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May 30, 2017

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 01/01/2017 THROUGH 03/31/2017 OF THE CALIFORNIA MEDI-CAL 2020 DEMONSTRATION

Dear Ms. Garner, Ms. Ross, and Ms. Sam-Louie:

Enclosed is the Quarterly Progress Report as required by Paragraph 25 and Attachment I of the Special Terms and Conditions of California's Section 1115 Waiver, entitled *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the third quarterly progress report for Demonstration Year Twelve, which covers the period from January 1, 2017, through March 31, 2017.

If you or your staff have any questions or need additional information regarding this report, please contact Angeli Lee by phone at (916) 324-0184 or by email at Angeli.Lee@dhcs.ca.gov. Thank you!

Sincerely,

[redacted]

Mari Cantwell
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Enclosure:
Medi-Cal 2020 Demonstration Year 12 Quarter 3 Progress Report

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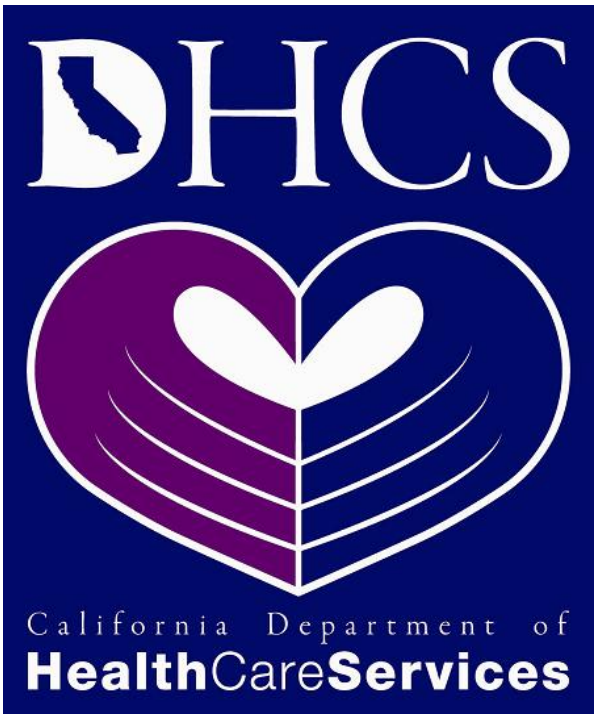
CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)



Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Twelve (07/01/2016 – 06/30/2017)
Third Quarter Reporting Period: 01/01/2017 – 03/31/2017

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INTRODUCTION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 24: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Demonstration on January 9, 2017, February 13, 2017, and March 12, 2017.

The following topics were discussed:

- Negative Account Balances Issues
- CMS Comments on Draft Evaluation Designs
- CCS Counties' Implementation Efforts
- Access Assessment
- Budget Neutrality Monitoring Tool
- DMC-ODS Program Updates and Tribal Discussions
- DTI Program Updates
- WPC Second Round of Applications
- Attachment R/Alternate Payment Methodology (APM) Framework
- Attachment N Amendment for Acupuncture and Non-Medical Transportation

- Health Homes Program Waiver Amendment
- Managed Care Final Rule Timelines

STCs Items 178-180: Uncompensated Care Reporting

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

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

California's Medi-Cal 2020 Demonstration Special Terms and Conditions (STCs), paragraphs 65-69, require the 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 July 25, 2016, Governor Brown signed Assembly Bill (AB) 1568 (Chapter 42, Statutes of 2016) and Senate Bill (SB) 815 (Chapter 111, Statutes of 2016), establishing the Medi-Cal 2020 Demonstration and requirements for implementation of the STCs and providing DHCS the authority to conduct the Assessment. Within 90 days of the signature of the legislation, DHCS completed an amendment to its EQRO contract to perform the Assessment.

The goal of the Assessment is to evaluate primary, core specialty, and facility access to care for managed care beneficiaries, based on the current health plan network adequacy requirements set forth in the State's Knox-Keene Health Care Service Plan Act of 1975 and Medi-Cal managed care health plan contracts, as applicable. The Assessment will consider State Fair Hearing and Independent Medical Review (IMR) decisions, as well as grievances and appeals, and complaints data.

Per the STCs, DHCS established an advisory committee to provide input into the Assessment design, including network adequacy requirements and metrics, as well as feedback on the initial draft report and final report. The Advisory Committee includes representatives from consumer advocacy organizations, providers, provider associations, health plans, health plan associations, and legislative staff.

DHCS will submit the Assessment design to the CMS in April 2017 for review and approval. Once approved, 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. In addition, the EQRO will provide recommendations in response to any systemic network adequacy issues, if identified. The initial draft report and final report will describe the State's current compliance with the access and network adequacy standards set forth in federal regulations (Title 42 Code of Federal Regulations Part 438).

Assessment Milestones:

- September 23, 2016: DHCS submitted a finalized and signed EQRO contract amendment to CMS for approval
- November 18, 2016: First Advisory Committee Meeting – Input into the Assessment design
- January 31, 2017: Second Advisory Committee Meeting – Input into the Assessment design
- March 28, 2017: Third Advisory Committee Meeting – Review of and comment of Assessment design

Projected Assessment Timeline:

- TBD: Assessment design submitted to CMS
- TBD: Assessment design approved by CMS
- TBD: EQRO begins to conduct the Assessment (assuming CMS approval of Assessment design)
- TBD: Initial draft report posted for public comment and meeting to present to the advisory committee for review and comment
- Ten months following CMS design approval: Final report submission to CMS

DHCS and its EQRO, Health Services Advisory Group (HSAG), finalized and signed the EQRO contract amendment to include the Access Assessment project. On September 23, 2016, DHCS sent the EQRO contract amendment to CMS for its review and approval.

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

The first advisory committee was held on November 18, 2016 and subsequent meetings were held on January 31 and March 28, 2017. Once CMS approves the Assessment design, EQRO will begin to conduct the Assessment. An advisory committee meeting will be scheduled to provide feedback on the initial draft report. The Assessment webpage is updated regularly and can be accessed using the following link: http://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx

Consumer Issues:

Not applicable.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

Not applicable.

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 titled Medi-Cal 2020 is focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction, and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improvement of care for all 186,000 children enrolled in CCS.

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

The table below represents the most current enrollment numbers and the capitation rates for HPSM for the period July 1, 2015 through March 31, 2017. 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
July 2015	1,591	$1,535.45	$ 2,442,900.95
August 2015	1,590	$1,535.45	$ 2,441,365.50
September 2015	1,598	$1,535.45	$ 2,453,649.10
October 2015	1,581	$1,535.45	$ 2,427,546.45
November 2015	1,588	$1,535.45	$ 2,438,294.60
December 2015	1,585	$1,535.45	$ 2,433,688.25
January 2016	1,580	$1,535.45	$ 2,422,940.10
February 2016	1,589	$1,535.45	$ 2,439,830.05
March 2016	1,607	$1,535.45	$ 2,467,468.15
April 2016	1,624	$1,535.45	$ 2,493,570.80
May 2016	1,619	$1,535.45	$ 2,485,893.55
June 2016	1,622	$1,535.45	$ 2,490,499.90
July 2016	1,650	$1,481.08	$ 2,443,782.00
August 2016	1,638	$1,481.08	$ 2,426,009.04
September 2016	1,610	$1,481.08	$ 2,384,538.80
October 2016	1,644	$1,481.08	$ 2,434,895.52
November 2016	1,633	$1,481.08	$ 2,418,603.64
December 2016	1,636	$1,481.08	$ 2,423,046.88
January 2017	1,630	$1,481.08	$ 2,414,160.40
February 2017	1,653	$1,481.08	$ 2,448,225.24
March 2017	1,651	$1,481.08	$ 2,445,263.08
		TOTAL	**$51,276,172**

Capitation rates for July 2016 through March 2017 pending review and approval from CMS.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

<u>CCS Pilot Protocols</u>

California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by Federal

Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. As of September 30, 2016, revised Protocols were submitted to CMS.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

Recurring conference calls between DHCS and HPSM are conducted on a regular basis to discuss various contract issues, such as financials, information technology, and deliverable reporting. DHCS met in person with HPSM on January 26, 2017 to discuss the CCS Pilot Overview and best practices and lessons learned.

Contract Amendments

HPSM contract amendment A02 is in process. This amendment is to extend the contract one year as allowed by Request for Proposal #11-88024; and increase the total budget to compensate the Contractor for continuing to perform services for an additional year. New rates have been added for Fiscal Years 15/16 and 16/17. Payments for Hepatitis C and Behavioral Health Therapy (BHT) services have also been included. The contract has also been updated to include the aid codes for eligible beneficiaries, and "R Letter" language approved by CMS to include in managed care contracts. Amendment A02 was submitted to CMS on February 8, 2017 and is currently under review. Once CMS approves A02, the updated rates and other edits stated here will be included in the existing contract.

Rady Children's Hospital of San Diego Demonstration Project

DHCS and RCHSD meet regularly to collaborate on many implementation topics, including, but not limited to: Knox-Keene Waiver, Pre-Implementation contract, Memorandum of Understanding, beneficiary commitment letter, enrollment, covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, and transition of the CCS population from a fee-for-service based system to a capitated model. DHCS is in the process of confirming contractual compliance with the new Medicaid Final Rule.

Demonstration Schedule

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

Consumer Issues:

CCS Quarter Grievance Report #14

HPSM submitted a "CCS Quarterly Grievance Report" for the second quarter, October – December 2016. During the reporting period, HPMS received and processed 8 member grievances.

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

- 2 grievances were designated as Accessibility:
  - 1 was coded as "Excessive long wait time/appt. schedule time" and was resolved in favor of Member.
  - 1 was coded as "Lack of specialist availability" and was resolved in favor of Plan.

- 3 grievances were designated as Quality of Care/Services:
  - 3 were coded as "Plan denial of treatment"; one was resolved in favor of Member and two were resolved in favor of Plan.

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

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

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

Report Name	Date Due	Received
Formulary Report (Rpt #3)	1/30/2017	1/28/2017
Grievance Log/Report (Rpt #15)	1/30/2017	1/19/2017
Member Services Guide/Evidence of Coverage (Rpt #4)	1/30/2017	12/13/2016
Provider Network Reports (Rpt #15)	2/15/2017	2/3/2017
Quarterly Financial Statements (Rpt #15)	2/15/2017	2/13/2017
Report of All Denials of Services Requested by Providers (Rpt #14)	2/15/2017	2/8/2017

Evaluations:

The draft CCS evaluation is located at http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx. DHCS received CMS' comments for the CCS draft evaluation design on March 16, 2017 and currently has 60 days to respond. CMS provided feedback for the following sections: Goals and Objectives, Evaluation Design and Methods, Evaluation Measures, Access to Care, Client Satisfaction, Provider Satisfaction, Quality of Care, and Care Coordination.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

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

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

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

Enrollment and Assessment Information:

Per Special Terms and Conditions (STCs) 48, CBAS enrollment data for both MCP and FFS members per county for Demonstration Year 12 (DY12), Quarter 3 (Q3), represents the period of January 2017 to March 2017. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 7 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

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

[1] CBAS access/capacity must be provided in every county except those that did not previously have ADHC centers: Del Norte, Siskiyou, Modoc, Trinity, Lassen, Mendocino, Tehama, Plumas, Glenn, Lake, Colusa, Sutter, Yuba, Nevada, Sierra, Placer, El Dorado, Amador, Alpine, San Joaquin, Calaveras, Tuolumne, Mariposa, Mono, Madera, Inyo, Tulare, Kings, San Benito, and San Luis Obispo.

MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. FFS claims data identified in Table 1, reflects data through the quarter of October 2016 to December 2016 because of the lag factor of about two to three months. Data for DY12, Q3, will be reported in the next quarterly report.

Table 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY11 Q2 Jan - Mar 2016		DY11 Q3 Apr - Jun 2016		DY12 Q1 Jul - Sept 2016		DY12 Q2 Oct - Dec 2016	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	507	103%	502	102%	504	76%	542	82%
Butte	*	*	35	34%	45	44%	37	36%
Contra Costa	214	67%	208	65%	206	64%	240	75%
Fresno	548	50%	585	53%	619	56%	602	55%
Humboldt	94	24%	95	24%	95	24%	94	24%
Imperial	344	62%	345	62%	426	76%	328	59%
Kern	77	23%	75	22%	81	24%	79	23%
Los Angeles	19,786	63%	21,311	69%	21,041	67%	21,178	67%
Merced	85	40%	91	43%	91	43%	95	45%
Monterey	89	48%	106	57%	102	55%	118	63%
Orange	2,051	57%	2,073	55%	2,100	54%	2,199	56%
Riverside	428	39%	459	42%	453	42%	445	41%
Sacramento	585	65%	563	63%	587	66%	457	51%
San Bernardino	594	110%	574	106%	590	109%	541	100%
San Diego	1,885	50%	1,549	38%	1,937	45%	2,031	51%
San Francisco	747	51%	752	51%	749	51%	723	49%
San Mateo	157	69%	166	73%	172	75%	174	76%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	660	47%	656	47%	655	47%	656	47%
Santa Cruz	90	59%	103	68%	109	72%	114	75%
Shasta	54	38%	*	*	*	*	*	*
Ventura	920	64%	916	64%	918	64%	901	63%
Yolo	75	20%	74	20%	74	20%	93	25%
Marin, Napa, Solano	68	14%	70	14%	79	16%	79	16%
Total	**30,091**	**59%**	**31,318**	**62%**	**31,648**	**61%**	**31,739**	**61%**

FFS and MCP Enrollment Data 12/2016

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

Table 1 reflects that enrollment has remained relatively consistent with over 30,000 CBAS participants. Additionally, the data reflects there is ample capacity for participant

enrollment into most CBAS Centers. According to Table 1, San Bernardino was operating over licensed capacity for the last three quarters, but is currently operating within licensed capacity because of a decrease in participant enrollment. In the second quarter of DY11, San Bernardino County had 594 CBAS participants, which overextended their licensed capacity to 110%. However, San Bernardino County experienced a slight decrease in enrollment during the last three quarters, which resulted in a decrease of licensed capacity from 110% to 100%.

In addition, Table 1 illustrates that in the last two quarters of DY11, Alameda County was operating over their maximum licensed capacity. However, as of DY 12, Q2 Alameda County is operating within their licensed capacity. The change in licensed capacity was caused by a reporting error. One of Alameda County's CBAS Centers failed to account for multiple shifts at its center. This resulted in the CBAS center failing to account for all of its licensing capacity when reporting its data. That CBAS center has since then updated their data to reflect corrected information. New data reflecting the correct data for DY12, Q2, shows that Alameda County is now operating within their licensed capacity at 82%.

While the closing of a CBAS Center in a county can contribute to the 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. For example, in Butte, Imperial, and Sacramento counties, there was more than a 5% decrease of licensed capacity used compared to the previous quarter. This decrease was due to the decline in 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.

CBAS Assessments for MCPs and FFS Participants

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

Table 2 entitled "*CBAS Assessment Data for MCP and FFS"* 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, Q2 through DY12, Q2. Data for DY12, Q3, 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 Q2 (1/1-3/31/2016)	2,404	2,370 (98.6%)	34 (1.4%)	19	19 (100%)	0 (0%)
DY11 Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
DY12 Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	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%)
5% Negative change between last Quarter		No	No		No	No

Note: Information is not available for January 2017 to March 2017 due to a delay in the availability of data.

Table 2 reflects a steady decrease in the number of CBAS FFS members and a steady increase in the number of managed care members with the transition of CBAS to managed care. Requests for CBAS services were collected and assessed by the MCPs and DHCS. According to Table 2, for DY12, Q2, there were 2,741 assessments completed by the MCPs, of which 2,689 were determined to be eligible and 52 were determined to be ineligible. For DHCS, it was reported that thirty-one participants submitted their requests for CBAS benefits under FFS. Twenty-six of the requests were deferred to managed care while five of the requests were determined to be FFS eligible by DHCS. Of these five requests, three of the requests not did follow through with the assessment. Table 2 identifies the two requests that were assessed and approved for CBAS FFS by DHCS.

CBAS Provider-Reported Data (per CDA) (STC 48.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 and the average daily attendance

(ADA). On average, the ADA at the 240 operating CBAS Centers is approximately 21,542 participants, which corresponds to 70% of total license capacity.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	240
Non-Profit Centers	56
For-Profit Centers	184
ADA @ 240 Centers	21,542
Total License Capacity	30,602
ADA per Centers	70%
CDA - MSSR Data 12/2016	

Note: Information is not available for January 2017 to March 2017due 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 projected to be implemented in mid-2017. 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. To date, one new CBAS center has opened, and CDA has several applications that are currently under review.

Consumer Issues:

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

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are usually related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized below in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Table 4 and Table 5 represents data covering to DY12, Q2. Data for DY 12, 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. Table 4 illustrates there were no complaints received by CDA for DY12, Q2. For complaints received by MCPs, Table 5 illustrates there were two complaints collected by the MCPs for DY12, Q2.

Table 4:

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY11 - Q2 (Jan 1 - Mar 31)	6	1	7
DY11 - Q3 (Apr 1 - Jun 30)	8	0	8
DY12 - Q1 (Jul 1 - Sept 30)	8	1	9
DY12 - Q2 (Oct 1 - Dec 31)	2	0	2

Plan data - Phone Center Complaints 12/2016

Note: Information is not available for January 2017 to March 2017due to a delay in the availability of data.

Table 5:

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

CDA Data - Complaints 12/2016

Note: Information is not available for January 2017 to March 2017 due to a delay in the availability of data.

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

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the lag factor in data reporting, grievances and appeals data from the MCPs are reported up to DY12, Q2. According to Table 6 entitled “Data on CBAS Managed Care Plan Grievances,” only one grievance was filed with the MCPs for DY12, Q2; the grievance

was regarding CBAS providers.

Table 6:

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

Plan data - Grievances 12/2016

Note: Information is not available for January 2017 to March 2017 due to a delay in the availability of data.

For DY12, Q2, there were five CBAS appeals filed with MCPs. Table 7 entitled "Data on CBAS Managed Care Plan Appeals", illustrates that all five appeals were related to denial of services or limited services. Due to a delay in information, data for DY12, 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
DY11 - Q2 (Jan 1 - Mar 31)	4	0	0	2	6
DY11 - Q3 (Apr 1 - Jun 30)	0	0	0	3	3
DY12 - Q1 (Jul 1 - Sep 30)	4	0	0	0	4
DY12 - Q2 (Oct 1 - Dec 31)	5	0	0	0	5

Plan data - Grievances 12/2016

Note: Information is not available for January 2017 to March 2017 due to a delay in the availability of data.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed.

Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY12, Q3, there were two requests for hearing related to CBAS services.

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS continues to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to DY12, Q2, because of delay in availability of data. Data for DY12, Q3, will be discussed in the next quarterly report.

Table 8:

County	CBAS Centers Licensed Capacity					
	DY11-Q2 Jan-Mar 2016	DY11-Q3 Apr-Jun 2016	DY12-Q1 Jul-Sep 2016	DY12-Q2 Oct-Dec 2016	Percent Change Between Last Two Quarters	Capacity Used
Alameda	290	290	390	390	0%	82%
Butte	60	60	60	60	0%	36%
Contra Costa	190	190	190	190	0%	75%
Fresno	652	652	652	652	0%	55%
Humboldt	229	229	229	229	0%	24%
Imperial	330	330	330	330	0%	59%
Kern	200	200	200	200	0%	23%
Los Angeles	18,536	18,291	18,406	18,731	2%	67%
Merced	124	124	124	124	0%	45%
Monterey	110	110	110	110	0%	63%
Orange	2,120	2,240	2,308	2,308	0%	56%
Riverside	640	640	640	640	0%	41%
Sacramento	529	529	529	529	0%	51%
San Bernardino	320	320	320	320	0%	100%
San Diego	2,233	2,408	2,518	2,353	-7%	51%
San Francisco	866	866	866	866	0%	49%
San Mateo	135	135	135	135	0%	76%
Santa Barbara	60	60	60	60	0%	0%
Santa Clara	830	830	830	830	0%	47%
Santa Cruz	90	90	90	90	0%	75%
Shasta	85	85	85	85	0%	9%
Ventura	851	851	851	851	0%	63%
Yolo	224	224	224	224	0%	25%
Marin, Napa, Solano	295	295	295	295	0%	16%
SUM =	29,999	30,049	30,442	30,602	-5%	61%

CDA Licensed Capacity as of 12/2016

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

Note: Information is not available for January 2017 March 2017 due to a delay in the availability of data.

Table 8 reflects the average licensed capacity used by CBAS participants is at 61% statewide since September 2016. Overall, CBAS Centers have not operated at full capacity with the exception of San Bernardino County. San Bernardino County is currently functioning at maximum licensed capacity. This demonstrates the capacity for CBAS Centers to enroll more managed care and FFS members should the need arise.

STCs 48(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 a decrease in provider capacity of five percent or more for San Diego for DY12, Q2. When Advantage Adult Day Health Care Center closed in December 2016, the CBAS provider licensed capacity for San Diego decreased from 2,518 to 2,353. This caused the licensed capacity to decrease by seven percent in San Diego. However, Los Angeles county's licensed capacity increased by two percent. Changes in the two counties resulted in a statewide decrease of five percent in licensed capacity.

Access Monitoring (STC 48.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Table 1 and Table 8, CBAS 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 44.b.iii.)

CDA certifies and provides oversight of CBAS Centers. CDA and DHCS continue to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the 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 DY12, Q3, CDA has 239 CBAS Center providers operating in California. Compare to the previous quarter, the numbers of CBAS Centers have decreased from 240 to 239 as a result of Clairemont Villa Adult Day Health Care Center in San Diego closing on February 22, 2017.

Table 9:

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
March 2017	239	0	0	0	239
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
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
November 2013	245	1	0	-1	244
October 2013	245	0	0	0	245
September 2013	243	0	2	2	245
August 2013	244	1	0	-1	243
July 2013	243	0	1	1	244
June 2013	244	1	0	-1	243
May 2013	245	1	0	-1	244
April 2013	246	1	0	-1	245
March 2013	247	0	0	0	246
February 2013	247	1	0	-1	246*
January 2013	248	1	0	-1	247
December 2012	249	2	1	-1	248
November 2012	253	4	0	-4	249
October 2012	255	2	0	-2	253
September 2012	256	1	0	-1	255
August 2012	259	3	0	-3	256
July 2102	259	0	0	0	259
June 2012	260	1	0	-1	259
May 2012	259	0	1	1	260
April 2012	260	1	0	-1	259

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

Financial/Budget Neutrality Development/Issues:

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

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

This domain was designed to increase the statewide proportion of children under the age of 20 enrolled in Medi-Cal for 90 continuous days or more who receive preventive dental services. Specifically, the goal is to increase the statewide proportion of children ages 1 to 20 who receive a preventive dental service by at least ten percentage points over a five-year period. The first program year for this domain captured all activity in 2016, and the second program year for this domain will capture all activity in 2017.

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

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

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

Domain 3 – Continuity of Care

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

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

Domain 4 – Local Dental Pilot Projects (LDPPs)

The LDPPs will support the aforementioned domains through up to 15 innovative pilot programs to test alternative methods to increase preventive services, reduce early childhood caries, and establish and maintain continuity of care. DHCS will solicit proposals and 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.

Enrollment Information:

Nothing to report at this time.

Outreach/Innovative Activities:

<u>Small Stakeholder Workgroup</u>

The objective of these meetings is to review monthly updates regarding all Domains with provider, dental plan, and county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a monthly basis, each third Wednesday of the month. This quarter, the workgroup met on January 4, February 15, and March 15, 2017.

<u>DTI Small Stakeholder Subgroups</u>

In addition to the DTI small stakeholder workgroup, DHCS has continued to assemble

the following sub-workgroups:

California Dental Association (CDA) Monthly Meeting

The subgroup is still active, and met on January 9, March 6, and March 27, 2017. The objective of these meetings is to review the monthly updates and discuss outreach strategies with the California Dental Association.

Domain 2 Workgroup

This meeting occurred on January 9, 2017. The purpose of this meeting was to review all the Domain 2 materials prior to posting on the DTI webpage.

Webinars

On January 24, 2017, DHCS hosted a DTI Domain 2 Webinar and provided the participants with the following information regarding the Caries Risk Assessment (CRA) and Disease Management:

- CRA form
- Announced a training partnership with CDA
- CRA and Individual Care Plan
- American Academy of Pediatric Dentistry (AAPD) Guideline on Caries Risk Assessment and Management for Infants, Children, and Adolescents
- CRA Tool developed by the DHCS CRA Workgroup
- Documentation requirements for claims submission
- Billing Instructions

The January 24, 2017 webinar presentation can be accessed here: Domain 2 CRA and Disease Management Training.

On March 29, 2017, DHCS hosted an instructional webinar to review the Safety Net Clinic Instructions for submitting encounter data and Current Dental Terminology (CDT) Codes to the Fee-For-Service Fiscal Intermediary (Delta Dental) for participation in Domains 1 and 3.

DHCS provided the participants with the following resources that are posted on the DTI webinar archives webpage:

- Safety Net Clinic Encounter Data Submission Presentation (.pptx)
- Safety Net Clinic Opt-in Form
- Safety Net Clinic Electronic Data Interchange Application
- Safety Net Clinic Encounter Data Paper Form (*Non-DHCS website)

DTI Webpage

The DTI webpage was updated regularly during DY12 Q3 and will continue to be updated as new information becomes available. The webpage contains program information, stakeholder engagement information, webinars, timelines, Frequently Asked Questions (FAQs), Medi-Cal 2020 Special Terms and Conditions (STCs), and the DTI inbox to direct comments, questions, or suggestions.

The DTI webpage can be accessed here: Dental Transformation Initiative (DTI) webpage.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY12 Q3. The email address 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 us directly and the listserv provides another opportunity, for those that sign up, to receive relevant and current DTI updates.

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

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

Outreach Plans

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

- January 9, 2017: Domain 2 Workgroup Meeting
- January 12, 2017: Covered CA Dental Technical Workgroup Meeting
- January 13, 2017: California Department of Public Health (CDPH) Oral Health Program + DHCS Data Sharing Meeting
- January 27, 2017: Oral Health Meeting with California Primary Care Association
- February 7, 2017: State Child Health and Disability Program Oral Health Subcommittee Teleconference
- February 16, 2017: DHCS Stakeholder Advisory Committee – Meeting Presentation
- February 17, 2017: Medi-Cal Dental Los Angeles Stakeholder Meeting
- February 21- February 24, 2017: Budget Revision Conference Calls with LDPPs
- February 23, 2017: Sacramento Medi-Cal Dental Advisory Committee
- March 3, 2017: Meeting with California Primary Care Association
- March 23, 2017: California Senate Budget Subcommittee Hearing on Medi-Cal Dental Program

- March 29, 2017: DTI Safety Net Clinic Encounter Data Submission Instructional Webinar

Operational/Policy Developments/Issues:

Domain 1

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

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

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

Domain 2

At the end of Q3, provider participation in Domain 2 was as follows:

- 36 providers opted-in to Domain 2, out of 475 total billing providers in Domain 2 counties.
- 106 providers completed the Treating Young Kids Everyday (TYKE) training.

Provider resources for Participation in Domain 2 have been posted online:

- CDA TYKE CRA Training
- Provider Opt-In Attestation
- January 24, 2017 Webinar Training Presentation

Additional resources:

- CRA Costing
- County Rankings
- Outreach Letter

- CRA and Disease Management Training
- CRA and Disease Management Resources
    - Reducing Early Childhood Caries (ECC): Strategies in Medicaid
- CRA Tool
- CRA Self-Management Goals for Parent/Caregiver
- Informed Consent for Silver Diamine Fluoride Template

Domain 3

DHCS presented the following Safety Net Clinic (SNC) Provider Resources for Encounter Data Submission

- SNC Opt-in Form
- SNC Electronic Data Interchange Application
- DTI Proprietary Encounter Form for Paper Billing

The payments for Domain 3 program year 1 (2016) are scheduled for distribution on June 30, 2017.

Domain 4

The Department announced the selection of DTI Local Dental Pilot Programs on February 10, 2017. DHCS is completing the budget and contract processes for these programs, and all programs are expected to be operational by July 2017.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

Nothing to report at this time.

Quality Assurance/Monitoring Activities:

Nothing to report at this time.

Evaluation:

The Department received feedback from CMS on the DTI Draft Evaluation Design, and is developing the Final Evaluation Design in response to that feedback.

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- January 4, 2017: DMC-ODS Meeting with California Rural Indian Health Board (CRIHB) with Department of Health Care Services (DHCS) and California Health and Human Services (CHHS) Agency
- January 5, 2017: Meeting with California HealthCare Foundation (CHCF)
- January 9, 2017: Provider Enrollment Division (PED) Drug Medi-Cal Provider Quarterly Conference Call Meeting
- January 11, 2017: Incidental Medical Services (IMS) Regulations Meeting
- January 11, 2017: DHCS and UCLA Conference Call to discuss UCLA's DMC-ODS Evaluation Contract Activities and Work Plan
- January 13, 2017: DHCS and CHCF Quarterly Meeting

- January 17, 2017: CMS' National Dissemination Webinar: Clinical Pathways & Payment Bundles for Medication Assisted Treatment (MAT)
- January 18, 2017: Medi-Cal Children's Health Advisory Panel (MCHAP)
- January 19, 2017: Treatment Taskforce Meeting with DHCS and California Department of Public Health (CDPH)
- January 30, 2017: Second Phase IV Meeting at County Behavioral Health Directors Association of California (CBHDA)
- February 6, 2017: Narcotic Treatment Program Advisory Committee Meeting
- January 7, 2017: Meeting with CHCF for The Indian Health Project
- February 10, 2017: External Quality Review Organization (EQRO), UCLA, and DHCS Quarterly Meeting
- February 13, 2017: California Association of Alcohol and Drug Programs Executives, Inc. (CAADPE) and Coalition of Alcohol and Drug Associations (CADA) Bi-Monthly Call
- February 13, 2017: Monthly CA Waiver Monitoring Call with CMS
- February 21, 2017: California Opioid Maintenance Providers (COMP) Board Meeting
- February 22, 2017: Innovative Accelerator Program (IAP) Webinar: SUD Treatment Provider and Service Capacity
- February 24, 2017: Indian Health Program Organized Delivery System (IHPODS) MAT Call
- March 2, 2017: DMC-ODS Monthly TA Webinar
- March 3, 2017: Conference Call with Los Angeles County for Transition Logistics for DMC-ODS Launch
- March 6, 2017: CHCF Behavioral Health Project Conference Call
- March 8, 2017: DHCS and UCLA Conference Call
- March 8, 2017: CBHDA and DHCS Executive Committee Meeting
- March 10, 2017: DHCS Parity Meeting
- March 14, 2017: DHCS Academy Presentation
- March 16, 2017: Indiana Conference Call regarding Addiction Residential Rules Based on ASAM Criteria
- March 17, 2017: Senate Budget and Fiscal Review Pre-Hearing
- March 21, 2017: California Consortium of Addiction Programs and Professionals (CCAPP) Legislative Conference
- March 22, 2017: County Behavioral Health Directors Association of California (CBHDA) Policy Committee Meeting
- March 23, 2017: CDPH New Treatment Taskforce Meetings
- March 23, 2017: Association of Criminal Justice Researchers Conference
- March 24, 2017: Assembly Budget Subcommittee 1 Pre-Hearing
- March 30, 2017: Senate Budget and Fiscal Review Pre-Hearing

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

DHCS provided the Compliance Monitoring Workshops to the following counties. Participants are the County Compliance Manager or Compliance Officer:

- February 10, 2017: Sacramento Compliance Monitoring Workshop
- March 07, 2017: Fresno Compliance Monitoring Workshop
- March 23, 2017: San Bernardino Compliance Monitoring Workshop

Evaluation:

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP) will conduct an evaluation to measure and monitor outcomes of the DMC-ODS demonstration project.

The evaluation will focus on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and the medical and mental health services. UCLA will utilize data gathered from a number of existing state data sources as well as new data collected specifically for the evaluation.

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

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 Dental Transformation Initiative (DTI) program.

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$21,004,142	$42,008,284	DY 11	$21,004,142
(Qtr 2 Oct - Dec)	$18,731,270	$37,462,540	DY 11	$18,731,270
(Qtr 3 Jan – Mar)	$18,647,737	$37,295,474	DY 11	$18,647,737
Total	**$58,383,149**	**$116,766,298**		**$58,383,149**

For the quarter ending March 31, 2017, the Department claimed **$18,647,737** 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 reconciliations for DY3 through DY9.

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
	$286,502,138.50	$286,502,138.50	Oct. 1, 2016 – Dec. 2016	$573,004,277

DY12 Q3 reporting is for services from October 2016 through December 2016.

This quarter, PHCS received **$286,502,138.50** in federal funds payments and **$286,502,138.50** in IGT for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

On January 17, 2017, DHCS in collaboration with the Center for Maternal Quality Care Coalition (CMQCC), held a technical assistance webinar for participating PRIME entities on Baby Friendly USA Requirements and Safe Implementation of Practices, which falls under project 2.1 *Improvements in Perinatal Care*. All hospitals taking on project 2.1 participated in this technical assistance call to learn how to comply with measurement and reporting requirements.

On February 24, 2017, DHCS held a PRIME Learning Collaborative Kick-Off Webinar featuring guest speaker, Dr. Nirav Shah MD, MPH, Senior Vice President and Chief Operating Officer for Clinical Operations at Kaiser Permanente Southern California. Dr. Shah spoke to PRIME entities about his knowledge and experience in quality improvement as Health Commissioner of New York as well as his time at Kaiser Permanente.

On March 16 and 17, 2017, DHCS engaged participating PRIME entities two Learning Collaborative Brainstorm conference calls to determine the most relevant topics for future Learning Collaborative sessions in an effort to maximize the Learning Collaboratives' value for each entity.

Operational/Policy Developments/Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr 1 July - Sept)	$199,810,000	$199,810,000	DY 11	$399,620,000
(Qtr 2 Oct – Dec)	$598,626,428.57	$598,626,428.57	DY 11	$1,197,252,857.14
(Qtr 3 Jan-Mar)	$562,500.00	$562,500.00	DY 11	$1,125,000.00
Total	**$798,998,928.57**	**$798,998,928.57**		**$1,597,997,857.14**

In DY12 Q3, Sonoma West Medical Center was unable to complete the IGT transfer for their DY 11 annual report for achievements between January 1, 2016 – June 30, 2016, due to lack of funds. They were able to complete the IGT transfer and receive payment in January 2017.

For DY12 Q3, Designated Public Hospitals and District/Municipal Public Hospitals received **$562,500** in federal fund payments for PRIME-eligible services.

Consumer Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

DY12 Interim Mid-Year Reports were due to DHCS from all participating PRIME entities on March 31, 2017. DHCS received all reports on time and plans to conduct their clinical and administrative reviews for mid-year payments.

Evaluations:

DHCS selected the UCLA Center for Health Policy Research as the PRIME external evaluator.

On August 29, 2016, DHCS submitted the PRIME Draft Evaluation Design to CMS for review. On November 18, 2016, CMS provided feedback to the Draft Design. DHCS provided a response to CMS feedback on January 17, 2017. On March 2, 2017, DHCS provided CMS a Final Draft Evaluation Design and supporting documents for review and approval. DHCS is currently awaiting feedback from CMS.

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 SPDs 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 SPDs 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
January 2017 – March 2017

County	Total Member Months
Alameda	88,287
Contra Costa	52,942
Fresno	71,515
Kern	56,041
Kings	7,906
Los Angeles	602,722
Madera	7,253
Riverside	104,658
San Bernardino	110,703
San Francisco	115,574
San Joaquin	121,451
Santa Clara	45,958
Stanislaus	50,528
Tulare	67,802
Sacramento	36,798
San Diego	32,213
Total	**1,572,351**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
January 2017 – March 2017

County	Total Member Months
Alameda	57,876
Contra Costa	25,748
Fresno	35,509
Kern	23,251
Kings	3,636
Los Angeles	1,105,293
Madera	3,651
Marin	19,388
Mendocino	17,344
Merced	48,265
Monterey	48,441
Napa	14,058
Orange	373,556
Riverside	153,338
Sacramento	56,971
San Bernardino	150,107
San Diego	217,858
San Francisco	39,794
San Joaquin	24,445
San Luis Obispo	24,664
San Mateo	68,775
Santa Barbara	45,556
Santa Clara	147,933
Santa Cruz	31,145
Solano	58,918
Sonoma	52,700
Stanislaus	13,267
Tulare	15,629
Ventura	84,995
Yolo	25,931
Total	**2,988,042**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
January 2017 – March 2017

County	Total Member Months
Alpine	63
Amador	1,167
Butte	19,643
Calaveras	1,805
Colusa	806
El Dorado	5,246
Glenn	1,667
Imperial	10,357
Inyo	530
Mariposa	688
Mono	215
Nevada	3,331
Placer	9,360
Plumas	1,057
San Benito	262
Sierra	118
Sutter	5,905
Tehama	5,215
Tuolumne	2,648
Yuba	6,790
Total	**76,873**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
January 2017 – March 2017

County	Total Member Months
Del Norte	8,045
Humboldt	27,070
Lake	19,158
Lassen	4,421
Modoc	1,891
Shasta	40,581
Siskiyou	11,020
Trinity	2,821
Total	**115,007**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

WHOLE PERSON CARE (WPC)

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

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

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

Enrollment Information:

Eighteen first round WPC pilots began program implementation and enrolling WPC members beginning in January 1, 2017; however, this quarter's data is not available yet due to a data lag. The DY12-Q3 data will be reported in the next quarterly report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

During January and February 2017, DHCS established the secure file transfer protocol site (SFTP) for WPC pilots to use for the reporting and sharing of data. WPC pilots completed SFTP testing prior to submitting data reports on February 28, 2017.

On January 4, 2017, DHCS posted the 18 first round WPC applications on DHCS' website for public information and for the second round WPC applicants to use as a reference in developing their applications.

On January 10, 2017, the draft WPC Enrollment Reporting Template with Instructions

was released to the 18 first round WPC pilots and stakeholders for review and comment. This draft template included the monthly required data elements for reporting, including but not limited to, WPC member enrollment, homeless status, and reason for disenrollment. The reported data will be used to manage and evaluate the program, and the pilots will submit the report according to the instructions provided.

Beginning January 11, 2017, DHCS implemented regularly scheduled bi-weekly technical assistance calls with the 18 first round WPC pilots (legacy LEs). Once a month, the calls focus on the Learning Collaborative as well as administrative and policy issues.

The Learning Collaborative provides information and assists with WPC pilot implementation and closeout, shares best practices and lessons learned across WPC pilots, and provides a forum for the State to provide information, discuss requirements, and report data about the WPC pilots. The topics of the three Learning Collaborative calls held this quarter were an overview of the Learning Collaborative's goals and structure, survey of key topics for future discussion, the Sharing Ideas for Technology Across the WPC pilots presentation (eligibility systems, other IT systems, tools, and vendors), and planning for the May 15th in-person meeting. The Learning Collaborative also launched the collaborative project portal, which provides additional resources including project calendar and project participant's contact information.

On January 13, 2017, DHCS released the second round WPC pilot application template and instructions for use by new entities interested in applying in the second round of pilots. WPC legacy LEs that were approved in the first round and were interested in expanding their WPC pilot programs through participation in the second round used a separate application process developed specifically for WPC program expansion. These application documents were posted to the WPC website with an application due date of Wednesday, March 1, 2017.

On January 25, 2017, a draft technical specification document for reporting universal and variant metrics was distributed to the WPC pilots and stakeholders for comment.

On January 27, 2017, a second round application webinar was held for new WPC applicants to discuss the application process. WPC legacy LEs also participated and received technical assistance in applying for the expansion of their existing WPC pilot programs. Expansion includes new target populations and/or services and interventions. The funding for the second round of pilots is approximately $120 million in total funds available annually through December 2020.

On January 31, 2017, the WPC enrollment reporting template, including instructions, was distributed for WPC pilot use. The template was revised based on prior WPC pilot and stakeholder comments. The template included the monthly required data elements for reporting enrollment, including but not limited to, WPC member enrollment, homeless status, and reason for disenrollment. The reported data will be used to manage and evaluate the program and will be submitted by first round WPC pilots on a

monthly basis.

Beginning February 2017, the Learning Collaborative was included in the Bi-Weekly Technical Assistance Calls with the WPC legacy LEs. DHCS contracted with consultants to administer the Learning Collaborative and a survey was conducted to determine potential key discussion topics.

Throughout February 2017, DHCS held technical assistance meetings with potential applicants, which included a city and a consortium of smaller counties, as requested.

On February 28, 2017, the first round WPC pilots submitted the enrollment reports for January 2017.

On March 1, 2017, DHCS received 15 applications for the second round of the WPC pilot program. Of the 15 applications received, eight applications were from existing WPC legacy LEs interested in expanding their WPC pilot programs. The remaining seven were new applicants, including one city and a consortium of three smaller counties. The WPC pilots are intended to provide locally-based, comprehensive care to specified target populations, using coordinated physical health, behavioral health, and social services in a patient-centered manner, while improving the health and well-being of beneficiaries through a more efficient and effective use of resources. The services target Medi-Cal beneficiaries who are high users of multiple health systems and continue to have poor health outcomes. These beneficiaries include those who were released from institutions or incarceration, have mental illness or a substance use disorder, and/or are currently homeless or at risk of homelessness.

On March 1, 2017, the 15 second round WPC applications entered the review process where they were examined for the quality and scope of the application. The 15 applications have been undergoing extensive review by DHCS staff, and ongoing technical assistance has been provided individually to applicants through emails, teleconferences, and in-person meetings.

On March 7, 2017, DHCS released the final WPC Universal and Variant Metric Technical Specifications to provide the requirements for reporting universal and variant metrics.

On March 7, 2017, DHCS submitted a technical amendment proposal to CMS that will allow DHCS to accept applications and designate a city to be a LE in the second round application process. DHCS requested an effective date of July 1, 2017, to allow the State to award the program year (PY) 1 unallocated funding to WPC pilots and accept a city as a LE.

On March 24, 2017, the Learning Collaborative held their first webinar. The webinar included the following topics: *Start-Up Issue and Challenges: Experience from New York Health Homes*, and *Coordinating with Managed Care Organizations: Experiences from Peer Counties*. The webinar also included a question and answer session.

Consumer Issues:

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

Financial/Budget Neutrality Development/Issues:

On January 10, 2017, an advance notice was sent to WPC LEs as a reminder that the Intergovernmental Transfer (IGT) notice would be released on January 17th. The IGT notice specified the amount the LE would need to remit to DHCS for the non-federal share portion of the IGT. The payment consists of the federal funds and non-federal funds paid to the LE to complete the IGT process.

On February 3, 2017, DHCS released the first series of IGT payments to the 18 approved WPC pilots for PY 1. Through the IGT process, 24 payments totaling $433,689,880.50 were made during the quarter 3. These payments represent the 50% FFP ($216,844,940.25) and 50% local non-federal share ($216,844,940.25).

Payment	FFP	IGT	Service Period	Total Funds Payment
Quarter 3 (January 1- March 31, 2017)	$216,844,940.25	$216,844,940.25	DY11 (PY1)	**$433,689,880.50**

Notes:

- WPC pilot PY is January 1 - December 31 with PY 1 beginning in 2016.
- An additional 12 payments were initiated in Q 3 but were not paid due to time limitations. These 12 payments will be paid in Q 4.

Quality Assurance/Monitoring Activities:

DHCS released the Plan Do Study Act (PDSA) template and reporting instructions for use by WPC pilots for program improvement. The PDSA template is utilized for each PDSA a pilot conducts. The WPC pilots are required to review, at a minimum quarterly, universal and variant metrics. PDSA reporting will be included in the semi-annual and annual WPC reports.

DHCS continues to work on the development of the WPC baseline, mid-year, and annual report templates.

Evaluations:

On January 31, 2017, DHCS released a request for proposal for external independent evaluation services to seven qualified institutions. These institutions will assist in

developing the final WPC evaluation design and produce two required evaluation reports.

DHCS submitted the WPC Draft Evaluation Design to CMS on November 7, 2016. DHCS received CMS feedback on the draft report on March 16, 2017. The Final Evaluation Design is due to CMS within 60 days from receipt of CMS comments. DHCS will select an independent evaluation services institution from the seven qualified institutions and begin to develop an agreement with this evaluator. After the agreement is executed, the selected independent evaluation services institution will work with DHCS to finalize the WPC Evaluation Design.