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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

February 27, 2018

Ms. Angela Garner, Director
Division of System Reform Demonstrations
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Ms. Heather Ross
Project Officer
Division of State Demonstrations Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Ms. Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

QUARTERLY PROGRESS REPORT FOR THE PERIOD OCTOBER 1, 2017, THROUGH DECEMBER 31, 2017, OF CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION

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

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 Thirteen, which covers the period from October 1, 2017, through December 31, 2017.

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

Sincerely,

[redacted]

Mari Cantwell
Chief Deputy Director
Health Care Programs

Enclosures: Medi-Cal 2020 DY13-Q2 Progress Report
DY13-Q2 DMC-ODS Expenditures

cc: Ms. Sarah Brooks
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Sarah.Brooks@dhcs.ca.gov

Dr. Julia Logan
Acting Medical Director
Office of the Medical Director
Department of Health Care Services
Julia.Logan@dhcs.ca.gov

Ms. Lindy Harrington
Deputy Director
Health Care Financing
Department of Health Care Services
Lindy.Harrington@dhcs.ca.gov

Ms. Anastasia Dodson
Associate Director
Director's Office
Department of Health Care Services
Anastasia.Dodson@dhcs.ca.gov

Ms. Rene Mollow
Deputy Director
Health Care Benefits and Eligibility
Department of Health Care Services
Rene.Mollow@dhcs.ca.gov

Ms. Brenda Grealish
Acting Deputy Director
Mental Health & Substance Use Disorder Services
Department of Health Care Services
Brenda.Grealish@dhcs.ca.gov

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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Thirteen (07/01/2017 – 06/30/2018)
Second Quarter Reporting Period: 10/01/2017 – 12/31/2017

Table of Contents

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted monthly waiver monitoring conference calls to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration on October 20, November 13, and December 11, 2017.

The following topics were discussed:

- Pending Waiver Evaluation Designs
- Health Homes Program Pending Waiver Amendment
- GPP Payment Summary Reports
- Access Assessment
- Financial Reporting Activities
- Attachment R Developments

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

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

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

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

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

There has been no activity in DY13-Q2.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

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

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

Month	HPSM Enrollment	Capitation Rate	Capitation Payment
15-Jan	1,526	$1,658.05	$2,530,184
15-Feb	1,501	$1,658.05	$2,488,733
15-Mar	1,545	$1,658.05	$2,561,687
15-Apr	1,551	$1,658.05	$2,571,636
15-May	1,568	$1,658.05	$2,599,822
15-Jun	1,588	$1,658.05	$2,632,983
15-Jul	1,590	$1,535.45	$2,441,366
15-Aug	1,589	$1,535.45	$2,439,830
15-Sep	1,597	$1,535.45	$2,452,114
15-Oct	1,580	$1,535.45	$2,426,011
15-Nov	1,587	$1,535.45	$2,436,759
15-Dec	1,584	$1,535.45	$2,432,153
16-Jan	1,577	$1,535.45	$2,421,405
16-Feb	1,587	$1,535.45	$2,436,759
16-Mar	1,605	$1,535.45	$2,464,397
16-Apr	1,622	$1,535.45	$2,490,500
16-May	1,618	$1,535.45	$2,484,358
16-Jun	1,621	$1,535.45	$2,488,964
16-Jul	1,648	$1,481.08	$2,440,820
16-Aug	1,636	$1,481.08	$2,423,047
16-Sep	1,607	$1,481.08	$2,380,096
16-Oct	1,640	$1,481.08	$2,428,971
16-Nov	1,628	$1,481.08	$2,411,198
16-Dec	1,631	$1,481.08	$2,415,641
17-Jan	1,625	$1,481.08	$2,406,755
17-Feb	1,649	$1,481.08	$2,442,301
17-Mar	1,647	$1,481.08	$2,439,339
17-Apr	1,633	$1,481.08	$2,418,604
17-May	1,630	$1,481.08	$2,414,160
17-Jun	1,617	$1,481.08	$2,394,906
17-Jul	1,609	$1,481.08	$2,383,058
17-Aug	1,614	$1,481.08	$2,390,463
17-Sep	1,616	$1,481.08	$2,393,425
17-Oct	1,605	$1,481.08	$2,377,133
17-Nov	1,575	$1,484.08	$2,332,701
17-Dec	1,590	$1,481.08	$2,354,917
		Total	**$88,047,196**

Member Months:

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	1,605	1,575	1,590	2	4,770

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. As of September 30, 2016, revised Protocols were submitted to CMS.

Health Plan of San Mateo Demonstration Project

DHCS Communications with HPSM

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

Contract Amendments

HPMS had no contract amendments updates during DY13-Q2.

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

Rady Children's Hospital of San Diego Demonstration Project

DHCS and RCHSD have been working closely and are committed to the implementation of this pilot demonstration. RCHSD has reviewed and commented on the boilerplate contract used for managed care plans, begun submitting plan readiness deliverables, and worked diligently on establishing a provider network to meet the needs of the pilot-eligible population. DHCS is developing the infrastructure needed for RCHSD to operate as a full-risk provider in the Medi-Cal managed care system; including developing payment systems, rates, and enrollment processes.

Pre-Implementation Contract/Data Use Agreement

DHCS and RCHSD will be reaching out to CCS Demonstration Project pilot-eligible members within San Diego County to gauge their interest in the CCS pilot. Along with the pilot interest letter, a cover sheet and FAQ document will be provided. DHCS is finalizing the pre-implementation contract which will allow for data-sharing between DHCS and RCHSD. This contract will allow the Department to provide RCHSD with member information for potentially eligible members currently working with RCHSD.

Demonstration Schedule

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

Consumer Issues:

CCS Quarter Grievance Report

In January 2018, HPSM submitted a "CCS Quarterly Grievance Report" for the second quarter, October – December 2017. During the reporting period, HPMS received and processed 10 member grievances.

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

- 3 grievances were designated as Quality of Care/Service
  - All 3 were coded as "Plan denial of treatment"; two were resolved in member's favor. One was resolved in favor of plan.
- 7 grievances were labeled as Other:
  - 6 were resolved in favor of the CCS Member and 4 were resolved in favor of the plan.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Report Name	Due Date	Received
Grievance Log/Report	2/15/18	1/12/18
Provider Network Reports	2/15/18	Not submitted yet
Quarterly Financial Statements	2/15/18	Not submitted yet
Report of All Denials of Services Requested by Providers (NOA)	2/15/18	1/22/18

Evaluation:

The CCS evaluation design was originally submitted to CMS on September 19, 2016. DHCS submitted a revised evaluation design to CMS on May 15, 2017. DHCS received CMS' draft evaluation comments on June 19, 2017, and DHCS responded to CMS on July 14, 2017. DHCS received further CMS comments on September 12, 2017, and DHCS responded to CMS on October 10, 2017.

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

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

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

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

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

Enrollment and Assessment Information:

Per STC 48, CBAS enrollment data for both MCP and FFS members per county for DY13-Q2, represents the period of October 2017 to December 2017. CBAS enrollment data is shown in Table 1 entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* Table 8 entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into Table 1.

The CBAS enrollment data as described in Table 1 is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population. FFS claims data identified in Table 1, reflects data through the quarter of July 2017 to

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

September 2017 (DY13-Q1) because of the lag factor of about two to three months. Data for DY13-Q2, will be reported in the next quarterly report.

Table 1

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY12 Q2 Oct - Dec 2016		DY12 Q3 Jan - Mar 2017		DY12 Q4 Apr - June 2017		DY13 Q1 Jul - Sept 2017	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	542	82%	530	80%	541	82%	512	78%
Butte	37	36%	42	41%	40	39%	43	42%
Contra Costa	240	75%	210	65%	213	66%	212	66%
Fresno	602	55%	615	56%	639	58%	611	55%
Humboldt	94	24%	97	25%	95	24%	95	24%
Imperial	328	59%	330	59%	357	64%	352	63%
Kern	79	23%	73	22%	67	20%	66	19%
Los Angeles	21,178	67%	21,299	67%	21,720	68%	22,176	69%
Merced	95	45%	94	45%	91	43%	95	45%
Monterey	118	63%	116	62%	122	65%	107	57%
Orange	2,199	56%	2,256	54%	2,103	51%	2,166	52%
Riverside	445	41%	459	42%	483	45%	463	43%
**Sacramento	**521	58%	561	63%	520	58%	501	80%
**San Bernardino	**598	110%	601	111%	564	104%	522	70%
San Diego	2,031	51%	1,990	54%	1,995	54%	1,951	52%
San Francisco	723	49%	722	49%	730	50%	716	46%
San Mateo	174	76%	175	77%	174	76%	168	73%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	656	47%	674	48%	643	46%	758	54%
Santa Cruz	114	75%	98	64%	119	78%	95	62%
Shasta	*	*	*	*	*	*	*	*
Ventura	901	63%	943	65%	937	65%	914	63%
Yolo	93	25%	79	21%	80	21%	82	22%
Marin, Napa, Solano	79	16%	74	15%	81	16%	86	17%
Total	**31,860	**61%**	**32,044**	**62%**	**32,295**	**62%**	**31,756**	**61%**

FFS and MCP Enrollment Data 09/2017

Note: Information is not available for October 2017 to December 2017 due to a delay in the availability of data.
**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***Data for these counties are updated by the MCPs to reflect accurate information for DY12-Q2.*

Table 1 reflects that enrollment has remained relatively consistent with over 30,000 CBAS participants. The data reflects ample capacity for participant enrollment into most CBAS Centers. In the previous quarter, San Bernardino County reported operating over its center capacity. As of this quarter, they are reporting at appropriate levels due to an increase in overall center licensing capacity as a result of a new CBAS Center opening in August 2017. Table 8 below identifies a 38% increase for San Bernardino between this quarter and last quarter. In situations where counties report operating over centers capacity, CBAS participants are able to choose an alternate CBAS center in nearby counties should the need arise for ongoing CBAS services.

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

CBAS Assessments for MCPs and FFS Participants

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

Table 2 entitled "*CBAS Assessments Data for MCPs and FFS"* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Due to a delay in the availability of data, Table 2 represents data from DY11-Q3 (April 2016 – June 2016) through DY13-Q1 (July 2017 to September 2017). Data for DY13-Q2 (October 2017 – December 2017), will be provided in the next quarterly report.

Table 2

CBAS Assessments Data for MCPs and FFS:						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY11-Q3 (4/1-6/30/2016)	2,647	2,608 (98.5%)	39 (1.5%)	18	18 (100%)	0 (0%)
DY12-Q1 (7/1-9/30/2016)	2,600	2,514 (96.7%)	85 (0.03%)	11	11 (100%)	0 (0%)
DY12-Q2 (10/1-12/31/2016)	2,741	2,689 (98.1%)	52 (0.02%)	2	2 (100%)	0 (0%)
DY12-Q3 (1/1-3/31/2017)	2,476	2,439 (98.5%)	37 (0.01%)	5	5 (100%)	0 (0%)
DY12-Q4 (4/1-6/30/2017)	2,449	2,408 (98.3%)	41 (0.01%)	8	7 (100%)	1 (0%)
DY13-Q1 (7/1-09/30/2017)	2,157	2,123 (98.4%)	34 (0.02%)	3	3 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

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

As indicated in Table 2, the number of CBAS FFS participants has remained relatively low due to the transition of CBAS into managed care. In addition, there was a decrease in the number of new assessments completed by MCPs in DY13-Q1. Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to Table 2, for DY13-Q1, there were 2,157 assessments completed by the MCPs, of which 2,123 were determined to be eligible and 34 were determined to be ineligible. For DHCS, it was reported that 26 participants submitted their requests for CBAS benefits under FFS. Twenty-three of the requests were deferred to managed care while three of the requests were determined to be FFS eligible. Table 2 identifies three requests were assessed and approved for CBAS FFS by DHCS.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity

and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 3 entitled “CDA – CBAS Provider Self-Reported Data” identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY13-Q1. Due to a delay in availability of data, DY13-Q2 data will be reported in the next quarterly report. The ADA at the 241 operating CBAS Centers is approximately 22,424 participants, which corresponds to 73% of total license capacity.

Table 3

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	241
Non-Profit Centers	56
For-Profit Centers	185
ADA @ 240 Centers	22,424
Total Licensed Capacity	30,852
Statewide ADA per Center	73%

CDA - MSSR
Data 09/2017

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

Outreach/Innovative Activities:

Stakeholder Process

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

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

Operational/Policy Developments/Issues:

DHCS and CDA continue to work with CBAS providers and MCPs to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA engaged MCPs and CBAS providers in the development of an application process for prospective new CBAS providers. MCP and provider input were instrumental in the development of a high quality application and certification process for new centers. Two new CBAS Centers opened during DY13-Q1, and CDA has several applications that are currently under review.

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY13-Q1. DHCS delayed implementation of the revised CBAS IPC from April 2017 to April 2018. This delay was determined necessary by DHCS and CDA to align the IPC changes with existing IPC instructions in the CBAS Provider Manual. Moving forward, DHCS and CDA have updated the CBAS form/template revision process to include identification of all related forms/templates/publications that will require corresponding updates.

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

Consumer Issues:

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

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." Due to the lag factor in collecting data, Tables 4 and 5 represent data covering July 2017 to September 2017 (DY13-Q1). Data for October 2017 to December 2017 (DY13-Q2), will be provided in the next quarterly report.

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may

have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY13-Q1, as illustrated in Table 4. Table 5 shows that MCPs received no beneficiary complaints in DY13-Q1.

Table 4

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

CDA Data - Complaints 09/2017

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

Table 5

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

Plan data - Phone Center Complaints 09/2017

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

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

Grievance and appeals data is provided to DHCS by the MCPs. As a result of the delay in data reporting, grievances and appeals data from the MCPs are reported up to DY13-Q1. According to Table 6 entitled "*Data on CBAS Managed Care Plan Grievances*," three grievances were filed with the MCPs for DY13-Q1; the grievances were related to CBAS providers.

Table 6

Data on CBAS Managed Care Plan Grievances					
Demonstration Year and Quarter	**Grievances**				
	CBAS Providers	**Contractor Assessment or Reassessment**	**Excessive Travel Times to Access CBAS**	**Other CBAS Grievances**	**Total Grievances**
DY12-Q1 (Jul 1 - Sep30)	4	0	0	0	4
DY12-Q2 (Oct 1 - Dec 31)	1	0	0	0	1
DY12-Q3 (Jan 1 - Mar 31)	1	0	0	1	2
DY12-Q4 (Apr 1 - Jun 30)	4	0	0	3	7
DY13-Q1 (Jul 1 - Sep 30)	2	0	0	1	3

Plan data - Grievances 09/2017

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

For DY13-Q1, one CBAS appeal was filed with the MCPs. Table 7 entitled "*Data on CBAS Managed Care Plan Appeals*", illustrates that the appeal was related to denial of services or limited services. Due to a delay in information, data for DY13-Q2, will be available in the next quarterly report.

Table 7

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

Plan data - Grievances 09/2017

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

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY13-Q1 (July 2017 to September 2017), there was one request for hearing related to CBAS services filed.

Financial/Budget Neutrality Development/Issues:

Pursuant to STC item 50(b) of the Medi-Cal 2020 Demonstration, MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP, to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. MCP payment relationships with CBAS Centers have not affected the center's capacity to date and adequate networks remain for this population.

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

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under the Medi-Cal 2020 Waiver. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 8 also illustrates overall utilization of licensed capacity by CBAS participants statewide up to DY13-Q1, due to a delay in availability of data. Data for DY13-Q2, will be discussed in the next quarterly report.

Table 8 reflects the average licensed capacity used by CBAS participants at 61% statewide as of September 30, 2017. Overall, most of the CBAS Centers have not operated at full capacity with the exception of San Bernardino County, which operated at full capacity until the opening of a new CBAS Center in DY13-Q1. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was a decrease in provider capacity of five percent or more in Sacramento County due to the closure of Rancho Cordova Adult Day Health Care Center, which had a license capacity of 160. In Table 8, San Bernardino and San Francisco Counties saw an increase of five percent or more in their license capacity in DY13-Q1 compared to DY12-Q4. The changes in center license capacity resulted in an overall increase of 15% in the total licensed capacity statewide.

<u>Access Monitoring (STC 48.e.)</u>

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

<u>Unbundled Services (STC 44.b.iii.)</u>

CDA certifies and provides oversight of CBAS Centers. CDA and DHCS continue to review any possible impact on participants by CBAS Center closures. In counties that do not have a CBAS Center, the managed care plans work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participant's if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center

not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for each of the CBAS participants they provide services for CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. Table 9 entitled "*CBAS Center History*," illustrates the history of openings and closings of the centers. According to Table 9, for DY13-Q1 (April 2017 to September 2017), CDA currently has 241 CBAS Center providers operating in California. In DY13-Q1, two centers closed and two centers were reportedly opened. DY13-Q1. Table 9 shows there was not a negative change of more than 5% from the prior quarter so no analysis is needed to addresses such variances. Data for DY13-Q2, will be discussed in the next quarterly report due to a delay in availability of data.

Table 8

County	CBAS Centers Licensed Capacity					
	DY12-Q2 Oct-Dec 2016	DY12-Q3 Jan-Mar 2017	DY12-Q4 Jan-Mar 2017	DY13-Q1 Jul-Sep 2017	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	390	0%	78%
Butte	60	60	60	60	0%	42%
Contra Costa	190	190	190	190	0%	66%
Fresno	652	652	652	652	0%	55%
Humboldt	229	229	229	229	0%	24%
Imperial	330	330	330	330	0%	63%
Kern	200	200	200	200	0%	19%
Los Angeles	18,731	18,796	18,996	19,088	0%	69%
Merced	124	124	124	124	0%	45%
Monterey	110	110	110	110	0%	57%
Orange	2,308	2,458	2,458	2,458	0%	52%
Riverside	640	640	640	640	0%	8%
Sacramento	529	529	529	369	-30%	80%
San Bernardino	320	320	320	440	38%	15%
San Diego	2,353	2,188	2,188	2,198	0%	52%
San Francisco	866	866	866	926	7%	46%
San Mateo	135	135	135	135	0%	73%
Santa Barbara	60	60	60	60	0%	60%
Santa Clara	830	830	830	830	0%	54%
Santa Cruz	90	90	90	90	0%	62%
Shasta	85	85	85	85	0%	85%
Ventura	851	851	851	851	0%	63%
Yolo	224	224	224	224	0%	22%
Marin, Napa, Solano	295	295	295	295	0%	17%
TOTAL	30,602	30,652	30,852	30,974	15%	61%

CDA Licensed Capacity as of 09/2017

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

Table 9

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
September 2017	241	1	0	-1	240
August 2017	240	1	2	1	241
July 2017	240	0	0	0	240
June 2017	240	0	0	0	240
May 2017	240	0	0	0	240
April 2017	240	0	0	0	240
March 2017	239	0	1	1	240
February 2017	240	1	0	0	239
January 2017	240	0	0	0	240
December 2016	240	1	1	0	240
November 2016	240	0	0	0	240
October 2016	240	0	0	0	240
September 2016	240	0	0	0	240
August 2016	240	0	0	0	240
July 2016	241	1	0	-1	240
June 2016	241	0	0	0	241
May 2016	241	0	0	0	241
April 2016	241	0	0	0	241
March 2016	242	1	0	-1	241
February 2016	242	0	0	0	242
January 2016	241	0	1	1	242
December 2015	242	2	1	-1	241
November 2015	242	0	0	0	242
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245

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

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

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

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

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

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

Domain 3 – Continuity of Care

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

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

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

Domain 4 – Local Dental Pilot Projects (LDPPs)

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

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

Enrollment Information:

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

Statewide Preventive Service Utilization for Children Ages 1-20	September	October	November	December
Measure Period	Oct. 2016 – Sept. 2017	Nov. 2016 – Oct. 2017	Dec. 2016 – Nov. 2017	Jan. 2017 – Dec. 2017
Denominator[2]	5,715,568	5,712,905	5,686,306	5,669,532
Numerator[3]	2,543,878	2,547,684	2,543,404	unavailable[4]
Preventive Service Utilization	44.5%	44.6%	44.7%	unavailable

[1] Data Source - Dental Dashboard DM3 Dec 2017 MIS/DSS Data. Utilization does not include one-year full run-out allowed for claim submission.

[2] Denominator: Eligible Children Age 1-20 - beneficiaries who are enrolled in the same dental plan for at least three continuous months; not reflective of potential retroactive eligibility.
[3] Numerator: Eligible Children age 1-20 who received Preventive Services during the measure period; not reflective of potential retroactive eligibility.
[4] Performance for the third month of each quarter is not available due to claim submission time lag.

2017 Statewide Active Service Offices, Rendering Providers and Safety Net Clinics [1]

2017 Statewide Active Billing & Rendering Providers & Safety Net Clinics							
Delivery System	Provider Type	Quarter 1			Quarter 2		
		July	August	September	October	November	December
FFS	Service Offices	5543	5558	5585	5602	5579	5588
	Rendering	8881	8998	9046	9262	9044	9044
GMC[2]	Service Offices	136	137	140	141	143	145
	Rendering	354	350	355	350	355	350
PHP[2]	Service Offices	1103	1119	1123	1129	1113	1101
	Rendering	2004	2009	2011	1984	1947	1922
Safety Net Clinics		532	529	530	531	531	531

[1] Active service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008A, PS-O-008B, and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of Safety Net Clinics is based on encounter data from the DHCS data warehouse as of 1/18/18. Only Safety Net Clinics who submitted at least one dental encounter were included.
[2] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.

Outreach/Innovative Activities:

DTI Small Workgroup

The objective of these meetings is to review monthly updates regarding all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup now meets on a bi-monthly basis, the third Wednesday of the month. This quarter, the workgroup met on October 18, 2017. December's meeting was rescheduled to January 17, 2018.

In addition to the DTI small stakeholder workgroup, DHCS continued its efforts to target specific groups with the assistance of stakeholders.

Domain 2 Caries Risk Assessment Workgroup

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

Domain 2 Subgroup

This subgroup did not convene this quarter. In lieu of meeting, DHCS sent updates regarding outreach efforts to the group. The subgroup will reconvene in March 2018. The purpose of the subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. The subgroup will continue to meet on a bi-monthly basis in the next quarter to discuss continued outreach efforts.

DTI Clinic Workgroup

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

Domain 3 Subgroup

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

DTI Webpage

The DTI webpage was updated as information became available during DY13-Q2 and will continue to be updated regularly. This quarter's updates were primarily for Domain 2. The updates included claims examples for Fee-for-Service (FFS), Dental Managed Care (DMC), and Safety Net Clinic (SNC) providers, an updated CRA tool, and a Domain 2 provider summary document. Other updates included the Domain 4 LDPP application summary, an LDPP Frequently Asked Questions (FAQ), and updated budget information for the LDPP entities.

DTI Inbox and Listserv

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

Most inquiries in the DTI inbox during this reporting period included, but were not limited to the following categories: How to opt into Domain 1 for Program Year (PY) 2, payment deadlines and dispute inquiries for PY 1 and 2, and SNCs Electronic Data Interchange (EDI) testing; Domain 2 implementation policy and billing questions; Domain 3 payment inquiries, and SNC EDI testing; and Domain 4 budget changes and reimbursement inquiries. All requests were researched and responded to within seven business days.

The DTI outreach efforts included SNC Encounter Data Resubmission Processes, updated DTI electronic submission instructions, and data submission deadlines. The EDI instructions provided detailed steps for providers to follow to ensure successful EDI testing and subsequent submissions. The EDI testing cutoff date was November 17, 2017, and SNC providers were informed they must complete EDI testing by that date or can initiate EDI testing in January 2018. For Domain 1, the final PY 1 payments will be issued in February 2018. SNC providers were informed of the following deadlines via email and on the DTI webpage: December 8, 2017 was the deadline for proprietary paper claims submission and December 23, 2017 was the deadline for EDI claims.

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

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

Outreach Plans

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

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

Operational/Policy Developments/Issues:

Domain 1

During DY13-Q2, DHCS met with its Dental Fiscal Intermediary (FI), Delta Dental, on a weekly basis to prepare for the upcoming 2018 payment. The payment timeline shifted from January 31, 2018 to early February 2018 due to payment methodology adherence standards and DHCS' commitment to provide payments that accurately reflect the preventive service utilization changes. This payment will reflect the last payment for PY 1 and the first payment for PY 2.

PY 1 participants had until November 17, 2017 to complete their EDI testing. The deadline to submit PY 1 encounter data, via proprietary paper form, was December 8, 2017. The deadline to submit PY 1 encounter data, via EDI, was December 23, 2017.

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

Domain 2

During this reporting period:

- The total incentive claims paid was $475,155.50, of this total:
    - FFS: Sacramento $95,723; Tulare $286,596.50; Kings $882; and Glenn $1,908
    - DMC: Sacramento $200,513
    - SNC: Mendocino $21,672
- 33 providers opted into Domain 2.
- 110 providers completed the TYKE training.

From the start of Domain 2 in February 2017 through DY13-Q2:

- The total incentive payments were $1,292,744.60. This total includes:
    - $274,349 DMC incentive payments (Sacramento)
    - $995,715.60 FFS incentive payments to four counties (Tulare, Sacramento, Kings and Glenn)
    - $22,680 SNC incentive payments (Inyo and Mendocino)
- 138 providers opted into Domain 2.
- 410 providers completed the TYKE training, however this number is inclusive on providers in non-Domain 2 counties.

Domain 2 Outreach Efforts

DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation. DHCS has been working closely with the Dental FI to target outreach efforts in low-participating Domain 2 counties, including in-person visits and telephone calls to providers. The Dental FI has contacted providers via phone and has focused their outreach efforts on counties with low participation such as Mendocino, Sierra, and Humboldt counties. The Dental FI has also been following up with providers who want to opt-in and with those with billing concerns. A provider outreach letter was mailed out on November 3, 2017. The November provider bulletin included Domain 2 claim examples and was posted to the

Denti-Cal provider bulletin webpage, and the Domain 2 claim examples were also posted to the Domain 2 DTI webpage.

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

- Domain 2 Provider Summary (Weekly)
- Provider Bulletin with Domain 2 claim examples (November 2017)
- Domain 2 claim examples for SNCs (November 2017)
- Domain 2 claim examples for FFS and DMC plans (November 2017)

Domain 3

Through its ongoing program monitoring efforts, DHCS determined the Dental FI was interpreting the Domain 3 payment methodology incorrectly. Therefore, payment factors and measures were re-evaluated and validated to ensure providers received correct incentive payments. DHCS identified 22 providers that qualified for $114,120 in additional incentive payments. These additional incentive payments were mailed to providers on November 9, 2017. As a result, the Domain 3 PY 1 payment total is $9,546,560 for 956 participating service office locations.

Domain 3 Outreach Efforts

As mentioned in the last quarterly report, DHCS identified 17 SNCs enrolled in Domain 1 that are also eligible for Domain 3. DHCS emailed an outreach letter and the Domain 3 opt-in form to the eligible SNCs on September 22, 2017, to encourage them to opt into PY 2. Subsequently, six (6) opted into Domain 3 (35% outreach success rate) and ten (10) additional SNCs not included in this outreach opted into Domain 3 PY 2, totaling to 16 new opt-ins. The total number of SNC providers opted into Domain 3 PY 2 is 66 service office locations.

DHCS also identified the top performing providers for Domain 3 PY 1 and sent acknowledgement letters with recognition awards in early October 2017. A conference call was also held on October 24, 2017, with the top performing providers for an opportunity to share best practices and outreach efforts they performed to retain continuity of care. Only six providers participated and shared feedback on how they increased continuity of care by implementing frequent follow-up by telephone and text messages, as well as additional educational materials, including showing preventive dental videos in their waiting rooms. Due to low participation in that conference call, DHCS will offer an electronic survey to these providers in January 2018.

Domain 4

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

DHCS set up an email inbox LDPPinvoices@dhcs.ca.gov to allow for electronic submission invoices. Invoices are to be submitted on a quarterly basis. DHCS has received 10 invoices from the LDPPs in this quarter, and 12 invoices YTD, seven of which have been paid during quarter 2 for a total of $269,722.95. Three of the invoices have been sent to Accounting awaiting payment totaling $398,127.72, and two invoices are still under review with DHCS. DHCS is expecting more invoices to come from the LDPPs that currently have executed agreements.

At the end of DY13-Q2, 2 of the 14 agreements were still in progress as shown in the table below. DHCS has been working with the two applicants regarding their budget calculations and providing technical assistance/feedback on a regular basis. In addition, DHCS scheduled monthly calls with the LDPPs including those that have not finalized their contracts with DHCS. DHCS has also provided the LDPPs with a FAQ document for invoicing and budget related concerns.

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

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

Lead Entity	Status
San Francisco City and County Department of Public Health	Executed June 27, 2017
Sonoma County	Executed May 15, 2017
University of California, Los Angeles	Executed May 15, 2017

DTI Annual Report

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

Highlights from the annual report include:

Domain 1

- The preventive service utilization rate for children (ages 1-20) increased by 4.67 percentage points from CY 2014 to CY 2016. (*Figure 1)*
- The number of Medi-Cal dentists providing preventive dental services to at least ten children increased by 6.07 percent from CY 2014 to CY 2016. (*Figure 2)*
- DHCS provided a total of $24.19 million in Domain 1 incentive payments in January and July 2017. (*Figure 4)*

Domain 3

- From CY 2015 to CY 2016, across the 17 pilot counties, the percentage of children receiving continuity of care from the same service office location increased by 2.6 percentage points. (*Figure 7*)
- DHCS sent $9.5 million in Domain 3 incentive payments to 695 dental service office locations in 17 counties in June 2017. (*Figure 8*)

Domains 1 and 3: two positive results

- Preventive Services Utilization rates are higher in Domain 3 counties. From CY 2014 to CY 2016, utilization of preventive services increased 7.46 percent in Domain 3 counties, and 3.74 percent in non-Domain 3 counties. (*Figure 10)*
- Correlation between Continuity of Care and Preventive Services Utilization. Among the 17 counties in Domain 3, those counties with higher continuity of care between CY 2015 and CY 2016 also had higher utilization of preventive services in CY 2016. (*Figure 11*)

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

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

Quality Assurance/Monitoring Activities:

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

Evaluation:

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

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

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

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of forty-one implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings, and Partnership Health Plan of California. DHCS has approved the following counties' implementations plans: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Los Angeles, Marin, Contra Costa, Monterey, Ventura, Orange, Alameda, Sonoma, San Luis Obispo, Imperial, San Bernardino, Napa, Yolo, Santa Barbara, Placer, Stanislaus, Kern, San Diego, Merced, Nevada, San Joaquin, Partnership Health Plan of California, Tulare, El Dorado, San Benito, and Fresno. The remaining fifteen counties' implementation plans are currently in review by DHCS and CMS.

Enrollment Information:

Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY12-Q3	2,360	935	3,258
DY12-Q4	3,727	1,368	5,031
DY13-Q1	12,713	7,914	20,391
DY13-Q2	11,536*	7,267*	18,732*

*For DY13-Q2, there is only partial data available at this time since counties have up to sixty days to submit claims after the month of service.

Member Months:

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. “Current Enrollees (to date)” represents the total number of unique clients for the quarter.

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	0	1,821	2,061	DY12-Q3	2,360
	2,215	2,240	2,865	DY12-Q4	3,727
	8,267	9,583	9,835	DY13-Q1	12,713
	10,126	7,836	54	DY13-Q2	11,536
Non-ACA	0	753	808	DY12-Q3	935
	868	845	1,077	DY12-Q4	1,368
	5,546	6,461	6,532	DY13-Q1	7,914
	6,659*	5,000*	15*	DY13-Q2	7,267*

*For DY13-Q2, there is only partial data available at this time since counties have up to sixty days to submit claims after the month of service.

Outreach/Innovative Activities:

- Monthly Technical Assistance Calls with Counties’ Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Waiver
- October 2, 2017: Phase 5 Conference Call for the Indian Health Program Organized Delivery System (IHP-ODS)
- October 2, 2017: IHP-ODS Fiscal Training
- October 9, 2017: Partnership Health Plan of California (PHC) Planning Meeting
- October 10, 2017: Meeting with Harbage Consulting for PHC
- October 11, 2017: States Discussion of ASAM Assessment Tools Call with Massachusetts
- October 12, 2017: California Behavioral Health Directors Association of California (CBHDA) Meeting
- October 12, 2017: Blue Shield of California Foundation and California Health Care Foundation (CHCF) Co-Sponsorship Conference Call
- October 13, 2017: Conference Call with Parker and Dennison Consultants for the IHP-ODS
- October 17, 2017: Harbage Meeting for PHC
- October 17, 2017: CBHDA Readiness Review Presentation
- October 19, 2017: Stakeholder Advisory Committee Meeting regarding Innovative Approaches to Substance Use Treatment in Medi-Cal
- October 23, 2017: California Consortium for Urban Indian Health (CCUIH) Meeting

- October 23, 2017: IHP-ODS Conference Call
- October 25, 2017: University of California, Los Angeles (UCLA) Integrated Care Conference Presentation
- October 25, 2017: Opioid Workgroup Meeting
- October 25, 2017: PHC Fiscal Plan Meeting
- October 31, 2017 PHC Regional Model Meeting
- November 2, 2017: California Association of DUI Treatment Programs (CADTP) Fall Forum Presentation
- November 2, 2017: Medi-Cal Tribal & Indian Health Program Designee Meeting
- November 3, 2017: IHP-ODS Eligibility Discussion
- November 6, 2017: California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) Conference Call
- November 9, 2017: DHCS Meeting regarding Opioid Efforts
- November 11-16, 2017: DHCS conducted mock utilization reviews, shadowed County compliance monitoring staff, and provided comprehensive technical assistance to County staff overseeing the DMC-ODS Waiver implementation in Marin County
- November 14, 2017: Senator McGuire's Opioid Town Hall Meeting
- November 15, 2017: Conference Call with Parker and Dennison Consultants regarding administrative claiming options
- November 16, 2017: Opioid Process Mapping Workgroup Meeting
- November 21, 2017: DHCS Opioid Workgroup Meeting
- November 27, 2017: SUD Data-Sharing with CHCF
- November 29, 2017: Opioid Process Mapping Workgroup Meeting
- December 4, 2017: CAADPE Conference Call
- December 4, 2017: IHP-ODS Meeting at California Rural Indian Health Board (CRIHB)
- December 8, 2017: Conference Call with Parker and Dennison Consultants for the IHP-ODS
- December 8, 2017: Opioid Process Mapping Workgroup Meeting
- December 12-13, 2017: DHCS conducted mock utilization reviews, shadowed County compliance monitoring staff, and provided comprehensive technical assistance to County staff overseeing the DMC-ODS Waiver implementation in San Mateo County
- December 13, 2017: CBHDA/DHCS Exec-to-Exec Meeting
- December 14, 2017: Chapa-De Community Health Center Visit
- December 18, 2017: IHP-ODS Conference Call
- December 18, 2017: DHCS Opioid Workgroup Meeting
- December 18, 2017: Mental Health Parity Compliance Plan Webinar

Operational/Policy Developments/Issues:

During this reporting period, CMS has been assisting DHCS with program and fiscal questions on Attachment BB for the IHP-ODS.

Consumer Issues:

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

Contra Costa did not identify the categories of grievances recorded so only the total amount is presented in the table.

Grievance	L.A.	Marin	Riverside	S.F.	San Mateo	Contra Costa	Santa Clara
Access to Care	-	1	0	0	0	-	-
Quality of Care	-	0	1	0	0	-	-
Program Requirements	-	1	0	1	0	-	-
Service Denials	-	0	0	0	0	-	-
Failure to Respect Enrollee's Rights	-	1	0	0	0	-	-
Interpersonal Relationship Issues	-	3	1	0	3	-	-
Other	-	0	0	0	0	-	-
Other	-	0	0	2	0	-	-
Other	-	0	0	1	0	-	-
Other	-	0	0	1	4	-	-
Totals	-	**6**	**2**	**5**	**7**	**19**	-

Resolution	L.A.	Marin	Riverside	S.F.	San Mateo	Contra Costa	Santa Clara
Grievances	-	2	0	2	1	-	-
Appeals	-	0	0	0	0	-	-
Totals	-	**2**	**0**	**2**	**1**	-	-

Financial/Budget Neutrality Development/Issues:

In DY13-Q2, Napa County started providing services in mid-December, which brings the total number of DMC-ODS operational counties to eight. The total approved claims over four quarters (through DY13-Q2) for both ACA and non-ACA

beneficiaries is $69,518,325. The top three services provided in this time period are Narcotic Treatment Program-Methadone (dosing) at 27.63% of approved claims, Residential 3.5 at 21.14%, and Residential 3.1 at 17.26%. Approved claims for these services are $19,205,858, $14,698,890, and $11,997,354, respectively.

Aggregate Expenditures: ACA and Non-ACA

DY12-Q3				
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	93,095	$3,402,975.66	$2,973,169.65	$332,130.30
Non-ACA	40,410	$954,089.29	$484,020.12	$205,743.37
DY12-Q4				
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	164,050	$6,373,632.89	$5,672,085.80	$513,659.93
Non-ACA	71,584	$1,938,349.98	$978,429.51	$478,900.58
DY13-Q1				
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	1,116,781	$22,209,808.59	$19,751,061.05	$1,623,493.59
Non-ACA	730,342	$11,141,086.97	$5,588,994.08	$1,349,300.04
DY13-Q2				
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
ACA	808,094	$15,658,309.55	$13,934,352.25	$1,094,929.81
Non-ACA	513,000	$7,856,991.44	$3,954,835.97	$993,460.02

ACA and Non-ACA Expenditures by Level of Care for DY12-Q3 through DY13-Q2

Levels of Care: Key to Expenditure Tables

IOT	Intensive Outpatient Treatment Counseling
IOT/CM	Intensive Outpatient Treatment – Case Management
NTP/CM	Narcotic Treatment Program – Case Management
NTPI	Narcotic Treatment Program – Individual Counseling
NTPG	Narcotic Treatment Program – Group Counseling
NTPM	Narcotic Treatment Program – Methadone
ODF/CM	Outpatient Drug Free – Case Management
ODF/MAT	Outpatient Drug Free – Medication Assisted Treatment
ODFG	Outpatient Drug Free – Group Counseling
ODFI	Outpatient Drug Free – Individual Counseling
RES	Residential (Levels of care 3.1, 3.2, 3.3, & 3.5)

RES/CM	Residential – Case Management
RES/WM	Residential – Withdrawal Management
ODFI/RS	ODFI - Recovery Services
ODFG/RS	ODFG – Recovery Services

ACA Expenditures for DY12-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	8,556.18	$269,967.81	$229,415.97	$38,754.85	$1,796.99
ODS/IOT/CM	1,065.20	$23,920.86	$21,696.40	$1,080.85	$1,143.61
ODS/NTPI	11,180.00	$155,402.00	$136,299.06	$6,516.49	$12,586.45
ODS/NTPM	46,366.00	$554,073.70	$485,236.98	$23,245.20	$45,591.52
ODS/ODF/CM	1,366.54	$20,021.86	$17,765.77	$844.26	$1,411.83
ODS/ODF/MAT	9.07	$368.56	$350.11	$18.45	$0.00
ODS/ODFG	5,393.48	$98,075.34	$83,828.04	$3,811.36	$10,435.94
ODS/ODFI	7,983.34	$145,120.97	$123,749.71	$5,509.92	$15,861.34
RES 3.1	1,071.00	$125,691.68	$106,969.84	$18,721.84	$0.00
RES 3.1/CM	56.00	$2,032.24	$1,930.60	$101.64	$0.00
RES 3.2	732.00	$162,572.96	$146,987.33	$7,300.10	$8,285.53
RES 3.5	9,139.00	$1,839,832.46	$1,613,339.39	$225,930.57	$562.50
RES 3.5/CM	155.93	$5,658.82	$5,375.89	$282.93	$0.00
ODS/ODFI/RS	20.00	$222.60	$211.45	$11.15	$0.00
ODS/ODF/CM/RS	1.00	$13.80	$13.11	$0.69	$0.00

ACA Expenditures for DY12-Q4					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	13,378.12	$447,624.07	$380,850.45	$62,363.48	$4,410.14
ODS/IOT/CM	1,402.87	$32,153.30	$29,895.16	$1,535.24	$722.90
ODS/NTP/CM	222.40	$6,894.56	$5,811.41	$262.57	$820.58
ODS/NTPG	12.00	$72.84	$36.42	$0.00	$36.42
ODS/NTPI	19,569.00	$272,058.93	$239,446.21	$11,501.49	$21,111.23
ODS/NTPM	82,107.00	$981,293.35	$859,586.74	$41,174.65	$80,531.96
ODS/ODF/CM	2,013.07	$32,338.41	$28,316.34	$1,332.83	$2,689.24
ODS/ODF/MAT	45.53	$1,851.02	$1,635.14	$78.98	$136.90
ODS/ODFG	9,722.23	$247,032.25	$214,420.80	$10,079.05	$22,532.40
ODS/ODFI	14,050.41	$325,462.63	$275,798.06	$12,362.39	$37,302.18
RES 3.1	1,924.00	$216,273.81	$196,278.57	$19,995.24	$0.00
RES 3.1/CM	246.67	$8,951.55	$7,971.51	$388.49	$591.55
RES 3.2	1,251.00	$291,045.78	$266,989.17	$13,496.53	$10,560.08
RES 3.5	17,504.00	$3,491,513.29	$3,147,355.91	$338,182.07	$5,975.31

ACA Expenditures for DY12-Q4					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
RES 3.5/CM	438.60	$15,916.84	$14,826.94	$763.28	$326.62
ODS/ODFI/RS	109.00	$2,073.75	$1,844.32	$89.78	$139.65
ODS/ODFG/RS	25.20	$503.58	$478.38	$25.20	$0.00
ODS/ODF/RS	28.67	$572.93	$544.27	$28.66	$0.00

ACA Expenditures for DY13-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	366,035.62	$1,500,390.26	$1,305,002.33	$162,871.29	$32,516.64
ODS/IOT/CM	7,368.13	$230,576.51	$197,087.02	$9,085.02	$24,404.47
ODS/NTP/CM	178.00	$5,716.15	$5,168.64	$256.61	$290.90
ODS/NTPG	234.00	$802.62	$686.84	$31.72	$84.06
ODS/NTPI	128,309.00	$1,969,334.21	$1,775,824.79	$87,892.71	$105,616.71
ODS/NTPM	401,267.00	$5,251,734.89	$4,692,841.93	$230,415.82	$328,477.14
ODS/ODF/CM	9,532.34	$310,210.36	$268,922.38	$12,480.96	$28,807.02
ODS/ODF/MAT	72.94	$2,826.54	$2,624.15	$134.61	$67.78
ODS/ODFG	37,854.97	$1,148,968.48	$991,047.35	$46,019.44	$111,901.69
ODS/ODFI	84,670.37	$1,616,870.50	$1,392,423.14	$63,719.75	$160,727.61
RES 3.1	45,884.00	$5,215,969.26	$4,704,022.12	$511,947.14	$0.00
RES 3.1/CM	6,967.67	$235,863.10	$209,945.55	$10,192.51	$15,725.04
RES 3.2	1,263.00	$298,606.82	$266,446.58	$12,950.53	$19,209.71
RES 3.2-WM/CM	35.00	$1,184.05	$1,048.74	$50.73	$84.58
RES 3.3	21.00	$2,958.69	$2,620.62	$338.07	$0.00
RES 3.5	25,019.00	$4,355,145.98	$3,880,697.26	$472,536.22	$1,912.50
RES 3.5/CM	1,378.87	$47,187.97	$41,763.67	$1,997.08	$3,427.22
ODS/ODFI/RS	493.07	$10,758.51	$8,793.01	$379.46	$1,586.04
ODS/ODFG/RS	92.27	$1,829.47	$1,642.90	$81.05	$105.52
ODS/ODF/CM/RS	58.13	$1,832.60	$1,534.43	$68.72	$229.45
ODS/ODF/RS	45.67	$932.34	$813.78	$38.69	$79.87

ACA Expenditures for DY13-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	277,226.12	$1,040,119.01	$909,749.18	$108,113.72	$22,256.11
ODS/IOT/CM	6,015.60	$197,817.08	$174,763.31	$8,379.42	$14,674.35
ODS/NTP/CM	360.33	$12,005.24	$10,924.14	$546.55	$534.55
ODS/NTPG	240.00	$823.20	$698.64	$31.91	$92.65
ODS/NTPI	97,486.00	$1,498,417.96	$1,350,530.93	$66,801.98	$81,085.05

ACA Expenditures for DY13-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/NTPM	261,522.00	$3,428,981.42	$3,057,767.57	$149,664.10	$221,549.75
ODS/ODF/CM	9,314.74	$311,423.86	$269,273.63	$12,472.11	$29,678.12
ODS/ODF/MAT	15.87	$597.89	$568.02	$29.87	$0.00
ODS/ODFG	28,390.72	$908,679.91	$777,622.99	$35,397.97	$95,658.95
ODS/ODFI	65,940.23	$1,261,130.00	$1,091,265.39	$50,279.63	$119,584.98
RES 3.1	35,713.00	$4,074,132.35	$3,682,307.29	$391,825.06	$0.00
RES 3.1/CM	7,420.20	$250,785.83	$222,855.06	$10,691.19	$17,239.58
RES 3.2-WM	1,500.00	$405,805.64	$374,484.57	$19,062.64	$12,258.43
RES 3.2-WM/CM	97.00	$3,281.51	$2,706.42	$118.37	$456.72
RES 3.3	201.00	$28,318.89	$26,903.85	$1,415.04	$0.00
RES 3.3/CM	117.00	$3,958.11	$3,760.20	$197.91	$0.00
RES 3.5	13,685.00	$2,149,544.57	$1,912,245.97	$237,298.60	$0.00
RES 3.5/CM	1,760.53	$59,889.82	$47,437.17	$1,803.25	$10,649.40
ODS/ODFI/RS	395.20	$11,322.28	$9,068.93	$378.73	$1,874.62
ODS/ODFG/RS	128.27	$2,629.96	$2,108.24	$88.12	$433.60
ODS/ODF/CM/RS	77.80	$1,723.18	$1,500.39	$70.97	$151.82
ODS/ODF/RS	61.33	$1,209.90	$1,095.52	$54.53	$59.85

Non-ACA Expenditures for DY12-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	1,814.34	$56,537.90	$28,541.81	$24,269.75	$3,726.34
ODS/IOT/CM	192.93	$4,169.41	$2,084.66	$0.00	$2,084.75
ODS/NTPI	6,328.00	$87,959.20	$43,979.60	$0.00	$43,979.60
ODS/NTPM	24,254.00	$289,835.30	$144,796.38	$0.00	$145,038.92
ODS/ODF/CM	462.07	$6,494.26	$3,279.49	$50.60	$3,164.17
ODS/ODF/MAT	5.00	$203.25	$101.62	$0.00	$101.63
ODS/ODFG	1,842.47	$32,391.48	$16,062.51	$0.00	$16,328.97
ODS/ODFI	3,335.13	$57,564.01	$29,645.84	$279.30	$27,638.87
RES 3.1	333.00	$40,234.79	$20,435.71	$19,799.08	$0.00
RES 3.1/CM	0.00	$0.00	$0.00	$0.00	$0.00
RES 3.2-WM	210.00	$44,596.38	$22,896.36	$0.00	$21,700.02
RES 3.5	1,602.00	$332,978.32	$171,633.68	$161,344.64	$0.00
RES 3.5/CM	31.00	$1,124.99	$562.46	$0.00	$562.53
ODS/ODFI/RS	0.00	$0.00	$0.00	$0.00	$0.00
ODSODF/CM/RS	0.00	$0.00	$0.00	$0.00	$0.00

Non-ACA Expenditures for DY12-Q4					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	2,882.01	$94,583.65	$47,817.81	$43,388.00	$3,377.84
ODS/IOT/CM	204.93	$4,256.96	$2,133.67	$0.00	$2,123.29
ODS/NTP/CM	57.13	$1,771.15	$885.55	$0.00	$885.60
ODS/NTPG	0.00	$0.00	$0.00	$0.00	$0.00
ODS/NTPI	11,370.00	$158,056.59	$79,028.29	$0.00	$79,028.30
ODS/NTPM	44,065.00	$526,606.35	$263,106.91	$0.00	$263,499.44
ODS/ODF/CM	624.27	$10,390.24	$5,400.19	$104.60	$4,885.45
ODS/ODF/MAT	10.80	$439.02	$219.50	$0.00	$219.52
ODS/ODFG	2,888.47	$67,718.99	$34,273.75	$103.74	$33,341.50
ODS/ODFI	4,799.94	$108,828.06	$55,633.59	$2,002.83	$51,191.64
RES 3.1	146.00	$17,093.35	$8,546.41	$8,546.94	$0.00
RES 3.1/CM	8.00	$290.32	$145.16	$0.00	$145.16
RES 3.2-WM	254.00	$58,646.63	$29,323.07	$0.00	$29,323.56
RES 3.5	4,100.00	$884,291.32	$449,227.03	$424,754.47	$10,309.82
RES 3.5/CM	117.13	$4,250.78	$2,125.30	$0.00	$2,125.48
ODS/ODFI/RS	38.00	$758.10	$379.05	$0.00	$379.05
ODS/ODFG/RS	11.80	$235.47	$117.73	$0.00	$117.74
ODS/ODF/RS	6.67	$133.00	$66.50	$0.00	$66.50

Non-ACA Expenditures for DY13-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	151,343.71	$596,030.49	$301,996.90	$233,699.99	$60,333.60
ODS/IOT/CM	3,695.00	$120,152.59	$59,723.75	$82.80	$60,346.04
ODS/NTP/CM	140.27	$4,636.95	$2,318.27	$0.00	$2,318.68
ODS/NTPG	650.00	$2,229.50	$1,114.55	$0.00	$1,114.95
ODS/NTPI	109,108.00	$1,675,687.84	$837,793.78	$0.00	$837,894.06
ODS/NTPM	388,077.00	$5,082,159.67	$2,540,346.64	$0.00	$2,541,813.03
ODS/ODF/CM	4,546.67	$151,464.86	$75,815.77	$0.00	$75,649.09
ODS/ODF/MAT	0.00	$0.00	$0.00	$0.00	$0.00
ODS/ODFG	16,245.53	$490,265.24	$249,689.75	$102.72	$240,472.77
ODS/ODFI	37,263.62	$613,685.37	$309,695.86	$177.78	$303,811.73
RES 3.1	10,650.00	$1,194,154.59	$595,035.88	$597,439.31	$1,679.40
RES 3.1/CM	1,847.00	$62,484.01	$31,222.47	$473.62	$30,787.92
RES 3.2-WM	171.00	$39,460.89	$19,730.21	$0.00	$19,730.68
RES 3.2-WM/CM	9.00	$304.47	$152.23	$0.00	$152.24
RES 3.3	9.00	$1,268.01	$633.96	$634.05	$0.00
RES 3.5	5,933.00	$1,085,136.61	$552,638.80	$516,635.13	$15,862.68

Non-ACA Expenditures for DY13-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
RES 3.5/CM	566.80	$19,484.33	$9,844.60	$0.00	$9,639.73
ODS/ODFI/RS	34.67	$918.05	$459.00	$0.00	$459.05
ODS/ODFG/RS	4.47	$76.43	$38.21	$0.00	$38.22
ODS/ODF/CM/RS	18.73	$762.02	$380.96	$0.00	$381.06
ODS/ODF/RS	27.13	$615.77	$307.85	$0.00	$307.92

Non-ACA Expenditures for DY13-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ODS/IOT	126,310.31	$433,479.12	$221,884.08	$155,873.93	$55,721.11
ODS/IOT/CM	3,068.20	$101,547.57	$52,057.94	$867.12	$48,622.51
ODS/NTP/CM	252.33	$8,439.30	$4,219.45	$0.00	$4,219.85
ODS/NTPG	531.00	$1,825.58	$912.61	$0.00	$912.97
ODS/NTPI	82,146.00	$1,262,637.06	$631,288.25	$0.00	$631,348.81
ODS/NTPM	235,756.00	$3,091,174.16	$1,545,284.18	$0.00	$1,545,889.98
ODS/ODF/CM	4,484.00	$151,193.12	$71,700.97	$169.15	$79,323.00
ODS/ODF/MAT	7.67	$255.33	$127.66	$0.00	$127.67
ODS/ODFG	12,464.02	$387,236.03	$198,793.16	$1,134.32	$187,308.55
ODS/ODFI	29,909.54	$508,315.44	$261,760.83	$440.30	$246,114.31
RES 3.1	9,790.00	$1,113,804.18	$559,300.95	$550,636.89	$3,866.34
RES 3.1/CM	2,291.00	$77,504.53	$38,797.17	$575.11	$38,132.25
RES 3.2-WM	274.00	$76,568.02	$38,282.72	$0.00	$38,285.30
RES 3.2-WM/CM	28.00	$947.24	$473.59	$0.00	$473.65
RES 3.3	234.00	$32,968.26	$16,482.96	$16,485.30	$0.00
RES 3.3/CM	159.00	$5,378.97	$2,689.41	$0.00	$2,689.56
RES 3.5	3,431.00	$560,447.10	$286,397.18	$267,074.92	$6,975.00
RES 3.5/CM	828.53	$28,087.17	$16,795.50	$202.98	$11,088.69
ODS/ODFI/RS	103.40	$2,058.87	$1,029.43	$0.00	$1,029.44
ODS/ODFG/RS	26.60	$552.22	$276.07	$0.00	$276.15
ODS/ODF/CM/RS	18.00	$373.20	$186.54	$0.00	$186.66
ODS/ODF/RS	59.60	$1,209.89	$604.92	$0.00	$604.97

Quality Assurance/Monitoring Activities:

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

- November 7, 2017: Monterey
- November 14, 2017: Imperial
- December 5, 2017: Orange
- December 5, 2017: San Bernardino

Evaluation:

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

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

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

The following activities occurred during this reporting period:

- October 10, 2017 Presentation: UCLA-EQRO-DHCS Meeting*
- October 17, 2017 Technical Assistance: Partnership Health Plan of California and Evaluation Planning for the Regional Model
- November 28, 2017 Meeting: State Epidemiology Workgroup (SEW)
- December 6, 2017 Presentation: CBHDA SAPT Committee Quarterly Meeting
- October-December 2017 Technical Assistance: CalOMS-Tx System Revision
- October-December 2017Technical Assistance: Treatment Perceptions Survey (TPS; Patient Perceptions)

Enclosure/Attachment:

Per CMS' request, attached is a Microsoft Excel file, titled "DY13-Q2 DMC-ODS Expenditures," which contains the data tables contained in this report.

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program (DSHP)

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$18,679,158	$37,358,316	DY 12	$18,679,158
(Qtr 2 Oct - Dec)	$21,977,686	$43,955,371	DY 12	$21,977,686
Total	**$40,656,844**	**$81,313,687**		**$40,656,844**

This quarter, the Department claimed **$21,977,686** in federal fund payments for DSHP eligible services.

Low Income Health Program (LIHP)

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

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

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

DY13-Q2 reporting is for payments made on October 15, 2017. The payments made during this time period were for PY 2, Interim Quarter (IQ) 4, and PY3-IQ1 (July 1, 2017 – September 30, 2017).

This quarter, the PHCS received $497,877,791.50 in federal fund payments and $497,877,791.50 in IGT for GPP. The DSH reduction was applied to the payment methodology for the PY3-IQ1 payment.

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY2-IQ-4	$235,602,039.50	$235,602,039.50	Apr. 1, 2017 – June 2017	$471,204,079.00
PY3-IQ-1	$262,275,752.00	$262,275,752.00	Jul. 1, 2017 – Sept. 2017	$524,551,504.00
Total	**$497,877,791.50**	**$497,877,791.50**		**$995,755,583.00**

Quality Assurance/Monitoring Activities:

PHCS must submit encounter data for PY 2 by March 31, 2018. DHCS developed a secured SharePoint site for the encounter data to be transmitted from the PHCS to DHCS. DHCS is currently conducting an optional round of testing where PHCS can submit data to the SharePoint site to ensure for a smooth transfer of data on March 31, 2018.

Evaluation:

Per STC 173 *Evaluations of provider expenditures and activities under the global payment program*, the State must conduct two evaluations of provider expenditures and activities under the global payment methodology. The first evaluation (using 24 months of data) will occur at the midpoint of the demonstration. The second will occur as part of the interim evaluation report due at the end of GPP PY 4. The two evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the Demonstration. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by PHCS and patients' experience, with a focus on understanding the benefits and challenges of the program.

The RAND Corporation contract term date is from November 15, 2017 – June 30, 2019. On November 15, 2017, DHCS and RAND held a kickoff meeting. RAND SharePoint authorized users have confirmed access to the GPP Encounter Data SharePoint Extranet site for sharing data sets. DHCS has been working with RAND regarding PHCS engagement, survey topics, and survey design.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

On November 15, 2017, DHCS hosted the DY 12 in-person PRIME Learning Collaborative in Sacramento at the Sheraton Grand Hotel with 52 PRIME entities in attendance. The event focused on two major themes for improving the quality of health care delivery – Patient and Community Engagement and Collaboration and Integration.

For the theme of Patient and Community Engagement, Contra Costa Regional Medical Center showcased its work in actively engaging patients in design of improvements to care. Their presentation included a patient panel discussion. Other presentations were provided by Kaweah Delta Health Care District and DHCS regarding patient engagement and community engagement. The University of California, Davis Medical Center and San Francisco Health Network also presented on work achieved within their entities for two required PRIME projects – Integration of behavioral health and Engaging patients in exclusive breastfeeding efforts (as part of the Perinatal Project), respectively.

For the theme of Collaboration and Integration of Care, the Los Angeles County Department of Health Services (LACDHS) presented its journey in integrating its system of care over the past decade, including successful quality improvement interventions which eliminated fragmented care. LACDHS' presentation was followed by a panel discussion with two other PRIME entities, San Mateo Medical Center and Salinas Valley Memorial Healthcare System, who have worked to achieve integration under a fee-for-service business model. The panel discussion provided all PRIME entities with ideas for collaboration and integration, regardless of their individual reimbursement model.

The learning collaborative event featured a poster session where each PRIME entity submitted a storyboard poster showcasing their vision for the sustainable changes that will be made within their system following the end of PRIME in 2020. The entities' posters were both informative and beautifully creative. All in attendance were inspired by the thought and effort that went into creating the entities' posters.

DHCS hosted a networking session the night before the event, on November 14, 2017. PRIME entities were able to meet contacts within other PRIME entities for help

and collaborating on similar PRIME projects.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr 1 July - Sept)	$0	$0	DY 12	$0
(Qtr 2 Oct – Dec)	$460,140,476.00	$460,140,475.99	DY 12	$920,280,951.99
Total	**$460,140,476.00**	**$460,140,475.99**		**$920,280,951.99**

In DY13-Q2, DY 12 annual payments were issued beginning October 1, 2017. Jerold Phelps Community Hospital and Tulare Regional Medical Center payments are excluded in the table above. Jerold Phelps Community Hospital were not paid until January 5, 2018. Tulare Regional Medical Center is still pending approval from DHCS.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$460,140,476.00** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

DY 12 Year-End reports have been approved for completeness and are currently under clinical and comprehensive review.

Evaluation:

The University of California Los Angeles Center for Health Policy Research (UCLA CHPR) is the PRIME external evaluator, and UCLA CHPR continued its gathering of data elements during DY13-Q2 for both OSHPD and Medi-Cal data.

UCLA CHPR continued to develop a PRIME entity staff survey which will supply quantitative data for the evaluation. The survey will be piloted among select PRIME entities in DY13-Q3. Following results of the pilot, a final survey will be launched in DY13-Q3.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

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

Total Member Months for Mandatory SPDs by County

County	Total Member Months
Alameda	87,453
Contra Costa	52,758
Fresno	72,119
Kern	56,667
Kings	7,912
Los Angeles	596,579
Madera	7,249
Riverside	104,866
San Bernardino	109,384
San Francisco	115,613
San Joaquin	121,893
Santa Clara	44,652
Stanislaus	49,850
Tulare	67,434
Sacramento	36,205
San Diego	31,924
Total	**1,562,558**

Total Member Months for Existing SPDs by County

County	Total Member Months
Alameda	62,603
Contra Costa	28,734
Fresno	38,697
Kern	25,971
Kings	4,004
Los Angeles	1,160,475
Madera	3,972
Marin	19,529
Mendocino	17,627
Merced	48,357
Monterey	48,299
Napa	14,328
Orange	372,843
Riverside	161,283
Sacramento	62,592
San Bernardino	157,622
San Diego	228,610
San Francisco	43,233
San Joaquin	25,849
San Luis Obispo	25,125
San Mateo	66,820
Santa Barbara	46,456
Santa Clara	151,799
Santa Cruz	31,840
Solano	59,279
Sonoma	53,218
Stanislaus	15,593
Tulare	17,653
Ventura	86,499
Yolo	26,151
Total	**3,105,061**

Total Member Months for SPDs in Rural Non-COHS Counties

County	Total Member Months
Alpine	79
Amador	1,114
Butte	19,369
Calaveras	1,754
Colusa	846
El Dorado	5,253
Glenn	1,652
Imperial	10,258
Inyo	515
Mariposa	665
Mono	208
Nevada	3,343
Placer	9,366
Plumas	1,016
San Benito	273
Sierra	116
Sutter	5,895
Tehama	5,170
Tuolumne	2,654
Yuba	6,484
Total	**76,030**

Total Member Months for SPDs in Rural COHS Counties

County	Total Member Months
Del Norte	8,086
Humboldt	26,729
Lake	19,324
Lassen	4,490
Modoc	1,888
Shasta	40,857
Siskiyou	11,197
Trinity	2,818
Total	**115,389**

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Not applicable.

WHOLE PERSON CARE (WPC)

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

The local WPC pilots 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 to expand access to supportive housing options for these high-risk populations. The WPC pilots are developed and operated locally by an organization eligible to serve as the lead entity (LE). LEs must be a county, a city, a city and county, a health or hospital authority, a designated public hospital or a district/municipal public hospital, a federally-recognized tribe, a tribal health program operated under contract with the federal Indian Health Services, or a consortium of any of the above entities.

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

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

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

The second round LEs began implementing the new WPC pilots, and changes to existing pilots, on July 1, 2017. With the existing 18 first round WPC pilots, the 7 new WPC pilots make a total of 25 WPC pilots.

WPC pilot Program Years (PY) are full calendar years for first round WPC pilots. For the second round WPC pilots, PYs 1 and 2 are half a year each, with full years starting in PY 3. The WPC pilots that started in the first round and expanded their programs in the

second round follow the PY structure for the first round. PYs become identical for both rounds in PY 3.

Medi-Cal 2020 Demonstration Years (DY) are based on fiscal years from July through June of the following year. The table below shows the WPC pilot PYs with the corresponding DYs, including the quarters (Q) of the DY.

First Round WPC Pilots

WPC Pilot PY	Corresponding DYs
PY 1: January 1 – December 31, 2016	DY 11: January 1 – June 30, 2016 DY 12, Q 1 and 2: July 1 – December 31, 2016
PY 2: January 1 – December 31, 2017	DY 12, Q 3 and 4: January 1 – June 30, 2017 DY 13, Q 1 and 2: July 1 – December 31, 2017
PY 3: January 1 – December 31, 2018	DY 13, Q 3 and 4: January 1 – June 30, 2018 DY 14, Q 1 and 2: July 1 – December 31, 2018
PY 4: January 1 – December 31, 2019	DY 14, Q 3 and 4: January 1 – June 30, 2019 DY 15, Q 1 and 2: July 1 – December 31, 2019
PY 5: January 1 – December 31, 2020	DY 15, Q 3 and 4: January 1 – June 30, 2020 DY 16, Q 1 and 2: July 1 – December 31, 2020

Second Round WPC Pilots

WPC Pilot PY	Corresponding DYs
PY 1: January 1 – June 30, 2017	DY 12, Q 3 and 4: January 1 – June 30, 2017
PY 2: July 1 – December 31, 2017	DY 13, Q 1 and 2: July 1 – December 31, 2017
PY 3: January 1 – December 31, 2018	DY 13, Q 3 and 4: January 1 – June 30, 2018 DY 14, Q 1 and 2: July 1 – December 31, 2018

PY 4: January 1 – December 31, 2019	DY 14, Q 3 and 4: January 1 – June 30, 2019 DY 15, Q 1 and 2: July 1 – December 31, 2019
PY 5: January 1 - December 31, 2020	DY 15, Q 3 and 4: January 1 – June 30, 2020 DY 16, Q 1 and 2: July 1 – December 31, 2020

Enrollment Information:

Quarterly enrollment counts include unique enrollees. DY13-Q2 (October to December 2017) data is not available due to normal data lag and will be reported in the next quarterly report. Enrollment data is extracted from the LE self-reported Quarterly Enrollment and Utilization reports. DY13-Q1 is the first data submission for the seven new LEs that implemented WPC pilot programs on July 1, 2017. Enrollment numbers reflect the various stages of WPC pilot implementation.

Lead Entity	DY13-Q1 (July – Sept 2017) Unduplicated Enrollees	Total Unduplicated Enrollees through DY13-Q1
Alameda	666	1,059
Contra Costa	7,941	15,262
Kern	34	34
Kings*	5	5
Los Angeles	2,785	9,498
Marin*	0	0
Mendocino*	0	0
Monterey	9	41
Napa	82	82
Orange	745	1,307
Placer	59	123
Riverside	0	0
Sacramento*	0	0
San Bernardino	106	113
San Diego	0	0
San Francisco	1,725	8,087
San Joaquin	39	39
San Mateo	114	2,357

Lead Entity	DY13-Q1 (July – Sept 2017) Unduplicated Enrollees	Total Unduplicated Enrollees through DY13-Q1
Santa Clara	13	2,730
Santa Cruz*	149	149
SCWPCC*	0	0
Shasta	52	86
Solano	9	40
Sonoma*	0	0
Ventura	133	133
Total	**14,666**	**41,145**

* Indicates new LEs that implemented WPC pilots on July 1, 2017.

Note: Enrollment numbers reflect updated data files submitted by LEs after the publishing date of the prior quarterly report.

Member Months:

Quarterly and cumulative member months are reflected in the table below. Member months are extracted from the LE self-reported Quarterly Enrollment and Utilization reports. DY13-Q1 is the first data submission for the seven new LEs that implemented their programs on July 1, 2017. DY13-Q2 (October to December 2017) data is not available due to normal data lag and will be reported in the next quarterly report. Member months reflect the various stages of WPC pilot implementation.

Lead Entity	DY13-Q1 (July-Sept 2017)	Cumulative through DY13-Q1
Alameda	2,683	3,965
Contra Costa	34,010	50,270
Kern	34	34
Kings*	5	5
Los Angeles	17,561	44,578
Marin*	0	0
Mendocino*	0	0
Monterey	112	187
Napa	238	238
Orange	3,278	4,764
Placer	284	453

Lead Entity	DY13-Q1 (July-Sept 2017)	Cumulative through DY13-Q1
Riverside	0	0
Sacramento*	0	0
San Bernardino	107	114
San Diego	0	0
San Francisco	21,223	47,451
San Joaquin	79	79
San Mateo	6,000	17,948
Santa Clara	7,915	12,819
Santa Cruz*	149	149
SCWPCC*	0	0
Shasta	172	214
Solano	113	189
Sonoma*	0	0
Ventura	196	196
Total	**94,159**	**183,653**

*Indicates new LEs that implemented WPC pilots on July 1, 2017.

Note: Member months reflect updated data files submitted by LEs after the publishing date of the prior quarterly report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Due to the devastating effects of multiple fires, Governor Edmund G. Brown Jr. declared a state of emergency in this quarter in the following counties participating in WPC: Los Angeles, Mariposa, Mendocino, Napa, Orange, San Diego, Solana, Sonoma, and Ventura. The fires destroyed hundreds of homes and structures, caused the evacuation of thousands of residents, and damaged critical infrastructure. DHCS held a teleconference on November 13, 2017, with LEs in the counties affected by these disasters and offered the option for LEs to request reallocation of their existing WPC funds to increase services already in place, such as additional housing assistance, to assist in the recovery effort, as allowed in accordance with the STCs. As of December 31, 2017, DHCS did not receive any reallocation requests.

DHCS continued bi-weekly technical assistance (TA) calls with the LEs during this quarter. TA calls provide opportunities for the LEs to engage with DHCS, the Learning

Collaborative (LC) team, and one another. Calls alternate between focusing on administrative issues, such as reporting and learning, and LC topics, such as staffing and data systems. Administrative topics include DHCS guidance, reporting templates, timelines, and expectations. LC-focused topics are generated in response to LE needs. The LC-focused call topics during this quarter included Strategies for Engaging the Full Range of Community Partners, In-Person Meeting Debrief, and Maximizing Limiting Housing Stock.

The following list of resources and documents are available at the WPC Learning Collaborative Portal:

- Project calendar
- Project contacts
- Project resources

On October 10, 2017, DHCS held a Budget Adjustment and Rollover webinar to provide responses to LEs' questions and resources needed for LEs to submit optional Budget Adjustment and Rollover requests. A Budget Adjustment allows LEs to reallocate funds for subsequent PYs, while a Rollover allows LEs to forward remaining funds from the current year to a future year to cover costs not already incurred. These requests allow LEs the flexibility to more fully maximize funding integral to the success of the WPC and support the activities aligned with WPC pilot goals and objectives, including the expansion of services and enrollment.

On October 13, 2017, DHCS held a LC-focused webinar on Sharing Engagement Strategies: Pilot Approaches for Engaging Hard to Reach Populations. The webinar provided an opportunity for LEs to hear from peers in Contra Costa, San Francisco, and Los Angeles about the challenges and successes they experienced in outreaching to and engaging with the WPC-eligible population.

On October 24, 2017, DHCS held the second bi-annual in-person meeting in Burbank, California, in collaboration with LC consultants. Attendees included LEs, the California Association of Public Hospitals/Safety Net Institute, and DHCS staff. The agenda included Key Strategies for Creating Effective Partnerships, Developing and Leveraging Data Infrastructure, Risk Stratification Strategies, Improving Care Coordination, Addressing the Needs of the Homeless and Justice-Involved Populations, Sustaining Change: Change Management Strategies, Engaging Hard to Reach Clients, Hiring, and Workforce Engagement, one-on-one meetings between DHCS and LEs at LEs' requests, and a panel discussion with State staff.

On November 30, 2017, 19 LEs submitted Budget Adjustment requests and 18 LEs submitted initial Rollover requests. DHCS anticipates approving Budget Adjustment requests in the next quarter. LEs may submit final Rollover requests by January 31, 2018, with approval anticipated in the subsequent quarter.

On December 15, 2017, DHCS held a LC webinar on Data Interoperability with

discussion on Health Information Technology (HIT) infrastructure (including client enrollment and tracking), care management, health information exchange, and reporting/analytics. In order to provide care planning and care coordination, LEs have entered into new and challenging HIT territory by endeavoring to integrate data from health providers, county agencies, prisons/jails, and social service partners. Representatives from Contra Costa County, SWCPCC, and the City of Sacramento also shared their challenges, successes, and opportunities in working toward better data interoperability.

Consumer Issues:

DHCS continues to work with stakeholders on the implementation and operation of the WPC pilot program.

Financial/Budget Neutrality Development/Issues:

On October 11, 2017, DHCS released the final Budget Adjustment and Rollover templates after completing the development of both the optional Budget Adjustment and Rollover processes. The Budget Adjustment process allows adjustments to future PY budgets within each LE budget, while the Rollover process allows an LE to move budgeted funds from the current year to the next year's budget.

On November 17, 2017, DHCS released the WPC payments for DY 12 to the 18 first round LEs. These payments, totaling $126,619,305.36, were made through the intergovernmental transfer (IGT) process. The payments included the 50% federal financial participation (FFP) and 50% local non-federal share amounts of $63,309,652.68 for the time period January 1 through June 30, 2017.

Payment	FFP	IGT	Service Period	Total Funds Payment
DY13-Q1 (July 1 – Sept 30, 2017)	$9,730,650.50	$9,730,650.50	DY 12	$19,461,301.00
DY13-Q2 (Oct 1– Dec 31, 2017)	$63,309,652.68	$63,309,652.68	DY 12	$126,619,305.36
Total	**$73,040,303.18**	**$73,040,303.18**		**$146,080,606.36**

On November 30, 2017, LEs submitted their Budget Adjustment and initial Rollover requests to DHCS. DHCS anticipates approving Budget Adjustment requests in the next quarter. LEs may submit final Rollover requests by January 31, 2018.

Payments

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 3 (Jan 1 - March 31)	$216,844,940.25	$216,844,940.25	DY 11 (PY 1)	$433,689,880.50
Qtr 4 (April 1 - June 30)	$22,206,521.50	$22,206,521.50	DY 11 (PY 1)	$44,413,043.00
DY 13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr 1 (July 1 - Sept 30)	$9,730,650.50	$9,730,650.50	DY 12 (PY 1)	$19,461,301.00
Total	**$248,782,112.25**	**$248,782,112.25**		**$497,564,224.50**

DHCS continues to develop both the budget adjustment and rollover processes. The budget adjustment process allows adjustments to future PY budgets within each WPC LE budget, while the rollover process allows an LE to move budgeted funds from the current year to the next year's budget. DHCS released the budget adjustment and rollover templates for comment. The final templates are anticipated to be released early next quarter.

Quality Assurance/Monitoring Activities:

On September 30, 2017, each of the 18 first round LEs submitted a Mid-Year report with the Variant and Universal Metrics and Plan Do Study Act (PDSA) reports and an invoice. The November 17, 2017, IGT payments were based on these reports and invoices.

On October 31, 2017, each LE submitted a third quarter Enrollment and Utilization report. This report includes required data elements for enrollment status, homeless status, and disenrollment.

These reports are tools for counties and DHCS to assess the degree to which the LEs are achieving their goals. In addition, metrics tracking will inform decisions on appropriate changes by LEs and DHCS, when necessary, to improve the performance of WPC pilots. These reports are also used to monitor and evaluate the WPC pilot programs and for payment purposes to verify invoice payments.

Evaluation:

On October 16, 2017, DHCS executed a contract with the University of California at Los Angeles (UCLA), effective November 1, 2017, to provide evaluation services for the WPC.

On November 1, 2017, UCLA initiated the following evaluation activities:

- Applications to the UCLA Office of the Human Protection Program and the DHCS Institutional Review Board to conduct the research.
- Collection of first round WPC pilot applications from DHCS and analyses of that data.
- Development of preliminary instruments and questionnaires for structured and semi-structured interviews to collect initial qualitative data from LEs. These results will describe the WPC pilots' implementation, challenges, and strategies.

On December 8, 2017, DHCS submitted the WPC Final Evaluation Design to CMS in response to CMS' comments and suggestions provided on September 21, 2017, and November 22, 2017.