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

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February 28, 2020

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QUARTERLY PROGRESS REPORT FOR THE PERIOD OCTOBER 1, 2019, THROUGH DECEMBER 31, 2019, OF CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION

Dear Ms. Garner, Ms. Ross, and Mr. Scott:

Enclosed is the Quarterly Progress Report as required by Special Terms and Conditions Paragraph 27 and Attachment I of California's Section 1115 Waiver, entitled *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the second quarterly progress report for Demonstration Year Fifteen, which covers the period from October 1, 2019, through December 31, 2019.

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If you or your staff have any questions or need additional information regarding this report, please contact Anastasia Dodson by phone at (916) 440-7414, or by email at Anastasia.Dodson@dhcs.ca.gov.

Sincerely,

[redacted]

Chief Deputy Director
Health Care Programs
State Medicaid Director

Enclosures: Medi-Cal 2020 DY15-Q2 Progress Report
DY15-Q2 DMC-ODS Expenditures

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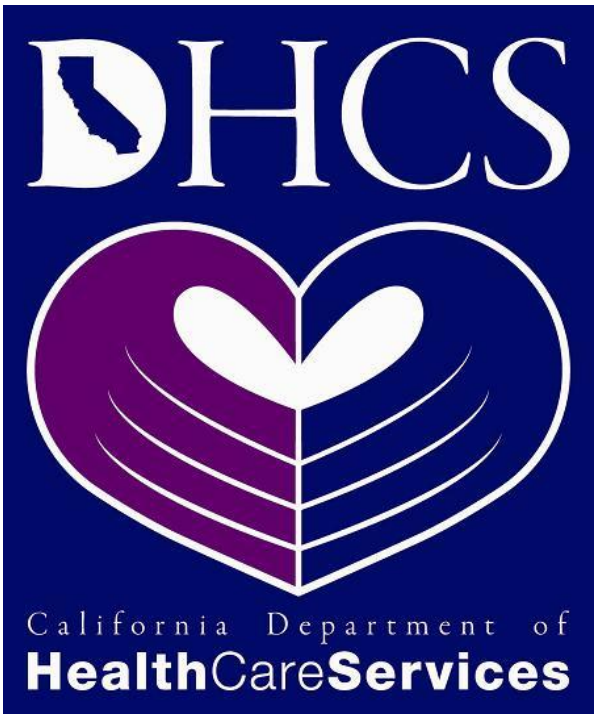
CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)



Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fifteen (07/01/2019 – 06/30/2020)
Second Quarter Reporting Period: 10/01/2019 – 12/31/2019

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 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-Q2, DHCS hosted a SAC meeting on October 29, 2019. DHCS discussed follow-up items from previous meetings, the Comprehensive Quality Strategy Report, and CalAIM (Currently known as Medi-Cal Healthier California for All).

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/SAC_Agenda_102919.pdf.
The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/SAC-OCT2019.pdf.

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on October 21, 2019, and November 18, 2019, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following topics were discussed: Whole Person Care Program Updates, Health Homes Program Updates, Financial Reporting, and the Global Payment Program Evaluation Comments received by CMS.

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 Medicare and Medicaid 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. The final report was published on DHCS' website on October 10, 2019.[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:

- DHCS submitted the final report to CMS on October 8, 2019;
- CMS confirmed receipt on October 10, 2019 and did not have any questions or concerns regarding the report.

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[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 Table 1 below. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Table 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
19-Oct	351	$2,733.54	$959,472.54
19-Nov	351	$2,733.54	$959,472.54
19-Dec	348	$2,733.54	$951,271.92
Total			$14,088,665.16

Table 2: RCHSD Monthly Enrollment

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	351	351	348	2	1,050

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 January 2020, RCHSD submitted their CCS Quarterly Grievance Report for reporting period October – December 2019. During the reporting period, RCHSD did not receive any member grievances.

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 is currently running 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 since completed qualitative interviews with families of CCS pilot patients. UCSF has used the qualitative data obtained in the interviews to develop a telephone survey instrument for parents of CCS children in both Fee-for-Service and CCS pilot transition counties which will commence in April 2020. DHCS has received a six-month extension to submit the CCS Pilots Interim Report to Centers for Medicare & Medicaid Services (CMS) and the Interim Report is now due to CMS on June 30, 2020.

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. However, due to unexpected delays in the availability of data, DHCS will report CBAS MCP data for DY15-Q2 in the next quarterly report.

[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.

Table 3: 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								

**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 Table 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.

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 77 percent, 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.

Table 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.

Table 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-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%)
DY15-Q2 (10/01-12/31/2020)	*	*	*	3	3 (100%)	0 (0%)
5% Negative change between last Quarter		*	*		No	No

**MCP assessment information is not reported for DY15-Q2 due to a delay in the availability of the data.*

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. Assessment data for MCPs for DY15 Q2 will be reported in the next quarterly report due to a delay in the availability of the data. For DY15 Q2, the table identifies that three participants were assessed for CBAS benefits under FFS, with all three 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.

Table 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-Q2. The ADA at the 260 operating CBAS Centers is approximately 23,680 participants, which corresponds to 68 percent Statewide Average Daily Attendance (ADA) per center. A slight decrease in statewide ADA was seen compared

to the previous quarter. Additionally, one new CBAS Center opened during DY15-Q2 that resulted in an overall increase in total statewide license capacity at 34,833.

Table 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	260
Non-Profit Centers	55
For-Profit Centers	205
ADA @ 260 Centers	23,680
Total Licensed Capacity	34,833
Statewide ADA per Center	68%
	CDA - MSSR Data 12/2019

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 (October 8, 2019 and December 13, 2019) and three ACLs (October 1, 2019, October 4, 2019, and November 8, 2019) which included updates on the following topics: (1) CBAS training requirements, (2) CBAS Participation Agreement instructions, (3) provider reimbursement related to California's 2019 Budget Act, (4) provider screening and Medi-Cal enrollment requirements, and (5) upcoming education and training opportunities such as the California Association for Adult Day Services (CAADS) 2020 Fall Conference. In addition, at the CAADS 2020 Fall Conference, CDA presented a workshop 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 December 11, 2019. CDA provided MCPs with an update and requested feedback on the following: (1) CBAS center applications, (2) CBAS Quality Assurance & Improvement Strategy activities including setting standards for person-centered care and multi-disciplinary team (MDT) practices, and (3) CURES Act requirements specific to screening, enrollment, credentialing, and re-credentialing of MCPs' provider

networks.

CDA convenes triannual 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. No calls were scheduled during this reporting period.

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-Q2. The primary operational and policy development issues during this quarter were the following: (1) CURES Act implementation and impact on CBAS centers and their staff/subcontractors, (2) provider reimbursement related to the California 2019 Budget Act – Proposition 56, and (3) CBAS center compliance with the federal Home and Community-Based Settings requirements.

<u>CURES Act</u>

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, credentialing, and re-credentialing of their provider networks which will impact CBAS centers and their staff/subcontractors.

<u>Proposition 56 – Supplemental Funds</u>

The California State Budget for 2019-2020, signed by the Governor on June 27, 2019, included $13.7 million from the California Healthcare, Research, and Prevention Tax Act of 2016 (Proposition 56) funding for supplemental payments to CBAS providers through December 31, 2021. DHCS and CDA worked collaboratively to develop the structure for the supplemental payments.

<u>Home and Community-Based (HCB) Settings and Person-Centered Planning Requirements</u>

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-Q2, as illustrated in Table 6, titled *Data on CBAS Complaints*. Table 7, titled *Data on CBAS Managed Care Plan Complaints* shows that MCPs received eight beneficiary complaints and zero provider complaints in DY15-Q1

As indicated in the prior report, total complaints, as reported by MCPs, decreased during the last quarter. MCP complaint information for DY15-Q2 will be presented in the next quarterly report due to a delay in the availability of data.

Table 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
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
DY15-Q2 (Oct 1 – Dec 31)	0	0	0
CDA Data - Complaints 12/2019			

Table 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			

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

Grievance and appeals data is provided to DHCS by the MCPs. According to Table 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." MCP grievance information for DY15 Q2 will be presented in the next quarterly report due to a delay in the availability of data.

Table 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					

MCP appeals information for DY15 Q2 will be presented in the next quarterly report due to a delay in the availability of data.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY15-Q2 (October 2019 to December 2019), there was one request for a fair hearing in Los Angeles County due to a delay/denial of CBAS services. This request for a fair hearing was granted.

Table 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. Table 10, titled *CBAS Centers Licensed Capacity*, indicates the number of each county's total licensed capacity since

DY14-Q3. Overall utilization of licensed capacity by CBAS participants for DY15 Q2 will be presented in the next quarterly report due to a delay in the availability of data. Quality Assurance/Monitoring Activity reflects data through October 2019 to December 2019.

Table 10: CBAS Centers Licensed Capacity

County	DY14-Q3 Jan-Mar 2019	DY14-Q4 Apr-Jun 2019	DY15-Q1 Jul-Sep 2019	DY15-Q2 Oct-Dec 2019	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	**390**	0%	*
Butte	60	60	60	**60**	0%	*
Contra Costa	190	190	220	**220**	0%	*
Fresno	772	822	822	**822**	0%	*
Humboldt	229	229	229	**229**	0%	*
Imperial	355	355	355	**355**	0%	*
Kern	200	400	400	**400**	0%	*
Los Angeles	20,026	20,578	21,492	**21,522**	+0.1%	*
Merced	109	109	109	**109**	0%	*
Monterey	110	110	110	**110**	0%	*
Orange	2,638	2,638	2,638	**2,638**	0%	*
Riverside	760	760	720	**920**	+27.8%	*
Sacramento	609	609	609	**609**	0%	*
San Bernardino	440	440	590	**590**	0%	*
San Diego	2,233	2,233	2,233	**2,233**	0%	*
San Francisco	926	926	926	**926**	0%	*
San Mateo	135	135	135	**135**	0%	*
Santa Barbara	60	100	100	**100**	0%	**
Santa Clara	850	780	780	**780**	0%	*
Santa Cruz	90	90	90	**90**	0%	*
Shasta	85	85	85	**85**	0%	**
Ventura	851	851	851	**851**	0%	*
Yolo	224	224	224	**224**	0%	*
Marin, Napa, Solano	295	295	295	**295**	0%	*
SUM	32,637	33,409	34,463	**34,693**	+0.7%	*
CDA Licensed Capacity as of 12/2019						

**Capacity used information is not available for DY15-Q2 due to a delay in the availability of the data.*
***Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and*

Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.

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.TC 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. As demonstrated in the table titled *CBAS Centers Licensed Capacity*, no counties experienced a negative change in total capacity. Both Riverside and Los Angeles Counties experienced increases in total provider capacity per County. The significant increase in provider capacity in Riverside County is due to the opening of a new CBAS center, while the slight increase in Los Angeles County is likely due to a change in ownership or an increase of licensing capacity of a single CBAS center.

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-Q2 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. Table 11, titled *CBAS Center History*, shows the history of openings and closings of the centers. According to the Table below, for DY15-Q2 (October 2019 to December 2019), CDA currently has 260 CBAS Center providers operating in California. In DY15-Q2, zero centers closed, and one center opened in Riverside County. Table 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.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
December 2019	260	0	0	0	260
November 2019	260	0	0	0	260
October 2019	259	0	1	1	260
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

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 in 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.

Medi-Cal beneficiaries are enrolled in one of the two dental delivery systems: Fee-for-Service (FFS) and Dental Managed Care (DMC). DMC plans are only in Sacramento and Los Angeles counties. The Geographic Managed Care (GMC) plans are mandatory in Sacramento. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, DMC and SNC can participate in DTI.

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

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- December 31, 2020)

Overview of Domains

Domain 1 – Increase Preventive Services for Ages 20 and under[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 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

[3] DTI Domain 1
[4] DTI Domain 2
[5] DTI Domain 3

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.

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

Table 12: Statewide Beneficiaries Ages 1-20 with Three Months Continuous Enrollment and Preventive Dental Service Utilization[7]

Measure Period	10/2018-09/2019	11/2018-10/2019	12/2018-11/2019	01/2019-12/2019
Denominator[8]	5,381,140	5,372,358	5,352,848	5,345,683
Numerator[9]	2,523,426	2,526,792	2,513,727	N/A[10]
Preventive Dental Service Utilization	46.89%	47.03%	46.96%	N/A[8]

[6] DTI Domain 4
[7] Data Source: DHCS Data Warehouse MIS/DSS Dental Dashboard January 2020. 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.

Table 13: State Fiscal Year 2019-2020 Statewide Active Service Offices, Rendering Providers, and SNCs[11]

Delivery System and Plan[12] Delivery	Provider Type	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019
FFS	Service Offices	5,848	5,869	5,877	5,909	5,919	5,921
FFS	Rendering	10,829	10,923	10,992	11,077	11,149	11,207
GMC	Service Offices	127	128	149	125	135	136
GMC	Rendering	283	284	287	264	273	285
PHP	Service Offices	925	922	922	916	916	915
PHP	Rendering	1,613	1,598	1,614	1,539	1,581	1,546
Both FFS and DMC	Safety Net Clinics	575	582	576	566	567	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 had one meeting scheduled on November 21, 2019, but was repurposed to focus on stakeholder education and feedback regarding the dental proposals included in the Medi-Cal Healthier California for All initiative. The next DTI Small Workgroup meeting will resume on January 16, 2020.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities, discuss ways to encourage providers who are eligible, to participate in the domain, and to

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[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 January 2020. 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.

provide an open forum for questions and answers specific to this domain. The group meets quarterly as needed. The subgroup did not meet this quarter, but email updates were shared on October 31, 2019. The update consisted of payments made per service delivery system and the total counts of providers.

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. The subgroup did not meet this quarter.

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, the October teleconference was rescheduled to November 4, 2019 to include discussions regarding the Medi-Cal Healthier California for All dental proposals that were released on October 29, 2019. In addition, an email update was sent December 18, 2019, in lieu of the regular bi-monthly teleconference.

DTI Webpage

This quarter's webpage posting included the DTI Interim Evaluation Report. DHCS submitted DTI PY 3 Annual Report to CMS in late December 2019 and was published on February 6, 2020.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY15-Q2. In this quarter,

there were 155 inquiries in the DTI inbox for domains 1, 2 and 3. Most inquiries during this reporting period included, but were not limited to, the following categories: county expansion, encounter data submissions, opt-in form submissions, payment status and calculations, resource documents, and Domain 2 billing and opt-in questions.

Number of DTI Inbox Inquiries by Domain:

Domain	Inquiries
1	70
2	71
3	14
Total	**155**

In a separate LDPP inbox for Domain 4, participants submitted 155 inquiries this quarter, with questions related to budget revisions, asset tagging, site visits, and reimbursement.

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:

- October 17, 2019: LA Dental Stakeholder Meeting (agenda)
- October 18, 2019: Tribal and Indian Health Program Designee Follow Up Meeting (presentation)
- November 5, 2019: Child Health and Disability Prevention Program
- November 19, 2019: California Department of Public Health's Office of Oral Health Project Directors Meeting
- December 5, 2019: Medi-Cal Dental Advisory Committee Meeting
- December 12, 2019: LA Dental Stakeholder Meeting (agenda)

Operational/Policy Developments/Issues

Domain 1

Domain 1 providers are paid semiannually; once at the end of January and once at the end of July. The next payment release for 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. Table 14 below represents incentive claims, paid as of December 2019, for FFS, SNC, and DMC providers during the DY15-Q2 reporting period. During this time, a total of $19,304,017.72 incentive claims were paid to 2,654 providers who have opted into the domain.

Table 14: Incentive Claims as of December 2019

County	FFS	DMC	SNC
Contra Costa	$253,002.00	-	-
Fresno	$997,112.20	-	$ 17,528.00
Glenn	$630.00	-	-
Humboldt	-	-	-
Imperial	$13,913.00	-	-
Inyo	-	-	-
Kern	$1,084,725.12	-	-
Kings	$3,402.00	-	-
Lassen	-	-	-
Los Angeles	$5,456,373.50	$120,419.00	$752,488.00
Madera	$164,506.00	-	-
Mendocino	-	-	-
Merced	$139,362.25	-	-
Monterey	$788,667.00	-	-
Orange	$1,239,434.00	-	$ 237,074.00
Plumas	-	-	-
Riverside	$1,094,405.50	-	-
Sacramento	$155,811.50	$781,330.00	-
San Bernardino	$1,018,897.00	-	-
San Diego	$1,483,007.60	-	$134,664.00
San Joaquin	$399,454.00	$ 126.00	$18,322.00
Santa Barbara	$390,312.50	-	-
Santa Clara	$361,037.00	-	-
Sierra	-	-	-
Sonoma	$82,895.00	-	$136,746.00
Stanislaus	$582,423.00	-	-
Tulare	$691,915.05	-	-
Ventura	$616,531.50	-	$87,504.00
Yuba	-	-	-
Total	**$17,017,816.72**	**$901,875.00**	**$1,384,326.00**

Table 15, below 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-Q2

reporting period, December 2019. The total incentive claims paid for this period was $57,397,979.25.

Table 15: Incentive claims from February 2017 until December 2019

County	FFS	DMC	SNC
Contra Costa	$495,613.00	-	-
Fresno	$2,652,082.20	-	$17,528.00
Glenn	$8277.00	-	-
Humboldt	$70.00	-	$126.00
Imperial	$52,402.00	-	-
Inyo	-	-	$36,414.00
Kern	$3,697,812.12	-	-
Kings	$25,420.50	-	-
Lassen	-	-	-
Los Angeles	$15,200,300.20	$156,077.00	$965,772.00
Madera	$381,759.00	-	-
Mendocino	-	-	$503,394.00
Merced	$302,974.25	-	-
Monterey	$1,732,968.10	-	-
Orange	$3,447,921.00	-	$237,074.00
Plumas	-	-	-
Riverside	$2,532,752.25	-	-
Sacramento	$1,426,483.90	$2,986,070.00	-
San Bernardino	$2,653,180.00	$126.00	-
San Diego	$4,116,318.60	-	$243,419.00
San Joaquin	$1,024,910.00	$126.00	$18,322.00
Santa Barbara	$1,103,997.50	-	-
Santa Clara	$1,093,044.88	-	-
Sierra	-	-	-
Sonoma	$209,448.00	-	$679,020.00
Stanislaus	$1,434,878.00	-	-
Tulare	$5,827,365.29	-	-
Ventura	$1,890,952.96	-	$243,580.00
Yuba	-	-	-
Total	**$51,310,931.25**	**$3,142,399.00**	**$2,944,649.00**

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 1115 Waiver DY 14 Annual Report.

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. The ASO vendor visited 19 Domain 2 counties during this reporting period. DHCS also continued to respond to provider inquiries via the DTI Inbox.

Domain 3

In this quarter, the ASO's outreach team visited 21 of the 36 pilot counties (Butte, Contra Costa, Fresno, Kern, Madera, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Shasta, Stanislaus, Sutter, Tulare, and Ventura). Outreach efforts included offering benefits information available to Medi-Cal beneficiaries, Medi-Cal Dental training for dental office staff, and resource information. An additional 9 SNCs elected to opt-in for participation during this quarter, bringing the total from 100 to 109.

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 $7,924,609.94 was paid in total for invoices.

Throughout this reporting period, DHCS staff completed two LDPP site visits to observe the administrative and clinical initiatives as outlined in each LDPP's executed contract: November 6, 2019 (Riverside); November 7, 2019 (Orange County). DHCS visits to all LDPPs for 2019 will conclude on January 21, 2020 with Alameda County.

Consumer Issues

There is nothing new to report at this time.

Financial/Budget Neutrality Development/Issues

There are no financial or budget neutrality development issues.

Quality Assurance/Monitoring Activities

There are no quality assurance issues or monitoring activities for this quarter.

Evaluation

During DY15-Q2, Mathematica, the DTI independent evaluator, continued to work on the DTI Interim Evaluation report and other tasks associated with the final evaluation. Mathematica also participated in bi-monthly LDPP conference calls and bi-weekly conference calls with DHCS. Mathematica plans to complete their provider survey tasks in late February or early March 2020.

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. Thirty counties are currently approved to deliver DMC-ODS services, representing 94 percent of the Medi-Cal population statewide. Eight additional counties are working with Partnership Health Plan of California to implement an alternative regional model.

Enrollment Information:

Table 16: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY14-Q3	35,961	16,964	52,222
DY14-Q4	37,916	17,507	54,663
DY15-Q1	35,572	16,480	51,361
DY15-Q2	23,634	10,758	34,034

Member Months:

To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded. The term “eligible member months” refers to the number of months in which persons are eligible to receive services.

For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

Table 17

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	26059	26130	27623	DY14-Q3	35,961
	28205	28024	27869	DY14-Q4	37,916
	27199	26475	21668	DY15-Q1	35,572
	20304	15762	6131	DY15-Q2	23,634
Non-ACA	13443	13494	13869	DY14-Q3	16,964
	13778	13952	14009	DY14-Q4	17,507
	13698	13286	10348	DY15-Q1	16,480
	9695	7850	3311	DY15-Q2	10,758

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:

Table 18: Counties where DMC-ODS documentation occurred

County	Training Dates	Training Attendees
Santa Cruz	October 8-9, 2019	12
El Dorado	November 13-14, 2019	15

Additional DMC-ODS activities are listed below:

- October 1, 2019 – Partnership DMC-ODS Rates Meeting
- October 21, 2019 – Call with CMS on Waiver Update
- October 23, 2019 – Monthly DMC-ODS Calls with CMS and other Divisions
- October 25, 2019 – DMC-ODS Regional Model Overview with CMS
- November 1, 2019 – DMC-ODS Regional Model Overview Meeting
- December 2, 2019 – DMC-ODS Regional Model Overview with CMS
- December 5, 2019 – DMC-ODS Monthly TA Webinar
- December 12, 2019 – DMC-ODS STC Planning
- December 16, 2019 – DMC-ODS Proposal Meeting
- Miscellaneous Behavioral Health Workgroups Meetings

Operational/Policy Developments/Issues:

DHCS has increased monitoring and policy guidance by hosting monthly all-county technical assistance and training conference calls and individual county calls to deliver general and individualized technical assistance counties. In addition, DHCS is hosting bi-weekly calls with regional model counties and Partnership Healthplan of California to support implementation of the regional model.

DHCS formally released the Medi-Cal Healthier California for All proposal on October 29, 2019. A Behavioral Health workgroup was established to provide input on the proposal to integrate county-level mental health and substance use disorder programs under a single contract. Workgroup meetings were held:

- Friday, November 8, 2019
- Friday, December 13, 2019
- Friday December 20, 2019

Financial/Budget Neutrality Developments/Issues:

Table 19: Aggregate Expenditures: ACA and Non-ACA

DY14-Q3					
Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
ACA	2,607,615	$67,346,022.53	$58,024,356.11	$5,465,502.21	$3,856,164.21
Non ACA	1,390,127	$26,184,580.81	$13,220,832.82	$3,076,514.96	$9,887,233.03
DY14-Q4					
ACA	2,402,888	$69,869,899.84	$59,998,802.20	$5,672,096.90	$4,199,000.74
Non ACA	1,273,902	$26,002,589.25	$13,148,671.18	$3,048,589.61	$9,805,328.46
DY15-Q1					
ACA	2,094,283	$65,288,431.91	$56,250,386.10	$5,050,958.16	$3,987,087.65
Non ACA	1,171,379	$24,822,619.16	$12,530,687.09	$3,039,182.76	$9,252,749.31
DY15-Q2					
ACA	1,132,166	$37,275,071.51	$32,123,594.61	$2,973,402.50	$2,178,074.40
Non ACA	646,548	$13,594,777.17	$6,785,773.91	$1,640,071.01	$5,168,932.25

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 reporting 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 is as follows:

Table 20: Grievances

Grievance	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals
Alameda	1	-	-	-	-	-	1
Contra Costa	-	1	1	-	-	-	2
El Dorado	-	1	-	1	-	-	2
Fresno	1	1	-	1	-	-	3
Imperial	1	-	-	-	-	-	1
Kern	-	4	-	-	-	3	7
Los Angeles	4	2	2	4	-	3	15
Marin	-	1	-	-	2	-	3
Merced	-	-	-	-	-	-	0
Monterey	-	-	-	-	-	-	0
Napa	-	-	-	-	-	1	1
Nevada	-	-	-	-	-	-	0
Orange	-	-	-	2	3	1	6
Placer	-	2	6	1	4	-	13
Riverside	-	2	-	-	-	-	2
Sacramento	-	-	-	-	-	-	0
San Benito	-	-	-	-	-	-	0
San Bernardino	1	7	-	-	-	2	10
San Diego	5	29	-	4	-	4	42
San Francisco	-	-	-	-	-	1	1
San Joaquin	-	-	-	-	-	1	1
San Luis Obispo	-	6	-	-	2	-	8
San Mateo	2	3	-	-	-	-	5
Santa Barbara	-	-	-	-	3	-	3
Santa Clara	-	-	1	-	-	-	1
Santa Cruz	-	1	1	-	1	-	3
Stanislaus	-	16	-	-	1	1	18
Tulare	-	-	-	-	1	-	1
Ventura	1	1	2	-	-	-	4
Yolo	1	3	-	-	-	-	4

Table 21: Resolutions

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Transition of Care (TOC) requests	TOC Approved	TOC Denied
Alameda	2	1	-	1	-	-	-
Contra Costa	3	-	-	-	-	-	-
El Dorado	1	1	1	-	-	-	-
Fresno	3	-	-	-	-	-	-
Imperial	1	-	-	-	-	-	-
Kern	3	-	-	-	-	-	-
Los Angeles	8	-	-	-	-	-	-
Marin	3	-	-	-	-	-	-
Merced	-	-	-	-	-	-	-
Monterey	-	1	-	1	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-
Orange	5	-	-	-	-	-	-
Placer	13	2	1	1	-	-	-
Riverside	2	-	-	-	-	-	-
Sacramento	-	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	-	-	-	-	-	-	-
San Diego	35	8	7	1	-	-	-
San Francisco	-	-	-	-	-	-	-
San Joaquin	1	-	-	-	-	-	-
San Luis Obispo	6	-	-	-	-	-	-
San Mateo	3	-	-	-	-	-	-
Santa Barbara	3	1	1	-	-	-	-
Santa Clara	1	1	1	-	-	-	
Santa Cruz	3	2	1	1	-	-	-
Stanislaus	16	-	-	-	1	1	1
Tulare	-	-	-	-	-	-	-
Ventura	3	-	-	-	-	-	-
Yolo	2	-	-	-	-	-	-

Quality Assurance/Monitoring Activities:

DHCS 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.

DHCS conducted compliance monitoring reviews for the following County:

County	Date
Placer	December 16-17, 2019

Evaluation:

During this reporting period (October – Dec 2019), UCLA conducted the following activities:

2019 Evaluation Report of the Drug Medi-Cal Organized Delivery System

- UCLA finalized and posted the 2019 Evaluation Report documenting status, findings, and activities of implementation of the DMC-ODS waiver. The report can be found here: http://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-Year-4-Evaluation-Report-FY-2018-19.pdf

Administrative Data Analysis

- The evaluation makes use of various data sources including the California Outcomes Measurement System, Treatment (CalOMS-Tx), Drug Medi-Cal Claims, Medi-Cal Managed Care, Fee-For-Service (FFS) data, and client level-of-care data, as they become available to researchers. During this time period, UCLA received some Monthly Medi-Cal Eligibility Data System (MEDS) Extract File (MMEF) and Short Doyle Medi-Cal (SDMC) claims data in which to continue adding to the data to measure impact of the waiver on service utilization and beneficiary outcomes.

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 networks of providers administer the TPS. The 2019 TPS survey collection period took place from October 7-11, 2019. The deadline for submitting paper forms to UCLA was October 28, 2019, and the deadline for uploading electronic data to UCLA was November 25, 2019. Thirty counties participated in the TPS during this survey period; of these, 11 counties were collecting TPS data for the first time as part of the waiver in 2019. In December 2019, UCLA began disseminating TPS summary reports to the participating counties, with plans to share the reports with EQRO and DHCS in January 2020.

County Administrator Survey:

- UCLA conducts a survey of county substance use disorder (SUD) program administrators on an annual basis to obtain information and insights from all SUD administrators in the state. The survey addresses the following topics: access to care; screening and placement practices; services and training; quality of care; collaboration, coordination, and integration of services; and waiver implementation preparation/status, among others.

  During this reporting period, UCLA conducted weekly meetings to review the county administrator survey to revise and update it for dissemination in early 2020.

Provider Survey:

- UCLA is conducting surveys of providers in each waiver county throughout the state. Provider surveys are conducted at the care delivery unit level, referring to a treatment modality (e.g., inpatient, outpatient, methadone maintenance) at a specific site. Clinical directors are asked questions related to access (e.g., treatment capacity), quality (e.g., ASAM criteria, electronic health records) and coordination of care (e.g., partnerships with other treatment and recovery support providers, levels of integration with physical and mental health scare systems) in their treatment programs. During this period, UCLA continued to survey providers after they implemented services once “Live” under the waiver. As of the end of this reporting period, 98 surveys have been completed.

Beneficiary Access Line “Secret Shopper”:

- UCLA conducts “secret shopper” calls to evaluate access to counties’ beneficiary access lines. The purpose of these calls is 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. Initiation of these “secret shopper” calls occurs soon after the county’s contract with DHCS is executed. 101 calls were made to DMC-ODS counties’ beneficiary access lines during this reporting period. Each county receives feedback on their county’s beneficiary access line in the form of a written report.

Qualitative Interviews with Stakeholders:

- UCLA conducts key informant interviews with county administrators and SUD provider program administrators from counties participating in the DMC-ODS waiver to develop case studies on topics of particular interest to DHCS. Interviews were conducted in June and July 2019 with county administrators and the analyses included in the Year 4 Evaluation report. These interviews were meant to gather data on successful strategies implemented by counties under the waiver.

During this reporting period, UCLA also explored the possibility of interviewing administrators from counties that are not participating in the DMC-ODS waiver, with the

goal of learning more about the barriers these counties face in providing SUD services to their populations. On December 3, 2019, UCLA conducted a semi-structured interview with the administrator of a small, rural, non-waiver county. The interview lasted approximately one hour and covered unique challenges faced by remote, rural counties in delivering SUD services, and what support may be needed from UCLA or the State in addressing these challenges.

Additional Technical Assistance (TA) provided to State and Counties:

- During this reporting period, UCLA also provided ongoing technical assistance to the waivered counties on the data collection and submission processes for ASAM level of care data as well as the Treatment Perceptions Survey.

- On October 7, 2019, UCLA provided TA to Fresno County with feedback on the development of their county's full ASAM assessment tool (paper tool).

- On October 11, 2019, UCLA presented evaluation data from the ODS waiver at the DHCS/EQRO/UCLA quarterly meeting.

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.

Table 22: DY15-Q2 Federal Fund Payments for DSHP-eligible services

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July-Sept)	$0	$0		$0
(Qtr. 2 Oct - Dec)	$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:

Table 23: DY15-Q2 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 4, IQ4 (April - June)	$252,547,934.00	$252,547,934.00	DY 14	$505,095,867.00
PY 4 (July - March) Overpayment collection	$2,485,336.00	$2,485,336.00	DY 14	$4,970,672.00
PY 5 IQ1 (July - September)	$241,851,785.50	$241,851,785.50	DY 15	$483,703,571.00
Total	$491,914,383.50	$491,914,383.50		$983,828,767.00

DY 15 Q2 reporting includes GPP payments made on October 3, 2019 and October 11, 2019. The payments made during this time period were for Program Year (PY) 4, Interim Quarter (IQ) 4 (April 1, 2019 – June 30, 2019), and PY 5, IQ1 (July 1, 2019 – September 30, 2019).

In PY 4, IQ4, the PHCSs received $252,547,934.00 in federal fund payments and $252,547,934.00 in IGT for GPP.

DHCS recouped $4,970,672.00 in total funds for PY 4. The recoupment was due to overpayment to Ventura County Medical Center (VCMC). In PY 4, IQ1 – 3 (July 1, 2018 – March 31, 2019), VCMC was paid 75% of its total annual budget. On August 15, 2018, 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 in total funds from VCMC.

In PY 5, IQ, the PHCSs received $241,851,785.50 in federal fund payments and $241,851,785.50 in IGT for GPP.

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-Q2, DHCS concluded 2019 PRIMEd topic-specific learning collaborative (TLC) activities. For their last meetings of the calendar year, the TLC groups covered meeting topics such as:

- Colorectal Cancer Screening operational efficiencies including standardization of follow-up workflow for abnormal results and community linkages
- On-site tour of a co-located medical, dental and behavioral health clinic that serves children who are in foster care in Santa Clara County
- Behavioral health screenings and follow-up
- Suicide prevention risk assessment tools and resources for clinicians
- Strategies addressing barriers in behavioral health integration, including tools and resources to help connect hospitals to clinics, counties, and health plans

Also in DY15-Q2, DHCS held the annual PRIME Learning Collaborative in-person conference in Sacramento on October 29-30, 2019. PRIME entities from across the state convened to share learnings and best practices through a variety of venues during the two-day event. Participants heard presentations described below and had many opportunities for networking.

The official conference took place on Wednesday, October 30, with optional TLC workgroups and hospital-specific activities taking place on Tuesday, October 29, including “Office Hours” where a limited number of entities were able to sign-up for one-on-one meetings with the following subject matter experts:

- **Elliott Main, MD**, Medical Director for the California Maternal Quality Care Collaborative, was available for PRIME entities to discuss strategies for improving perinatal care.

- **Elisa Tong, MD**, an internist and professor at UC Davis who also leads the CA Quits initiative, was available for PRIME entities to discuss best practices in

tobacco cessation initiatives.

Entities also had the opportunity to participate in in-person meetings of the TLC workgroups in the following five topic areas: Maternal and Infant Health, Tobacco Cessation, Behavioral Health, Health Disparities and Care Transitions.

The conference included many presentations throughout the day. The keynote speaker, Jacey Cooper, DHCS' Deputy Director, presented on DHCS' priorities and plans for the new Medi-Cal Healthier California for All initiative. The CA Quits Team's Dr. Elisa Tong and Dr. Ulfat Shaikh, who discussed tobacco cessation strategies and the emerging vaping crisis, followed the keynote presentation. Then Dr. Kelly Pfeifer, DHCS' Deputy Director for Behavioral Health, presented on state efforts focused on behavioral health integration. After this, DHCS' Office of the Medical Director's Dr. Cristina Almeida and Dr. Karen Mark reflected on best practices for achieving quality improvement goals, discussed the state's plans for sustaining the work accomplished through PRIME, and solicited feedback on select aspects of future proposals including the Quality Incentive Pool (QIP) Program. The afternoon sessions included breakout sessions featuring a variety of topics and presenters and a presentation facilitated by BluePath Health on the use of telehealth to meet PRIME goals.

The conference concluded with an awards ceremony. DHCS announced the recipients of the **PRIMEd Award of Excellence**, which was awarded to entities whose efforts best exemplify the interventions or improvements that represent a commitment to the experience and health outcomes for Medi-Cal members and to the PRIME Program, as voted on by their peers.

The winners of the **PRIMEd Award of Excellence** were:

- **Contra Costa Regional Medical Center,** for their innovative metric, Comprehensive Medical Evaluation Following Placement within 30 Days, to better track the medical evaluations of foster children within 30 days of a new home placement.

- **Kaweah Delta Health Care District,** for their shift to the Patient Centered Medical Home with its team-based care model and holistic patient approach, and the implementation of a system-wide electronic health record.

DHCS announced the recipients of the **PRIMEd Ripple Effect Award**, which aimed to recognize entities or individuals whose dedication to PRIME has made a substantial impact on their peers. This included but was not limited to willingness to share best practices and strategies for success in PRIME, or colleagues that have helped peers overcome obstacles in PRIME work.

The winners of the **PRIMEd Ripple Effect Award**, as voted by their peers, were:

- **Sonia Duran-Aguilar** from Kaweah Delta Health Care District

- **Leigh Burns** from Marin Health

DHCS also announced the recipients of the **PRIMEd Program Manager of the Year** awards.

- **Scott Thompson** from UC Irvine
- **Sonia Duran-Aguilar** from Kaweah Delta Health Care District

A full conference agenda is available upon request.

Additionally, DHCS continues to release a monthly PRIME newsletter, titled the PRIME Times, which provides updates on upcoming events and important discussions on PRIMEone (DHCS' shared learning website). The PRIME Times also highlights specific PRIME entities and TLCs.

Operational/Policy Developments/Issues:

One PRIME entity's participation in PRIME, Sonoma Specialty Hospital (SSH), was terminated effective April 1, 2019. SSH became a privately owned hospital as of April 1, 2019 but it failed to notify DHCS of this change. In December 2019, DHCS determined the July 2, 2019 intergovernmental transfer (IGT) following the hospital's DY14 Mid-Year PRIME payment to be invalid. DHCS is in the process of recouping $270,000 in federal funds paid to the entity on this date. DHCS notified SSH of its termination from the PRIME Program and the corresponding recoupment in January 2020. There are now 51 PRIME entities in the PRIME program.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 24: DPH and DMPH Payments

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
(Qtr. 2 Oct - Dec)	$308,898,350.68	$308,923,350.54	DY 13/14	$617,821,701.22
Total	**$405,897,872.92**	**$405,922,872.61**		**$811,820,745.53**

In DY15 Q2, 16 DPHs and 30 DMPHs received payments.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$308,898,350.68** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

In DY15-Q2, the six PRIME entities that requested reporting extensions for their DY14 Year End reports submitted their reports and were approved for completeness. DHCS approved all 51 PRIME DY14 YE reports for completeness in DY15-Q2. Comprehensive and clinical reviews are currently underway.

Evaluations:

DHCS received CMS' feedback on the draft PRIME Interim Evaluation on November 27, 2019. In DY15-Q2, the CMS recommendations were incorporated into the final Interim Evaluation. The evaluator (UCLA) worked with DHCS to address limitations encountered in the initial draft of the Interim Evaluation report regarding the sample size of the control group data for the difference in difference model, which should improve the methodology for future reports.

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.

Table 25: TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY October 2019 – December 2019

County	Total Member Months
Alameda	54,038
Contra Costa	33,470
Fresno	46,913
Kern	38,359
Kings	5,293
Los Angeles	352,967
Madera	4,593
Riverside	70,395
Sacramento	69,519
San Bernardino	76,439
San Diego	76,758
San Francisco	26,623
San Joaquin	31,797
Santa Clara	42,905
Stanislaus	22,716
Tulare	20,881
Total	**973,666**

Table 26: TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
October 2019 – December 2019

County	Total Member Months
Alameda	46,063
Contra Costa	21,727
Fresno	28,354
Kern	20,939
Kings	2,973
Los Angeles	668,769
Madera	3,056
Marin	12,700
Mendocino	11,670
Merced	32,627
Monterey	31,864
Napa	9,979
Orange	222,867
Riverside	77,042
Sacramento	46,426
San Bernardino	74,964
San Diego	126,061
San Francisco	31,318
San Joaquin	19,932
San Luis Obispo	16,570
San Mateo	26,767
Santa Barbara	30,986
Santa Clara	81,325
Santa Cruz	21,015
Solano	40,141
Sonoma	34,480
Stanislaus	12,079
Tulare	13,321
Ventura	58,147
Yolo	17,092
Total	**1,841,254**

Table 27: TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
October 2019 – December 2019

County	Total Member Months
Alpine	30
Amador	711
Butte	11,452
Calaveras	1,082
Colusa	530
El Dorado	3,378
Glenn	1,102
Imperial	7,244
Inyo	317
Mariposa	464
Mono	106
Nevada	2,078
Placer	6,674
Plumas	689
San Benito	222
Sierra	75
Sutter	3,998
Tehama	3,460
Tuolumne	1,671
Yuba	4,071
Total	**49,354**

Table 28: TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
October 2019 – December 2019

County	Total Member Months
Del Norte	5,380
Humboldt	17,344
Lake	12,989
Lassen	2,959
Modoc	1,382
Shasta	26,546
Siskiyou	7,399
Trinity	1,765
Total	**75,764**

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 the above listed 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. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. 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 Table 29, reflects the most current unique new member enrollment counts 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 reflect the cumulative number of unique new members enrolled in Quarter One (Q1) of Demonstration Year (DY) 15. The total-to-date column reflects the cumulative number of unique new members enrolled from beginning of the program, DY 12 (January 2017), to the most current data available, DY 15-Q1 (July-September 2019). Due to a delay in availability of data, DY 15-Q2 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 15-Q1 data reported is point-in-time as of December 18, 2019.

Table 29: Enrollment Counts

Lead Entity	DY 15-Q1 (July - Sept. 2019) Unduplicated	Jan. 2017- Sept. 2019 Total-to-Date (Unduplicated)
Alameda	428	10,681
Contra Costa	3,059	39,156
Kern	252	1,346
Kings*	71	480
LA	5,485	46,321
Marin*	183	1,431
Mendocino*	18	306
Monterey	21	204
Napa	79	459
Orange	802	10,245
Placer	76	396
Riverside	651	5,111
Sacramento*	208	1,560
San Bernardino	89	972
San Diego	122	509
San Francisco	1,249	16,427
San Joaquin	181	1,377
San Mateo	110	3,481
Santa Clara	803	4,651
Santa Cruz*	9	457
SCWPCC*	22	118

Lead Entity	DY 15-Q1 (July - Sept. 2019) Unduplicated	Jan. 2017- Sept. 2019 Total-to-Date (Unduplicated)
Shasta	35	332
Solano	11	185
Sonoma*	209	1,588
Ventura	43	1,169
Total**	**14,216**	**148,962**

**Indicates one of seven LEs that implemented on July 1, 2017.*
*** Due to a delay in the availability of data, DY 15-Q2 data will be reported in the next quarterly report.*

Member Months:

The data reported below in Table 30 reflects the most current member month counts 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 reflects the cumulative number of member months from the beginning of the program, DY 12 (January 2017), to the most current data available, DY 15-Q1 (July – September, 2019). Due to a delay in availability of data, DY 15-Q2 data will be reported in the next report. Member months are extracted from the LE's self-reported QEU reports The DY 15-Q1 data reported is point-in-time as of December 18, 2019.

Table 30: Current Member Month Counts

Lead Entity	DY 15-Q1 (July – Sept. 2019)	Jan 2017- Sept. 2019 Cumulative Total-to-Date
Alameda	26,651	133,607
Contra Costa	40,669	399,101
Kern	3,666	11,516
Kings*	583	2,546
LA	51,390	324,170
Marin*	3,958	12,085
Mendocino*	317	3,217
Monterey	339	1,889
Napa	730	4,052
Orange	13,736	94,606

Lead Entity	DY 15-Q1 (July – Sept. 2019)	Jan 2017- Sept. 2019 Cumulative Total-to-Date
Placer	427	3,352
Riverside	12,862	38,454
Sacramento*	2,396	12,207
San Bernardino	1,506	11,756
San Diego	1,031	3,758
San Francisco	27,748	236,090
San Joaquin	2,905	12,426
San Mateo	6,672	69,762
Santa Clara	11,738	72,081
Santa Cruz*	1,101	8,100
SCWPCC*	199	831
Shasta	227	1,895
Solano	253	2,336
Sonoma*	1,934	6,081
Ventura	1,753	16,727
****Total**	**214,791**	**1,482,645**

**Indicates one of seven LEs that implemented on July 1, 2017.*
***Due to a delay in the availability of data, DY 15-Q2 data will be reported in the next quarterly report.*

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.

The LC hosted one webinar this quarter:

- November 21: *Medi-Cal Initiative.* LC presented the Medi-Cal Healthier California for All initiative and answered LE questions. Ninety eight people called into the webinar and every pilot was represented.

The LC advisory board met on December 20 to discuss how the LC can help LEs think about how to work with health plans to sustain aspects of their pilots under the umbrella of the new Medi-Cal initiative called Medi-Cal Healthier California for All.

On October 2, November 6, December 4, and December 16, DHCS held monthly teleconferences with LEs focused on administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various contract issues such as reporting, reporting templates, timeliness, and expectations. The calls included the following topics: annual invoicing guidance, annual report, budget adjustment, rollovers, QEU reports, the Medi-Cal Healthier California for All initiative.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

During this quarter, DHCS released the WPC payments for DY 15 for all 25 LEs. These payments, totaling $238,142,128.82, were made through the Intergovernmental Transfer (IGT) process. These payments represented the 50% Federal Financial Participation (FFP) and 50% local non-federal share amounts of $119,071,064.41 for Program Year (PY) 4 midyear, which includes the time period of January through June of 2019.

Table 31: WPC Payments for DY 15 for all 25 LEs

DY 15 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 1 (July 1 – Sept 30)	$0	$0	DY 15 (PY* 4)	$0
Qtr 2 (Oct 1 – Dec 31)	$119,071,064.41	$119,071,064.41	DY 15 (PY* 4)	$238,142,128.82
Total	**$119,071,064.41**	**$119,071,064.41**		**$238,142,128.82**

** PYs are from January to December. The time period for PY 4 is from January 2019 to December 2019.*

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- Third quarter PY 4 QEU report; and
- PY 4 mid-year and PY 5 budget adjustment request.

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 will inform 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 STC 127 of the California Medi-Cal 2020 Demonstration Waiver, will assess: 1) if the LEs successfully implemented their planned strategies and improved care delivery; 2) whether these strategies resulted in better care and better health; and 3) whether 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 an assessment of reduction of avoidable utilization of emergency and inpatient services, and associated costs, challenges and best practices, and assessments of sustainability.

During this quarter, DHCS' independent evaluator, the University of California, Los Angeles:

- Developed project management timelines for key evaluation activities to be included in the WPC final evaluation report.
- Tested modifications to the difference-in-difference model used in the interim evaluation report to improve analysis for the final evaluation report.
- Developed refined service categories to better understand services provided to WPC enrollees. These new categories will be used in the LE survey along with the recent list of per member per month and Fee-For-Service categories from the Enrollment and Utilization reports in order to get more up-to-date data for the WPC final evaluation report.
- Began development of a "report card" template, which will compare WPC pilots based on outcome metrics by target populations, alongside key descriptive elements and metrics, including enrollee demographics, care coordination elements, implementation measures, and service availability.
- Began development of a shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final evaluation report.
- Drafted the final LE survey instrument to be released. Key content areas include data sharing infrastructure, perceived WPC pilot impact on better health, better care, cost savings, and plans in for sustainability of critical WPC components.

- Completed qualitative data analysis software coding to include challenges, successes, and lessons learned related to (1) identifying, engaging, and enrolling clients, (2) care coordination, (3) data sharing, (4) outcomes and sustainability, and (5) biggest barriers to implementation as discussed by LEs in PY 4 mid-year narrative reports. Preliminary analysis was completed.
- Addressed draft WPC interim evaluation report feedback from DHCS in October, November, and December.