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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fifteen (07/01/2019 – 06/30/2020)
First Quarter Reporting Period: 07/01/2019 – 09/30/2019

Table of Contents

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 18: Post Award Forum

The purpose of the Stakeholder Advisory Committee (SAC) is to provide DHCS with valuable input from the stakeholder community on ongoing implementation efforts for the State's Section 1115 Waiver, as well as other relevant health care policy issues impacting DHCS. SAC members are recognized stakeholders/experts in their fields, including, but not limited to, beneficiary advocacy organizations and representatives of various Medi-Cal provider groups. SAC meetings are conducted in accordance with the Bagley-Keene Open Meeting Act, and public comment occurs at the end of each meeting.

In DY15-Q1, DHCS hosted a SAC meeting on July 10, 2019. DHCS discussed the 1115 Waiver and 1915b Waiver Processes. Some of the other topics discussed included: the Governor's Executive Order, 340B Updates and Stakeholder Input, a comprehensive review of Proposition 56, and an Audit and Budget resources update.

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/SAC%20Agenda_071019.pdf.
The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/071019_SAC_summary.pdf.

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on July 8, 2019, August 12, 2019, and September 9, 2019, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following topics were discussed: WPC Program Updates, HHP Updates, Waiver Evaluation Reports, and Medi-Cal 2020 Evaluation and Close Out Reporting.

ACCESS ASSESSMENT

California's Section 1115(a) Medicaid Waiver Demonstration Special Terms and Conditions (STCs) required the Department of Health Care Services (DHCS) to contract with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct a one-time assessment of access to care. This assessment evaluated primary, core specialty, and facility access to care during 2017-18 for Medi-Cal managed care members based on requirements in the Knox-Keene Health Care Service Plan Act of 1975 and existing MCP contracts.

HSAG began working with DHCS in October 2016 to develop the overall access assessment evaluation design. An advisory committee was formed to provide input on the assessment structure. The advisory committee included representatives from consumer advocacy organizations, providers, provider associations, Medi-Cal managed care health plans (MCPs), health plan associations, and legislative staff. With participation from the advisory committee, DHCS submitted a draft evaluation design to the Centers for Medicaid and Medicare Services (CMS) for review in April 2017. The evaluation design included:

- Network Capacity;
- Geographic Distribution;
- Appointment Availability;
- Service Utilization; and
- Grievances and Appeals.

HSAG hosted a final access assessment advisory committee meeting in June 2019 to review the results and provide guidance to the committee for submitting its feedback to HSAG. DHCS and HSAG then presented an initial draft of the California 2017-18 Access Assessment Report for public comment.[1]

Summary of results:

- No critical access issues were identified that would require immediate attention; and
- Although some MCPs did not meet all standards, no single MCP consistently performed poorly.

Project is near completion:

- HSAG presented DHCS with a final report;
- DHCS will submit the final report to CMS by the end of October 2019.

[1] An initial draft of the CA 2017-18 Access Assessment Report is available on the DHCS website at: https://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

In addition to Health Plan of San Mateo (HPSM), DHCS contracted with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning July 1, 2018.

Enrollment Information:

The monthly enrollment for RCHSD CCS Demonstration Project (DP) is reflected in Figure 1 below. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Figure 1: Monthly Enrollment for RCHSD CCS Demonstration Project (DP)

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-July	0	$2,733.54	$0.00
18-Aug	44	$2,733.54	$120,275.76
18-Sep	128	$2,733.54	$349,893.12
18-Oct	151	$2,733.54	$412,764.54
18-Nov	210	$2,733.54	$574,043.40
18-Dec	321	$2,733.54	$877,466.34
19-Jan	357	$2,733.54	$975,873.78
19-Feb	357	$2,733.54	$975,873.78
19-Mar	369	$2,733.54	$1,008,676.26
19-Apr	365	$2,733.54	$997,742.10
19-May	367	$2,733.54	$1,003,209.18
19-Jun	368	$2,733.54	$1,005,942.72
19-Jul	363	$2,733.54	$992,275.02
19-Aug	354	$2,733.54	$967,673.16
19-Sep	350	$2,733.54	$956,739
Total			$11,218.448.16

Figure 2: RCHSD Monthly Enrollment

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	363	354	350	1	1,067

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 Waiver, was approved by Federal CMS on December 30, 2015. The Waiver contains 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. DHCS is awaiting approval for the CCS protocols, however DHCS received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design.

Rady Children's Hospital of San Diego Demonstration Project

RCHSD – San Diego pilot demonstration was implemented on July 1, 2018. RCHSD was brought up as a full-risk Medi-Cal managed care health plan that services CCS beneficiaries in San Diego County that have been diagnosed with one of five eligible medical conditions. Members are currently being enrolled into RCHSD.

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. In October 2019, RCHSD submitted their CCS Quarterly Grievance Report for reporting period July – September 2019. During the reporting period, RCHSD received and processed one member grievance.

The one member grievance reported was related to the enrollment process and resolved in the Plan's favor.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Regents of the University of California, San Francisco (UCSF) was selected as the evaluator for the California Children's Services (CCS) evaluation design. This evaluation will run from July 1, 2019, to June 30, 2021, and will be completed in two phases. Phase one will include Health Plan San Mateo (HPSM), and phase two will include Rady Children's Hospital of San Diego (RCHSD). In July 2019, UCSF began its contracting work on the evaluation and has received applicable data sets. UCSF is working on the Interim Report due to Centers for Medicare & Medicaid Services (CMS) on December 31, 2019, which is mandated by California's Section 1115(a) Medicaid Waiver.

The final evaluation design is available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

COMMUNITY-BASED ADULT SERVICES (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services as a Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, sought to challenge the elimination of ADHC services. In settlement of this lawsuit, ADHC was eliminated as a payable benefit under the Medi-Cal program effective March 31, 2012, and was replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. DHCS amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR waiver) to include CBAS, which was approved by the Centers for Medicare & 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 the California Department of Aging (CDA) facilitated extensive stakeholder input regarding the continuation of CBAS. DHCS proposed an amendment to the CBAS BTR waiver to continue CBAS as a managed care benefit beyond August 31, 2014. CMS approved the amendment to the CBAS BTR waiver, which extended CBAS for the duration of the BTR Waiver through October 31, 2015.

CBAS will continue as a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver approved by CMS on December 30, 2015.

Program Requirements:

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

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

The State must ensure CBAS access and capacity in every county where ADHC

services were provided prior to CBAS starting on April 1, 2012[2]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service (FFS) benefit. On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model (available in 14 counties), Geographic Managed Care plans (available in two counties), and the final COHS county (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS-eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and Fee-for-Service (FFS) members per county for Demonstration Year 15 (DY15), Quarter 1 (Q1), represents the period of July 2019 to September 2019. CBAS enrollment data is shown in the table, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.* The table titled *CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

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

[2] 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.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY14-Q2		DY14-Q3		DY14-Q4		DY15-Q1	
	Oct - Dec 2018		Jan - Mar 2019		Apr - Jun 2019		Jul – Sep 2019	
County	Unduplicated Participants (MCP & FFS)		Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	532	81%	533	81%	528	80%	513	78%
Butte	34	33%	34	33%	36	35%	30	30%
Contra Costa	212	64%	217	67%	202	63%	219	59%
Fresno	658	50%	614	47%	638	46%	646	46%
Humboldt	107	28%	97	25%	**4	**1%	85	22%
Imperial	305	51%	309	51%	387	64%	389	65%
Kern	96	28%	73	22%	76	11%	65	10%
Los Angeles	21,591	64%	21,595	64%	21,978	63%	21,994	60%
Merced	95	45%	97	53%	90	49%	95	51%
Monterey	105	56%	113	61%	106	57%	119	64%
Orange	2,440	55%	2,475	55%	2,519	56%	2,595	58%
Riverside	465	43%	464	36%	508	39%	538	44%
Sacramento	332	40%	442	43%	500	48%	503	49%
San Bernardino	694	93%	709	95%	768	103%	773	77%
San Diego	2,079	56%	2,100	56%	2,647	70%	2,630	70%
San Francisco	705	45%	660	42%	688	44%	679	43%
San Mateo	63	28%	66	29%	78	34%	66	29%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	606	42%	644	45%	626	47%	617	47%
Santa Cruz	107	70%	104	68%	101	66%	102	67%
Shasta	*	*	*	*	*	*	*	*
Ventura	909	63%	906	63%	910	63%	931	65%
**Yolo	290	76%	287	76%	279	74%	275	72%
Marin, Napa, Solano	79	16%	81	16%	84	17%	85	17%
Total	**32,504**	**59%**	**32,625**	**59%**	**33,765**	**60%**	**34,016**	**58%**
FFS and MCP Enrollment Data 09/2019								

Figure 3: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS

**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.*
***The DY14:Q4 Humboldt County drop in capacity utilization was due to a one-time data collection error that has been corrected for DY15:Q1 and ongoing reporting.*

The data provided in Figure 3 shows that while enrollment has slightly increased between DY14-Q4 & DY15-Q1, it has remained consistent with over 34,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers. Statewide, license capacity utilization has decreased slightly from the prior quarter, which stems from the opening of seven new CBAS centers, five in Los Angeles County, one in San Bernardino County, and one in Kern County.

While the closing of a CBAS Center in a county can contribute to increased utilization of the license capacity in a county, it is important to note the amount of participation can also play a significant role in the overall amount of licensed capacity used throughout the State. In Monterey and Humboldt Counties, there was a more than five percent increase in licensed capacity utilized compared to the previous quarter. The increase of capacity utilization in Monterey County is due to a slight increase in number of members provided CBAS services, likely due to a fluctuation in attendance, as there were no center closures or changes in overall license capacity for Monterey in DY15 Q1. For Humboldt County, their increase in capacity utilization is due to an error in reporting for DY14 Q4, which was accounted for in the DY14 Annual report. In DY14 Q4, health plans submitted numbers only for members new to CBAS services, and did not include all who had received CBAS services. This error has since been remedied by the health plan, which has been updated and reflected in the current report. This correction is currently reflected on a go-forward basis and while the DY15 Q1 capacity utilization data is correct, the DY14 Q4 capacity utilization data is still not valid. The valid Humboldt County capacity utilization data for DY14 Q4 will be updated and reflected in future progress reports.

In San Bernardino County, there was a more than 5 percent decrease of license capacity utilization compared to the previous quarter. A new CBAS center opened in San Bernardino County, which caused the overall license capacity to increase and accounts for the decrease in license capacity utilization. Prior to this new CBAS center opening, San Bernardino County was operating over their license capacity at 103percent license capacity utilization. With the opening of the new center, San Bernardino is back to a more accommodating capacity utilization of 77percent, which allows room for new participants to enroll in CBAS services in their County of residence.

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

Figure 4, titled *CBAS Assessments Data for MCPs and FFS* reflects the number of new

assessments reported by the MCPs. The FFS data for new assessments listed in this table is reported by DHCS.

Figure 4: *CBAS Assessments Data for MCPs and FFS*

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY14-Q2 (10/01-12/31/2018)	2,256	2,208 (97.9%)	48 (2.1%)	6	6 (100%)	0 (0%)
DY14-Q3 (01/01-03/31/2019)	2,146	2,089 (97.3%)	57 (2.7%)	6	4 (66.7%)	2 (33.3%)
DY14-Q4 (04/01-06/30/2019)	2,343	2,296 (98%)	47 (2%)	4	1 (25%)	3 (75%)
DY15-Q1 (07/01-09/30/2019)	2,449	2,401 (98%)	48 (2%)	6	6 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	Yes

Requests for CBAS services are collected and assessed by the MCPs and DHCS. As indicated in the table above, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. According to the table, for DY15-Q1, there were (2,449) assessments completed by the MCPs, of which (2,401) were determined to be eligible and (48) were determined to be ineligible. The table identifies that six participants were assessed for CBAS benefits under FFS, with all six determined eligible.

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

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

Figure 5 titled *CDA – CBAS Provider Self-Reported Data* identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY15-Q1. The ADA at the 259 operating CBAS Centers is approximately 24,037 participants, which corresponds to 69percent Statewide ADA per center. As the

result of an increase in the total unduplicated participants in DY15-Q1, a rise in raw ADA was seen compared to the previous quarter. Additionally, seven new CBAS Centers opened during DY15-Q1 that resulted in an overall increase in total statewide license capacity at 34,603 and a slight decrease in Statewide ADA percentage compared to the previous quarter.

Figure 5: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	259
Non-Profit Centers	54
For-Profit Centers	205
ADA @ 259 Centers	24,037
Total Licensed Capacity	34,603
Statewide ADA per Center	69%
	CDA - MSSR Data 09/2019

Outreach/Innovative Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans and other interested stakeholders via the *CBAS Updates* newsletter, CBAS All Center Letters (ACL), CAADS conference presentations, and ongoing MCP and CBAS Quality Advisory Committee calls.

In the past quarter, CDA distributed two newsletters (June 25, 2019 and September 6, 2019) and an ACL (August 13, 2019) which included an update on the following: (1) implementation of the revised CBAS Individual Plan of Care (IPC) (2) submission of the revised Participant Characteristics Report (PCR), effective July 1, 2019, which CBAS centers use to report participant information to CDA via the new PCR electronic submission process using the CDA Peach Provider Portal internet-based application, and (3) upcoming education and training opportunities such as the California Association for Adult Day Services (CAADS) 2019 Fall Conference. CDA will present a workshop at the CAADS conference titled *Guidance on Completing the New CBAS Individual Plan of Care (IPC)*.

CDA convenes triannual calls/outreach with all MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update them on CBAS activities and data including policy directives, and (3) request feedback on any CBAS provider issues requiring CDA assistance. The most recent MCP call was held on August 7, 2019. CDA provided MCPs with an update and requested feedback on the

following: (1) CBAS center applications, (2) CBAS IPC implementation, (3) CBAS Quality Assurance & Improvement Strategy activities including training requirements and CBAS center use of assessment/screening tools, and (4) CURES Act requirements specific to screening and enrollment, and credentialing and recredentialing of MCPs' provider networks.

CDA convenes quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. During this quarter, CDA convened a call on September 25, 2019 and provided an update and requested feedback on the following: (1) Completed list of Assessment/Screening Tools for CBAS providers to assist in the identification of specific conditions that may be experienced by CBAS participants such as cognitive impairment, depression, fall risk, suicide, anxiety, alcohol/substance abuse, loneliness, pain, and many more. The use of these tools by CBAS providers is considered a best practice; (2) Completed list of Education and Training Resources on a range of needs/conditions of CBAS center participants. CBAS providers are required to provide orientation and ongoing training of their staff to comply with ADHC/CBAS state and federal requirements but also to promote quality care. CDA posted these resources on the CDA website and will distribute a CBAS Updates newsletter about these new resources.

Operational/Policy Developments/Issues:

DHCS and CDA continue to work and communicate with CBAS providers and MCPs on an ongoing basis to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. This includes conducting triannual calls with MCPs, distributing All Center Letters and CBAS Updates newsletter for program and policy updates, and responding to ongoing written and telephone inquiries.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY15-Q1. The primary operational and policy development issues during this quarter were the following: (1) CBAS IPC implementation, (2) CURES Act implementation and impact on CBAS centers and their staff/subcontractors, and (3) CBAS center compliance with the federal Home and Community-Based Settings requirements.

<u>CBAS IPC</u>

As background, the CBAS IPC was revised through a year-long stakeholder process in 2015-1016 to comply with federal Home and Community-Based (HCB) Settings and Person-Centered Planning Requirements directed by CMS in the 1115 Waiver. DHCS approved the revised CBAS IPC and revised the CBAS sections of the DHCS Medi-Cal Provider Manual which was published on March 15, 2019. Implementation of the new CBAS IPC was effective June 1, 2019. However, due to technical difficulties with the new IPC form for CBAS providers not using vendor-provided software, CDA extended

the IPC implementation date for those providers until October 1, 2019. CDA distributed an All Center Letter (ACL) on August 13, 2019 informing CBAS providers, MCPs, software vendors and other interested stakeholders of the IPC implementation extension. CDA provided a webinar training on the new IPC in October 2018 and will continue to provide technical assistance to CBAS providers during CDA's on-site CBAS Medi-Cal certification surveys of all CBAS centers and at training conferences sponsored by the California Association for Adult Day Services (CAADS).

CURES Act

DHCS and CDA are collaborating to ensure that CBAS providers are informed about the State's implementation of the CURES Act and the MCPs' responsibilities specific to screening and enrollment, and credentialing and recredentialing of their provider networks which will impact CBAS centers and their staff/subcontractors.

Home and Community-Based (HCB) Settings and Person-Centered Planning Requirements

CDA in collaboration with DHCS continues to implement the activities and commitments to CMS for compliance of CBAS centers with the federal Home and Community-Based (HCB) settings requirements by March 17, 2022, and thereafter. CDA determines CBAS center for compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS's directive in the CBAS sections of the 1115 Waiver (STC 48c), CDA developed the *CBAS HCB Settings Transition Plan* which is an attachment to California's *Statewide Transition Plan (STP)*. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions of the STP and CBAS Transition Plan before it will grant final approval. DHCS has not yet determined the submission date of the STP to CMS for final approval. DHCS and CDA continue to participate in ongoing CMS technical assistance calls and webinar training for States.

Consumer & Provider Issues:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 52.e.iv)
DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the Press, and members of the Legislature on various aspects of the CBAS program. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBASinfo@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the

authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Figure 6 entitled "*Data on CBAS Complaints"* and Figure 7 entitled "*Data on CBAS Managed Care Plan Complaints*."

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY15-Q1, as illustrated in the table, titled *Data on CBAS Complaints*. Figure 7, titled *Data on CBAS Managed Care Plan Complaints* shows that MCPs received eight beneficiary complaints and zero provider complaints in DY15-Q1. Overall, total complaints have decreased during the last quarter, as reported by the managed care plans.

Figure 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY14-Q2 (Oct 1 – Dec 31)	0	0	0
DY14-Q3 (Jan 1 – Mar 31)	0	0	0
DY14-Q4 (Apr 1– Jun 30)	0	0	0
DY15-Q1 (Jul 1 – Sep 30)	0	0	0

Figure 7: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY14-Q2 (Oct 1 - Dec 31)	2	13	15
DY14-Q3 (Jan 1 - Mar 31)	8	0	8
DY14-Q4 (Apr 1 - Jun 30)	12	0	12
DY15-Q1 (Jul 1 - Sep 30)	8	0	8
Plan data - Phone Center Complaints 09/2019 CDA Data - Complaints 09/201			

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

Grievance and appeals data is provided to DHCS by the MCPs. According to Figure 8, titled *Data on CBAS Managed Care Plan Grievances*, seven grievances were filed with

the MCPs for DY15-Q1; 4 grievances were related to “CBAS Providers,” one grievance was related to “Contractor Assessment of Reassessment”, and the remaining two grievances were related to “Other CBAS grievances.”

Figure 8: 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
DY14-Q2 (Oct 1 - Dec 31)	5	1	0	19	25
DY14-Q3 (Jan 1 - Mar 31)	3	0	2	3	8
DY14-Q4 (Apr 1 - Jun 30)	2	0	0	8	10
DY15-Q1 (Jul 1 - Sep 30)	4	1	0	2	7
Plan data - Grievances 09/2019					

For DY15-Q1, three CBAS appeals were filed with the MCPs as shown in Figure 9 titled “*Data on CBAS Managed Care Plan Appeals.”* Two appeals were related to “Denials or Limited Services” and one was due to “Other CBAS Appeals”.

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 DY15-Q1 (July 2019 to September 2019), there were no requests for hearings related to CBAS services filed.

Figure 9: 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
DY14 – Q2 (Oct 1 – Dec 31)	1	0	0	2	3
DY14 – Q3 (Jan 1 – Mar 31)	0	0	0	0	0
DY14 – Q4 (Apr 1 – Jun 30)	3	0	0	3	6
DY15 – Q1 (Jul 1 – Sep 30)	2	0	0	1	3
		Plan data - Grievances 09/2019			

Financial/Budget Neutrality Development/Issues:

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

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

Quality Assurance/Monitoring Activity:

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. CDA continues to convene quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy.

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Figure 10, titled *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. The table below also

shows overall utilization of licensed capacity by CBAS participants statewide for DY15-Q1. Quality Assurance/Monitoring Activity reflects data through July 2019 to September 2019.

	Figure 10: CBAS Centers Licensed Capacity					
County	**DY14-Q2 Oct-Dec 2018**	**DY14-Q3 Jan-Mar 2019**	**DY14-Q4 Apr-Jun 2019**	**DY15-Q1 Jul-Sep 2019**	**Percent Change Between Last Two Quarters**	**Capacity Used**
Alameda	390	390	390	**390**	0.0%	78%
Butte	60	60	60	**60**	0.0%	30%
Contra Costa	195	190	190	**220**	+15.8%	59%
Fresno	772	772	822	**822**	0.0%	46%
Humboldt	229	229	229	**229**	0.0%	22%
Imperial	355	355	355	**355**	0.0%	65%
Kern	200	200	400	**400**	0.0%	10%
Los Angeles	19,984	20,026	20,578	**21,492**	+4.4%	60%
Merced	124	109	109	**109**	0%	51%
Monterey	110	110	110	**110**	0%	64%
Orange	2,638	2,638	2,638	**2,638**	0%	58%
Riverside	640	760	760	**720**	-5.3%	44%
Sacramento	489	609	609	**609**	0%	49%
San Bernardino	440	440	440	**590**	+11.4%	77%
San Diego	2,198	2,233	2,233	**2,233**	0%	70%
San Francisco	926	926	926	**926**	0%	43%
San Mateo	135	135	135	**135**	0%	29%
Santa Barbara	60	60	100	**100**	0%	*
Santa Clara	850	850	780	**780**	0%	47%
Santa Cruz	90	90	90	**90**	0%	67%
Shasta	85	85	85	**85**	0%	*
Ventura	851	851	851	**851**	0%	65%
Yolo	224	224	224	**224**	0%	72%
Marin, Napa, Solano	295	295	295	**295**	0%	17%
SUM	32,340	32,637	33,409	**34,463**	+3.2%	58%
CDA Licensed Capacity as of 09/2019						

**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.*

The above table reflects the average licensed capacity used by CBAS participants at 58 percent statewide as of September 30, 2019. Overall, most of the CBAS Centers have not operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STC 52(e) (v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. In the table titled *CBAS Centers Licensed Capacity*, RiversideCounty licensing capacity decreased slightly more than five percent during DY15-Q1. This decrease in total license capacity in Riverside County is due to the licensed capacity for one center being reduced by CDPH from 125 to 85. .

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS*, and *CBAS Centers Licensed Capacity* CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. There were no closures of any CBAS Centers over the DY15-Q1 reporting period, therefore, closures did not negatively affect the CBAS Centers and the services they provide to beneficiaries.

Unbundled Services (STC 48.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. Figure 11, titled *CBAS Center History*, shows the history of openings and closings of the centers. According to Table below, for DY15-Q1 (July 2019 to September 2019), CDA currently has 259 CBAS Center providers operating in California. In DY15-Q1, zero centers closed, and seven centers opened, five in Los Angeles County, one in San Bernardino County, and one in Kern County. Figure 11 below shows there was not a negative change of more than five percent from the prior quarter so no analysis is needed to addresses such variances.

Figure 11: CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
September 2019	256	0	3	3	259
August 2019	253	0	3	3	256
July 2019	252	0	1	1	253
June 2019	253	1	0	-1	252
May 2019	253	0	0	0	253
April 2019	251	0	2	2	253
March 2019	251	0	0	0	251
February 2019	250	0	1	1	251
January 2019	248	0	2	2	250
December 2018	248	0	0	0	248
November 2018	248	0	0	0	248
October 2018	247	0	1	1	248
September 2018	245	0	2	2	247

Evaluation:

Nothing to report.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Given the importance of oral health to the overall well-being 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 DTI, DHCS aims to:

- Improve the beneficiary experience by ensuring consistent and easy access to high-quality dental services that support 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 itself, providers, plans, and other partners accountable for improved dental performance and overall health outcomes.

For reference, Figure 12 below illustrates DTI's program years (PYs) with the corresponding 1115 Demonstration Waiver Years (DY):

Figure 12: DTI Program Years and 1115 Demonstration Waiver Years

DTI PYs	1115 Waiver DYs
1 (January 1 – December 31, 2016)	11 (January 1 - June 30, 2016) and 12 (July 1, 2016 - June 30, 2017)
2 (January 1 – December 31, 2017)	12 (July 1, 2016 - June 30, 2017) and 13 (July 1, 2017 - June 30, 2018)
3 (January 1 – December 31, 2018)	13 (July 1, 2017 - June 30, 2018) and 14 (July 1, 2018 - June 30, 2019)
4 (January 1 – December 31, 2019)	14 (July 1, 2018 - June 30, 2019) and 15 (July 1, 2019 - June 30, 2020)
5 (January 1 – December 31, 2020)	15 (July 1, 2019 - June 30, 2020) and 16 (July 1, 2020 - Dec 31, 2020)

Overview of Domains

Domain 1 – Increase Preventive Services for Children[3]

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

[3] DTI Domain 1

over a five-year period.

Domain 2 – Caries Risk Assessment (CRA) and Disease Management[4]

This domain is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages six 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 rendering services in one of the pilot counties must take the DHCS approved training and submit a completed provider opt-in attestation form.

The following are the initial eleven (11) counties originally selected as pilot counties under this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba. The following are the eighteen (18) expansion counties as of January 1, 2019: Merced, Monterey, Kern, Contra Costa, Santa Clara, Los Angeles, Stanislaus, Sonoma, Imperial, Madera, San Joaquin, Fresno, Orange, San Bernardino, Riverside, Ventura, Santa Barbara, and San Diego.

Domain 3 – Continuity of Care[5]

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing ongoing relationships between a beneficiary and a dental provider in selected counties. Incentive payments are issued 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. For PYs 1-3, DHCS began this effort as a pilot in seventeen (17) select counties. At the end of PY 3, based on the positive outcomes of the first three years, DHCS decided to expand this domain effective January 1, 2019, to an additional nineteen (19) counties, bringing the total to 36 pilot counties.

The following are the initial 17 counties selected as pilot counties and are currently participating in this domain: Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus, and Yolo. The following are nineteen (19) expansion counties added effective January 1, 2019: Butte, Contra Costa, Imperial, Merced, Monterey, Napa, Orange, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Solano, Sutter, Tehama, Tulare, and Ventura.

---

[4] DTI Domain 2
[5] DTI Domain 3

Domain 4 – Local Dental Pilot Projects (LDPPs) [6]

The LDPPs support the aforementioned domains through 13 innovative pilot programs to test alternative methods to increase preventive services, reduce early childhood caries, and establish and maintain continuity of care. DHCS solicited proposals to review, approve, and make payments to LDPPs in accordance with the requirements stipulated. The LDPPs are required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

The approved lead entities for the LDPPs are as follows: Alameda County; California Rural Indian Health Board, Inc.; California State University, Los Angeles; First 5 San Joaquin; First 5 Riverside; Fresno County; Humboldt County; 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

Figure 13: Statewide Beneficiaries Ages 1-20 with Three Months Continuous Enrollment and Preventive Dental Service Utilization[7]

Measure Period	08/2018-07/2019	07/2018-08/2019	08/2018-09/2019
Denominator[8]	5,403,195	5,389,282	5,374,105
Numerator[9]	2,432,612	2,389,282	N/A[10]
Preventive Dental Service Utilization	45.02%	43.25%	N/A[10]

[6] DTI Domain 4
[7] Data Source: DHCS Data Warehouse MIS/DSS Dental Dashboard October 2019. Utilization does not include one-year full run-out allowed for claim submission.
[8] Denominator: Three months continuous enrollment - Number of beneficiaries ages one (1) through twenty (20) enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.
[9] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (Current Dental Terminology (CDT) codes D1000-D1999 with or without safety net clinics' (SNCs) dental encounter with International Classification of Diseases (ICD)-10 diagnosis codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) during the measure year.
[10] Utilization for the third month of each quarter is not available due to claim submission time lag.

Figure 14: State Fiscal Year 2019-2020 Statewide Active Service Offices, Rendering Providers, and SNCs[11]

Delivery System and Plan[12]	Provider Type	July 2019	August 2019	September 2019
FFS	Service Offices	5,848	5,869	5,877
FFS	Rendering	10,829	10,923	10,992
GMC	Service Offices	127	128	149
GMC	Rendering	283	284	287
PHP	Service Offices	925	922	922
PHP	Rendering	1613	1598	1614
Both FFS and DMC	Safety Net Clinics	575	582	N/A[13]

Outreach/Innovative Activities

DTI Small Workgroup

This workgroup meets on a bi-monthly basis, the third Wednesday of the month. During this quarter, this workgroup sent an email update in lieu of the July 18, 2019 meeting and met on September 19, 2019. DHCS shared updates on all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. Stakeholders inquired about dental benefits and incentives after DTI expires on December 31, 2020. DHCS directed the stakeholders to the California Advancing and Innovating Medi-Cal (CalAIM) website for information about dental proposals under consideration post DTI. The next DTI Small Workgroup will be held on November 21, 2019.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities, discuss ways to increase participation from providers who are eligible to participate in the domain, and to provide an open forum for questions and answers specific to this

[11] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of SNCs is based on encounter data from the DHCS data warehouse as of October 2018. Only SNCs that submitted at least one dental encounter within a year were included.
[12] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.
[13] Count of SNCs for the third month of each quarter is not available due to claim submission time lag.

domain. The group meets quarterly as needed. The subgroup did not meet this quarter, but email updates were shared on July 31, 2019. The update consisted of payments made per service delivery system and the total counts of providers. The next subgroup meeting is scheduled for October 15, 2019.

DTI Clinic Subgroup

The clinic subgroup is still active; however, the subgroup did not meet this quarter.

Domain 3 Subgroup

The purpose of this subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup is still active; however, it did not meet this quarter.

DTI Data Subgroup

The purpose of the DTI data subgroup is to provide an opportunity for stakeholders and DHCS to discuss various components of the DTI annual report and for opportunities to examine new correlations and data. Since the release of the DTI PY 2 Annual Report, stakeholders reviewed the report and shared written feedback with DHCS. The feedback included positive comments, follow up questions and a suggestion to add previous years' Domain 1 statewide utilization to the Annual Report. DHCS responded to the follow up questions, reworded the report narrative for clarification and agreed to incorporate the stakeholders' feedback in the PY 3 DTI Annual Report.

Domain 4 Subgroup

DHCS continues the bi-monthly teleconferences with all LDPPs as an opportunity to educate, provide technical assistance, offer support, and address concerns. Additional teleconferences are conducted as needed. During this reporting period, two LDPP conference calls were held: the regular bi-monthly teleconference on August 22 and an additional call to specifically discuss DTI run out on September 23, 2019.

DTI Webpage

This quarter's webpage postings included Domain 3 Incentive Payments for PY 1 and 2.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY15-Q1. In this quarter,

there were 206 inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to, the following categories: county expansion, encounter data submission, opt-in form submission, payment status and calculations, resource documents, and Domain 2 billing and opt-in questions.

Figure 15: Number of DTI Inbox Inquiries by Domain

Domain	Inquiries
1	69
2	115
3	22
Total	**206**

In a separate LDPP inbox for Domain 4, participants submitted 163 inquiries this quarter. The inquiries pertained to status requests, budget revisions, asset tagging, and reimbursement questions.

Outreach Plans

The dental Administrative Services Organization (ASO) shares DTI information with providers during outreach events, specifically about domains 1-3. DHCS presented information on the DTI at several venues during this reporting period. Below is a list of venues where DTI information was disseminated:

- July 30, 2019: National Academy for State Health Policy webinar
- August 1, 2019: Medi-Cal Dental Advisory Committee Meeting (agenda)
- August 6, 2019: Child Health and Disability Prevention Statewide Oral Health Subcommittee
- August 15, 2019: LA Dental Stakeholder Meeting (agenda)
- August 16, 2019: San Francisco City and County Department of Public Health Dental Access Collaborative Expert Meeting

Operational/Policy Developments/Issues

Domain 1

The July 2019 payment was successfully disbursed using the new baseline and benchmark methodology established in January 2019. The next payment in January 2020 is on schedule.

Domain 2

FFS providers are paid on a weekly basis and SNC and DMC providers are paid on a monthly basis. Figure 16 represents incentive claims, paid as of September 2019, for FFS, SNC, and DMC providers during the DY15-Q1 reporting period. During this time, $18,034,521.94 in total incentive claims were paid to 2,374 providers who have opted into the domain.

Figure 16: Incentive Claims

County	FFS	DMC	SNC
Contra Costa	$173,147.00	-	-
Fresno	$952,685.00	-	-
Glenn	$252.00	-	-
Humboldt	-	-	-
Imperial	$26,530.00	-	-
Inyo	-	-	$1,638.00
Kern	$1,304,627.00	-	-
Kings	$4,536.00	-	-
Lassen	-	-	-
Los Angeles	$5,776,228.90	$66,181.00	$91,717.00
Madera	$191,432.00	-	-
Mendocino	-	-	$756.00
Merced	$124,669.00	-	-
Monterey	$775,775.10	-	-
Orange	$1,265,188.00	-	-
Plumas	-	-	-
Riverside	$923,856.00	-	-
Sacramento	$148,610.15	$229,409.00	-
San Bernardino	$1,029,745.00	-	-
San Diego	$1,496,562.00	-	$26,143.00
San Joaquin	$488,033.00	-	-
Santa Barbara	$318,305.00	-	-
Santa Clara	$419,167.88	-	-
Sierra	-	-	-
Sonoma	$81,360.00	-	$164,547.00
Stanislaus	$558,156.80	-	-
Tulare	$707,639.65	-	-
Ventura	$683,289.46	-	$4,336.00
Yuba	-	-	-
Total	**$17,449,794.94**	**$295,590.00**	**$289,137.00**

Figure 17 represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program, February 2017, until the end of DY15-Q1 reporting

period, September 2019. The total incentive claims paid for this period was $29,983,488.09.

Figure 17

County	FFS	DMC	SNC
Contra Costa	$221,183.00	-	-
Fresno	$1,548,549.00	-	-
Glenn	$2,016.00	-	-
Humboldt	$70.00	-	$126.00
Imperial	$36,473.00	-	-
Inyo	-	-	$10,584.00
Kern	$2,470,319.00	-	-
Kings	$7,434.00	-	-
Lassen	-	-	-
Los Angeles	$9,171,083.20	$101,839.00	$132,541.00
Madera	$199,991.00	-	-
Mendocino	-	-	$38,220.00
Merced	$152,783.00	-	-
Monterey	$879,165.10	-	-
Orange	$2,084,649.00	-	-
Plumas	-	-	-
Riverside	$1,318,784.25	-	-
Sacramento	$422,373.15	$792,826.00	-
San Bernardino	$1,521,630.00	$126.00	-
San Diego	$2,497,211.00	-	$46,681.00
San Joaquin	$566,247.00	-	-
Santa Barbara	$680,969.00	-	-
Santa Clara	$704,201.88	-	-
Sierra	-	-	-
Sonoma	$121,168.00	-	$355,046.00
Stanislaus	$804,261.80	-	-
Tulare	$1,873,310.25	-	-
Ventura	$1,217,291.46	-	$4,336.00
Yuba	-	-	-
Total	**$28,501,163.09**	**$894,791.00**	**$587,534.00**

Domain 3

There were no payments issued during this quarter as Domain 3 annual payments are made annually in June. The Domain 3 payment for this year was reported in the previous report – 1115 Waiver DY 14 Annual Report, although the payment was issued at the beginning of this quarter.

Outreach Efforts

Domain 2

DHCS has continued to engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation through the various workgroups and sub-groups that meet throughout the reporting period. D2 outreach was conducted in 21 of the 29 counties. DHCS has continued to direct our ASO vendor to take the opportunity during their standard operational outreach activities to engage with providers rendering services in Domain 2 counties. DHCS also continues to respond to provider inquiries via the DTI Inbox.

Domain 3

In this quarter, the ASO's outreach team visited 23 of the 36 pilot counties (Fresno, Madera, Merced, Modoc, Monterey, Nevada, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Stanislaus, Tehama, Tulare, and Ventura). Outreach efforts included increasing provider participation and promoting Domain 3 expansion in the 19 new counties. As a result, an additional 17 SNCs elected to opt-in for participation, bringing the total from 83 to 100.

Domain 4

The LDPPs have utilized the email inbox to submit invoices electronically on a quarterly basis and this inbox is also used to communicate any necessary follow-up requests for back up documentation from the LDPPs. During this quarter $9,818,135 was paid.

Throughout this reporting period, DHCS staff completed three LDPP site visits to observe the administrative and clinical initiatives as outlined in each LDPP's executed contract: September 24, 2019 (Humboldt), September 25, 2019 (San Luis Obispo), and September 27, 2019 (Fresno). DHCS visits will continue to all LDPPs through 2019.

Consumer Issues

There is nothing new to report at this time.

Financial/Budget Neutrality Development/Issues

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

Quality Assurance/Monitoring Activities

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

DHCS is currently working on an outstanding overpayments report to summarize the existing overpayments for Domain 1. The overpayments are reconciled bi-annually with each payment. Either outstanding overpayments are deducted from earned incentives or the provider will remit payment(s) to DHCS directly.

Evaluation

During DY15-Q1, Mathematica, the DTI independent evaluator, worked on finalizing the DTI Interim Evaluation report and continued to work on tasks associated with the final evaluation. Mathematica also participated in bi-monthly LDPP conference calls, DHCS-led DTI stakeholder engagements and bi-weekly conference calls with DHCS. During the next quarter, Mathematica is planning to conduct their second round of provider and stakeholder surveys. DHCS will share progress on this effort in future quarters.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of 40 implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings, and Partnership Health Plan of California, which will offer a regional model covering Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano, and Trinity Counties. As of January 18, 2018, DHCS has approved all counties' implementation plans. With the 40 submitted implementation plans, 97.54% of California's population will be covered under the DMC-ODS. As of August 2019, 30 counties began implementation of the 1115 Demonstration Waiver.

Enrollment Information:

Prior quarters have been updated based on new claims data.

Figure 18: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY14-Q2	30,593	14,809	44,879
DY14-Q3	35,805	16,886	52,048
DY14-Q4	37,178	17,219	53,748
DY15-Q1	20,669	9,760	31,156

Member Months:

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. "Current Enrollees (to date)" represents the total number of unique clients for the quarter. Prior quarters' statistics have been updated. Since counties have up to six months to submit claims after the month of service, some quarters may have only partial data available at this time.

Figure 19

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	21657	21919	23521	DY14-Q2	30,593
	25942	26003	27491	DY14-Q3	35,805
	28071	26217	25919	DY14-Q4	37,178
	16531	14718	9941	DY15-Q1	20,669
Non-ACA	11638	11708	12356	DY14-Q2	14.809
	13395	13447	13824	DY14-Q3	16,886
	13711	12923	12956	DY14-Q4	17,219
	8370	7598	5058	DY15-Q1	9,760

Outreach/Innovative Activities:

DHCS staff conducted documentation trainings for DMC-ODS. The trainings included technical assistance for county management as well as general trainings for county staff. The focus of these trainings was to address requirements for all DMC-ODS treatment services and commonly identified deficiencies. The training occurred in the following counties:

Figure 20

County	Training Dates	Training Attendees
Stanislaus County	August 27, 2019	52
Merced County	August 29, 2019	12
Sacramento County	September 9-10, 2019	45

Additional DMC-ODS activities are listed below:

- July 2, 2019 Behavioral Health Concepts Meeting
- July 16, 2019 Translating Detox into Recovery: Innovations in Opioid Treatment Webinar

- July 22, 2019 Drug Medi-Cal Phase I Program Meeting
- July 23, 2019 DHCS ODS Oversight Meeting
- August 16, 2019 Quarterly CAADPE / CADA Meeting
- August 20-22, 2019 Annual Substance Use Disorders Conference
- August 28, 2019 Monthly DMC-ODS Call
- September 4, 2019 California Rehabilitation Oversight Board (C-ROB) Meeting
- September 9, 2019 DMC-ODS STC Review Meeting
- September 9, 2019 ODS Partnership, Regional Model, Status Update Meeting IGAs
- September 10, 2019 LAO: DMC-ODS Request and Briefing
- September 20, 2019 DMC-ODS STCs Meeting
- September 25, 2019 Monthly DMC-ODS Call
- September 26, 2019 ODS Partnership, Regional Model, Status Update Meeting
- September 27, 2019 Cal AIM DMC-ODS, Medical Necessity, BHI, and Regional Contract Comment Review
- September 30, 2019 DMC-ODS Regional Model: Fiscal Methodology CPE Follow Up
- October 11, 2019: DHCS/UCLA/BHC Quarterly DMC-ODS Meeting

Operational/Policy Developments/Issues:

DHCS has worked closely with CMS and has made significant progress toward implementing the Partnership Healthplan regional model that will cover 8 northern California Counties. The planned effective date for this model will be March 1, 2020. Implementation is dependent on resolution of fiscal issues with the model, which are still under discussion with CMS.

DHCS publicly launched California Advancing and Innovating Medi-Cal (CalAIM), which is a multi-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots from the previous federal waivers and will result in better quality of life for Medi-Cal members as well as long-term cost savings/avoidance. DHCS is approaching the next waiver submission to continue the DMC-ODS program though the broader CalAIM process.

Financial/Budget Neutrality Developments/Issues:

Figure 21: Aggregate Expenditures: ACA and Non-ACA

DY14-Q2					
Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
ACA	2,095,491	$56,344,291.49	$49,425,699.33	$4,003,323.74	$2,915,268.42
Non ACA	1,199,205	$23,245,604.12	$11,730,687.13	$3,086,682.98	$8,428,234.01
DY14-Q3					
ACA	2,598,241	$66,996,003.54	$57,746,879.77	$5,412,655.94	$3,836,467.83
Non ACA	1,385,068	$26,020,490.15	$13,134,870.29	$3,049,009.00	$9,836,610.86
DY14-Q4					
ACA	2,283,312	$65,940,714.84	$56,718,043.52	$5,294,048.37	$3,928,622.95
Non ACA	1,198,901	$24,461,613.13	$12,368,161.44	$2,868,597.96	$9,224,853.73
DY15-Q1					
ACA	1,122,056	$34,512,907.90	$29,688,028.99	$2,635,681.27	$2,189,197.64
Non ACA	663,186	$13,410,292.03	$6,761,047.49	$1,389,320.15	$5,259,924.39

ACA and Non-ACA Expenditures by Level of Care

For the detail of ACA and Non-ACA expenditures by level of care, please refer to the attached Excel file, tabs “ODS Totals ACA” and “ODS Totals Non-ACA.” Beginning in DY14-Q1, a revised reporting format is being used to report expenses. A level of care is now reported on one line, rather than reported by location. For example, Case Management can be provided in Intensive Outpatient Treatment (IOT) and Outpatient (ODF) settings. Rather than report two lines for Case Management under IOT and ODF, all Case Management expenses are reported on one line.

Consumer Issues:

All counties that are actively participating in the DMC-ODS Waiver track grievances and appeals. An appeal is defined as a request for review of an action (e.g. adverse benefit determination) while a grievance is a report of dissatisfaction with anything other than an adverse benefit determination. Grievance and appeal data, reported by issue type, is as follows.

Figure 22: Grievances

Grievance	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals
Alameda	1	1	-	-	-	-	2
Contra Costa	-	-	-	-	-	2	2
El Dorado	-	-	-	-	-	-	0
Fresno	-	1	-	-	-	-	0
Imperial	-	-	-	-	-	-	0
Kern	-	1	1	-	-	-	2
Los Angeles	1	1	3	1	-	3	9
Marin	-	-	2	-	1	1	4
Merced	-	-	-	-	-	1	1
Monterey	-	-	-	-	-	-	0
Napa	-	-	-	-	-	-	0
Nevada	-	1	-	-	-	-	1
Orange	-	-	-	2	-	-	2
Placer	1	-	-	1	4	-	6
Riverside	1	6	-	-	-	3	10
Sacramento	-	1	-	-	-	-	1
San Benito	-	-	-	-	-	-	0
San Bernardino	-	5	2	-	-	-	7
San Diego	-	52	-	19	-	3	74
San Francisco	-	1	-	1	-	-	2
San Joaquin	1	3	-	-	-	7	11
San Luis Obispo	-	-	-	2	-	2	4
San Mateo	-	-	-	-	-	-	0
Santa Barbara	-	-	-	-	2	-	2
Santa Clara	1	1	2	-	1	-	5
Santa Cruz	-	1	-	-	-	-	1
Stanislaus	-	8	-	-	-	-	8
Tulare	-	-	-	-	-	-	0
Ventura	-	-	-	-	-	-	0
Yolo	-	-	-	1	-	-	1

Figure 23: Resolutions

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Transition of Care (TOC) requests	TOC Approved	TOC Denied
Alameda	1	-	-	-	-	-	-
Contra Costa	1	-	-	-	-	-	-
El Dorado	-	-	-	-	-	-	-
Fresno	3	-	-	-	-	-	-
Imperial	-	-	-	-	-	-	-
Kern	2	-	-	-	-	-	-
Los Angeles	7	-	-	-	-	-	-
Marin	2	-	-	-	-	-	-
Merced	1	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-
Orange	-	-	-	-	-	-	-
Placer	5	-	-	-	-	-	-
Riverside	9	-	-	-	-	-	-
Sacramento	-	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	-	-	-	-	-	-	-
San Diego	38	4	3	1	-	-	-
San Francisco	3	-	-	-	-	-	-
San Joaquin	11	-	-	-	-	-	-
San Luis Obispo	2	2	1	1	-	-	-
San Mateo	-	-	-	-	-	-	-
Santa Barbara	2	-	-	-	-	-	-
Santa Clara	5	1	1	-	-	-	-
Santa Cruz	2	6	4	2	-	-	-
Stanislaus	10	2	2	-	1	-	-
Tulare	-	-	-	-	-	-	-
Ventura	-	-	-	-	-	-	-
Yolo	1	-	-	-	-	-	-

An appeal is defined as a review of a beneficiary adverse benefit determination.

A grievance is defined as a report of beneficiary dissatisfaction with any matter other than an adverse benefit determination. Grievances are reported by type of dissatisfaction.

Quality Assurance/Monitoring Activities:

DHCS has assigned an analyst to work with San Diego County to determine why the number of grievances continues to be high. DHCS will provide technical assistance as needed.

Evaluation:

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

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

UCLA's approved evaluation plan is available online at: http://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

UCLA continues to hold monthly conference calls with updates, activities, and meetings. The evaluation reports, design and surveys are posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/dmc-ods-eval/html/reports-presentations.html

During this reporting period UCLA conducted the following activities:

Treatment Perceptions Survey (TPS):

- The Treatment Perceptions Survey (TPS) is used to measure client satisfaction under the DMC-ODS waiver. As part of the waiver evaluation, counties are required to have their network of providers administer the TPS. UCLA completed the preparation of county-level and program-level TPS surveys for the October 2019 survey period, and updated resource materials on the TPS website (e.g. frequently asked questions and answers, checklist for county administrators/providers).

County Administrator Survey:

- UCLA conducts a survey of county SUD program administrators on an annual basis to obtain information and insights from all SUD administrators in the state.

Secret Shopper:

- UCLA conducts secret shopper calls to evaluate access to counties' beneficiary access lines. The purpose of these calls are to verify that the requirement of having a phone number available to beneficiaries is being met by counties that have started providing DMC-ODS services. UCLA continued to conduct secret shopper calls and provide feedback to counties.

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP

Designated State Health Program

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

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

Figure 24

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July-Sept)	$0	$0		$0
Total	$0	$0		$0

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

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) assists 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 receive GPP payments that are 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 is 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 Disproportionate Share Hospital (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:

Figure 25

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 3 (July – June) Overpayment collection	($6,911,530.00)	($6,911,530.00)	DY 13	($13,823,060.00)
PY 3 Final Rec. (July – June)	$78,411,655.00	$78,411,655.00	DY 13	$156,823,310.00
PY 4 IQ4 (Apr – June) Overpayment collection	($2,485,336.00)	($2,485,336.00)	DY 14	($4,970,672.00)
Total	$69,014,789.00	$69,014,789.00		$138,029,578.00

DY 15 Q1 reporting includes a GPP payment made on August 9, 2019. The payment made during this time period was for Program Year (PY) 3, Final Reconciliation (July 1, 2017 – June 30, 2018). The PHCSs received $78,411,655.00 in federal fund payments and $78,411,655.00 in IGT for GPP. DHCS also recouped $13,823,060.00 in total funds for PY 3. The recoupment process is a result of four PHCSs that submitted final year-end reports with revisions to the interim report. Figure 26 below shows the PHCS PY 3 Interim and Final reporting differences.

Figure 26: PHCS PY 3 Interim and Final Reporting Differences

Public Health Care System	Interim Report % of threshold met	Final Report % of threshold met
Alameda Health System	100%	99%
San Mateo Medical Center	99%	98%
Santa Clara Valley Medical Center	94%	91%
Ventura County Medical Center	63%	62%

The four PHCSs received interim quarterly GPP payments based on their percent of threshold met as reported in the interim report. Their final report indicates a decrease in percent of threshold met. The payments previously received by the PHCS exceeded the amounts earned as reported in the final report. DHCS adjusted the payments previously made to the PHCSs for GPP PY 3 and recouped the difference in the amount of $13,823,060.00. The final year-end report served as the basis for the final reconciliation of GPP payments and recoupments for GPP PY 3.

DHCS recouped the $4,970,672.00 in total funds from Ventura County Medical Center (VCMC). The recoupment was due to overpayment to VCMC. In PY 4, IQ 1-3 (July 1, 2018 – March 31, 2019), VCMC was paid 75% of its total annual budget. On August 15, 2019, VCMC submitted an interim year-end summary aggregate report. The

threshold points earned for VCMC was 7,078,031 GPP Points, or 70.55% of GPP thresholds. The 70.55% is less than 75% of its total annual budget. DHCS adjusted the payments previously made to VCMC for GPP PY 4 and recouped the difference in the amount of $4,970,672.00 in total funds from VCMC.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

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

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

The PRIME Program aims to:

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

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

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

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

Projects in Domain 3 – Resource Utilization Efficiency will reduce unwarranted variation

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

In DY15-Q1, DHCS hosted two webinars on the topic of telehealth. The first webinar was a basic introduction to telehealth and the second webinar explained how PRIME entities are using telehealth to meet PRIME goals. Medi-Cal providers are now using both synchronous and asynchronous telehealth modalities to improve patients' access to care and provider workflow, helping to achieve PRIME metrics. This webinar provided DPH and DMPHs examples of how telehealth can be used to increase patients' specialty touches, reduce wait times, enhance the care team experience, and improve providers' efforts to close the loop in communications.

In DY15-Q1, DHCS also continued 2019 PRIMEd topic-specific learning collaborative (TLC) activities in the form of web-based meetings, Power Point presentations, and webinars. The TLC groups covered meeting topics such as:

- Social determinants of health and how addressing them can help improve health disparities
- Resilience and mindfulness to improve health comes and overcome adverse childhood experiences
- The impact of the opioid epidemic on the foster care population including neonatal abstinence syndrome and tips and for providing compassionate care to birth mothers struggling with addiction
- Behavioral health screenings and follow-up
- Suicide prevention risk assessment tools and resources for clinicians
- Challenges and strategies around improving pregnant women’s receipt of prenatal care
- Efforts to improve care transition communications and improve performance on the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey metrics in PRIME

Operational/Policy Developments/Issues:

DHCS received 9 plan modification proposals from DMPHs seeking to add projects for their final DY of PRIME activities. Of these, 7 DMPHs were approved for adding one PRIME project and one DMPH was approved to add two PRIME projects. Approvals were based on the information provided to DHCS in the plan modification and entities' demonstrated success in existing PRIME projects and metrics. DHCS denied one DMPH's proposal because the entity could not demonstrate consistent progress in meeting PRIME gap closure goals for existing PRIME metrics. Entities were notified of their plan modification approval or denial via email in early August 2019.

As mentioned in the Annual Report, the administrative process of calculating and distributing the funds in the DY13 High Performance Pool proved to be very burdensome. Payment of these funds was not completed until DY15-Q1. Because it was a shared pool of funds, all DY13 YE reports had to be completely closed out, with all reporting and clinical review questions sufficiently addressed, and some entities needed assistance identifying their High Performing Metrics. DHCS provided technical assistance with respect to these issues and worked with entities to finalize their unearned funds claims. Claims to the shared pool of funds were prorated based on the funds available. DHCS made changes to the claiming form in an effort to have a smoother process for the DY14 High Performance Pool.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Figure 27

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$96,999,522.24	$96,999,522.07	DY 12/13/14	$193,999,044.31
Total	$96,999,522.24	$96,999,522.07		$193,999,044.31

In DY15 Q1, One DPH and four DMPHs received payments.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$96,999,522.24** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

In DY15-Q1, of the 52 PRIME entities, 46 submitted their DY14 Year End reports to DHCS on or before September 30, 2019. There were six PRIME entities that requested a reporting extension into DY15-Q2, two DPHs and four DMPHs.

Evaluations:

DHCS delivered the draft PRIME Interim Evaluation to CMS on September 27, 2019, and is awaiting CMS feedback.

As mentioned in the DY14 Annual Report, there were data referred to in the CMS-approved evaluation design that UCLA was unable to obtain. The evaluation was limited by managed care assignment data availability and therefore did not include the second Prime Eligible Population (PEP) criteria, “Individuals of all ages who are in Medi-Cal Managed Care with 12 months of continuous assignment to the PRIME Entity during the Measurement Period” for any data analyses. The evaluators did not have access to this data because DHCS does not have access to which hospitals Medi-Cal beneficiaries are assigned by managed care plans. The managed care health plan is responsible for assignment to the hospital and this data is not merged back into the Medi-Cal claims or enrollment databases. As such, Managed Care enrollees were included in UCLA’s analysis if they met PEP 1 criteria, but not included if they only met PEP 2 criteria.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
July 2019 – September 2019

Figure 28

County	Total Member Months
Alameda	54,277
Contra Costa	33,677
Fresno	46,789
Kern	38,123
Kings	5,222
Los Angeles	353,231
Madera	4,584
Riverside	70,098
Sacramento	69,726
San Bernardino	75,750
San Diego	76,618
San Francisco	27,046
San Joaquin	32,107
Santa Clara	43,011
Stanislaus	22,815
Tulare	20,699
Total	**973,773**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2019 – September 2019

Figure 29

County	Total Member Months
Alameda	65,665
Contra Costa	30,968
Fresno	41,039
Kern	28,072
Kings	4,197
Los Angeles	1,045,931
Madera	4,231
Marin	19,278
Mendocino	17,930
Merced	48,996
Monterey	49,778
Napa	14,874
Orange	334,366
Riverside	117,336
Sacramento	65,676
San Bernardino	113,522
San Diego	193,617
San Francisco	43,756
San Joaquin	28,395
San Luis Obispo	25,083
San Mateo	42,635
Santa Barbara	46,771
Santa Clara	124,839
Santa Cruz	31,935
Solano	61,044
Sonoma	53,496
Stanislaus	16,672
Tulare	18,999
Ventura	87,388
Yolo	26,269
Total	**2,802,758**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
July 2019 – September 2019

Figure 30

County	Total Member Months
Alpine	57
Amador	1,097
Butte	19,067
Calaveras	1,756
Colusa	848
El Dorado	5,206
Glenn	1,667
Imperial	10,711
Inyo	535
Mariposa	679
Mono	183
Nevada	3,177
Placer	9,833
Plumas	1,085
San Benito	290
Sierra	110
Sutter	5,975
Tehama	5,344
Tuolumne	2,654
Yuba	6,396
Total	**76,670**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
July 2019 – September 2019

Figure 31

County	Total Member Months
Del Norte	8,210
Humboldt	26,539
Lake	19,798
Lassen	4,369
Modoc	2,137
Shasta	40,834
Siskiyou	11,194
Trinity	2,800
Total	**115,881**

WHOLE PERSON CARE

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

The local WPC pilots identify high-risk, high-utilizing target populations, share data between systems, provide comprehensive care in a patient-centered manner, coordinate care in real time, and evaluate individual and population health progress. WPC pilots may also choose to focus on homelessness and expanding access to supportive housing options for these high-risk populations.

Organizations that are eligible to serve as lead entities (LEs) develop and locally operate the WPC pilots. LEs must be a county, a city, a city and county, a health or hospital authority, a designated public hospital or a district/municipal public hospital, a federally recognized tribe, a tribal health program operated under contract with the federal Indian Health Services, or a consortium of any of these entities.

WPC pilot payments support infrastructure to integrate services among LEs and may support the provision of services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population. These services may include housing components or other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Eighteen LEs began implementing and enrolling WPC members on January 1, 2017. In addition, after approval of the initial WPC pilots, DHCS accepted a second round of applications. DHCS approved fifteen WPC pilot applications in the second round. The second round LEs began implementation on July 1, 2017.

In total, there are 25 LEs operating a WPC pilot.

- Ten LEs are from the initial eighteen LEs. These LEs continue to implement their originally approved pilots that began implementation and enrollment on January 1, 2017.
- Eight LEs are also part of the initial eighteen LEs. These eight reapplied during the second round and were approved to expand their existing pilots. These eight LEs continue to implement their originally approved pilots that began implementation and enrollment on January 1, 2017 as well as new aspects that were approved during the second round that began implementation and enrollment on July 1, 2017.
- Seven new LEs applied and were approved in the second round and began implementation and enrollment on July 1, 2017.

Enrollment Information:
The data reported below in Figure 32 reflects the most current data available, including updated data files submitted by LEs after the publishing date of the prior quarterly

report. Enrollment data is updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly enrollment counts are the cumulative number of unique new members enrolled for the reported quarter. The total-to-date column includes all previously submitted data, beginning with Demonstration Year (DY) 12, as well as DY 14-Q4 (April - June) data. Due to a delay in availability of data, DY 15-Q1 data will be reported in the next report. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (QEU) reports. The DY 14-Q4 data reported is point-in-time as of September 30, 2019.

Figure 32

Lead Entity	DY 14-Q1 (July - Sept. 2018) Unduplicated	DY 14-Q2 (Oct. – Dec. 2018) Unduplicated	DY 14-Q3 (Jan. - March 2019) Unduplicated	DY 14-Q4 (April - June 2019) Unduplicated	Jan. 2017 – June 2019 Total-to-Date Unduplicated
Alameda	764	4,370	720	527	10,208
Contra Costa	2,272	3,701	2,220	2,962	36,097
Kern	62	319	224	296	1,094
Kings*	53	78	66	96	410
LA***	4,111	3,544	5,725	4,970	40,836
Marin*	30	652	263	246	1,248
Mendocino*	50	16	22	4	287
Monterey	2	1	39	48	183
Napa	41	44	49	47	376
Orange	1,045	800	1,105	783	9,252
Placer	37	7	17	31	320
Riverside	954	1,391	675	664	4,460
Sacramento*	251	173	236	214	1,352
San Bernardino	95	62	73	106	885
San Diego	77	73	37	103	383
San Francisco	1,321	1,145	948	1,130	15,167
San Joaquin	55	463	135	228	1,196
San Mateo	107	53	189	86	3,371
Santa Clara	134	243	313	655	3,771
Santa Cruz*	15	31	29	14	448
SCWPCC*	18	15	8	14	96
Shasta	37	22	28	33	297
Solano	14	12	14	7	176
Sonoma*	101	290	485	289	1,379
Ventura	120	95	50	28	1,126
Total**	**11,766**	**17,600**	**13,670**	**13,581**	**134,418**

** Indicates one of seven LEs that implemented on July 1, 2017.*

*** Due to a delay in the availability of data, DY 15-Q1 data will be reported in the next quarterly report.*
**** As discussed previously, DHCS engaged in conversations with LA's WPC pilot and LA reports growth starting in July 2019. The next report will reflect that growth.*

Member Months:

The data reported below in Figure 33 reflects the most current data available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months are updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly and cumulative total-to-date member months are reflected in the table below. The cumulative total-to-date column includes all previously submitted data, beginning with DY 12, as well as DY 14-Q4 (April-June) data. Due to a delay in availability of data, DY 15-Q1 data will be reported in the next report. Member months are extracted from the LE's self-reported QEU reports. The DY 14-Q4 data reported is point-in-time as of September 30, 2019.

Figure 33

Lead Entity	DY 14-Q1 (July - Sept. 2018)	DY 14-Q2 (Oct. - Dec 2018)	DY 14-Q3 (Jan. - March 2019)	DY 14-Q4 (April - June 2019)	Jan. 2017 – June 2019 Cumulative Total-to-Date
Alameda	11,430	16,933	25,553	25,990	106,783
Contra Costa	44,838	43,938	40,709	39,976	358,434
Kern	634	1,243	2,023	2,914	7,838
Kings*	273	354	424	504	1,963
LA***	32,510	34,735	41,511	44,200	272,780
Marin*	197	1,593	2,678	3,360	8,127
Mendocino*	616	571	512	431	2,900
Monterey	188	172	232	323	1,557
Napa	486	491	546	544	3,291
Orange	10,776	10,887	11,600	11,055	78,488
Placer	400	352	301	312	2,925
Riverside	2,087	3,324	8,470	10,158	25,592
Sacramento *	1,427	1,790	1,990	2,141	9,810
San Bernardino	1,603	1,550	1,542	1,569	10,250
San Diego	426	645	602	698	2,588
San Francisco	23,646	25,542	12,697	18,740	186,943

Lead Entity	DY 14-Q1 (July - Sept. 2018)	DY 14-Q2 (Oct. - Dec 2018)	DY 14-Q3 (Jan. - March 2019)	DY 14-Q4 (April - June 2019)	Jan. 2017 – June 2019 Cumulative Total-to-Date
San Joaquin	783	2,027	2,210	2,673	9,521
San Mateo[14]	6,455	6,456	6,713	6,611	63,090
Santa Clara	6,812	7,282	8,893	10,526	61,972
Santa Cruz*	984	1,034	1,137	1,105	6,999
SCWPCC*	87	118	136	151	632
Shasta	249	231	255	230	1,703
Solano	276	267	277	260	2,083
Sonoma*	252	486	1,512	1,642	4,147
Ventura	2,490	2,725	2,543	1,980	14,968
Total**	**149,925**	**164,746**	**175,066**	**188,093**	**1,245,384**

**Indicates one of seven LEs that implemented on July 1, 2017.*
*** Due to a delay in the availability of data, DY 15-Q1 data will be reported in the next quarterly report.*
**** As discussed previously, DHCS engaged in conversations with LA's WPC pilot and LA reports growth starting in July 2019. The next report will reflect that growth.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

During this quarter, DHCS, along with the WPC Learning Collaborative (LC), communicated with the LEs through surveys, phone calls, and emails to understand the issues that are of most interest and concern to guide DHCS technical assistance (TA) and LC content. The LC structure includes a variety of learning activities, such as in-person convenings, webinars, teleconferences, and access to a resource portal as a means to address the topics and questions from LEs.

On July 3 and August 7, 2019, DHCS held teleconferences with LEs focused on administrative topics and TA. LEs were allowed to ask questions about DHCS' guidance and various contract issues such as reporting deliverables, timelines, budget adjustments, sustainability, closeout, and DHCS expectations. The calls included the availability of state funding for WPC one-time housing projects for enrollees who are mentally ill and are experiencing homelessness, or who are at risk of homelessness.

[14] San Mateo has reached and continues to maintain the enrollment target.

The LC advisory board met on August 15, 2019, and focused on developing the agenda and providing speaker recommendations for the September 10, 2019, WPC LC convening.

On September 10, 2019, DHCS held the WPC bi-annual in-person convening in Sacramento, California, in collaboration with LC consultants. Attendees included 160 representatives from all twenty-five LEs, California Association of Public Hospitals/ Safety Net Institute, California HealthCare Foundation, and the University of California, at Los Angeles (UCLA). The theme of the convening was *sustainability* and the agenda provided attendees with the opportunity to hear from DHCS, fellow pilots, and subject matter experts about different strategies LEs can use to sustain WPC services post-2020. The agenda included the following subjects: *A Vision for Medi-Cal Beyond 2020, Considerations for Sustaining WPC Services,* and *Understanding New Resources to Support Efforts to End Homelessness in California*. Additionally, the convening included time for LEs to network and discuss challenges and opportunities.

On September 19, 2019, the LC advisory board met and provided feedback from the WPC convening on September 10, 2019, including the suggestion that the LC provide TA on the state's new Medi-Cal initiative entitled California Advancing and Innovating Medi-Cal (CalAIM).

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

During this quarter, no WPC payments were made. This is in accordance with the WPC payment schedule. Program Year (PY) 4 mid-year invoices were due August 31, 2019, and payments are scheduled for October 2019.

Quality Assurance/Monitoring Activities:

During the first DY 15 quarter, LEs submitted the reports listed below:

- Second quarter (April-June) PY 4 QEU; (7/31/19)
- PY 4 Mid-year Narrative and Plan Do Study Act (8/30/19)

Accurate reporting is fundamental to the success of WPC. These reports are tools for LEs and DHCS to assess the degree to which the LEs are achieving their goals. In addition, metric tracking informs decisions on appropriate changes by LEs and DHCS, when necessary, to improve the performance of WPC pilots. DHCS also uses these reports to monitor and evaluate the WPC pilot programs and to verify invoice payments for payment purposes.

Evaluation

The WPC evaluation report, required pursuant to Special Terms and Conditions 127 of the California Medi-Cal 2020 Demonstration Waiver, will assess if: 1) the LEs successfully implemented their planned strategies and improved care delivery, 2) these strategies resulted in better care and better health, and 3) better care and health resulted in lower costs through reductions in utilization.

The midpoint report, due to CMS in 2019, will include an assessment of population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, although only preliminary outcome data will be available. The final report, due to CMS in 2021, will provide the complete assessment of care and outcome improvements, including an assessment of the impact of the various packages of interventions on specific target populations. The final report will also include assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

During the first quarter, UCLA, DHCS' independent evaluator:

- Further refined the propensity score model and an optimal matching algorithm based on exact and rank-based distance matching to develop a control group. UCLA applied the developed methodology to identify a final control group for all WPC enrollees through 2018.

- Constructed metrics with Medi-Cal data to model these outcomes in the time periods before and after WPC enrollment. The difference in the pre and post period was compared with the same difference among the control group using difference-in-difference methodologies.

- Developed a database of services based on the LE's WPC Per-Member Per-Month and Fee for Service categories.

- Compiled self-reported data from WPC LE reports, including baseline reporting through annual PY 3 reporting. UCLA summarized and analyzed these findings overall and by pilot. Additionally, UCLA performed sub-analyses examining rates by pilots that selected specific target populations, and by pilots with or without pay for outcome incentives.

- Wrote and submitted the draft WPC interim evaluation report for DHCS review on September 30, 2019.