff conducted DMC-ODS Waiver documentation trainings for Waiver counties and contract providers. This included technical assistance training for county management as well as general trainings for providers and county staff that participate in the documentation and the billing process. The focus of these trainings was to address documentation requirements for all Waiver treatment services and commonly identified deficiencies.

County	Technical Assistance Date	County/Provider Staff Training Dates	County/Provider Staff Training Attendees
Marin County	January 22, 2018	January 23-34, 2018	73
Santa Clara County	February 1, 2018	January 30-31, 2018	75-80
Los Angeles County	March 8, 2018	March 9, 2018	45-50
Alameda County	March 28, 2018	March 29, 2018	24

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

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

Operational/Policy Developments/Issues:

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

Consumer Issues:

DHCS sent an email to remind counties to submit their Grievance and Appeal logs by January 25, 2018. As of January 30, 2018, Los Angeles and Santa Clara still have not submitted their logs to DHCS.

Contra Costa did not identify the categories of grievances recorded so only the total amount is presented in the table. Santa Cruz County provided a verbal report of grievance and appeal data as the county was experiencing technical difficulties with electronic submission. An appeal is defined as a request for review of an action (e.g. adverse benefit determination) while a grievance is a report of dissatisfaction with anything other than an adverse benefit determination.

Grievance	Contra Costa	Los Angeles	Marin	Napa	Riverside	San Bernardino	San Francisco	San Luis Obispo	San Mateo	Santa Clara	Santa Cruz
Access to Care		3									
Quality of Care					1						
Program Requirements		5					2			4	
Service Denials		1									
Failure to Respect Enrollee's Rights											
Interpersonal Relationship Issues					1					2	
Other			1					1			
Totals	**0**	**9**	**1**	**0**	**2**	**0**	**2**	**1**	**0**	**6**	**0***

Resolution	Contra Costa	Los Angeles	Marin	Napa	Riverside	San Bernardino	San Francisco	San Luis Obispo	San Mateo	Santa Clara	Santa Cruz
Grievances		2	4		1		4	1	6	5	
Appeals	18										
Totals	**18**	**2**	**4**	**0**	**1**	**0**	**4**	**1**	**6**	**5**	**0***

Appeal: Defined as a review of a beneficiary adverse benefit determination.

Grievance: Defined as a report of beneficiary dissatisfaction with any matter other than an adverse benefit determination. Grievances are reported by type of dissatisfaction.

Grievance	Los Angeles	Santa Clara
Access to Care	2	1
Quality of Care	1	
Program Requirements	-	2
Service Denials	-	1
Failure to Respect Enrollee's Rights	-	
Interpersonal Relationship Issues	-	2
Other	-	
Other: UA policy	-	1
Other: Billing	-	3
Other:	-	-
Totals	**3**	**10**

Resolution	Los Angeles	Santa Clara
Grievances	2	7
Appeals	-	-
Totals	**2**	**7**

Financial/Budget Neutrality Development/Issues:

Per CMS' request, attached is a Microsoft Excel file, titled "DY13-Q3 DMC-ODS Expenditures," which contains the expenditures data for the program.

Quality Assurance/Monitoring Activities:

On-site Readiness Reviews were conducted in the following counties:

County	Date
El Dorado	March 19, 2018
Kern	January 30, 2018
Merced	March 26, 2018
Nevada	February 20, 2018
Placer	March 27, 2018
San Benito	February 20, 2018
San Diego	March 20, 2018
San Joaquin	March 13, 2018

Evaluation:

UCLA and DHCS continue to hold monthly conference call with updates, activities, and meetings. The evaluation is posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

Summarized below are the activities UCLA conducted from January – March 2018:

- January 25-26, 2018: Technical Assistance: Treatment Placement/Level of Care Reporting for Champions Recovery in Hanford, CA
- January 30, 2018: Technical Assistance: Treatment Placement/Level of Care Reporting for Ventura County
- January 31, 2018: Presentation: Senate Health Committee
- February 7, 2018: Technical Assistance: CalOMS-TX System Revision
- February 9, 2018: Presentation: UCLA, EQRO, and DHCS Meeting
- February 11, 2018: Technical Assistance: Recommendation for CMS Adult Core Measure Set
- February 12, 2018: Presentation: CMS Quality Conference
- February 22, 2018: Technical Assistance: Treatment Placement/Level of Care Reporting for CIBHS and Nevada County
- February 28, 2018: Meeting: State Epidemiology Workgroup
- March 21, 2018: Presentation: CBHDA Substance Abuse Prevention and Treatment Committee Quarterly Meeting
- January 2018 to March 2018 Technical Assistance: Treatment Perceptions Survey (TPS; Patient Perceptions)

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July - Sept)	$18,679,158	$37,358,316	DY 12	$18,679,158
(Qtr. 2 Oct - Dec)	$21,977,686	$43,955,371	DY 12	$21,977,686
(Qtr. 3 Jan - Mar)	$19,819,695	$39,639,391	DY 12	$19,819,695
Total	**$60,476,539**	**$120,953,078**		**$60,476,539**

This quarter, the Department claimed **$19,819,695** in federal fund payments for DSHP eligible services.

Low Income Health Program (LIHP)

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

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

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 3, Q2	$262,275,752.00	$262,275,752.00	DY13-Q2	$ 524,551,504.00
Total	**$262,275,752.00**	**$262,275,752.00**		**$ 524,551,504.00**

DY13-Q2 reporting is for payment made on January 15, 2018. The payments made during this time period were for PY3-Q2 (October 1, 2017 – December 31, 2017).

In PY3-Q2, the PHCS received **$262,275,752.00** in federal fund payments and **$262,275,752.00** in IGT for GPP. The DSH reduction was applied to the payment methodology for the PY3-Q2 payment. H.R. 1892 passed on February 9, 2018. This rule postpones the DHS reduction until 2020.

Quality Assurance/Monitoring Activities:

PHCS must submit two PY 2 Final Reports: (1) Aggregate Report and (2) encounter data by April 2, 2018. In preparation for the encounter data, DHCS developed a secured SharePoint site for the encounter data to be transmitted from the PHCS to DHCS, and from DHCS to the RAND Corporation.

Evaluation:

The STCs require the State to conduct two evaluations of provider expenditures and activities under the global payment methodology. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of GPP PY 4. The two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the demonstration. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by PHCS and patients' experience, with a focus on understanding the benefits and challenges of the program.

The RAND Corporation (RAND) was selected to conduct the evaluations. The contract term date is from November 15, 2017 – June 30, 2019. RAND developed a midpoint survey to collect data from the PHCS. On February 21, 2018, RAND distributed the midpoint surveys to all 12 PHCS and they were due on March 1, 2018. RAND will submit the draft midpoint evaluation report to DHCS by May 1, 2018.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

In DY13-Q3, DHCS launched the 2018 PRIME Learning Collaborative activities with the first webinar of a three-part webinar series entitled, *Fundamentals of Quality Improvement*. The series was facilitated by nationally renowned quality improvement expert, Jane Taylor, EdD. These webinars support PRIME entities in their efforts to begin or continue a Quality Improvement (QI) project. The first webinar, "Getting Started," occurred on February 27, 2018, and the next two webinars occurred in the following quarter.

In March 2018, DHCS coordinated and finalized plans for Topic-Specific Learning Collaboratives (TLCs), a variety of workgroups offered to help PRIME entities meet their project goals and improve care delivery through peer-to-peer learning, an exchange of ideas, and the dissemination of best practices on common topics. The TLC workgroups launched kickoff meetings in the following quarter.

DHCS also began to plan for the annual PRIME Learning Collaborative in-person conference that will be held in Sacramento on October 29-30, 2018. Dr. Taylor will provide in-person technical assistance, and TLC workgroups will have the opportunity to convene face-to-face.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$0	$0	DY 12	$0

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 2 Oct – Dec)	$460,140,476.00	$460,140,475.99	DY 12	$920,280,951.99
(Qtr. 3 Jan-Mar)	$9,194,936.17	$9,194,936.17	DY 12	$18,389,872.34
Total	**$469,335,412.17**	**$469,335,412.16**		**$938,670,824.33**

In DY13-Q3, DY 12 supplemental payments were issued beginning January 5, 2018. Nine DPHs and one DMPH received supplemental payments in DY13-Q3. Jerold Phelps Community Hospital's DY 11 Annual payment is included in DY13-Q3 payments as the payment was made on January 5, 2018.

This quarter, DPHs and DMPHs received **$9,194,936.17** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

DY13-Q3 started with 54 active PRIME entities; however, one was terminated from PRIME on March 8, 2018 with an effective date of October 29, 2017. Tulare Regional Medical Center's (TRMC) participation in PRIME was terminated due to the closure of their hospital following serious patient safety concerns and reorganizational needs. As such, TRMC is ineligible to consistently measure and submit DY 13 data reports as part of the 5-year program. In addition, TRMC failed to submit a complete and timely DY 12 Year-End Report, and was therefore ineligible to receive final DY 12 funding.

Of the remaining 53 PRIME entities, 45 submitted their DY 13 Mid-Year reports to DHCS on or before March 31, 2018. There were 8 PRIME entities, all DMPHs, which requested a reporting due date extension into DY13-Q4.

Evaluation:

The UCLA Center for Health Policy Research (UCLA CHPR) is the PRIME external evaluator. UCLA CHPR received inpatient discharge data from the Office of Statewide Health Planning and Development in early February 2018 and began conducting data analysis for applicable PRIME measures. In addition, the evaluation contract between DHCS and UCLA CHPR required an amendment in order to share DHCS' Medi-Cal claims and enrollment data with UCLA. The amendment to the contract was fully executed on March 29, 2018.

UCLA CHPR also piloted a comprehensive survey regarding the planned and ongoing activities of PRIME entities among select PRIME entities and made revisions to the final survey based on their feedback.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

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

Total Member Months for Mandatory SPDs by County

County	Total Member Months
Alameda	85,975
Contra Costa	52,568
Fresno	71,558
Kern	56,803
Kings	7,841
Los Angeles	590,081
Madera	7,003
Riverside	105,051
San Bernardino	108,122
San Francisco	114,828
San Joaquin	120,902
Santa Clara	43,626
Stanislaus	49,313
Tulare	66,933
Sacramento	35,957
San Diego	31,903
Total	**1,548,464**

Total Member Months for Existing SPDs by County

County	Total Member Months
Alameda	62,847
Contra Costa	28,936
Fresno	38,943
Kern	26,422
Kings	4,018
Los Angeles	1,027,978
Madera	3,975
Marin	19,549
Mendocino	17,684
Merced	48,748
Monterey	49,182
Napa	14,598
Orange	330,885
Riverside	114,294
Sacramento	62,588
San Bernardino	111,699
San Diego	187,453
San Francisco	41,263
San Joaquin	26,826
San Luis Obispo	25,065
San Mateo	41,379
Santa Barbara	46,882
Santa Clara	124,205
Santa Cruz	31,607
Solano	59,970
Sonoma	53,206
Stanislaus	15,811
Tulare	18,064
Ventura	86,752
Yolo	26,131
Total	**2,746,960**

Total Member Months for SPDs in Rural Non-COHS Counties

County	Total Member Months
Alpine	57
Amador	1,106
Butte	19,255
Calaveras	1,695
Colusa	836
El Dorado	5,164
Glenn	1,659
Imperial	10,478
Inyo	516
Mariposa	657
Mono	207
Nevada	3,203
Placer	9,402
Plumas	1,047
San Benito	241
Sierra	115
Sutter	5,896
Tehama	5,438
Tuolumne	2,630
Yuba	6,367
Total	**75,969**

Total Member Months for SPDs in Rural COHS Counties

County	Total Member Months
Del Norte	8,050
Humboldt	26,310
Lake	19,536
Lassen	4,436
Modoc	2,072
Shasta	40,528
Siskiyou	11,179
Trinity	2,806
Total	**114,917**

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WHOLE PERSON CARE (WPC)

The Whole Person Care 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 have poor health outcomes.

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

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

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

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

WPC First Round

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

WPC Second Round

WPC Pilot PY	Corresponding DYs
1 (January 1 - June 30, 2017)	12 (July 1, 2016 - June 30, 2017)
2 (July 1 - December 31, 2017)	13 (July 1, 2017 - June 30, 2018)
3 (January 1 – December 31, 2018)	13 (July 1, 2017 - June 30, 2018) and 14 (July 1, 2018 - June 30, 2019)
4 (January 1 – December 31, 2019)	14 (July 1, 2018 - June 30, 2019) and 15 (July 1, 2019 - June 30, 2020)
5 (January 1 – December 31, 2020)	15 (July 1, 2019 - June 30, 2020) and 16 (July 1, 2020 - December 31, 2020)

Enrollment Information:

Quarterly enrollment counts are the cumulative number of unique new beneficiaries enrolled for the reported quarter with year-to-year totals reflected in the table below. Enrollment data is extracted from the LE self-reported Quarterly Enrollment and Utilization Reports. The data reported is point-in-time as of April 18, 2018. Enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY13-Q2 (Oct – Dec 2017) Unduplicated	Total to Date Unduplicated
Alameda	724	1,783
Contra Costa	1,338	16,601
Kern	56	90
Kings*	24	29
LA	3,911	12,455
Marin*	14	14
Mendocino*	21	21
Monterey	5	46
Napa	35	113
Orange	568	2,762
Placer	36	158
Riverside	151	151
Sacramento*	236	236
San Bernardino	216	330
San Diego	0	0
San Francisco	1,283	8,211
San Joaquin	104	143
San Mateo	97	2,454
Santa Clara	35	2,765
Santa Cruz*	23	202
SCWPCC*	3	3
Shasta	16	102
Solano	39	79
Sonoma*	0	0
Ventura	318	450
Total	**9,253**	**49,198**

*Note: *Indicates one of seven new LEs that implemented WPC pilots on July 1, 2017.*
Due to a delay in availability of data, DY13-Q3 data will be reported in the next quarterly report.

Member Months:

Quarterly and cumulative year-to-date member months are reflected in the table below. Member months are extracted from the LE self-reported Quarterly Enrollment and Utilization Reports. The data reported is point-in-time as of April 18, 2018. Member months are updated during the reporting period to reflect retroactive changes to

enrollment status and may not match prior reports. The data reported reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY13-Q2 (Oct – Dec 2017)	Cumulative Year-to-Date
Alameda	4,467	8,432
Contra Costa	30,359	80,631
Kern	211	245
Kings*	58	63
LA	21,274	62,037
Marin*	20	20
Mendocino*	21	21
Monterey	98	285
Napa	283	485
Orange	6,368	14,234
Placer	341	491
Riverside	151	151
Sacramento*	368	368
San Bernardino	217	332
San Diego	0	0
San Francisco	20,655	60,903
San Joaquin	318	397
San Mateo	6,000	23,948
Santa Clara	7,546	20,365
Santa Cruz*	567	1,102
SCWPCC*	3	3
Shasta	159	373
Solano	201	386
Sonoma*	0	0
Ventura	998	1,192
Total	**100,683**	**276,764**

*Note: *Indicates one of seven new LEs that implemented on July 1, 2017.*
Due to a delay in availability of data, DY13-Q3 data will be reported in the next quarterly report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

In January 2018, the WPC Learning Collaborative (LC) convened an advisory board of eight LEs. The advisory board meets on a monthly basis to discuss LC strategy, provide general feedback, and help develop agendas for WPC in-person meetings. Advisory board members were selected based on past participation in the bi-weekly TA calls and on their willingness to commit to monthly meetings for the 2018 calendar year. Membership reflects rural/urban and small/large pilots, and includes LEs from Alameda, Los Angeles, Napa, Placer, San Bernardino, San Francisco, San Mateo, as well as SCWPCC. This quarter, the advisory board met on January 18, February 15, and March 18, 2018.

Beginning January 2018, the bi-weekly TA calls with LEs were reduced to monthly calls with the addition of topic-specific affinity groups calls. These changes were based on LE survey results, LC advisory board recommendations, and the goal of improving responsiveness to LE needs.

DHCS held bi-weekly TA calls with the 25 LEs on January 10, January 24, and March 7, 2018. These TA calls provided opportunities for the LEs to engage with DHCS, the LC team, and one another to address both administrative issues, such as reporting and learning, and LC topics, such as staffing and data systems. The calls during this quarter, included the following topics: advisory board activities, budget adjustment, rollover, fourth quarter Enrollment and Utilization Reports, and future plans for the bi-weekly TA calls.

In March 2018, the LC launched five topic-specific affinity groups based on LE feedback and discussions with the LC advisory board. These affinity groups focus on the following areas: data, care coordination, sustainability, housing, and re-entry. Each affinity group is led by a LC staff member who is responsible for working with his or her group to understand the challenges LEs are facing in each area, and then helping the LEs share best practices and work toward finding solutions. LEs were encouraged to have frontline staff and partners participate in groups relevant to their role in WPC. All groups will meet in-person at breakout sessions during the WPC LC convening on April 30, 2018 in Sacramento. Each affinity group plans to meet at least monthly through the duration of 2018, although this will depend on the needs of each group.

On March 2, 2018, DHCS held a LC-focused webinar entitled *Re-entry Health Policy Project: Meeting the Health and Behavioral Health Needs of Prison and Jail Inmates Returning from Custody to their Communities*. David Panush of California Health Policy Strategies presented on his research concerning how three counties in California addressed the mental health needs of post-incarceration individuals returning to their communities. Mr. Panush framed the findings from his research in the context of WPC in order to provide pilots focused on the re-entry population with best practices and considerations specific to this population.

During this quarter, twenty-five LEs submitted rollover requests to DHCS to move unspent PY 2 funds from PY 2 to PY 3. DHCS anticipates approving these rollover requests in the next quarter.

In addition, DHCS approved budget adjustment requests for eighteen LEs that allow budget line item adjustments to future PY budgets within each LE budget.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

During this quarter, no WPC payments were made in accordance with the WPC payment schedule. PY 2 annual invoices are due to DHCS on April 2, 2018. The next scheduled payments are scheduled for May 2018, based on the approved PY 2 annual invoices.

Quality Assurance/Monitoring Activities:

On January 31, 2018, all twenty-five LEs submitted their fourth quarter enrollment and utilization reports. This report includes required data elements for enrollment status, homeless status, and disenrollment.

Accurate reporting is fundamental to the success of WPC. Reports are the tools used by each county and DHCS to monitor and evaluate the programs, assess the degree to which the LEs are achieving their goals, and to verify invoices for payment. Additionally, LEs can use the trajectory of Universal and Variant metrics within the reports to make the most informed decisions while implementing performance improvements.

Evaluation:

UCLA received approval for conducting the evaluation from the UCLA Office of the Human Research Protection Program and the California Health and Human Services Agency (which includes DHCS) Committee for the Protection of Human Subjects.

During this quarter, UCLA conducted the following planned evaluation activities:

- Completed qualitative analysis of the WPC applications and narrative sections of mid-year reports;
- Continued to develop preliminary instruments and questionnaires for structured and semi-structured interviews to collect initial qualitative data from WPC LEs; these data will be used to discuss how each LE implemented their program, challenges they encountered, and strategies they used to overcome those challenges; and
- Collaborated with DHCS to obtain Medi-Cal data to identify the most appropriate variables for the analysis; available list was finalized at the end of the quarter.

Control/Comparison Group Selection Methodology

WPC LEs primarily enroll a subset of high-risk, high-utilization Medi-Cal beneficiaries from the total population of Medi-Cal beneficiaries receiving care in their service area. In order to conduct its evaluation, UCLA will receive a list of WPC-enrolled beneficiaries from DHCS. However, UCLA will not have access to the person-level data used by the LEs to identify their target populations, nor will UCLA receive a list of WPC-eligible beneficiaries who chose not to enroll. Due to these data limitations, UCLA proposed to identify the control group using statistical methods from the total population of high-risk high-utilization Medi-Cal beneficiaries as described in Exhibit 1.

The comprehensive common control group criteria have to be determined, but are likely to include beneficiaries with at least one of the criteria identified in Exhibit 1. While all LEs target high-risk, high-utilization Medi-Cal beneficiaries, the exact definitions of the target populations vary significantly by LEs. Target populations may include individuals satisfying one or more high-utilization definition. Further, comprehensive data on some of the WPC-eligibility criteria is only available to LEs; for example, data on homelessness or risk of homelessness is not available in Medi-Cal data.

In addition, LEs vary in the proportion of their eligible population enrolled, and this will change over time. UCLA assumes that larger LEs such as LA are less likely to enroll the full share of their eligible beneficiaries due to the scale of their WPC geographic area, but small LEs are more likely to enroll most of their eligible beneficiaries. In the latter group, the potential control group in the same region is likely to be inadequate for purposes of analysis. These factors contribute to a number of methodological and logistical challenges in selection of the control group.

Exhibit 1: WPC Eligibility Criteria & Identification of Control Group

WPC Eligibility Criteria	Identification of Control Group
• Beneficiaries with repeated incidents of avoidable emergency department (ED) visits, hospital admissions, or nursing facility placement	• Two or more non-trauma ED visits per year • Any non-trauma hospitalization • Nursing facility admission and non-trauma hospitalization
• Beneficiaries with mental health and/or substance use disorders	• Mental health or substance use diagnosis and one or more non-trauma ED visits or hospitalization
• Beneficiaries currently experiencing homelessness; and/or individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility,	• Address will be used to identify homelessness • Aid code while incarcerated will be used to identify post-incarceration status

WPC Eligibility Criteria	Identification of Control Group
rehabilitation facility, institution for mental diseases, county jail, state prisons, or other)	

The proposed selection criteria are designed to identify both high-utilization and at-risk for high utilization beneficiaries from the total population of Medi-Cal beneficiaries for potential inclusion in the WPC Program.

UCLA proposes to conduct the following actions to identify groups of beneficiaries who are difficult to explicitly identify in enrollment and claims data:

The first group includes post-incarceration beneficiaries. UCLA proposes to identify this group by assessing the prior months' aid codes in enrollment data as an indicator of previous incarceration.
The second group includes beneficiaries who are homeless or are at-risk for homelessness. To identify members of this group, UCLA proposes to use the exact address information entered in enrollment data, in a data extraction process following methodology established by Vickery et al, 2017.
The third group includes beneficiaries receiving care in a skilled nursing facility (SNF). UCLA also proposes to be given access to SNF data since three LEs, including Los Angeles, Contra Costa, and Santa Cruz, target these individuals and inclusion of SNF data would allow UCLA to assess the overall service use and expenditures for this population.

UCLA proposed that DHCS first identify the total eligible Medi-Cal beneficiary population in California using the comprehensive common criteria used by all LEs, listed in the left column of Exhibit 1. UCLA would apply the propensity score matching method this data to select the control group.

The composition of WPC enrollees will change over time as enrollees enter and exit the program on a rolling basis. UCLA will develop a model using the data in the first delivery to predict the propensity of beneficiaries likely to enroll in WPC and will use this model to select the control group. UCLA expects to develop this model between June 2018 and March 2019.

UCLA will continue to assess the outcomes of this model to ensure the control group remains a valid measure. The control group will be updated subsequently for the Interim and Final Reports to adapt to churn and growth in the WPC enrollee population. UCLA will refine the criteria to finalize the control group by August 1, 2019 for the Interim Report, and by March 1, 2021 for the Final Report.

<u>Timeline for Medi-Cal Data Delivery</u>

The timeline for delivery of Medi-Cal data is mapped below with three data deliveries. The timeline is based on DHCS using the broad common criteria approach and requires

three data deliveries.

- 1st Data Delivery – May 2018: Medi-Cal claims and encounter data for WPC enrollees and a potential control/comparison group. UCLA will use this data to develop the match algorithm and draft evaluation measures. The Baseline is included to conduct a pre/post analysis using the same Medi-Cal variables.
- 2nd Data Delivery – May 2019: Medi-Cal claims and encounter data for WPC enrollees and the potential control/comparison group; purpose of the delivery is analysis for the Interim Report.
- 3rd Data Delivery – October 2020: Medi-Cal claims and encounter data for WPC enrollees and the potential control/comparison group; purpose of the delivery is analysis for the Final Report.

The above timeline information is displayed below in Exhibit 2: Timeline for Control Group Selection Table.

Exhibit 2: Timeline for Control Group Selection Table

Year	Activity Date	PY 3 (2018)				PY 4 (2019)				PY 5 (2020)				2021	
Quarter		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Medi-Cal Data Collection and Analysis															
First Data Delivery to UCLA	May 2018		X												
• Baseline Medi-Cal Data (Jan. 2015 – Dec. 2016)															
• WPC start date (Jan. 2017)															
• UCLA develops the match methodology to create a control group for WPC enrollees between June 2018 – Mar. 2019	Mar. 2019					X									
Second Data Delivery to UCLA	May 2019						X								
• Includes data for all WPC enrollees and potential control group															
• UCLA updates criteria to finalize the control group for the Interim Report to adapt to churn and growth in the WPC enrollee population	Aug. 2019							X							
• UCLA updates the metrics for the Interim Report	Oct. 2019								X						
Third Data Delivery to UCLA	Oct. 2020												X		
• UCLA updates criteria to finalize the control group for the Final Report to adapt to churn and growth in the WPC enrollee population	Mar. 2021														X
• UCLA updates the metrics for the Final Report	Apr. 2021													X	
Interim Evaluation Report to CMS	Dec. 2019								X						