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

Section 1115 Waiver Annual Report

Demonstration Reporting Period:
Demonstration Year: Twelve (July 1, 2016 – June 30, 2017)

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INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 12 to the Centers for Medicare & Medicaid Services (CMS), in accordance with Item 26 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 12:

- Accomplishments
- Program Highlights
- Qualitative and Quantitative Findings
- Policy and Administrative Issues or Challenges
- Progress on the Evaluation and Findings

DHCS submitted an application to renew the State's Section 1115 Waiver Demonstration to CMS on March 27, 2015 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 (STCs). The conceptual agreement included the following core elements:

- Global Payment Program for services to the uninsured in designated public hospital (DPH) systems
- Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals, known as PRIME
- Dental Transformation Incentive program
- Whole Person Care pilot program that would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations
- Independent assessment of access to care and network adequacy for Medi-Cal managed care members
- Independent studies of uncompensated care and hospital financing

- The continuation of programs currently authorized in the Bridge to Reform waiver, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Coordinated Care Initiative, and Community-Based Adult Services (CBAS)

Effective on December 30, 2015, CMS approved the extension of California's section 1115(a) Demonstration (11-W-00193/9). 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.

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 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). The bill, chaptered on July 8, 2016, establishes and implements the provisions of the State's Waiver Demonstration as required by the STCs from CMS. The bill also provides clarification for changes to the current Disproportionate Share Hospital (DSH) methodology and its recipients for facilitating the GPP program.

On 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.

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.

On June 1, 2017, DHCS 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.

TIME PERIODS:

Demonstration Year

The periods for each Demonstration Year (DY) of the Waiver will consist of 12 months, except for DY 11 and DY 16, which will be 6 months respectively. The DY timeframes are identified below:

- 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

Annual Report

This report covers the period from July 1, 2016 through June 30, 2017.

GENERAL REPORTING REQUIREMENTS:

- **Item 8 of the STCs – Amendment Process**

Dental Transformation Initiative

On August 15, 2016, DHCS submitted a waiver amendment package to CMS to revise the methodology in determining the baseline metrics that will be used by new and existing dental service office locations for purposes of receiving incentive payments. In addition, the amendment would authorize DHCS to disburse partial incentive payments to provider service office locations that partially meet annual increases in the preventive services provided to children above the pre-determined baseline. DHCS received CMS' approval for this waiver amendment on December 8, 2016.

Health Homes Program

On November 10, 2016, DHCS submitted an amendment to the STCs to allow a freedom of choice waiver to provide Health Homes Program (HHP) services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Fee-For-Service (FFS) beneficiaries who meet HHP eligibility criteria may choose to enroll in a Medi-Cal managed care health plan (MCP) to receive HHP services as well, as all other state plan services that are provided through MCPs. HHP services will not be provided through a FFS delivery system.

On November 23, 2016, DHCS received notice from CMS stating its preliminary review of the state's amendment request met the requirements for a complete amendment request as specified in the STCs. In accordance with STC 7, CMS acknowledged receipt of the state's amendment request.

Medi-Cal Access Program Transition to Managed Care

On February 16, 2017, DHCS sent CMS a request for a waiver amendment that would enable DHCS to add the Medi-Cal Access Program (MCAP) population to the Medi-Cal managed care delivery system. DHCS requested this waiver amendment have an effective date of July 1, 2017. DHCS requested a May 1, 2017, amendment approval date in order to ensure the smooth and timely transition of MCAP subscribers to the Medi-Cal managed care delivery system effective July 1, 2017.

On April 26, 2017, DHCS met with CMS regarding the February 16, 2017, 1115 waiver amendment request to discuss the flexibilities and options that exist under a Children's Health Insurance Program (CHIP) State Plan Amendment (SPA). After the meeting, CMS instructed DHCS to withdraw the 1115 Waiver and cover the MCAP transition to the managed care delivery system through the CHIP SPA. DHCS has been given until

June 30, 2018, to submit the MCAP managed care delivery system SPA, with a retroactive effective date of July 1, 2017.

Whole Person Care Pilot

On June 15, 2016, DHCS submitted an amendment request to expand the definition of an allowable Whole Person Care (WPC) pilot lead entity (LE) to include Federally Recognized Tribes and Tribal Health Programs operating under a Public Law (PL) 93-638 contract with the Federal Indian Health Services (IHS). This amendment was approved by CMS on December 8, 2016.

On March 7, 2017, DHCS submitted a technical amendment to the STCs to allow DHCS to accept applications and designate a city to be a pilot LE. This technical amendment was approved by CMS on June 1, 2017.

Out-of-State Former Foster Care Youth

On May 19, 2017, DHCS submitted an amendment request to CMS to allow DHCS to continue providing Medicaid coverage for former foster care youth under age 26. DHCS requested an effective date no later than November 1 for this waiver amendment proposal in order to have sufficient time for providing guidance to the counties for implementation.

- **Item 16 of the STCs – Public Notice, Tribal Consultation, and Consultation with Interested Parties**

Dental Transformation Initiative

Public Notice:

- The amendment was discussed during all DTI sub-workgroup meetings.
- The DTI Domain 1 fact sheet, which includes a description of the amended process, was posted on the DTI website on June 1, 2016.
- DHCS advised meeting participants of the proposed amendment request during the June 14, 2016 webinar.
- On July 14, 2016, the waiver amendment request was posted on the DTI website.
- An email announcement was sent to the DTI stakeholder distribution list on July 28, 2016.
- A DTI program overview and amendment update were provided for the DHCS Stakeholder Advisory Committee on August 11, 2016.
- The amendment was raised during the budget template webinar on August 18, 2016.

Tribal Notice:
On July 14, 2016, DHCS' Primary, Rural, and Indian Health Division issued a tribal notice regarding the State's intention to request the waiver amendment and posted it for thirty days on the DHCS website at: http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx. The tribal notice is available online at: http://www.dhcs.ca.gov/services/rural/Documents/Web1115MC2020WA-DTIV1.pdf.

No questions or comments regarding the amendment were received.

Health Homes Program – Freedom of Choice Amendment

Public Notice:
On September 26, 2016, DHCS, in its Medi-Cal 2020 News Update, provided public notice regarding its amendment to the STCs allowing a freedom of choice waiver to provide HHP services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care.

Tribal Notice:
On September 20, 2016, DHCS submitted a tribal notice seeking advice from designees of Indian Health Programs (IHPs) and Urban Indian Organizations (UIOs) concerning its amendment to the STCs implementing the HHP in Medi-Cal managed care. No questions were received. Additional information can be found on DHCS' IHP's website: http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx

Additionally, DHCS advised meeting participants of the amendment during the May 5, 2017, Medi-Cal Tribal and IHP Designee Meeting webinar. The webinar presentation is available at: http://www.dhcs.ca.gov/services/rural/Documents/ACA2703HealthHome_5-5-17.pdf

Medi-Cal Access Program (MCAP) Transition to Managed Care

Public Notice:
On December 13, 2016, DHCS publicly shared this amendment request in the Medi-Cal 2020 newsletter.

Tribal Notice:
On December 5, 2016, CMS accepted DHCS' written rationale for no tribal consultation.

Out-of-State Former Foster Care Youth Amendment

Public Notice:
DHCS publicly shared this amendment through the following channels:

- Stakeholder meetings on December 8, 2016; January 12, 2017; February 9, 2017; March 9, 2017; and May 11, 2017
- Stakeholder call on April 26, 2017

- Notice was posted to the DHCS website on May 1, 2017
- Distribution through DHCS listservs and Medi-Cal 2020 Newsletter on May 1, 2017

No stakeholder questions or comments were received prior to submission of the waiver amendment request to CMS.

Tribal Notice:
On April 14, 2017, CMS accepted DHCS' written rationale for no tribal consultation or publication.

WPC Pilot – Tribal Entity Amendment

Public Notice:
Various stakeholder meetings were conducted, and continued to be conducted, through in-person meetings, webinars, and teleconferences through the amendment process.

Tribal Notice:
On May 10, 2016, DHCS issued a notice to all Tribal Chairpersons, Designees of IHPs, and UIOs regarding this proposed amendment in accordance with California's State Plan requirements for Tribal notice of Medi-Cal program proposed changes (35 days prior to submission of the amendment request to CMS).

On May 31, 2016, DHCS presented on this amendment at the "Medi-Cal Tribal and Designee Quarterly Webinar Regarding Proposed Changes to the Medi-Cal Program."

On November 30, 2016, DHCS held a second webinar for tribes and tribal organizations to discuss proposed changes to the Medi-Cal program. Upon CMS approval of the STCs, tribes and tribal organizations may apply as LEs. As with all WPC pilots, LEs must provide a source of the non-federal share of funding (50% of the program funding) to support the WPC pilot. Additional information can be found on the DHCS Indian Health Program's website:
http://www.dhcs.ca.gov/services/rural/Documents/Web_WPC-Medi-Cal_2020_Waiver_Amendment.pdf

WPC Pilot – City Entity Technical Amendment

Public Notice:
In early March 2017, DHCS provided public notice for this proposed amendment through a notice emailed to the DHCS General Stakeholders distribution list, which included approximately 4,500 individuals, who joined the list to receive significant Medi-Cal updates.

Tribal Notice:
On February 27 and 28, 2017, CMS accepted the state's written rationale for not providing a tribal consultation or publication related to its technical amendment to the STCs to designate a city as a pilot LE.

- **Item 17 of the STCs – Post Award Forum**

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

In DY 12, DHCS hosted four SAC Meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- August 11, 2016
- October 24, 2016
- February 16, 2017
- May 17, 2017

In the August 2016 meeting, DHCS discussed the findings of the first Uncompensated Care Report and the GPP Funding for DY 12-15. Moreover, DHCS provided updates on DTI's Domains 1-3 and the timeline and process for Domain 4's local dental pilot projects (LDPPs).

In the October 2016 meeting, DHCS offered an update on WPC applications, which were pending CMS' approval at the time. The California Association of Public Hospitals and Health Systems shared some information regarding the baseline data collection for PRIME and potential next steps for the program. SAC members also inquired about the WPC pilot implementation timeline, GPP reporting requirements, Medi-Cal 2020 evaluation efforts, and the DMC-ODS approved projects.

In the February 2017 meeting, DHCS shared the Coordinated Care Initiative Duals Demonstration Project, DTI, and WPC program updates. The California Dental Association provided an overview of the Medi-Cal dental program, oral health, and the

DTI; similarly, the State Oral Dental Director from the California Department of Public Health presented on the State Oral Health Plan. DHCS provided an overview of the first round of WPC approved pilot projects and described the process for the second round of applications open to all county, city, or tribal entities. In addition, representatives from Los Angeles and Placer Counties shared overviews and implementation progress updates for their respective WPC pilot projects.

- **Item 23 of the STCs – Contractor Reviews**

Nothing to report.

- **Item 24 of the STCs – Monthly Calls**

CMS and DHCS schedules monthly conference calls to discuss any significant or actual anticipated developments affecting the Demonstration. During DY 12, the conference calls were held on the following dates:

- August 8, 2016
- November 21, 2016
- December 12, 2016
- January 9, 2017
- February 13, 2017
- March 12, 2017
- April 10, 2017
- May 8, 2017
- June 12, 2017

The main discussion topics included: the access assessment report, financial reporting and budget neutrality for the waiver, updates on waiver evaluation designs, various waiver program implementation updates, and the completion of other waiver deliverables.

- **Item 25 of the STCs – Demonstration Quarterly Reports**

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each Demonstration quarter. Four reports for DY 12 were submitted to CMS electronically on the following dates:

- Quarter 1 (07/01/16 – 09/30/16) – Submitted 11/28/16
- Quarter 2 (10/01/16 – 12/31/16) – Submitted 03/01/17
- Quarter 3 (01/01/17 – 03/31/17) – Submitted 05/30/17

- Quarter 4 (04/01/17 – 06/30/17) – Submitted 08/24/17

- **Item 26b of the STCs – Primary Care Access Measures for Children**

DHCS requires MCPs to annually report on the quality metrics that DHCS identifies in the External Accountability Set. In Reporting Year 2017, which includes data from January 1 – December 31, 2016, MCPs reported rates for the following four primary care access measures for children (Children and Adolescents' Access to Primary Care Practitioners - 12 to 24 Months, Children and Adolescents' Access to Primary Care Practitioners - 25 Months to 6 Years, Children, and Adolescents' Access to Primary Care Practitioners - 7 to 11 Years, and Children and Adolescents' Access to Primary Care Practitioners - 12 to 19 Years). When establishing Minimum Performance Levels (MPLs) and High-Performance Levels (HPLs) for quality metrics, DHCS utilizes the national Medicaid benchmarks from the National Committee for Quality Assurance Quality Compass, setting the MPL at the 25th percentile and the HPL at the 90th percentile. In Reporting Year 2017, the difference between the national Medicaid 25th percentile and 90th percentile was 10 percentage points or less for the four primary care access measures. DHCS publicly reports the results of the quality metric reporting annually as part of the online External Quality Review Organization (EQRO) Technical Report.

- **Item 28 of the STCs – Revision of the State Quality Strategy**

On behalf of DHCS, the Office of the Medical Director (OMD) is overseeing the annual revision to the DHCS Strategy for Quality Improvement in Health Care (Quality Strategy) http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdf.

All Divisions and Offices throughout DHCS have been invited to update their respective quality improvement projects and report on their progress to date. In addition, the OMD team is reaching out across the Department to invite new participation. The Quality Strategy serves as a blueprint, outlining specific programs and policies the Department is undertaking and prioritizing to improve clinical quality and advance population health among the members, patients, and families we serve. This marks the fifth version of the blueprint to be distributed by the Department. Future updates of the Quality Strategy will accommodate the requirements from the CMS Final Rule and will be created in collaboration with multiple divisions across the Department.

- **Item 29 of the STCs – External Quality Review**

DHCS meets all of the requirements found in Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E. DHCS releases an annual External Quality Review (EQR) Technical Report to CMS and the public. EQR Technical Reports are viewable on

DHCS' Medi-Cal Managed Care – Quality Improvement & Performance Measurement webpage at:
htt://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx

- **Item 30 of the STCs – Certified Public Expenditures (CPE)**

Drug Medi-Cal Organized Delivery System

DHCS proposed a revised CPE Protocol/Attachment AA of the STCs to CMS on March 27, 2017 for DMC-ODS. DHCS and CMS continue to work through the proposed revisions for the existing CPE Protocol.

- **Item 31 of the STCs – Designated State Health Programs**

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

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

The Medi-Cal 2020 STCs allow the State to claim Federal Financial Participation (FFP) using the CPE of approved DSHP. The annual FFP limit the State may claim for DSHPs during each demonstration year is $75 million for a five-year total of $350 million.

In DY 12, Designated Health Program received $75,000,000 in federal fund payments.

Payment	FFP	CPE	Service Period	Total Claim
(Qtr 1 July - Sept)	$21,004,142	$42,008,284	DY 11	$21,004,142
(Qtr 2 Oct - Dec)	$18,731,270	$37,462,540	DY 11	$18,731,270
(Qtr 3 Jan – Mar)	$18,647,737	$37,295,474	DY 11	$18,647,737
(Qtr 4 Apr – June)	$16,616,851	$33,233,702	DY 11	$16,616,851
Total	**$75,000,000**	**$150,000,000**	**-**	**$75,000,000**

- **Item 34 of the STCs – Managed Care Expansions**

The Department awarded contracts to two plans, United Health Care and Aetna, both of which will operate in Sacramento and San Diego Counties. United Health Care completed the required plan readiness process and is going live October 1, 2017. Aetna is currently completing the Plan readiness process and is set to go live no sooner than January 1, 2018, assuming they meet all necessary readiness requirements.

- **Item 35 of the STCs – Encounter Data Validation Study for New Health Plans**

The Encounter Data Quality Unit annually performs an Encounter Data Validation study with its EQRO. During each study, encounter data is reviewed for completeness and accuracy; and is obtained from a sample of medical records as required by STC 35. Newly established MCPs are subject to this requirement 18 months after their effective date.

Since DY 8, DHCS has contracted with Health Services Advisory Group, Inc. (HSAG), to conduct an Encounter Data Validation (EDV) study. In 2015, DHCS signed a new three-year contract with HSAG to continue conducting EDV studies.

DY 11 EDV activities focused on providing technical assistance to MCPs in an effort to ameliorate the findings of the DY 2013-14 EDV study. Results of the technical assistance activities identified data quality areas for improvement. DHCS transitioned its MCPs to a national standard format in 2015, which alleviated some of the data quality issues originally identified during the review process.

The DY 12 EDV study began examining the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs and Specialty Health Plans. The study reviewed DHCS' encounter data from the data warehouse against MCP medical records. Due to a migration from multiple provider files to a consolidated, enhanced provider file, HSAG did not complete the study as indicators could not accurately be determined from the data collected, resulting in inaccurate analysis.

In DY 13, with the full conversion of DHCS' provider data file, DHCS anticipates a complete EDV study examining the completeness and accuracy of DHCS encounter data submissions when compared to information contained within the MCP medical records.

- **Item 36 of the STCs – Submission of Encounter Data**

The State is working with CMS to submit encounter data through the Transformed Medicaid Statistical Information System (TMSIS) in alignment with current Federal laws,

policy, and regulations. Encounter data file submissions are received and checked for completeness and accuracy, which includes eligibility verification checks upon receipt of the data to the State from the managed care entities. The State was approved to move into production for data transmission for the TMSIS in May 2017. As of June 30, 2017, the State had TMSIS files through November 2015. The State expects to be current with TMSIS reporting by March 2018.

- **Item 38 of the STCs – Contracts**

Nothing to report.

- **Item 40 of the STCs – Network Adequacy**

To ensure that each MCP has a provider network that is sufficient to provide access to all services covered in the contract, DHCS performs a network certification and network readiness review when expansion occurs or there is a significant benefit change.

DHCS requires all MCPs to submit quarterly reports that include network adequacy data and notice of significant changes. MCPs also submit provider network data to DHCS on a monthly basis. Data summaries are included with quarterly waiver reports to CMS. DHCS actively works with MCPs to resolve any issues and concerns identified.

Data analysis and inquiries are incorporated in the Department of Managed Health Care (DMHC)/DHCS joint review letters, and they are sent to the MCPs quarterly for responses and necessary resolutions. MCPs then provide responses to the identified deficiencies, which DMHC/DHCS evaluates during the next quarterly review. Network adequacy indicators that are monitored include, but are not limited to, the following:

  - Primary Care Provider (PCP) Capacity (PCPs accepting new enrollees)
  - PCP-to-member ratios
  - Physician-to-member ratios
  - DMHC Help Center data of complaints
  - Termination of contracts
  - Material modification
  - PCP time and distance standards
  - Reasonable geographical access to specialists
  - Availability of PCPs and specialists
  - Timely access to PCPs and specialists
  - MCP alternate access standards
  - Out of network requests/approvals/denials
  - Hospital admitting privileges
  - Hospital geographical access
  - State Fair Hearings

- Independent Medical Reviews

During DY 12, DHCS closely monitored all MCP provider networks and reviewed and analyzed the quarterly and monthly network adequacy data. These monitoring activities are conducted on an ongoing quarterly basis.

- **Item 41 of the STCs – Network Requirements**

In DY 12, in addition to existing network requirements, DHCS continued the process of implementing new network adequacy standards. These standards will consider elements specified in 42 CFR Section 438.68 such as anticipated enrollment, expected utilization, the numbers and types of providers required to provide contracted services, the ability of providers to communicate with limited English proficient beneficiaries in their preferred language, and the availability of telehealth and other evolving technological solutions that will benefit the Medi-Cal population. Included within the network adequacy requirements are time and distance standards for CMS identified provider types, including primary care for adults and pediatric beneficiaries, OB/GYN, behavioral health for adult and pediatric, specialists for adult and pediatric, hospital, pharmacy, pediatric dental, Long Term Services and Supports (LTSS) providers, and additional provider types that promote the health of Medi-Cal beneficiaries, including waiver populations. To the extent that any MCP is unable to provide any medically-necessary covered services to its members, the MCP must adequately and timely cover these out-of-network services for the member, for as long as the entity is unable to provide them. The proposed network adequacy standards were posted online and made publicly available for comment on July 19, 2017.

DHCS also developed a process for MCPs to request alternative access network adequacy standards. The alternative access request template allows MCPs that are unable to meet network adequacy standards to request an alternative standard for specific service areas/zip codes. This application process is ongoing.

- **Item 42 of the STCs – Certification (Related to Health Plans)**

DHCS developed statewide provider network adequacy standards. The standards will be evaluated using a DHCS created network certification tool. The tool and geo-access maps will be reviewed and documentation will be produced that supports the assurance of provider network adequacy for each contracted MCP. Documentation will be included in the DHCS' network certification report that will submitted to CMS as an assurance of compliance.

Annually, DHCS' report must provide documentation to demonstrate each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area in compliance with CFR Section 438.68 (network adequacy standards) and Section 438.206 (c)(1) (availability of services).
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to the needs of the anticipated number of enrollees in the service area.
- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services, such as changes in services, benefits, geographic service area, composition of or payments to its provider network, or enrollment of a new population.

- **Item 52 of the STCs – CCS Demonstration Project Approval**

The CCS Demonstration Project (DP) is testing two health care delivery models for children enrolled in the CCS Program. The CCS DP approval is contingent on provisions being met for the two demonstration models: 1) ensuring adequate protections for the population served, 2) sufficient network of appropriate providers, and 3) timely access to out of network care when necessary. The pilot programs are limited to HPSM and RCHSD and will include specific criteria for evaluation of the models.

- **Item 53 of the STCs – CCS Demonstration Project Protocol**

Nothing to report.

- **Item 54 of the STCs – 2016 CCS Pilot Update**

DHCS updated the report and sent it to CMS on December 14, 2016. The report meets the STCs' requirements and includes:

- Brief description of the pilot program
- Description of HPSM as a MCP
- HPSM DP status update
- Description of RCHSD as an ACO
- RCHSD DP status update
- Number of children enrolled and cost of care

- **Items 65-69 of the STCs – Access Assessment**

On September 23, 2016, DHCS sent the EQRO contract amendment to CMS for review and approval. CMS granted approval of the contract amendment with an effective date of October 23, 2016.

In 2016, DHCS established an Access Assessment Advisory Committee (Committee) to provide input into the Assessment structure and design, and to provide feedback on the initial draft and final report. DHCS created and scored Committee Applications and posted the selected members on the DHCS Access Assessment webpage. The Committee includes representatives from consumer advocacy organizations, providers, provider associations, health plans, health plan associations, and legislative staff. The first Advisory Committee meeting was held on November 18, 2016.

With participation from the Advisory Committee, DHCS submitted a draft design to CMS for review on April 21, 2017. Once approved, HSAG will prepare a list of data requirements, begin collection, and conduct the analysis. Throughout the process, the Committee will be included to provide input and feedback.

- **Item 160 of the STCs – Negative Account Balance**

California and CMS have worked diligently over the past year to reduce the PMS negative account balances from $1,277,770,233 to $341,165,037 (as of September 20, 2017) and resolve deferrals. On July 10, 2017, CMS staff verbally notified California that STC 160 had been deemed satisfied. California and CMS continue to work together to bring all remaining items to conclusion.

- **Items 177-180 of the STCs – Uncompensated Care Reporting**

The State must commission two reports from an independent entity on uncompensated care in the state. Both of the reports are available on the DHCS website: http://www.dhcs.ca.gov/provgovpart/Pages/UncompensatedCareReport.aspx.

The objective of the first independent report is to support a determination of the appropriate level of the Uncompensated Care Pool component of the total GPP funding for participating DPHs in PY 2-5. Navigant conducted the first report, which DHCS submitted to CMS on May 15, 2016. On July 14, 2016, CMS authorized up to $472 million in total funds for the Uncompensated Care component of the GPP program for PY 2-5.

The second independent report will focus on uncompensated care, provider payments, and financing across hospital providers that serve Medicaid beneficiaries and the uninsured under the current Demonstration. It was submitted to CMS on the due date of

June 1, 2017. The report included information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California's Medicaid beneficiaries for the uninsured.

- **Items 201-202 of the STCs – Budget Neutrality**

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

- **Items 211-216 of the STCs – Evaluation of the Demonstration**

Detailed information about the CCS, DTI, GPP, SPD, PRIME, and WPC evaluations are available in their respective program updates provided below. Copies of the program evaluations are available on the DHCS website at: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S 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 Medi-Cal 2020 is focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction, and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improvement of care for all 189,312 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) (MCP)

In addition to Health Plan San Mateo (HPSM), it is anticipated DHCS will contract with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning in FY 2018.

Accomplishments:

Date	Pilot Action Items
January – September 2016	CCS Pilot Protocols (Protocols) were updated with the required addition of performance measures. Protocols were submitted by the specified due date of September 30, 2016.
January 2016 – September 2017	Draft evaluation design was re-submitted on May 15, 2017. On June 29, 2017, DHCS received additional CMS comments on the CCS Evaluation Design. DHCS received additional comments from CMS on September 12th and are currently addressing.
Date	**HPSM Pilot Action Items**
July 2015 – Pending	Contract Amendment A02 is currently with HPSM for signature.
January 2017	DHCS met with HPSM in person
Date	**RCHSD Pilot Action Items**
July 2016 – June 2017	DHCS provided RCHSD with an updated deliverables list/ Policies and Procedures (P&Ps).
Anticipated FY 2018/19	Proposed start date no sooner than July 1, 2018, pending approval from CMS for rates and contract and RCHSD's readiness.

Program Highlights:

HPSM

CCS Pilot Protocols
California's 1115 Waiver Renewal, Medi-Cal 2020 (Waiver), was approved by Federal Centers for Medicare and Medicaid Services (CMS) on December 30, 2015. The Waiver contains Special Terms and Conditions (STCs) for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. As of September 30, 2016, revised Protocols were submitted to CMS.

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

RCHSD CCS DP

DHCS and RCHSD have begun meeting regularly to facilitate the Rady Children's Hospital – San Diego pilot demonstration. RCHSD will be brought up as a full-risk Medi-Cal managed care health plan servicing CCS beneficiaries in San Diego County that have been diagnosed with one of five eligible medical conditions. The meetings have focused on the onboarding activities that will occur prior to implementation, including, but not limited to, the deliverable review process, contract development process, and provider network adequacy review.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

The monthly enrollment for HPSM CCS 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 Numbers	Difference Prior Month
July 2016	1,649	-
August 2016	1,636	-13
September 2016	1,607	-29
October 2016	1,641	34
November 2016	1,629	-12
December 2016	1,632	3
January 2017	1,626	-6
February 2017	1,650	24
March 2017	1,648	-2
April 2017	1,634	-14
May 2017	1,631	-3
June 2017	1,617	-14

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

The draft evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

DHCS submitted a revised evaluation design to CMS on May 15, 2017, in response to CMS' comments that were received on March 16, 2017. DHCS received CMS' comments for the CCS draft evaluation design on June 29, 2017. CMS provided feedback on the following sections: Evaluation Design and Methods, Evaluation Measures, Access to Care, Provider Satisfaction, Quality of Care, and Care Coordination**.** DHCS and CMS continue to work together on finalizing the evaluation design.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

DHCS submitted an 1115 waiver, called "California Medi-Cal 2020 Demonstration" (Medi-Cal 2020) to CMS and it was approved on December 30, 2015. CBAS will continue as a CMS-approved benefit through December 31, 2020, under Medi-Cal 2020.

Program Requirements

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020; and 4) exhibit ongoing compliance with 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 an 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 members, allowing them to remain in the community) if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services include local senior centers to engage members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the members with Activities of Daily Living or Instrumental Activities of Daily Living) through the Medi-Cal State Plan. If the member is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Program Highlights:

As a result of stakeholder processes during 2015 and 2016, CDA and DHCS in collaboration with CBAS providers, managed care plans and other interested stakeholders developed the following documents which impacted CBAS program activities during DY 12 (July 2016 through June 2017): (1) New CBAS Individual Plan of Care (IPC); (2) New standardized ADHC/CBAS Participation Agreement; (3) CBAS Quality Assurance and Improvement Strategy: A Five-Year Plan (dated October 2016); and (4) Revised CBAS Home and Community-Based (HCB) Settings Transition Plan (dated November 23, 2016)

[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.

These documents were developed in response to the following directives by CMS in the CBAS provisions of the 1115 Demonstration Waiver: (1) Special Terms and Conditions (STC) 44(c) and STC 45(c) requiring all CBAS settings to comply with the federal Home and Community-Based (HCB) Settings requirements (42 CFR 441.301(4)) and Person-Centered Planning requirements (42 CFR 441.301(c)(1)(2)(3)); and (2) STC 49, requiring the State to develop a quality strategy to assure the health and safety of Medi-Cal beneficiaries receiving CBAS. The following is an update on CBAS program activities related to each of these documents:

IPC

CDA provided training to CBAS providers, managed care plans and interested stakeholders on the new draft CBAS IPC (the "plan of care" for CBAS participants that identifies CBAS services to be provided) and the new standardized ADHC/CBAS Participation Agreement (the document that provides evidence of consent by the participant or the participant's authorized representative to attend the ADHC/CBAs center and to receive services identified on the participant's IPC.) The target date for implementation of the new IPC was initially projected for March/April 2017; however, implementation is now targeted for November 2017 as DHCS works with CDA to finalize the new IPC and the CBAS section of the Medi-Cal Provider Manual, which includes the IPC instructions. CBAS providers are required to continue using the current IPC until the new IPC is approved, which includes implementing person-centered planning principles in its care planning processes.

ADHC/CBAS Participation Agreement Update

CBAS providers began using the new Participation Agreement (CDA Form 7000) for new and continuing CBAS participants as of March 1, 2017, and are required to replace all non-standardized participation agreements in participants' health records with the new form on a rolling basis as participants' IPCs are developed and reauthorized. CBAS providers are required to have assessment and care planning policies and procedures in place prior to implementing the new Participation Agreement.

CBAS Quality Assurance and Improvement Strategy

The CBAS Quality Assurance and Improvement Strategy is a five-year plan to assure CBAS participant health and safety by addressing the following: (1) the quality and implementation of the CBAS beneficiary's person-centered IPC, (2) provider adherence to state and licensure and certification requirements, (3) quality metrics for person-centered care/continuity of care, (4) clinical and program outcome measures/indicators, (5) CBAS center staff training on best practices and quality improvement, and (6) improved use of existing enforcement provisions for CBAS centers that do not meet licensing or certification standards. The *CBAS Quality and Improvement Strategy* is

designed to assure federal partners, beneficiaries, and the public that CBAS providers meet program standards while they continue to develop new approaches to improving service delivery.

CDA and DHCS are implementing the goals and objectives of this report within specific timeframes in partnership with an Advisory Committee comprised of CBAS providers, managed care plans, and advocates. The short-term objectives identified in Goals I and II guided CBAS program activities for DY 12.

CBAS Home and Community-Based (HCB) Settings Transition Plan Update

All CBAS centers must comply with the federal HCB settings and person-centered planning requirements by March 17, 2022, and thereafter, or risk losing their CBAS Medi-Cal certification. The State submitted *California's Statewide Transition Plan (STP)* to the CMS on November 23, 2016, which includes an attachment the *Revised Draft CBAS HCB Settings Transition Plan* (dated November 23, 2016). CMS requested additional information from the State, which DHCS submitted on September 1, 2017. Although CMS has not yet provided initial approval for California's *STP* or *CBAS Transition Plan*, the State is implementing the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA is evaluating each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Qualitative and Quantitative Findings:

Enrollment and Assessment Information

Per STC 48, the CBAS Enrollment data for both MCP and FFS members per county for DY 12 represents the period of July 2016 to March 2017 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. Per the data presented in Table 1, enrollment for CBAS has been consistent in DY 12.

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. Enrollment with County Capacity data identified in Table 1, reflects data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report for DY13-Q1.

TABLE 1:

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS						
	DY12 Q1 Jul - Sept 2016		DY12 Q2 Oct - Dec 2016		DY12 Q3 Jan - Mar 2017	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	504	76%	542	82%	530	80%
Butte	45	44%	37	36%	42	41%
Contra Costa	206	64%	240	75%	210	65%
Fresno	619	56%	602	55%	615	56%
Humboldt	95	24%	94	24%	97	25%
Imperial	426	76%	328	59%	330	59%
Kern	81	24%	79	23%	73	22%
Los Angeles	21,041	67%	21,178	67%	21,299	67%
Merced	91	43%	95	45%	94	45%
Monterey	102	55%	118	63%	116	62%
Orange	2,100	54%	2,199	56%	2,256	54%
Riverside	453	42%	445	41%	459	42%
**Sacramento	587	66%	**521	58%	561	63%
**San Bernardino	590	109%	**598	110%	601	111%
San Diego	1,937	45%	2,031	51%	1,990	54%
San Francisco	749	51%	723	49%	722	49%
San Mateo	172	75%	174	76%	175	77%
Santa Barbara	*	*	*	*	*	*
Santa Clara	655	47%	656	47%	674	48%
Santa Cruz	109	72%	114	75%	98	64%
Shasta	*	*	*	*	*	*
Ventura	918	64%	901	63%	943	65%
Yolo	74	20%	93	25%	79	21%
Marin, Napa, Solano	79	16%	79	16%	74	15%
Total	**31,648**	**61%**	****31,860**	**61%**	**32,044**	**62%**

FFS and MCP Enrollment Data 03/2017

Note: Information is not available for April 2017 to June 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.*

The data provided in Table 1 shows enrollment has slightly increased throughout DY 12 and has remained consistent with over 30,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers with the exception of the centers located in San Bernardino County. San Bernardino County is currently operating over its center capacity due to a steady increase in participant enrollment. However, a majority of CBAS participants are able to choose an alternate CBAS Center in nearby counties should the need arise for ongoing CBAS services. As a result of reporting errors made by the MCPs, DY12-Q2's participation data for Sacramento and San Bernardino counties were modified from Quarter 2 report to reflect accurate information. The corrections in participation data for Sacramento and San

Bernardino counties resulted in the increase of statewide participation for CBAS services in DY12-Q2.

It is important to note the amount of member participation also plays a significant role in the overall license capacity used throughout the State. From July 2016 to March 2017, there was a one percent (1%) increase in the total number of participants enrolled in CBAS centers. As a result, San Diego and Monterey Counties experienced an increase of more than five percent (5%) in their licensed capacity used throughout DY 12. However, Contra Costa, Santa Cruz, and Imperial Counties experienced an overall decrease in participation, which resulted in a decrease of more than five percent (5%) of licensed capacity used. The utilization of licensed capacity in these counties was impacted by changes in member enrollment, not the closure of a center. A decrease in utilization can also be precipitated by CDA approving an increase in a CBAS Center's licensed capacity.

CBAS Assessments for MCPs and FFS Participants

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

Table 2 entitled "*CBAS Assessment Data for MCP and FFS"* lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in Table 2 is reported by DHCS. Assessment data identified in Table 2, reflects data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report for DY13-Q1.

Table 2:

CBAS Assessments Data for MCPs and FFS:						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
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%)
5% Negative change between last Quarter		No	No		No	No

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

Requests for CBAS services were collected by MCPs and DHCS. For DY12, (7,817) assessments were completed by the MCPs of which (7,642) were determined to be eligible and (174) were determined to be ineligible. A total of 136 participants submitted requests for CBAS benefits under FFS to DHCS. 105 of those requests were deferred to managed care while 18 of the requests were determined to be FFS-eligible by DHCS. Per the data provided in Table 2, the total number of eligible FFS participants continues to decline due to the CBAS transition to managed care. Table 2 only reflects actual assessments completed by MCPs and 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 DY 12. As of DY 12, the number of counties with CBAS Centers and the ADA of each center are listed below in Table 3. On average, the ADA at the 240 operating CBAS Centers is approximately 23,020 participants, which corresponds to 75 percent of total capacity. Provider-reported data identified in Table 3, reflects data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report for DY13-Q1.

Table 3:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	240
Non-Profit Centers	56
For-Profit Centers	184
ADA @ 240 Centers	23,020
Total Licensed Capacity	30,652
Statewide ADA per Center	75%

CDA - MSSR Data 03/2017

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

Outreach/Innovative Activities: Stakeholder Process

In DY 12 and 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 STCs, in the Medi-Cal 2020 Waiver, DHCS and CDA initiated workgroups 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 Fall of 2017. Updates and progress on stakeholder activities for CBAS can be found at: http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Archives/HCB_Settings_Stakeholder_Process/

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 CBAS@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 were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. No complaints were submitted to CDA for DY 12. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in Table 4 entitled "*Data on CBAS Complaints"* and Table 5 entitled "*Data on CBAS Managed Care Plan Complaints*." According to Table 4, a total of 0 complaints were submitted to CDA for DY12. For complaints received by MCPs, Table 5 illustrates there were fourteen beneficiary complaints submitted for the reporting period. From July 2016 to March 2017, the number of complaints had decreased by an average of four complaints. Beneficiary/Provider Call Center Complaints identified in Table 4 and Table 5, reflects data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report for DY13-Q1.

Table 4:

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
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

CDA Data - Complaints 03/2017

Note: Information is not available for April 2017 to June 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

Plan data - Phone Center Complaints 03/2017

Note: Information is not available for April 2017 to June 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. Per the data provided in Table 6 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 7 grievances were filed with MCPs during DY 12. Six of the grievances were solely regarding CBAS providers. One of those seven grievances were related to other grievance issues. Grievances/Appeals data identified in Tables 6 and 7, reflect data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4, will be reported in the next quarterly report for DY13-Q1.

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 - Sep 30)	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

Plan data - Grievances 03/2017

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

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
DY12 - Q3 (Jan 1 - Mar 31)	1	0	0	0	1

Plan data - Grievances 03/2017

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

Per Table 7 entitled "*Data on CBAS Managed Care Plan Appeals,*" there were ten CBAS appeals filed with MCPs during DY 12. The appeals were related to denial of services, limited services, or other CBAS issues. The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS.

Quality Assurance/Monitoring Activity

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 Medi-Cal 2020. Table 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Table 7 also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 12. Quality Assurance/Monitoring Activity reflects data through July 2016 to March 2017 because of the lag factor of about two to three months. Data for DY12-Q4 will be reported in the next quarterly report for DY13-Q1.

Table 8 reflects that the average licensed capacity used by CBAS participants is 62 percent statewide. Overall, most all of the CBAS Centers have not operated at full capacity with the exception of San Bernardino Counties. This allows for the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 48(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. There was a decrease in provider capacity of five percent or more for DY 12. San Diego County's licensed capacity decreased by seven percent when Advantage Adult Day Health Center closed in December 2016 and Clairemont Villa Adult Day Health Center closed in February 2017, reducing the licensed capacity from 2,518 to 2,188. However, Orange County licensed capacity increased by six percent when El Toro Adult Day Services Center opened in March 2017, which increased the licensed capacity from 2,308 to 2,458. The changes in these two counties resulted in an overall statewide decrease of one percent in the total licensed capacity across DY 12.

Table 8:

County	CBAS Centers Licensed Capacity						
	DY12-Q1 Jul-Sep 2016	DY12-Q2 Oct-Dec 2016	Percent Change Between Last Two Quarters	Capacity Used	DY12-Q3 Jan-Dec 2017	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	0%	82%	390	0%	80%
Butte	60	60	0%	36%	60	0%	41%
Contra Costa	190	190	0%	75%	190	0%	65%
Fresno	652	652	0%	55%	652	0%	56%
Humboldt	229	229	0%	24%	229	0%	25%
Imperial	330	330	0%	59%	330	0%	59%
Kern	200	200	0%	23%	200	0%	22%
Los Angeles	18,406	18,731	2%	67%	18,796	0%	67%
Merced	124	124	0%	45%	124	0%	45%
Monterey	110	110	0%	63%	110	0%	62%
Orange	2,308	2,308	0%	56%	2,458	6%	54%
Riverside	640	640	0%	41%	640	0%	42%
Sacramento	529	529	0%	51%	529	0%	63%
San Bernardino	320	320	0%	100%	320	0%	111%
San Diego	2,518	2,353	-7%	51%	2,188	-7%	54%
San Francisco	866	866	0%	49%	866	0%	49%
San Mateo	135	135	0%	76%	135	0%	77%
Santa Barbara	60	60	0%	0%	60	0%	1%
Santa Clara	830	830	0%	47%	830	0%	48%
Santa Cruz	90	90	0%	75%	90	0%	64%
Shasta	85	85	0%	9%	85	0%	3%
Ventura	851	851	0%	63%	851	0%	65%
Yolo	224	224	0%	25%	224	0%	21%
Marin, Napa, Solano	295	295	0%	16%	295	0%	15%
SUM =	30,442	30,602	-5%	61%	30,652	-1%	62%

CDA Licensed Capacity as of 06/2016

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

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

Access Monitoring (STC 48.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Table 1, CBAS capacity is adequate to serve Medi-Cal members in almost all counties with CBAS Centers with the exception of San Bernardino Counties. San Bernardino County is serving in excess of its allotted capacity. The closure of a CBAS Center did not negatively affect the other CBAS Centers and the services they provide to the beneficiaries. There are other centers in nearby counties that can assist should the need arise to allow for ongoing care of CBAS participants.

Unbundled Services (STC 44.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, the managed care plans will 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 participants 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 continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 12, CDA had 240 CBAS Center providers operating in California. According to Table 9 entitled "*CBAS Center History*," a total of three CBAS Centers were closed and two new centers were opened in DY12. Advantage ADHC Center, Clairemont Villa ADHC Center, and San Ysidro ADHC in San Diego County closed and/or were converted exclusively to serve PACE program in DY 12. Salida Del Sol Adult Day Health Care Center in Los Angeles County (December 2016) and El Toro Adult Day Services in Orange County (March 2017) opened and became operational, bringing the cumulative total to 240 centers throughout the state.

Table 9:

CBAS Center History

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

Table 9 shows there was no negative change of more than 5 percent in DY 12, from July 2016 to June 2017, so no analysis is needed to address such variances.

Policy/Administrative Issues and Challenges:

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY 12. As previously identified in the Program Highlights section, DHCS did delay implementation of the revised CBAS IPC from April to November 2017. 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 update.

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

Progress on the Evaluation and Findings:

Not applicable.

COORDINATED CARE INITIATIVE (CCI)

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disability (SPDs), including beneficiaries who are dually-eligible for Medi-Cal and Medicare (Duals), while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013).

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs);
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of Long Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal MediConnect.

The seven CCI counties participating in Cal MediConnect are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Four counties implemented CCI in April 2014 (San Bernardino, San Diego, San Mateo, and Riverside). Los Angeles County launched CCI in July 2014. Santa Clara County began in January 2015, and Orange County implemented in July 2015.

Accomplishments:

<u>Enrollment Strategies</u>

In 2017, DHCS has continued to pursue enrollment strategies that support voluntary “opt-in” enrollment. This is part of a comprehensive strategy to make program improvements to Cal MediConnect, which began in 2016.

This strategy focused on improving the quality of care and care coordination that beneficiaries receive through Cal MediConnect, ensuring that beneficiary satisfaction remains high and increases; therefore, generating sustainability for the program.

This strategy, which is designed to expand awareness of Cal MediConnect and encourages voluntary enrollment, builds on activities that DHCS and its partners are already conducting. This strategy also incorporates many of the lessons learned about how best to reach and educate beneficiaries and providers about the CCI and Cal MediConnect. These strategies include streamlined enrollment and mandatory Medi-Cal managed care health plan (MCP) enrollment for managed long-term services and supports (MLTSS).

Streamlined Enrollment
The streamlined enrollment process began in August 2016 and has contributed to a modest increase in enrollment. The streamlined enrollment process allows Cal MediConnect MMPs to collect enrollment-required information from beneficiaries and directly submit enrollment requests to the DHCS enrollment broker for processing. This provides beneficiaries an additional way to enroll into a Cal MediConnect MMP.

MLTSS Enrollment
In November 2016, DHCS began operationalizing ongoing, mandatory enrollment of MLTSS-eligible beneficiaries into MLTSS. These beneficiaries are receiving a new Cal MediConnect and MLTSS Resource Guide and Choice Book, which have gone through the University of California's beneficiary user testing process. The materials educate newly Medi-Cal-eligible beneficiaries about their options – joining Cal MediConnect or keeping their Medicare the way it is and joining an MLTSS plan. This has led to a modest increase in enrollment to Cal MediConnect.

Continuity of Care
DHCS announced that it would extend the continuity of care period for Medicare services from six months to 12 months to match the Medi-Cal continuity of care period, and modify requirements to just one visit with a specialist within the past 12 months, as is the case with primary care physicians.

DHCS worked with CMS to update Dual Plan Letter (DPL), 16-002, which was released in July 2016. DPL 16-002 can be found at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-002.pdf.

Provider Analysis and Outreach
DHCS conducted an analysis of beneficiary and provider data, matching beneficiaries who had opted out of Cal MediConnect with physicians and other providers in the Medi-Cal program. This data helped identify providers associated with large numbers of patients opting-out for targeted outreach and enrollment. DHCS staff, including Harbage Consulting outreach staff, worked with MMPs to develop strategies for communicating

with these providers. In some cases, MMPs took the lead in working with their contracted providers; in other cases, DHCS/Harbage staff undertook the outreach.

DHCS/Harbage outreach efforts during the reporting period focused on practices with the highest opt-out figures and yielded some positive gains across CCI counties. Over 200 outreach visits reached 57 different practices. Most practices had at least a basic understanding of the program; however, knowledge varied greatly from practice to practice. Some offices accepted both beneficiary and provider outreach materials and in others, physicians and office managers accepted presentations from outreach staff. Two offices returned outreach materials and requested no further outreach. Four offices had questions and/or problems with the MMPs in their county and outreach staff were able to connect them with the proper plan officials for assistance. Outreach to high opt-out practices is ongoing.

Cal MediConnect Best Practices Meetings
In 2016, DHCS launched a series of best practices meetings, convening the Cal MediConnect MMPs on key implementation topics. Topics were identified either through evaluation feedback from UC Berkeley, or identified by the Contract Management Team or other feedback mechanisms. Where appropriate, MMP staff were identified to report out on best practices, or external experts from community-based organizations or CMS were brought in to discuss national or statewide learnings. Topics included:

- LTSS referrals (July 2016);
- Onboarding new members (August 2016);
- Marketing and outreach (September 2016);
- Dementia Promising Practices (November 2016);
- Grievances (December 2016);
- Targeting care coordination for high utilizers (January 2017);
- Outreach to communities with diverse backgrounds (February 2017);
- Care transitions (March 2017);
- Homeless members/connecting members to housing (May 2017);
- Improper billing practices (July 2017); and
- Health Risk Assessment LTSS referral questions (September 2017).

Qualitative and Quantitative Findings:

<u>Enrollment</u>

As of July 1, 2017, approximately 116,286 beneficiaries were enrolled in Cal MediConnect MMPs across the seven participating counties. Detailed enrollment information for each CCI county is found below:

County	Number of Beneficiaries Enrolled	Eligible Population Enrolled (%)
Los Angeles	38,020	19%
Orange	15,469	32%
Riverside	14,534	45%
San Bernardino	14,203	43%
San Diego	14,594	33%
Santa Clara	10,219	40%
San Mateo	9,247	71%

2017 Enrollment and opt-out statistics can be found at the following link: http://calduals.org/wp-content/uploads/2017/08/July-2017-CMC-Enrollment-Dashboard-FINAL.pdf

Utilization

CCI Ombudsman Data
The Cal MediConnect Ombudsman is structured as an umbrella organization that contracts with local entities operating in CCI counties. The purpose of the local contracts is to ensure that the Ombudsman has the ability to provide local, personalized assistance to Cal MediConnect beneficiaries as they navigate the health care system.

The Cal MediConnect Ombudsman was involved with an extensive outreach and education strategy that includes, but is not limited to:

- Ombudsman contact information being included in the 30, 60, and 90-day beneficiary informing materials;
- Requiring the Cal MediConnect MMPs to include the Ombudsman contact information in beneficiary informing materials, such as the Evidence of Coverage, which is received by beneficiaries prior to enrollment;
- Including the Ombudsman contact information on the Cal MediConnect webpage: http://www.calduals.org/;
- Having the DHCS enrollment broker, MAXIMUS, refer beneficiaries to the Ombudsman when deemed appropriate;
- DHCS entering into a contract with Harbage Consulting to launch a very aggressive outreach and education campaign; and
- Adding the Ombudsman phone number to the 1-800-Medicare call script.

CCI Ombudsman Call Volume
From July 1, 2016 to June 30, 2017, the Cal MediConnect Ombudsman received approximately 4,964 calls from beneficiaries. Below is a breakdown of the Cal

MediConnect Ombudsman call data by each county's corresponding Ombudsman program:

- Legal Aid Society of San Diego (San Diego): 1,083
- Neighborhood Legal Services (Los Angeles): 1,455
- Inland Counties Legal Services (San Bernardino and Riverside): 708
- Bay Area Legal Aid: 409
- Legal Aid Society of Orange County: 245
- Legal Aid Society of San Mateo: 46
- Other Health Consumer Alliance programs: 709
- Abandoned calls: 237

Continuity of Care Data
DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. From Quarter 3 2016 to Quarter 2 2017, the total number of continuity of care requests was 763. 89 percent of the requests were approved; 11 percent were denied. Most denials were based on a lack of relationship between member and provider. The rest of the denials were related to providers who declined to work with managed care.

Policy/Administrative Issues and Challenges:

<u>Establishing Continuity of Care between the Cal MediConnect MMP and Out-of-Network Providers</u>

Transition issues with providers have often led to high opt-out rates or early disenrollments from Cal MediConnect.

To work toward stronger support of beneficiaries during transitions of care, DHCS and CMS are including continuity of care concerns through reviews of existing Dual Plan Letters (DPLs) and the three-way contract.

CCI continuity of care requirements for Cal MediConnect are defined in Welfare and Institutions Code (WIC), Sections 14182.17 and 14132.275. These requirements are also set forth in the three-way contract. The existing contract is under revision as of July 1, 2017, and continuity of care contract requirements may be revised.

The three-way contract establishes the following requirements:

- CMS and DHCS require Cal MediConnect MMPs to ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers;

- DHCS requires each participating Cal MediConnect MMP to follow continuity of care requirements established in current law;
- As part of the process to ensure that continuity of care and coordination of care requirements are met, a Cal MediConnect MMP must perform a Health Risk Assessment (HRA) within the timeframes specified in DPL 15-005. DPL 15-005 is under revision as of July 1, 2017. Upon the beneficiary's request, the Cal MediConnect MMP must allow the beneficiary to continue receiving services from out-of-network providers for primary and specialty care services and maintain his or her current providers and service authorizations at the time of enrollment for:
  - A period up to 12 months for Medicare services if the criteria are met under WIC Section 14132.275(l)(2)(A); and
  - A period of up to 12 months for Medi-Cal if all of the criteria are met under WIC Section 14182.17(d)(5)(G).

DHCS worked with CMS to update Continuity of Care DPL 15-003, to 16-002 in July 2016. When a beneficiary is unable to receive health care services from his or her provider who is not networked with Cal MediConnect, the beneficiary may request continuity of care if he or she meets the requirements contained in DPL 16-002.

Effective October 1, 2016, DPL 16-002 extends the continuity of care period from six to 12 months for Medicare services. The updates match the Medi-Cal continuity of care period and modify requirements of the beneficiary to needing just one visit with a specialist within the past 12 months, as is the case with primary care physicians.

Current DPLs may be found at the following link:
http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDDualsPlanLetters.aspx

Progress on the Evaluation and Findings:

Research Triangle Institute (RTI) International

CMS contracted with RTI to monitor the implementation of demonstrations under the federal Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations.

The goals of the evaluation are to monitor demonstration implementation, impact of the demonstration on beneficiary experience, unintended consequences, and impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI International collects qualitative and quantitative data from DHCS each quarter; analyzes Medicare and Medi-Cal enrollment and claims data; conducts site visits, beneficiary focus groups, and key informant interviews; and

incorporates relevant findings from any beneficiary surveys conducted by other entities. RTI released its Annual Evaluation Report in January 2017.

The report can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CCI-Evaluation_Outcome_Report_Jan_2017.pdf

The SCAN Foundation

The Scan Foundation (TSF) funded two evaluations of the Cal MediConnect program – a Rapid Cycle Polling Project and a longer-term University of California Evaluation of Cal MediConnect, as described below. While TSF has funded these evaluations, DHCS has been working collaboratively with TSF and stakeholders to initially develop and more recently to update the content of both evaluations.

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of Cal MediConnect on California's Duals population in as close to real time as possible. FRC has completed two waves of the project and is planning to conduct additional waves in 2016. The study compares the levels of confidence and satisfaction of Cal MediConnect enrollees with Duals who are eligible for Cal MediConnect but are not participating, or live in a non-Cal MediConnect county within California.

The fourth and final of the polls found that large majorities of Cal MediConnect enrollees express satisfaction and confidence with their health care services, as in previous waves. Of particular note for beneficiaries is 6% fewer enrollees than opt-outs reported being hospitalized in the last twelve months. The differences in hospitalization between enrollees and opt-outs are noteworthy, especially given that there are no significant differences in the self-reported health status of the two populations, with 49% of enrollees and 50% of opt-outs saying they are in fair or poor health. However, compared to enrollees, opt-outs do include a somewhat larger percentage of beneficiaries receiving Long-Term Services and Supports and those using specialized equipment, such as a cane, wheelchair, scooter, or special bed.

The most recent survey findings were released on December 7, 2016. The presentation can be found at:
http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration

The SCAN Foundation, along with The Commonwealth Fund, AARP Foundation, and AARP Public Policy Institute, maintains a state scorecard on long-term services and supports for older adults, people with physical disabilities and family caregivers. The scorecard showcases measures of state performance for creating a high-quality system of care in order to drive progress toward improvement in services for older adults and

people with physical disabilities, and their family caregivers. The focus is on state-level data because the U.S. does not have a single national system to address LTSS needs. California maintained its ranking of 9th among all 50 states, and is in the top 10 for Choice of Setting and Provider, and Support for Caregivers. More scorecard information can be found at: http://www.thescanfoundation.org/sites/default/files/picking_up_the_pace_of_change_ltss_scorecard_policy_brief_july_2017_updated.pdf

In 2014, an evaluation team comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health, designed a three-year evaluation of the CCI. The evaluation team engaged stakeholder input and built upon the national evaluation to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects.

While this evaluation is still underway, the report of the key findings from Phase One was presented at the SCAN Foundation LTSS Summit on September 13, 2016. This report discussed the results from 36 Key Informant interviews, a longitudinal telephone survey of over 2,000 beneficiaries, focus groups (plus interviews) with beneficiaries, and interviews with Cal MediConnect MMPs and stakeholders. This report is available on TSF's website at: http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf.

In May 2017, the evaluation team also released a brief, The Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings. The team performed an in-depth examination of the efforts of CMC plans to redirect care away from institutions and into home- and community-based settings. Key findings include:

- Many CMC plans have created unique programs to facilitate successful transitions of members to lower levels of care who may not have otherwise been able to leave institutional care.
- The financial incentives for CMC plans to transition members out of LTC facilities are working.
- Increased communication and collaboration among CMC plans, LTC facilities, and HCBS agencies have been crucial factors in promoting LTC transitions.
- The cost of housing, the lack of affordable housing, and challenges in paying for assisted living create a major barrier to locating and supporting beneficiaries in community-based settings.

For more information on these findings and the six major recommendations, go to the report: http://www.thescanfoundation.org/sites/default/files/the_impact_of_cal_mediconnect_on_transitions_from_institutional_to_community-based_settings_may_2017.pdf

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

Within the Safety Net Care Pool (SNCP), a Delivery System Reform Incentive Pool (DSRIP) is available for the development of a program of activity that supports California's public hospitals' efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable, and directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.

Payment	FFP	IGT	Service Period	Total Funds Payment
Delivery System Reform Incentive Pool (DSRIP)				
(Qtr 1 Jul - Sep)	($97,936.54)	($97,936.55)	DY 10	($195,873.09)
(Qtr 2 Oct – Dec)	$1,883,350	$1,883,350	DY 9	$3,766,700
(Qtr 2 Oct – Dec)	($328,769.74)	($328,769.74)	DY 10	($657,539.48)
Total	**$1,456,643.72**	**$1,456,643.72**		**$2,913,287.43**

In DY 12, DSRIP received $1,456,643.72 in federal fund payments. All DSRIP payments and recoupments have been reconciled for DY 6-10; therefore, this program will be going through the deactivation phase.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through the DTI, DHCS aims to:

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

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

Domain 1 – Increase Preventive Services for Children

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

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

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

The following pilot counties are 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 17 select pilot counties. Incentive payments will be made to dental service office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods. If the pilots are successful, this domain may be expanded to other counties, contingent on available DTI funding. The first program year for this domain was 2016.

The following pilot counties are 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 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: 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.

Accomplishments:

Program Timeline

Date	DTI Outreach Presentations (Venue)
July 22, 2016	Perinatal Infant Oral Health Quality Improvement (PIOHQI) Provider Workshop
July 26, 2016	State Child Health and Disability Prevention (CHDP) Oral Health Subcommittee
August 10, 2016	Northern California Legislative District Directors Meeting
August 11, 2016	DHCS Stakeholder Advisory Committee (SAC) – Meeting Materials

August 25, 2016	Sacramento Medi-Cal Dental Advisory Committee (MCDAC) – Meeting Materials
September 9, 2016	California Dental Association (CDA) Presents, San Francisco
September 13, 2016	Medi-Cal Children's Health Panel (MCHAP) Meeting – Meeting Summary
September 19, 2016	CDPH-DHCS Oral Health Workgroup
October 17, 2016	29th Annual State Health Policy Conference; *Open Wide: Innovations in Oral Health Policy*
October 24, 2016	SAC – Meeting Materials
October 27, 2016	MCDAC – Meeting Materials
November 1, 2016	CHDP Oral Health Subcommittee
November 1, 2016	Annual DHCS Tribal and Designee Meeting
November 3, 2016	California Primary Care Association (CPCA) and MDSD Quarterly Meeting
November 4, 2016	Medi-Cal Dental Los Angeles Stakeholder Meeting
November 15, 2016	MCHAP – Meeting Materials
November 21, 2016	Legislative Analyst's Office Briefing on Eligibility and Dental
December 12, 2016	California Department of Public Health (CDPH)-DHCS Oral Health Workgroup
January 9, 2017	Domain 2 Workgroup Meeting
January 12, 2017	Covered CA Dental Technical Workgroup Meeting
January 13, 2017	CDPH Oral Health Program + DHCS Data Sharing Meeting
January 27, 2017	Oral Health Meeting with CPCA
February 7, 2017	State CHDP Oral Health Subcommittee Teleconference
February 16, 2017	SAC – Meeting Materials
February 17, 2017	Medi-Cal Dental Los Angeles Stakeholder Meeting
February 21-February 24, 2017	Budget Revision Conference Calls with LDPPs
February 23, 2017	MCDAC – Meeting Materials
March 3, 2017	Meeting with CPCA
March 23, 2017	California Senate Budget Subcommittee Hearing on Medi-Cal Dental Program
March 29, 2017	DTI Safety Net Clinic Encounter Data Submission Instructional Webinar
April 14, 2017	Medi-Cal Dental Los Angeles Dental Stakeholder Meeting – Meeting Agenda
April 18, 2017	MCHAP – Meeting Minutes
April 20, 2017	DHCS-CPCA Meeting for Safety Net Clinics (SNC) Fact Sheet

April 24, 2017	Senate Subcommittee Hearing #3 (Waiver Updates and Contract Resources)
May 1, 2017	Assembly Subcommittee Hearing #1 (Cont. of Waiver Updates)
May 2, 2017	CHDP Statewide Oral Health Subcommittee Meeting
May 5, 2017	CDA Presents "The Art and Science of Dentistry" in Anaheim – Program
May 17, 2017	DHCS-CPCA Meeting for SNC Encounter Submissions (Technical Guide and Submitter Identification)
May 17, 2017	SAC – Meeting Materials
June 1, 2017	MCDAC – Meeting Materials
June 9, 2017	Medi-Cal Dental Los Angeles Dental Stakeholder Meeting – Meeting Materials

Date	DTI Webinars
August 18, 2016	DHCS held a DTI Stakeholder Webinar and provided the participants with the following: • Domain 4 Local Dental Pilot Project Application Budget Template and Instructions; • Updates to the Frequently Asked Questions; • Proposed Medi-Cal 2020 DTI Waiver Evaluation; and • Updates regarding Domains 1, 2, and 3. The webinar presentation may be accessed at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/DTIWebinar8.18.16.pdf
October 13, 2016	DHCS held a webinar titled, DTI SNC Data Submission Process, and provided the participants with the following resources: • Data collection template instructions • Domain 1 • Domain 3 • Naming convention & resubmission instructions The webinar presentation may be accessed at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/DTIWebinar10-13-16.pdf
December 19, 2016	DHCS held a webinar on the streamlined provider enrollment application, titled DHCS 5300 and Bulletin. The provider bulletin may be accessed at the following link: http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_32_Number_19.pdf.

January 24, 2017	DHCS hosted a DTI Domain 2 Webinar and provided the participants with the following information regarding the Caries Risk Assessment (CRA) and Disease Management: • CRA form • Announced a training partnership with CDA • CRA and Individual Care Plan • American Academy of Pediatric Dentistry (AAPD) Guideline on Caries Risk Assessment and Management for Infants, Children, and Adolescents • CRA Tool developed by the DHCS CRA Workgroup • Documentation requirements for claims submission • Billing Instructions The presentation can be accessed here: Domain 2 CRA and Disease Management Training.
March 29, 2017	DHCS hosted an instructional webinar to review the Safety Net Clinic Instructions for submitting encounter data and Current Dental Terminology (CDT) Codes to the Fee-For-Service Fiscal Intermediary (Delta Dental) for participation in Domains 1 and 3. DHCS provided the participants with the following resources that are posted on the DTI webinar archives webpage: • Safety Net Clinic Encounter Data Submission Presentation (.pptx) • Safety Net Clinic Opt-in Form • Safety Net Clinic Electronic Data Interchange Application Safety Net Clinic Encounter Data Paper Form (*Non-DHCS website)

Program Highlights:

Small Stakeholder Workgroup

This workgroup meets on a monthly basis, each third Wednesday of the month. The focus of these meetings is to provide monthly updates across all Domains with providers, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties.

In DY 12, the workgroup met on the following dates:

- July 20, 2016
- September 21, 2016
- October 19, 2016
- November 16, 2016
- December 21, 2016
- January 4, 2017
- February 15, 2017
- March 15, 2017
- April 26, 2017
- May 17, 2017
- June 21, 2017

Other Small Stakeholder Sub-workgroups

In addition to the DTI small stakeholder workgroup, DHCS continued to assemble the following sub-workgroups:

Caries Risk Assessment Sub-Workgroup
This sub-workgroup is still active and continues to review all Domain 2 materials prior to sharing publicly on the DTI webpage. In DY 12, it met on the following dates:

- August 1, 2016
- September 27, 2016
- November 30, 2016
- January 9, 2017

Safety Net Clinic Sub-Workgroup
This sub-workgroup is still active and continues to discuss the DTI data collection/submission process and address any outstanding questions and process clarifications from Safety Net Clinics. In DY 12, it met on December 21, 2016.

Domain 1

DHCS worked with CMS to amend the DTI Domain 1 STCs. On July 14, 2016, DHCS sent out a tribal notice to begin the 35-day review process for questions/comments as required for waiver amendments. On August 15, 2016, DHCS submitted its waiver amendment request package to CMS. On August 29, 2016, CMS determined that the State's amendment request has met the requirements for a complete amendment request as specified in the STCs. The open-comment period on CMS' website ended on October 1, 2016. CMS issued new STCs for the Domain1 approval on December 8, 2016, and the revised version was subsequently posted on the DTI webpage.

On August 8, 2016, the Domain 1 SNC data collection instructions and template were finalized and posted on the DTI webpage. On August 23, 2016, DHCS sent corresponding letters out to SNCs. In September 2016, DHCS began collecting Domain 1 SNC data.

To facilitate the submission process, DHCS posted the following documents on the DTI webpage:

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

The Domain 1 Fact Sheet was finalized to reflect the Domain 1 amendment, and can be located on the DTI webpage in addition to the following materials:

- Fee-For-Service (FFS) Outreach Letter
- Dental Managed Care Outreach Letter
- Safety Net Clinic (SNC) Outreach Letter
- Sample Domain 1 Explanation of Payment Statement

Domain 2

Efforts progressed to finalize a CRA tool as well as training materials and resources for implementation. In August 2016, 11 dentists pilot tested the CRA Sub-Workgroup's developed CRA tool. According to feedback received by Dr. Jayanth Kumar, State Dental Director, provided post-pilot, 10 of the 11 dentists were able to use the form to assess risk factors, follow the directions, classify children correctly, and identify self-management goals. Nine dentists submitted comments to improve the form. On September 9, 2016, the sub-workgroup submitted a revised tool based on these comments. The tool was finalized in January 2017.

DHCS, in collaboration with CDA, developed a Treating Young Kids Everyday (TYKE) training curricula for this domain. Providers are offered continuing education units for the completion of the required TYKE training course. All training and resource materials for the pilot were finalized in January 2017. Additionally, the Domain 2 Fact Sheet was finalized and posted to the DTI webpage on August 25, 2016.

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

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

Additional resources:

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

Domain 3

On August 8, 2016, Domain 3 SNC data collection instructions and template were finalized and posted to the DTI webpage. On September 7, 2016, Domain 3 SNC letters were printed and mailed out to providers in the 17 selected counties, and initial letters were sent out to all Denti-Cal service offices. The 17 established pilot counties are Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus, and Yolo.

The following materials can be located on the DTI webpage:

- Domain 3 Frequently Asked Questions and Answers
- Continuity of Care Baseline Benchmark by County
- Secure Email Instructions
- Fee-For-Service Outreach Letter
- SNC Outreach Letter
- Sample Domain 3 Explanation of Payment Statement

DHCS posted the following materials packaged as *SNC Provider Resources for Encounter Data Submission:*

- SNC Frequently Asked Questions and Answers
- Encounter Data Submission Process for SNCs (Revised May 22, 2017)
- SNC Opt-in Form
- DTI Proprietary Encounter Form for Paper Billing
- SNC Electronic Data Interchange Application

Domain 4

On July 28, 2016, DHCS revised its LDPP Application and posted it to the DTI webpage. On August 3, 2016, DHCS finalized and posted online its LDPP Budget Template and Instructions.

On September 30, 2016, DHCS received 23 LDPP applications from around the state. The Department announced the selection of DTI Local Dental Pilot Programs on February 10, 2017.

There were 15 LDPP applications selected to participate in this Domain. The final approved applications and budgets are posted on the DTI webpage as they become available.

At the end of DY 12, 11 of the 15 agreements have been executed and four are still in progress as identified in the table below:

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	Revisions Pending
Fresno County	Executed June 27, 2017
Humboldt County	Executed June 21, 2017
Northern Valley Sierra Consortium	Revisions Pending
Orange County	Executed June 30, 2017
Sacramento County	Executed June 30, 2017
San Luis Obispo County	Revisions Pending
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

Qualitative Findings:

Domain 2

In May and June 2017, DHCS provided targeted outreach to 35 clinics who were not participating in Domain 2 and 10 of them opted-in to participate. DHCS also met with CDA to discuss provider outreach strategies. The Domain 2 Sub-workgroup will

reconvene and continue to meet on a monthly basis in the next quarter to discuss outreach efforts and next steps.

Quantitative Findings:

Domain 1

The first incentive payment for this domain was issued in January 2017; the second will be in July 2017. In January, DHCS disbursed $21 million worth of incentive payments to 2,646 providers (2,426 FFS providers, 156 DMC providers, and 64 Safety Net Clinics) for services provided in calendar year 2016. SNC data submission deadlines for July 2017 payments were May 31, 2017 and June 23, 2017. DHCS advised the SNCs to submit data electronically, rather than via proprietary form, which resulted in 108 SNCs submitting data electronically out of the 204 SNCs that opted-in for Domain 1. DHCS estimates the July 2017 incentive payment amount, for any remaining services provided in calendar year 2016, to be on track with anticipated utilization.

Domain 2

By the end of DY 12, total provider participation and incentive payments in Domain 2 were as follows:

- 162 providers completed the TYKE training
- 81 providers opted-in to Domain 2 (50% of those who completed TYKE).
- $268,263.50 FFS incentive payments went to two counties – Tulare and Sacramento.
- $1,386 DMC incentive payments were paid (Sacramento).

Domain 3

On June 30, 2017, Program Year (PY) 1 incentive payments totaled $9,432,440 and were issued to 956 FFS and SNC service office locations. The next incentive payment for PY 2 is scheduled for release on June 30, 2018. For Domain 3, 25 SNCs submitted electronic data out of the 50 that opted-in. A Domain 3 Sub-workgroup will be established and convened in the next quarter to discuss outreach efforts and next steps.

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

On September 19, 2016, DHCS submitted a draft DTI evaluation design to CMS. DHCS posted the draft evaluation online and accepted public comments until Mid-October 2016. Throughout the first quarter of DY12, DHCS began outreach to potential evaluators for their capacity and interest in submitting proposals to perform the DTI evaluation.

The aim of the evaluation is to determine the causal impacts of the DTI Demonstration on how incentive payments influence:

- Increased statewide numbers of Medi-Cal children ages 1 through 20 that receive preventive dental services by at least 10 percentage points over a five-year period;
- Diagnoses of early childhood caries for targeted children 6 and under by utilizing a predefined CRA tool and treatment planning for managing this condition as a chronic disease based on the beneficiary's risk assessment in lieu of more invasive and costly procedures and restorative treatment; and
- Improved continuity of care for targeted children under the age of 21 through regular examinations with their established dental provider.

In anticipation of CMS' response to our draft DTI evaluation design, DHCS met with three organizations that expressed interest in conducting the DTI evaluation – Health Management Associates, Mathematica Policy Research, and University of California, Los Angeles (UCLA). DHCS chose Mathematica Policy Research as the independent evaluator for DTI. DHCS is finalizing the DTI evaluation contract with Mathematica.

DHCS submitted the DTI Final Evaluation Design to CMS on May 15, 2017, and received CMS' feedback for that report on June 29, 2017.

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 Department of Health Care Services (DHCS) issued ASAM designation. The DMC-ODS includes residential treatment service for all DMC beneficiaries in facilities with no bed limit.

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

Accomplishments:

The following counties have begun providing DMC-ODS services:

- February 1, 2017: Riverside County and San Mateo County
- April 1, 2017: Marin County
- June 15, 2017: Santa Clara County
- June 30, 2017: Contra Costa County
- July 1, 2017: San Francisco County and Los Angeles County

Program Highlights:

- Bi-Monthly Technical Assistance Calls with Counties' Leads
- Weekly Harbage Consulting Meetings regarding DMC-ODS Wavier
- July 1, 2016: Indian Health Service (IHS) Teleconference
- July 11, 2016: IHS Plan Questions
- July 13, 2016: DHCS and University of California Los Angeles (UCLA) Conference Call
- July 14, 2016: Fiscal Webinar Part 3
- July 15, 2016: Yolo County In-person Technical Assistance
- July 19, 2016: California Pan Ethnic Health Network (CPHEN) – Coordinating a Community Engagement Strategy around the DMC-ODS
- July 20, 2016: UCLA and External Quality Review Organization (EQRO) Meeting
- July 22, 2016: DHCS Phase I Program Meeting
- July 25, 2016: California Indian Health Service Follow-up Plan/Questions Call
- July 29, 2016: CMS and DHCS Overview of CMS Tribal Consultation Policy
- August 1, 2016: Aegis Treatment Centers Meeting regarding Medication Assisted Treatment
- August 1, 2016: California Association of Alcohol and Drug Program Executive, Inc. (CAADPE) Quarterly Meeting
- August 2, 2016: DMC-ODS Waiver Reporting Meeting
- August 4, 2016: DMC-ODS Monthly County Technical Assistance Call
- August 9, 2016: Tribal Consultation on Indian Organized Delivery System for Substance Use Disorder Services
- August 10, 2016: Blue Shield of California Foundation (BSCF) and California HealthCare Foundation (CHCF) Support for Indian Health Program Organized Delivery System (IHP-ODS) Conference Call
- August 10, 2016: County Behavioral Health Directors Association of California (CBHDA) Meeting
- August 17, 2016: DHCS and CMS Meeting for IHP-ODS
- August 18, 2016: Network Adequacy Review with CMS
- August 22-25, 2016: Statewide Substance Use Disorder Conference
- August 26, 2016: Dr. Mee Lee's ASAM Presentation
- August 29, 2016: California Indian Health Services Follow-up Plan/Questions
- August 31, 2016: Medicaid Institutions for Mental Diseases (IMD) Exclusion and Substance Use Treatment Conference Call
- September 1, 2016: DMC-ODS Medication Assisted Treatment (MAT) Webinar
- September 7, 2016: Narcotic Treatment Program (NTP) Advisory Committee Meeting
- September 13, 2016: Medi-Cal Children's Health Advisory Panel (MCHAP)

- September 14, 2016: California Health & Human Services (CHHS) Agency Office of Health Information Integrity Stakeholder Meeting
- September 21, 2016: CBHDA In-Person Medi-Cal Meeting
- September 21, 2016: DMC-ODS Informational Webinar for Providers
- September 23, 2016: IHP-ODS Grant Program
- September 26, 2016: DMC-ODS Reporting Meeting
- September 27, 2016: BSCF and CHCF Meeting on DMC-ODS
- September 28, 2016: Substance Abuse Prevention and Treatment (SAPT) Committee Meeting
- September 29, 2016: Medicaid Evidence Based Decisions Pre-Conference Call. Redesigning Substance Use Disorder Delivery Systems: Adult Residential Treatment as Part of the Continuum of Care Conference Call
- October 3, 2016: CAADPE Conference Call
- October 5, 2016: CBHDA Policy Committee Meeting
- October 10, 2016: Provider Enrollment Division (PED) Monthly Conference Call Meeting with Providers
- October 11, 2016: Alcohol and/or Drug Certification (AOD) Standards Meeting
- October 12, 2016: DHCS and UCLA Conference Call
- October 13, 2016: DHCS Meeting for MAT in Phase 4 Counties
- October 14, 2016: Collaborative Justice Courts Advisory Committee Meeting
- October 17, 2016: EQRO, UCLA, and DHCS October Quarterly Meeting
- October 19, 2016: UCLA's Integrated Care Conference 2016
- October 20, 2016: Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup Meeting
- October 21, 2016: DHCS Bi-Weekly Parity Meeting
- October 24, 2016: DHCS Stakeholder Advisory Committee
- October 27, 2016: Innovative Accelerator Program (IAP) SUD Call with DHCS regarding EQRO Performance Measures
- October 28, 2016: California Consortium of Addiction Programs and Professionals (CCAPP) Conference
- November 1, 2016: Medicaid Evidence-Based Decision Project Fall Conference
- November 2, 2016: Meeting with Partnership HealthPlan of California for a DMC Financial Model Discussion
- November 4, 2016: Phase 4 Regional Meeting Kick-off
- November 14, 2016: PED Monthly Conference Call Meeting
- November 18, 2016: DHCS Bi-Weekly Parity Meeting
- December 5, 2016: DHCS Bi-Weekly Parity Meeting
- December 6, 2016: CAADPE Annual Board Meeting
- December 6, 2016: CAADPE and DHCS Quarterly Meeting
- December 7, 2016: CBHDA Medi-Cal Policy Committee Conference Call

- December 7, 2016: IAP National Dissemination: Strategizing Managed Care Contract Language
- December 8, 2016: CBHDA Substance Abuse Prevention and Treatment (SAPT) Committee In-person Meeting
- December 12, 2016: PED Monthly Conference Call Meeting with Providers
- December 14, 2016: DHCS and UCLA Conference Call
- December 16, 2016: AOD Standards Stakeholder Meeting
- December 28, 2016: CBHDA Medi-Cal Policy Executive Committee Call
- January 4, 2017: DMC-ODS Meeting with California Rural Indian Health Board (CRIHB) with DHCS and CHHS Agency
- January 5, 2017: Meeting with CHCF
- January 9, 2017: PED Drug Medi-Cal Provider Quarterly Conference Call Meeting
- January 11, 2017: Incidental Medical Services (IMS) Regulations Meeting
- January 11, 2017: DHCS and UCLA conference call to discuss UCLA's DMC-ODS evaluation contract activities and work plan
- January 13, 2017: DHCS and CHCF Quarterly Meeting
- January 17, 2017: CMS' National Dissemination Webinar: Clinical Pathways and Payment Bundles for MAT
- January 18, 2017: MCHAP
- January 19, 2017: Treatment Taskforce Meeting with DHCS and CDPH
- January 30, 2017: Second Phase IV Meeting at CBHDA
- February 6, 2017: NTP Advisory Committee Meeting
- January 7, 2017: Meeting with CHCF for The Indian Health Project
- February 10, 2017: EQRO, UCLA, and DHCS Quarterly Meeting
- February 13, 2017: CAADPE and Coalition of Alcohol and Drug Associations (CADA) Bi-Monthly Call
- February 21, 2017: California Opioid Maintenance Providers (COMP) board meeting
- February 22, 2017: AP Webinar: SUD Treatment Provider and Service Capacity
- February 24, 2017: IHPODS MAT Call
- March 2, 2017: DMC-ODS Monthly TA Webinar
- March 3, 2017: Conference call with Los Angeles County for Transition Logistics for DMC-ODS Launch
- March 6, 2017: CHCF Behavioral Health Project Conference call
- March 8, 2017: DHCS and UCLA Conference Call
- March 8, 2017: CBHDA and DHCS Executive Committee Meeting
- March 10, 2017: DHCS Parity Meeting
- March 14, 2017: DHCS Academy Presentation

- March 16, 2017: Indiana Conference Call re: Addiction Residential Rules Based on ASAM Criteria
- March 17, 2017: Senate Budget and Fiscal Review Pre-Hearing
- March 21, 2017: CCAPP Legislative Conference
- March 22, 2017: CBHDA Policy Committee Meeting
- March 23, 2017: CDPH New Treatment Taskforce Meetings
- March 23, 2017: Association of Criminal Justice Researchers Conference
- March 24, 2017: Assembly Budget Sub 1 Pre-Hearing
- March 30, 2017: Senate Budget and Fiscal Review Pre-Hearing
- April 3, 2017: Assembly Budget Subcommittee No. 1
- April 5, 2017: HIS 2101 Tribal Consultation
- April 7, 2017: Meeting with CHCF of DMC-ODS Projects
- April 12, 2017: DHCS and UCLA Call Deliverables Conference Call
- April 13, 2017: DHCS Parity Meeting
- April 14, 2017: DHCS County of Responsibility Workgroup
- April 14, 2017: Assembly Budget Subcommittee No. 1
- April 17, 2017: Quarterly Meeting with BSCF and DHCS
- April 15-22, 2017: National Rx Drug Abuse Heroin Summit
- April 18, 2017: MCHAP
- April 18, 2017: DHCS Opioid Workgroup Meeting
- April 21, 2017: DHCS Parity Meeting
- April 24, 2017: Phase Four Dual County Managed Care Plan Meeting
- April 24, 2017: IHS-ODS MAT Project Meeting
- April 28, 2017: Conference Call with Substance Abuse and Mental Health Services Administration (SAMHSA) regarding Innovation
- May 4, 2017: Meeting with CHCF for Coalition Support
- May 5, 2017: Indian Health Program: Speaking Engagement
- May 10, 2017: Indian Health Program Meeting with CRIHB
- May 16, 2017: CADA 2017 Public Policy Conference
- May 16, 2017: BSCF and CIBHS Meeting
- May 18, 2017: Assembly Budget Subcommittee No. 1
- May 19, 2017: BSCF and CHCF Meeting regarding DMC-ODS IHS Implementation
- May 22, 2017: IAP SUD evaluation
- May 22, 2017: Tribal Programs Directors Meeting
- May 23, 2017: DHCS and CHCF Quarterly Meeting
- May 24, 2017: Direct Relief Non-Profit Conference Call regarding the Opioid Epidemic in California
- May 24, 2017: California Association of DUI Treatment Programs (CADTP) Spring Forum

- May 25, 2017: BayMark Health Services Conference Call
- May 25, 2017: New Treatment Taskforce Meetings
- May 25, 2017: Los Angeles County Substance Abuse Prevention and Control Transition Plan
- June 1, 2017: Opioid Crisis and Related Public Health Issues Summit
- June 1, 2017: Conference Call with CHCF regarding SUD Conference
- June 7, 2017: State Opioid Treatment Authority (SOTA), SAMHSA, and Drug Enforcement Agency (DEA) Conference Call
- June 9, 2017: Teleconference with CBHDA
- June 14, 2017: Indian Health Program Meeting
- June 19, 2017: State Health Information Guidance (SHIG) Advisory Group Meeting
- June 20, 2017: DHCS Opioid Workgroup Meeting
- June 28, 2017: CMS IAP Webinar

Qualitative Findings:

DHCS provided Compliance and Monitoring Workshops for Sacramento County on February 10, 2017, Fresno County on March 07, 2017, and San Bernardino County on March 23, 2017. DHCS provided technical assistance to Marin County, which included a checklist, grievance and appeals log, and expectations, on April 18-19, 2017. In Northern California, DHCS conducted Compliance Workshops on May 9, 2017, June 6, 2017, and June 23, 2017.

Quality Management Rule Requirements were set on May 4, 2017. On July 1, 2017, DHCS began developing a Readiness Review instrument for Counties that opt in to the Waiver. Three Counties are scheduled for Readiness Reviews in August 2017.

Quantitative Findings:

Table 1: Beneficiaries with FFP Funding

Quarter	Beneficiary Count
DY12-Q3	596
DY12-Q4	82

Table 2: DMC-ODS DY 12 Services and Expenditures by County

County	Service Period	Units of Service	Approved Amount	FFP Amount	SGF Amount
Marin	DY12-Q3	n/a	n/a	n/a	n/a
	DY12-Q4	732	$29,968.92	$23,280.61	$4,416.07
Riverside	DY12-Q3	2,132	$391,474.05	$332,762.60	$51,217.41
	DY12-Q4	0	$0	$0	$0
San Mateo	DY12-Q3	22,747	$445,427.98	$348,348.45	$30,338.76
	DY12-Q4	3,041	$101,005.86	$86,631.38	$9,489.27
Santa Clara	DY12-Q3	n/a	n/a	n/a	n/a
	DY12-Q4	74	$4,103.60	$3,473.08	$157.96

Table 3: DMC-ODS DY 12 Services and Expenditures

Level of Care	Service Period	Units of Service	Approved Amount	FFP Amount	SGF Amount
ODS/IOT Case Management	DY12-Q3	403	$14,287.52	$12,761.42	$624.18
	DY12-Q4	4	$124.00	$117.80	$6.20
ODS/IOT Counseling	DY12-Q3	537	$15,485.08	$12,136.90	$3,348.18
	DY12-Q4	425	$20,139.76	$16,570.85	$3,509.75
ODS/NTP Dosing Methadone	DY12-Q3	14,579	$174,219.05	$128,059.13	$4,575.00
	DY12-Q4	2,162	$25,835.90	$20,729.86	$872.39
ODS/NTP Individual Counseling	DY12-Q3	5,583	$77,603.70	$56,326.35	$1,949.40
	DY12-Q4	451	$6,268.90	$5,085.76	$217.09
ODS/ODF Case Management	DY12-Q3	0	$0.00	$0.00	$0.00
	DY12-Q4	11	$326.54	$194.88	$31.00
ODS/ODF Group Counseling	DY12-Q3	0	$0.00	$0.00	$0.00
	DY12-Q4	104	$3,740.62	$2,778.58	$100.90
ODS/ODF Individual Counseling	DY12-Q3	829	$25,623.10	$19,815.42	$778.20
	DY12-Q4	202	$8,904.40	$6,629.99	$865.06
RES 3.1	DY12-Q3	397	$45,282.14	$35,099.02	$10,183.12
	DY12-Q4	290	$32,465.50	$29,229.34	$3,236.16
RES 3.2	DY12-Q3	181	$33,205.36	$24,893.78	$921.04
	DY12-Q4	-	-	-	-
RES 3.5	DY12-Q3	2,370	$451,196.08	$392,019.03	$59,177.05
	DY12-Q4	198	$37,272.76	$32,048.01	$5,224.75

Marin County's DMC-ODS implementation started in April 2017. Santa Clara County's implementation started in June 2017.

Due to DHCS' Accounting policies for end-of-year processes, claims submitted after May 23, 2017 were not processed until after the start of the new state fiscal year, July 1, 2017. This impacts the data available, including client count and units of service, and explains the drop from third to fourth quarter. In the next report, the data will be a more accurate reflection of beneficiary count for DY12-Q4.

At this point in time, Riverside County's data was affected by the end-of-year Accounting policy noted above. If there are any errors or denials, claims must also be resubmitted.

Table 4: Member Months

Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
-	484	402	Qtr 3	596
64	10	33	Qtr 4	83

For DY12-Q4, there is only partial data available at time of this report submission.

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

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 (UCLA), Integrated Substance Abuse Programs (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 design and surveys are posted on UCLA's DMC-ODS website at: http://www.uclaisap.org/ca-policy/html/evaluation.html.

The first UCLA report for the DMC-ODS evaluation is located at: http://www.uclaisap.org/assets/documents/California-DMC-ODS-Evals/DMC-ODS-Evaluation-Report-FY-2015-2016-final.pdf.

GLOBAL PAYMENT PROGRAM (GPP)

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

The total amount of funds 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.

Accomplishments:

The Department developed a GPP Encounter Data Collection SharePoint Extranet site on May 19, 2017, to ensure each PHCS can submit encounter level data on their uninsured services using excel templates provided, in accordance with the STCs, Attachments EE and FF. The Department sent the PHCS encounter data manuals and reporting templates in preparation for a testing phase to ensure that there are no problems when they need to submit PY 2 encounter data in March 2018. The test submission is due August 15, 2017, and the final reporting is due March 31, 2018.

Program Highlights:

Program successfully completed PY 1 2015-16 Final Reconciliation, and PHCS were notified of the payment amount and IGT Notification on June 26, 2017.

Qualitative Findings:

Nothing to report

Quantitative Findings:

In DY 12, Public Health Care Systems received $1,109,452,659.50 in federal fund payments.

Payment	FFP	IGT	Service Period	Total Funds Payment
Global Payment Program (GPP)				
(Qtr 1 July-Sept)	$249,946,244.00	$249,946,244.00	Apr. 1, 2016 – June 2016	$499,892,488.00
(Qtr 2 Oct – Dec)	$286,502,138.50	$286,502,138.50	July 1, 2016 – Sept. 2016	$573,004,277.00
(Qtr 3 Jan-Mar)	$286,502,138.50	$286,502,138.50	Oct. 1, 2016 – Dec. 2016	$573,004,277.00
(Qtr 4 Apr – June)	$286,502,138.50	$286,502,138.50	Jan. 1, 2017 – Mar. 2017	$573,004,277.00
Total	**$1,109,452,659.50**	**$1,109,452,659.50**		**$2,218,905,319.00**

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

The GPP Draft Evaluation Design was submitted to CMS on September 19, 2016. In response to CMS' comments that were received on March 16, 2017, a revised report was submitted on May 15, 2017.

The Department is currently drafting the request for proposal for the proposed evaluation design. The evaluation is to assess the GPP goals of promoting value, not volume, by each individual PHCS. The proposal due date is September 1, 2017, and the award announcement will be made on September 11, 2017.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

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

PRIME Projects are organized into three domains. Participating DPH systems will implement at least nine 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: populations in need of perinatal care, individuals in need of post-acute care or complex care planning, foster children, individuals who are reintegrating into

society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

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.

Accomplishments:

In September 2016, DHCS successfully launched a secure PRIME Reporting Information System to serve as the basis for entity reporting activities throughout the duration of PRIME. The platform contains data entry fields for more than 100 PRIME metrics across the 18 PRIME projects. Data fields include numerators, denominators, qualitative narratives, and radio buttons. With a few exceptions, the platform automatically calculates metric achievement rates, achievement values and next DY target rates. The platform also contained fields for DMPH entities to report on, and determine achievement for infrastructure building activities.

In November 2016, DHCS launched a secure shared learning website via Microsoft SharePoint called PRIMEone. The shared learning website contains PRIME project discussion boards, libraries for documents and learning collaboratives materials, metric policies, and helpful links. Entities collaborate with each other on best practices, strategies for using their respective electronic health record systems and leveraging resources. DHCS and the California Health Care Safety Net Institute (SNI) monitor the site and DHCS provides administrate oversight when needed. The shared learning website has approximately 20 unique visitors per business day and has the added convenience of utilizing the same login credentials as the PRIME Reporting Portal.

DHCS collaborated with SNI and the District Hospital Leadership Forum (DHLF) on the release of the DY 11 V2.4 Metric Specification Manual and DY 11 Reporting Guide, released August 2016. These documents were later combined into the DY 12 Mid-Year PRIME Reporting Manual, a 1,000-page document that consolidated the most up-to-date PRIME metric specifications and reporting guidance, released February 2017.

In May 2017, DHCS established the Learning Collaborative Advisory Committee (LCAC), consisting of professionals from various entities, to advise DHCS on all aspects of the learning collaboratives, including:

- Providing feedback on potential Learning Collaborative discussion topics;
- Suggesting subject matter experts and speakers for in-person meetings, webinars, and conference calls;
- Advising DHCS on the agenda(s) for in-person LC meetings;
- Assisting with choosing topics for breakout sessions; and
- Recommending additional strategies for supporting the PRIME entities efforts to succeed in the PRIME program.

DHCS selected UCLA Center for Health Policy Research (UCLA CHPR) as an independent entity to conduct PRIME evaluation and established an interagency agreement on December 1, 2016.

Program Highlights:

On October 18, 2016, DHCS, SNI, and DHLF co-hosted the PRIME Reporting DY 11 Data Summit in South San Francisco. All participating PRIME entities attended, including DPHs and DMPHs, and shared actionable lessons from DY 11, data approaches that support the shift to pay-for-performance in DY 12, and reporting accomplishments for DY 11.

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

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

On April 10, 2017 and June 2, 2017, DHCS held Regional Learning Collaboratives in Riverside and Sacramento respectively. These in-person meetings engaged entities in a discussion of best practices and challenges in implementing PRIME. Areas of focus

were derived from direct input from the PRIME entities and included discussions on various elective PRIME projects, engaging providers and leadership, data governance, patient perceptions of changes to utilization, and electronic health record systems.

Qualitative Findings:

DY 11 Final Year-End Reports were due to DHCS from all participating PRIME entities on September 30, 2016. DHCS received all reports on time, conducted its clinical and administrative review of all reports, and approved them for payment.

DY 12 Interim Mid-Year Reports were due to DHCS from all participating PRIME entities on March 31, 2017. DHCS received all reports on time and conducted its clinical and administrative reviews for mid-year payments.

Quantitative Findings:

Payment	FFP	IGT	Service Period	Total Funds Payment
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)				
(Qtr 1 July-Sept)	$199,810,000.00	$199,810,000.00	DY 11	$399,620,000.00
(Qtr 2 Oct – Dec)	$598,626,428.57	$598,626,428.57	DY 11	$1,197,252,857.14
(Qtr 3 Jan-Mar)	$562,500.00	$562,500.00	DY 11	$1,125,000.00
(Qtr 4 Apr – June)	$314,688,578.33	$314,688,578.32	DY 12	$629,377,156.65
Total	**$1,113,687,506.90**	**$1,113,687,506.89**		**$2,227,375,013.79**

Payments for the PRIME hospitals 5-year plans (1st Semi-Annual Payment) went out in July 2016 due to the late submission and approval of the plans.

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

In DY12-Q4, interim DY 12 Mid-Year payments were issued by April 30, 2017. Eastern Plumas Health Care, Mendocino Coast District Hospital, and Salinas Valley Memorial

Healthcare System were unable to earn any incentive funds for their DY 12 Mid-Year Reports for achievements between January 1, 2016 – December 31, 2016.

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

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

On April 12, 2017, DHCS and CMS discussed feedback regarding the PRIME Draft Evaluation Design. Based on a discussion CMS provided feedback on April 27, 2017. On May 10, 2017, DHCS provided a response to CMS feedback along with an updated Evaluation Design and supporting documents.

On June 9, 2017, CMS provided an additional recommendation for the Evaluation Design. DHCS provided CMS a response to the additional recommendation and updated supporting documents on June 21, 2017.

DHCS selected the UCLA CHPR as the PRIME external evaluator. UCLA CHPR prepared an Office of Statewide Health Planning and Development (OSHPD) data analysis plan and submitted an application to OSHPD to obtain data that will allow for assessment of impact of PRIME on all California inpatient discharges. In addition, UCLA has prepared the Medi-Cal data analysis plan and has held several discussions with DHCS to determine what Medi-Cal data will be needed by UCLA for evaluation purposes.

UCLA CHPR has developed a statistical matching methodology to select control hospitals for comparison to entities participating in PRIME. The selection of these hospitals is in process.

UCLA CHPR began to review PRIME applications and created a database of hospital-specific characteristics, including information around patient mix, record systems, cultural competency, and leadership/engagement. UCLA CHPR has begun to create a data dictionary that identifies keywords and will assist in automating this process for future reporting periods. Additionally, to gain a better understanding of the

infrastructure, processes, and characteristics of PRIME participating hospitals at baseline, UCLA CHPR extracted sections from PRIME entities' applications and reports related to project selection logic and challenges/advantages to implementation and data reporting for PRIME projects. These sections will be used in later qualitative analysis.

Using the DY 11 reports, challenges to project implementation and data reporting have been categorized into overarching constructs (e.g. workflows, staff training/capacity, patient outreach, etc.) for the majority of hospitals. This will be used to help understand PRIME project implementation and assist in the design of the hospital survey instrument.

WHOLE PERSON CARE (WPC)

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

Local WPC pilots will identify high-risk, high-utilizer target populations; share data between systems; provide comprehensive care in a patient-centered manner; coordinate care in real time; and evaluate individual and population health progress. WPC pilots may also choose to focus on homelessness and expand access to supportive housing options for these high-risk populations. The WPC pilots are developed and operated locally by an organization eligible to serve as the LE, which must either be a city, a county, a city and county, a health or hospital authority, a consortium of any of the above entities serving a county or region consisting of more than one county, or a federally recognized tribe, a tribal health program operated under contract with the federal IHS.

WPC pilot payments will support infrastructure to integrate services among local entities that serve the target populations; 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.

Accomplishments:

Date	WPC Pilot Accomplishments
STC 117	
July 1, 2016	Eighteen applications for the WPC pilot were submitted to DHCS.
October 17, 2016	DHCS announced opening a second round of WPC pilot applications with applications due March 1, 2017.
December 5, 2016	All 18 applications were reviewed and approved.
December 11, 2016	DHCS submitted the revised WPC application for the second round of applications to CMS for approval.
December 23, 2016	CMS approved the selection criteria and the revised second round application.
March 1, 2017	DHCS received fifteen applications for the second round of the WPC pilot program.

Date	WPC Pilot Accomplishments
June 20, 2017	All 15 second round applications were reviewed and approved.
STC 118	
December 5, 2016	All 18 applicants executed agreements with DHCS for their WPC pilot programs.
June 30, 2017	All 15 applicants for the second round executed agreements with DHCS for their WPC pilot programs.
STCs 122 & 124	
July 22, 2016	DHCS provided CMS the variant metrics from the pilot applications for review.
September 2016	DHCS submitted the standardized variant metrics menu to CMS for approval of the standardized health outcomes variant metrics. DHCS revised and resubmitted based on CMS comments.
October 18, 2016	CMS approved the variant metrics menu.
October 21, 2016	CMS approved the updated Attachment MM to the STCs.
STC 126	
January 17, 2017	First notice sent to WPC pilot programs that their non-federal share of the intergovernmental transfer (IGT) was due.
February 3, 2017	DHCS released the first series of IGT payments to the 18 approved WPC pilots for program year (PY) 1.
STC 214	
May 11, 2017	CMS notified DHCS that a review of the evaluation design was completed with 12 comments and recommendations on the WPC evaluation design. In general, CMS recommended that the evaluation design be strengthened with specific details about the research design and organized around key components of the evaluation design.
June 27, 2017	DHCS submitted the revised evaluation design to CMS with the requested research and evaluation design details.

Program Highlights:

As mentioned previously, on July 1, 2017, DHCS received 18 WPC pilot applications. On October 21, 2016, DHCS and CMS determined that 14 of the WPC pilot applications complied with the STCs and approved the pilots to participate in the demonstration. On October 24, 2016, DHCS released approval notices including total funding allocations to the 15 approved WPC pilots.

On October 17, 2016, DHCS announced opening a second round of WPC pilot applications with a due date of March 1, 2017.

On November 7, 2016, DHCS submitted the Whole Person Care Draft Evaluation Design to CMS per STC 211 of California's *Medi-Cal 2020 Demonstration* (Project 11-W-00193/9) and invited public comment.

On November 23, 2016, DHCS submitted the final four updated pilot applications to CMS for approval. CMS determined that the four applications complied with the STCs and approved for the pilots to participate in the demonstration.

On November 30, 2016, DHCS held a second webinar for tribes and tribal organizations on proposed changes to the Medi-Cal program including WPC and a second round of applications for WPC.

On December 8, 2016, CMS approved the WPC amendment to California's Medi-Cal 2020 Waiver STCs. This amendment expanded the WPC pilots to allow federally recognized tribes and tribal health programs operated under PL 93-638 contract with the federal IHS to submit WPC applications and serve in the LE. Upon CMS approval, DHCS notified tribes and tribal organizations that they are eligible to apply as lead entities to submit applications in the second round of applications.

On December 14, 2016, DHCS began bi-weekly teleconferences with LEs to discuss issues and administrative topics.

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

On January 1, 2017, 18 LEs began implementing WPC pilots and enrolling WPC members.

Beginning February 2017, the Learning Collaborative was included in the Bi-Weekly Technical Assistance Calls with the WPC LEs for pilots approved in the first round of applications (legacy LEs). DHCS contracted with consultants to administer the Learning Collaborative and a survey was conducted to determine potential key discussion topics.

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

On March 1, 2017, DHCS received 15 applications for the second round of the WPC pilot program, which entered the review process where they were examined for the quality, and scope of the application. Of the 15 applications received, eight applications were from existing WPC legacy LEs interested in expanding their WPC pilot programs. The remaining seven were new applicants, including one city and a consortium of three smaller counties.

On March 7, 2017, DHCS submitted a technical correction to the STCs to CMS that will allow DHCS to accept applications from cities, and designate a city to be a LE in the second-round application process. DHCS requested an effective date of July 1, 2017, to allow the State to award the PY 1 unallocated funding to WPC pilots and accept a city as a LE.

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

On May 15, 2017, DHCS held an in-person meeting in collaboration with the Learning Collaborative consultants for the LEs of the approved WPC pilots. Topics included: *Prioritizing the Needs of Medicaid Patients; What Keeps You Up at Night; DHCS Vision for WPC: Toward Seamless Care Coordination; Open Questions and Answers with DHCS*; and breakout sessions on *Care Transitions, Ed Communications, Bio-Psycho-Social Integration and Care Coordination Tools*. On average, representatives from each of the 18 WPC pilots attended the daylong meeting, totaling more than 120 LE attendees in Sacramento.

On June 1, 2017, CMS approved the technical correction to the STCs allowing DHCS to designate a city to be a LE for the WPC pilot program.

On June 8, 2017, DHCS and CMS determined that the 15 applications complied with the STCs and approved the pilots to participate in the demonstration.

On June 12, 2017, after receiving CMS approval, DHCS approved the 15 second round WPC pilot applications.

By June 30, 2017, all WPC agreements were executed. The second-round agreement included, but was not limited to, total funds allocation for each calendar year, IGT payment process, Health Insurance Portability and Accountability Act business associate addendum, business associate data security requirements, the approved application, and terms of the agreement. The second round of WPC pilots will begin operation on July 1, 2017.

Qualitative and Quantitative Findings:

WPC pilot PYs are January 1 – December 31 beginning with PY 1 in 2016. DY 12 enrollment includes only the first 18 WPC pilots, which began enrollment January 1, 2016. Round 2 WPC pilots begin enrollment in PY 2.

Enrollment

WPC Enrollment for DY 12			
Lead Entity	**Quarter 3 (Jan-Mar) Unduplicated**	**Quarter 4 (Apr-Jun) Unduplicated**	**Total to Date**
Alameda	169	388	388
Contra Costa	194	7,321	7,322
Kern	0	0	0
LA	4,764	6,126	6,713
Monterey	7	31	31
Napa	0	0	0
Orange	200	455	655
Placer	0	64	64
Riverside	0	0	0
San Bernardino	0	7	7
San Diego	0	0	0
San Francisco	3,991	5,922	6,028
San Joaquin	0	0	0
San Mateo	2,078	2,129	2,243
Santa Clara	336	2,713	2,718
Shasta	0	15	15
Solano	8	23	31
Ventura	0	0	0
Total	**11,747**	**25,194**	**26,215**

Member Months

WPC Member Months for DY 12			
Lead Entity	**Quarter 3 (Jan-Mar)**	**Quarter 4 (Apr-Jun)**	**Cumulative Unduplicated Year-to-Date**
Alameda	355	914	1,269
Contra Costa	550	15,710	16,260
Kern	0	0	0
LA	12,335	14,682	27,017
Monterey	13	59	72
Napa	0	0	0
Orange	200	455	655
Placer	0	169	169
Riverside	0	0	0
San Bernardino	0	7	7
San Diego	0	0	0
San Francisco	9,204	15,522	24,726
San Joaquin	0	0	0
San Mateo	5,973	5,975	11,948
Santa Clara	336	4,884	5,220
Shasta	0	19	19
Solano	8	23	31
Ventura	0	0	0
Total	**28,974**	**58,419**	**87,393**

The first 18 LEs received $478,102,923.50 in federal fund payments for DY 11.

Policy/Administrative Issues and Challenges:

Nothing to report for DY 12.

Progress on the Evaluation and Findings:

DHCS submitted the WPC evaluation design on November 7, 2016.

On January 31, 2017, DHCS released a request for proposal for external independent evaluation services to seven qualified institutions. DHCS will select an independent evaluator from the seven qualified institutions and begin to develop an agreement with this evaluator. After the agreement is executed, the selected independent evaluator will work with DHCS to produce the two required evaluation reports.

On May 11, 2017, CMS notified DHCS that a review of the evaluation design submitted November 7, 2016, had been completed in accordance with the STCs. In general, CMS recommended that the evaluation design be strengthened with specific details about the research design and organized around key components of the evaluation design. DHCS submitted the revised evaluation design to CMS on June 27, 2017, with the requested research and evaluation design details.

On June 6, 2017, DHCS selected UCLA as the WPC independent evaluator from the request for proposals submitted. DHCS anticipates beginning contract negotiations in the next quarter with UCLA.

The WPC Evaluation will assess: 1) if the pilots successfully implemented their planned strategies and improved care delivery, 2) whether these strategies resulted in better care and better health, and 3) whether better care and health resulted in lower costs through reductions in avoidable utilization.

The evaluation will test the overall hypothesis that the WPC pilot program has achieved the STC goals in addition to achieving cost savings to the Medi-Cal program. It is hypothesized that WPC will achieve its goals by the development of infrastructure to promote integration among pilot entities. Infrastructure will in turn improve collaboration and delivery of high quality care by WPC pilots. These improvements will subsequently lead to better outcomes both in health of the high-risk, high-utilizing Medi-Cal beneficiaries and reduction of their health expenditures through reductions in avoidable utilization such as inpatient and emergency department utilization. WPC interventions are sustained when WPC LEs plan to maintain the relationships developed during the pilot program and have embedded care coordination practices in their routine operations.