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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fourteen (07/01/2018 – 06/30/2019)
Third Quarter Reporting Period: 01/01/2019 – 03/31/2019

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 18: Post Award Forum

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

In DY14-Q3, DHCS hosted a SAC meeting on February 13, 2019. DHCS discussed the potential 1115 waiver renewal opportunities and process for soliciting SAC members' input and discussion. Some of the topics discussed included: Care Coordination Workgroup Outcomes, Alternative Funding Mechanisms, Other Waiver Ideas, and the Stakeholder Process and Timing.

The meeting agenda is available on the DHCS website. The meeting minutes are also available online.

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on January 14, 2019, February 11, 2019, and March 11, 2019, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following topics were discussed: WPC Program Updates, HHP Updates, SUD Evaluation and Monitoring, Sustainability and Renewal of Waiver Programs, and Managed Care

Financial Reporting Activities.

STCs Item 201: Budget Neutrality Monitoring Tool

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

ACCESS ASSESSMENT

The STCs require DHCS to contract with its External Quality Review Organization (EQRO), Health Services Advisory Group, to conduct a one-time access assessment to care.

The EQRO prepared the final analytic data sets in January 2019 for the Access Assessment report. DHCS is reviewing the draft template and the preliminary data results.

DHCS and the EQRO will complete the following activities as part of the Access Assessment project:

- June 2019: Conduct the initial draft report meeting with the Access Assessment Advisory Committee (AAAC) for review and comment;
- July 2019: Release the initial draft report for 30-day public comment period;
- To Be Determined: Conduct exit AAAC meeting; and
- September 2019: Submit final report to CMS ten months following CMS' approval of the Access Assessment design and publish the report to DHCS' website.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

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

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-July	0	$2,733.54	$0.00
18-Aug	44	$2,733.54	$120,275.76
18-Sep	128	$2,733.54	$349,893.12
18-Oct	151	$2,733.54	$412,764.54
18-Nov	210	$2,733.54	$574,043.40
18-Dec	321	$2,733.54	$877,466.34
19-Jan	357	$2,733.54	$975,873.78
19-Feb	357	$2,733.54	$975,873.78
19-Mar	369	$2,733.54	$1,008,676.26
Total			**$5,294,866.98**

RCHSD Monthly Enrollment

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Enrollees
CCS	357	357	369	3	1,083

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 Waiver, was approved by Federal CMS on December 30, 2015. The Waiver contains STCs for the CCS Demonstration. STC 54 required DHCS to submit to CMS an updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. DHCS is awaiting approval for the CCS protocols, however DHCS received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design.

Rady Children's Hospital of San Diego Demonstration Project

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

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. RCHSD has notified DHCS that there are no member grievances to report for DY14-Q3.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

DHCS selected the Regents of the University of California, San Francisco (UCSF) as the evaluator of the CCS evaluation design. The CCS evaluation design was approved by CMS on November 17, 2017, and the approval documents and final design are available on the website. This evaluation will run from July 1, 2019, to June 30, 2021, and will be completed in two phases. Phase one will include HPSM, and phase two will include RCHSD. UCSF is slated to begin contracting work on July 1, 2019.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

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

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

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and FFS members per county for DY14-Q2, represents the period of October to December 2018. CBAS enrollment data is shown in the table, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.* The table titled *CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

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

[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.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY13-Q4		DY14-Q1		DY14-Q2		DY14-Q3	
	Apr - Jun 2018		Jul - Sep 2018		Oct - Dec 2018		Jan - Mar 2019	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	510	77%	539	82%	532	81%	533	81%
Butte	34	33%	37	36%	34	33%	34	33%
Contra Costa	232	72%	240	73%	212	64%	217	67%
Fresno	676	61%	602	46%	658	50%	614	47%
Humboldt	100	26%	95	24%	107	28%	97	25%
Imperial	307	51%	308	51%	305	51%	309	51%
Kern	83	25%	72	21%	96	28%	73	22%
Los Angeles	21,983	67%	21,414	63%	21,591	64%	21,595	64%
Merced	94	45%	94	45%	95	45%	97	53%
Monterey	107	57%	106	57%	105	56%	113	61%
Orange	2,329	53%	2,369	54%	2,440	55%	2,475	55%
Riverside	450	42%	470	43%	465	43%	464	36%
Sacramento	440	70%	367	59%	332	40%	442	43%
San Bernardino	650	87%	677	91%	694	93%	709	95%
San Diego	2,138	57%	2,238	60%	2,079	56%	2,100	56%
San Francisco	672	43%	684	44%	705	45%	660	42%
San Mateo	65	28%	65	28%	63	28%	66	29%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	224	16%	611	43%	606	42%	644	45%
Santa Cruz	110	72%	108	71%	107	70%	104	68%
Shasta	*	*	*	*	*	*	*	*
Ventura	905	63%	898	62%	909	63%	906	63%
**Yolo	282	74%	287	76%	290	76%	287	76%
Marin, Napa, Solano	80	16%	83	17%	79	16%	81	16%
Total	**32,489**	**61%**	**32,364**	**59%**	**32,504**	**59%**	**32,625**	**59%**
								FFS and MCP Enrollment Data 03/2019

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*

The data provided in the previous table shows that while enrollment has slightly increased between DY14-Q2 and DY14-Q3, it has remained consistent with over 32,000 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 close to 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.

While the closing of a CBAS Center in a county can contribute to increased utilization of the license capacity in a county, it is important to note the amount of participation can also play a significant role in the overall amount of licensed capacity used throughout the State. In Merced and Monterey Counties, there was a more than 5% increase in licensed capacity utilized compared to the previous quarter. For Merced County, the licensing capacity utilized changed due to an error in previous overall licensing capacity reports. Previously, total licensing capacity for Merced County was listed as 124, when the actual licensing capacity was 109. This error occurred due to a transition from an old database to a new database at CDA (California Department of Aging). DY14-Q3 was the first quarter to list the correct licensing capacity for Merced County, thus showing a change in license capacity utilization. The increase in capacity utilization for Monterey County is likely due to a fluctuation in attendance, as there were no center closures during the DY14-Q3 reporting period and no changes in their overall licensing capacity. In Kern and Riverside Counties, there was more than a 5% decrease of license capacity utilization compared to the previous quarter. For Riverside County, the decrease of more than 5% capacity utilization is likely due to an increase in overall licensing capacity for that county compared to the prior quarter, a decrease which may have been caused by a change in ownership of a facility, as no center openings in Riverside County occurred. The decrease in license capacity utilization in Kern County is likely due to general attendance fluctuation, as there were no center closures during the DY14-Q3 reporting period and no changes in their overall licensing capacities.

<u>CBAS Assessments for MCPs and FFS Participants</u>

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

The following table, titled *CBAS Assessments Data for MCPs and FFS* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments listed in this table is reported by DHCS.

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY13-Q4 (04/01-06/30/2018)	2,446	2,386 (97.5%)	60 (2.5%)	5	5 (100%)	0 (0%)
DY14-Q1 (07/01-09/30/2018)	2,369	2305 (97.3%)	64 (2.7%)	4	4 (100%)	0 (0%)
DY14-Q2 (10/01-12/31/2018)	2,256	2,208 (97.9%)	48 (2.1%)	6	6 (100%)	0 (0%)
DY14-Q3 (01/01-03/31/2019)	2,146	2,089 (97.3%)	57 (2.7%)	6	4 (66.7%)	2 (33.3%)
5% Negative change between last Quarter		No	No		Yes	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. As indicated in the table above, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. According to the table, for DY14-Q3, there were 2,146 assessments completed by the MCPs, of which 2,089 were determined to be eligible and 57 were determined to be ineligible. The table identifies that six participants were assessed for CBAS benefits under FFS, with four determined eligible and two determined not eligible by DHCS. The two FFS applicants were determined not eligible due to them residing in an ICF/DD-N (Intermediate Care Facility/Developmentally Disabled-Nursing), a community-based facility which provides 24-hour personal care and nursing HCBS waiver services.

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

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

The next table titled *CDA – CBAS Provider Self-Reported Data* identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY14-Q3. The ADA at the 251 operating CBAS Centers is approximately

23,104 participants, which corresponds to 70% Statewide ADA per center. As the result of an increase in the total unduplicated participants in DY14-Q3, a rise in raw ADA was seen compared to the previous quarter. Additionally, three new CBAS Centers opened during DY14-Q3 that resulted in an overall increase in total statewide license capacity at 32,777 and a slight decrease in Statewide ADA percentage compared to the previous quarter.

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	251
Non-Profit Centers	55
For-Profit Centers	196
ADA @ 251 Centers	23,104
Total Licensed Capacity	32,777
Statewide ADA per Center	70%
	CDA - MSSR Data 03/2019

Outreach/Innovative Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans and other interested stakeholders via the *CBAS Updates* newsletter. In the past quarter, CDA distributed two newsletters (February 6, 2019 and March 21, 2019) which included an update on the status of the revised CBAS Individual Plan of Care (IPC), a new ADHC/CBAS History & Physical Form developed by the California Association of Adult Day Services (CAADS) in collaboration with CDA, education and training opportunities such as the California Association of Adult Day Services (CAADS) 2019 Spring Conference, and the new CBAS Center Assessment Tool (CAT) on CBAS training requirements. The content of the newsletters are similar to the prior quarter however, updated information was included relevant to the current time frame, including information on the Spring 2019 CAADS conference and further implementation of the IPC form.

The IPC was revised through a year-long stakeholder process in 2015-2016 to comply with federal Home and Community-Based (HCB) Person-Centered Planning Requirements as directed in the Medi-Cal 2020 Waiver. The new IPC was published in the Medi-Cal Provider Manual on March 15, 2019, and CBAS providers are required to implement the new IPC effective June 1, 2019. CDA distributed an All Center Letter (ACL) on March 19, 2019 to CBAS providers, MCPs, software vendors and other interested stakeholders informing them of the official IPC implementation date.

CDA convenes triannual calls/outreach with all MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update them on CBAS activities and data including policy directives, and (3) request feedback on any CBAS provider issues requiring CDA assistance. The most recent MCP calls were held on December 12, 2018 and April 10, 2019. The upcoming MCP call is scheduled for August 7, 2019.

Operational/Policy Developments/Issues:

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

DHCS did not experience any significant policy and administrative issues or challenges with the CBAS program during DY14-Q3. DHCS approved the revised CBAS IPC and revised CBAS sections of the Medi-Cal Provider Manual which was published on March 15, 2019. Implementation of the new CBAS IPC is scheduled for June 1, 2019.

Consumer Issues:

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

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

Issues that generate CBAS complaints are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in the Table entitled "*Data on CBAS Complaints"* and the Table entitled "*Data on CBAS Managed Care Plan Complaints*."

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY14-Q3, as illustrated in the table, titled *Data on CBAS Complaints*. The table, titled *Data on CBAS Managed Care Plan Complaints* shows that MCPs received eight beneficiary complaints and zero provider complaints in DY14-Q3.

Overall, provider complaints have decreased during the last two quarters, as reported by the managed care plans.

DY13–Q4 (Apr 1 – Jun 30)	0	0	0
DY14-Q1 (Jul 1 – Sep 30)	0	0	0
DY14-Q2 (Oct 1 – Dec 31)	0	0	0
DY14-Q3 (Jan 1 – Mar 31)	0	0	0

CDA Data - Complaints 03/2019

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY13-Q4 (Apr 1 - Jun 30)	2	0	2
DY14-Q1 (Jul 1 - Sep 30)	2	8	10
DY14-Q2 (Oct 1 - Dec 31)	2	13	15
DY14-Q3 (Jan 1 - Mar 31)	8	0	8

Plan data - Phone Center Complaints 03/2019

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

Grievance and appeals data is provided to DHCS by the MCPs. According to the table, titled *Data on CBAS Managed Care Plan Grievances*, eight grievances were filed with the MCPs for DY14-Q3; three grievances were related to “CBAS Providers,” two grievances were related to “Excessive Travel Times to Access CBAS”, and the remaining three grievances were related to “Other CBAS grievances.”

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
DY13-Q4 (Apr 1 - Jun 30)	3	0	0	36	39
DY14-Q1 (Jul 1 - Sep 30)	1	0	0	5	6
DY14-Q2 (Oct 1 - Dec 31)	5	1	0	19	25
DY14-Q3 (Jan 1 - Mar 31)	3	0	2	3	8
Plan data - Grievances 03/2019					

For DY14-Q3, zero CBAS appeals were filed with the MCPs as shown in the table titled *Data on CBAS Managed Care Plan Appeals.*

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
DY13 – Q4 (Apr 1 – Jun 30)	8	0	0	0	8
DY14 – Q1 (Jul 1 – Sep 30)	13	1	0	2	16
DY14 – Q2 (Oct 1 – Dec 31)	1	0	0	2	3
DY14 – Q3 (Jan 1 – Mar 31)	0	0	0	0	0
Plan data - Grievances 03/2019					

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

Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY14-Q3 (January to March 2019), there were no requests for hearings related to CBAS services filed.

Financial/Budget Neutrality Development/Issues:

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

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

Quality Assurance/Monitoring Activities:

The CBAS Quality Assurance and Improvement Strategy, developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. CDA continues to convene quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans, and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. The table, titled *CBAS Centers Licensed Capacity*, indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also shows overall utilization of licensed capacity by CBAS participants statewide for DY14-Q3. Quality Assurance/Monitoring Activity reflects data through April 2018 to March 2019.

County	CBAS Centers Licensed Capacity					
	DY13-Q4 Apr-Jun 2018	DY14-Q1 Jul-Sep 2018	DY14-Q2 Oct-Dec 2018	DY14-Q3 Jan-Mar 2019	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	**390**	0.0%	81%
Butte	60	60	60	**60**	0.0%	33%
Contra Costa	190	195	195	**190**	-2.6%	67%
Fresno	652	772	772	**772**	0.0%	47%
Humboldt	229	229	229	**229**	0.0%	25%
Imperial	355	355	355	**355**	0.0%	51%
Kern	200	200	200	**200**	0.0%	22%
Los Angeles	19,380	19,974	19,984	**20,026**	+0.2%	64%
Merced	124	124	124	**109**	-12.0%	53%
Monterey	110	110	110	**110**	0.0%	61%
Orange	2,608	2,608	2,638	**2,638**	0.0%	55%
Riverside	640	640	640	**760**	0.0%	36%
Sacramento	369	369	489	**609**	+18.8%	43%
San Bernardino	440	440	440	**440**	0.0%	95%
San Diego	2,198	2,198	2,198	**2,233**	+1.6%	56%
San Francisco	926	926	926	**926**	0.0%	42%
San Mateo	135	135	135	**135**	0.0%	29%
Santa Barbara	60	60	60	**60**	0.0%	*
Santa Clara	830	830	850	**850**	0.0%	50%
Santa Cruz	90	90	90	**90**	0.0%	68%
Shasta	85	85	85	**85**	0.0%	*
Ventura	851	851	851	**851**	0.0%	63%
Yolo	224	224	224	**224**	0.0%	76%
Marin, Napa, Solano	295	295	295	**295**	0.0%	16%
SUM	31,441	32,160	32,340	**32,637**	+0.9%	59%

CDA Licensed Capacity as of 03/2019

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*

The above table reflects the average licensed capacity used by CBAS participants at 59% statewide as of March 31, 2019. Overall, most of the CBAS Centers have not

operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.

STC 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. In the table titled *CBAS Centers Licensed Capacity*, Merced County licensing capacity decreased more than five percent during DY14-Q3. This greater than five percent decrease in licensing capacity was due to an error in previous overall licensing capacity reports. Previously, total licensing capacity for Merced County was listed as 124, when the actual licensing capacity was 109. This error occurred due to a transition from an old database to a new database at CDA. DY14-Q3 was the first quarter to list the correct licensing capacity for Merced County, thus showing a decrease of greater than five percent. Sacramento County saw an increase of 18 percent in their license capacity in DY14-Q3 compared to DY14-Q2, and resulted in an overall increase in the total licensed capacity statewide. Sacramento County's increase in licensing capacity during DY14-Q3 was likely due to the opening of a new CBAS center, Love Joy Adult Day Health Care Center.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS*, and *CBAS Centers Licensed Capacity* CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. There were no closures of any CBAS Centers over the DY14-Q3 reporting period, therefore, closures did not negatively affect the CBAS Centers and the services they provide to beneficiaries. There are other centers in nearby counties that can assist should the need arise for ongoing care of CBAS participants.

Unbundled Services (STC 48.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. The table, titled *CBAS Center History*, shows the history of openings and closings of the centers. According to Table below, for DY14-Q3 (January to March 2019), CDA currently has 251 CBAS Center providers operating in California. In DY14-Q3, zero centers closed while three centers opened, two in Los Angeles County and one in Sacramento County. The table below shows there was not a negative change of more than five percent from the prior quarter so no analysis is needed to addresses such variances.

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
March 2019	251	0	0	0	251
February 2019	250	0	1	1	251
January 2019	248	0	2	2	250
December 2018	248	0	0	0	248
November 2018	248	0	0	0	248
October 2018	247	0	1	1	248
September 2018	245	0	2	2	247
August 2018	244	0	1	1	245
July 2018	243	0	1	1	244
June 2018	243	0	0	0	243
May 2018	242	0	1	1	243
April 2018	242	0	0	0	242
March 2018	242	0	0	0	242

Evaluation:

Not applicable.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through 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.

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

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

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

Domain 1[2] – 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.

[2] DTI Domain 1

Domain 2[3] – Caries Risk Assessment (CRA) and Disease Management

This domain is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages six and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this domain, a provider rendering services in one of the pilot counties must take the DHCS approved training and submit a completed provider opt-in attestation form.

The following are the initial eleven (11) counties selected as pilot counties and are currently participating in this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, and Yuba. At the beginning of DY14-Q3, DHCS expanded this pilot to an additional eighteen (18) counties to improve the pilot's success and to focus on a more robust provider and beneficiary participation. The following are the 18 expansion counties: Merced, Monterey, Kern, Contra Costa, Santa Clara, Los Angeles, Stanislaus, Sonoma, Imperial, Madera, San Joaquin, Fresno, Orange, San Bernardino, Riverside, Ventura, Santa Barbara, and San Diego.

Domain 3[4] – Continuity of Care

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

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

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

Domain 4[5] – Local Dental Pilot Projects (LDPPs)

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

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

Enrollment Information:

Statewide Beneficiaries Ages 1-20 with Three Months Continuous Enrollment and Preventive Dental Service Utilization[6]

Measure Period	Jan-Feb 2018	Feb 2018-Jan 2019	Mar 2018-Feb 2019	Apr 2018-Mar 2019
Denominator[7]	5,538,675	5,529,791	5,509,072	5,498,904
Numerator[8]	2,526,194	2,515,516	2,499,936	N/A[9]
Preventive Dental Service Utilization	45.61%	45.49%	45.38%	N/A[8]

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

State Fiscal Year 2018-2019 Statewide Active Service Offices, Rendering Providers, and SNCs [10]

Delivery System and Plan	Provider Type	December 2018	January 2019	February 2019	March 2019
FFS	**Service Offices**	5,815	5,843	5,850	5,901
FFS	**Rendering**	10,479	10,536	10,591	10,663
Geographic Managed Care (GMC)[11]	**Service Offices**	155	N/A[12]	N/A[11]	N/A[13]
GMC	**Rendering**	396	N/A [11]	N/A [11]	N/A[12]
Prepaid Health Plan (PHP)[10]	**Service Offices**	1,158	N/A [11]	N/A [11]	N/A[12]
PHP[10]	**Rendering**	2,039	N/A [11]	N/A [11]	N/A[12]
Both FFS and Dental Managed Care (DMC)	**Safety Net Clinics**	566	566	567	N/A[14]

Outreach/Innovative Activities:

DTI Small Workgroup

This workgroup meets on a bi-monthly basis, the third Wednesday of the month. This workgroup met on January 17, 2019, during this quarter. DHCS shared updates on all DTI domains with provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. There were no specific questions or concerns from the attendees. A subsequent meeting was scheduled on March 21, 2019. Since there were no specific agenda items received for discussion, DHCS cancelled the meeting and shared updates on all domains via email with no specific questions or concerns received from stakeholders.

[10] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of SNCs is based on encounter data from the DHCS data warehouse as of October 2018. Only SNCs that submitted at least one dental encounter within a year were included.

[11] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.
[12] GMC and PHP services office and rendering providers data is under DHCS review due to data discrepancy during the transition of new reporting template for 274 network reporting process. Data will be available in the next report.
[13] Data will be updated next quarter when DHCS receives the DMC deliverables.
[14] Count of SNCs for the third month of each quarter is not available due to claim submission time lag.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities, discuss ways to increase participation from providers who are eligible to participate in the domain, and to provide an open forum for questions and answers specific to this domain. The subgroup met on February 19, 2019, during this quarter. During this meeting, DHCS provided the following clarifications:

- Payments are directly paid to providers, which is the same as the other three domains;
- Any Medi-Cal Dental Program dental provider is eligible to participate so long as they complete the required training, submit an opt-in form, and render services in the pilot counties;
- Allied dental professionals cannot participate because they are not the dental providers completing the CRA;
- Payment levels for PYs 1-3; and
- Number of opted-in providers to date for the original 11 pilot counties.

The group also decided to change the frequency of the meetings to quarterly or as needed. The next subgroup meeting will be scheduled in June 2019.

DTI Clinic Workgroup

The clinic subgroup is still active; however, it did not meet this quarter. A meeting is currently scheduled on May 28, 2019, to discuss clinic participation in DTI.

Domain 3 Subgroup

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

DTI Data Subgroup

The purpose of the DTI data subgroup is to provide an opportunity for stakeholders and DHCS to discuss various components of the DTI annual report and for opportunities to examine new correlations and data. Since the release of the DTI PY 2 Report[15], stakeholders reviewed the report and shared some feedback with DHCS for an upcoming discussion. A meeting will be scheduled in the next quarter to further discuss stakeholder feedback.

[15] PY 2 Final Report for January-December 2017

Domain 4 Subgroup

DHCS holds bi-monthly calls with the LDPPs to receive status updates and address any outstanding questions. During this reporting period, one LDPP conference call was held on February 20, 2019.

DTI Webpage

This quarter's webpage postings included the DTI Domain 2 fact sheet update posted on February 8, 2019 and Domain 3 fact sheet update posted on February 19, 2019. Both domains' fact sheets were revised to include county expansion information. In addition, the DTI PY 2 report was posted in January 2019.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY14-Q3. In this quarter, there were 241 inquiries in the DTI inbox (DTI@dhcs.ca.gov). Most inquiries during this reporting period included, but were not limited to, the following categories: county expansion, encounter data submission, opt-in form submission, payment status and calculations, resource documents, and Domain 2 billing and opt-in questions. All requests were researched and responded to within seven business days.

Number of DTI Inbox Inquiries by Domain

Domain	Inquiries
1	126
2	99
3	16
Total	**241**

In this reporting period, DHCS received 276 requests to subscribe to the DTI Listserv. The DTI Listserv registration can be found on the website.

In a separate LDPP (LDPPInvoices@dhcs.ca.gov) inbox for Domain 4, participants sent 157 inquiries this quarter. The inquiries pertained to status requests, budget changes, additional funding requests, and reimbursement questions.

Outreach Plans

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

- January 11, 2019: Contra Costa County Oral Health
- January 24, 2019: Humboldt Dental Society Meeting
- February 21, 2019: LA Stakeholder Meeting (agenda)
- March 5, 2019: Mariposa County Oral Health Advisory Meeting
- March 7, 2019: Loma Linda University Dental School Presentation
- March 14, 2019: Oral Health Committee of the Public Health Commission
- March 15, 2019: Healthy Smiles OC Event
- March 26, 2019: Solano County Oral Health Advisory Committee
- March 28, 2019: Mendocino Oral Health Committee

Operational/Policy Developments/Issues:

Domain 1

DHCS delayed the January 2019 payment to ensure participating providers with historical claims data were not negatively impacted by the rebaseline methodology applied to the scheduled payment. The rebaseline methodology was refined to apply only to providers who entered the program with no historical claims data and given a county benchmark. The rebaselining will provide this group of providers with a performance-based baseline and subsequent benchmarks to achieve in order to earn the incentive payments. Impacted providers will be notified of their new baseline and benchmark by mail in early June 2019, and all providers eligible to receive the January 2019 payment will receive it in early June 2019.

Domain 2

FFS providers are paid on a weekly basis and SNC and DMC providers are paid on a monthly basis. The table below represents incentive claims paid (as of March 2019) for FFS, SNC, and DMC providers during the DY14-Q3 reporting period. During this time, $2,016,619.95 in total incentive claims were paid to 781 providers who opted into the domain.

County	FFS	DMC	SNC
Sacramento	$150,574.50	$413,275	-
Tulare	$674,547.45	-	-
Kings	$1,638	-	-
Glenn	$630	-	-
Humboldt	-	-	$126
Mendocino	-	-	$70,532
Inyo	-	-	$5,922
Contra Costa	$4,921	-	-
Fresno	$6,347	-	-

County	FFS	DMC	SNC
Kern	$150,165	-	-
Los Angeles	$188,420	-	-
Madera	$252	-	-
Merced	$126	-	-
Orange	$63,903	-	-
Riverside	$61,464	-	-
San Bernardino	$91,423	-	-
San Diego	$35,632	-	-
San Joaquin	$1,798	-	-
Santa Barbara	$47,280	-	-
Sonoma	-	-	$3,906
Stanislaus	$35	-	-
Ventura	$43,703	-	-
Total Incentive Claims Paid - $2,016,619.95			

The next table represents incentive claims paid (as of March 2019) for FFS, SNC, and DMC providers from the beginning of the Domain 2 program (February 2017) until the end of DY14-Q3 reporting period. The total incentive claims paid for this period was $7,301,345 to 991 providers opted into the domain.

County	FFS	DMC	SNC
Sacramento	$930,631.75	$1,708,215	-
Tulare	$3,527,399.04	-	-
Kings	$14,710.50	-	-
Glenn	$5,757	-	-
Humboldt	-	-	$126
Mendocino	-	-	$388,923
Inyo	-	-	$26,208
Contra Costa	$4,921	-	-
Fresno	$6,347	-	-
Kern	$150,165	-	-
Los Angeles	$188,420	-	-
Madera	$252	-	-
Merced	$126	-	-
Orange	$63,903	-	-
Riverside	$61,464	-	-
San Bernardino	$91,423	-	-
San Diego	$35,632	-	-
San Joaquin	$1,798	-	-
Santa Barbara	$47,280	-	-
Sonoma	-	-	$3,906
Stanislaus	$35	-	-
Ventura	$43,703	-	-
Total Incentive Claims Paid - $7,301,345.29			

Domain 2 Outreach Efforts

DHCS has continued to actively engage dental stakeholders in discussions around outreach strategies to increase Domain 2 provider participation through the various workgroups and sub-groups that meet throughout the PY. DHCS has continued to direct our ASO vendor to take the opportunity during their standard operational outreach activities to engage with providers rendering services in Domain 2 counties. During the DY14-Q3 reporting period, the ASO visited ninety-one (91) cities across the twenty-nine (29) eligible pilot counties. The ASO has also emphasized outreach in under-utilized counties, based on the ratio of beneficiaries to providers. DHCS and the ASO continue to issue provider notifications in the counties added during the expansion of this domain, and DHCS continues to respond to inquiries via the DTI Inbox.

Domain 3

In this quarter, the ASO's outreach team visited 13 of the 36 pilot counties (Butte, Contra Costa, Kern, Marin, Orange, Riverside, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Sonoma, and Ventura). Outreach efforts included increasing provider participation and promoting Domain 3 expansion in the 19 new counties. As a result, an additional six SNCs elected to opt-in for participation, bringing the total from 68 to 74.

Domain 4

The LDPPs have utilized the email inbox, LDPPinvoices@dhcs.ca.gov, to submit invoices electronically on a quarterly basis. During this quarter, $3,945,590 was paid. Invoices are still submitted on a quarterly basis and may require additional follow-up regarding backup documentation from the LDPP.

During this quarter, DHCS have completed site visits on February 21, 2019 (CRIHB), March 15, 2019 (First 5 San Joaquin), and March 18, 2019 (Sacramento) to observe the administrative and clinical initiatives as outlined in each LDPP's executed contract. DHCS visits will continue to all LDPPs through 2019. Bi-monthly teleconferences with all LDPPs continue as an opportunity to educate, provide technical assistance, offer support, and address concerns.

Consumer Issues:

Nothing to report at this time.

Financial/Budget Neutrality Development/Issues:

See the *Operational/Policy Developments/Issues* section for information on payments

under the respective domains, as applicable.

Quality Assurance/Monitoring Activities:

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

Evaluation:

During DY14-Q3, Mathematica continued to work on tasks associated with the evaluation; participated in DHCS-led DTI stakeholder engagements; and participated in bi-weekly conference calls with DHCS for status check-ins and updates. As of the submission of this report, Mathematica has been conducting telephone interviews to collect the provider surveys and data needed for the interim report.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. As of September 1, 2017, DHCS received a total of 40 implementation plans from the following counties: San Francisco, San Mateo, Riverside, Santa Cruz, Santa Clara, Marin, Los Angeles, Napa, Contra Costa, Monterey, Ventura, San Luis Obispo, Alameda, Sonoma, Kern, Orange, Yolo, Imperial, San Bernardino, Santa Barbara, San Benito, Placer, Fresno, San Diego, Merced, Sacramento, Nevada, Stanislaus, San Joaquin, El Dorado, Tulare, Kings, and Partnership Health Plan of California. As of January 18, 2018, DHCS has approved all counties' implementation plans. With the 40 submitted implementation plans, 97.54% of California's population will be covered under the DMC-ODS. Twenty-five counties are currently providing DMC-ODS services.

Enrollment Information:

Prior quarters have been updated based on new claims data. For State Fiscal Year (SFY) 18-19, DY14-Q2 and DY14-Q3, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY13-Q4	18,432	9,343	27,414
DY14-Q1	26,869	13,279	39,665
DY14-Q2	27,585	13,433	40,655
DY14-Q3	21,361	11,035	32,450

Member Months:

Under the DMC-ODS, enrollees reported are the number of unique clients receiving services. “Current Enrollees (to date)” represents the total number of unique clients for the quarter. Prior quarters’ statistics have been updated, and for SFY 18-19, DY14-Q2 and DY14-Q3, there is only partial data available at this time since counties have up to six months to submit claims after the month of service.

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	13,476	13,489	13,322	DY13-Q4	18,432
	19,402	20,127	20,005	DY14-Q1	26,869
	18,882	17,672	17,998	DY14-Q2	27,585
	16,723	14,369	8,292	DY14-Q3	21,361
Non-ACA	7,592	7,511	7,330	DY13-Q4	9,343
	10,641	10,747	10,842	DY14-Q1	13,279
	9,576	9,680	9,537	DY14-Q2	13,433
	8,828	7,751	4,262	DY14-Q3	11,035

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

- Monthly Technical Assistance (TA) Webinars with Counties’ Leads
- Monthly Harbage Consulting Meetings regarding DMC-ODS Waiver
- California Association of Alcohol and Drug Programs Executives, Inc. Bi-Monthly Calls
- SUD Waiver States Bi-Monthly Conference Calls
- California Health Care Foundation (CHCF) Bi-Monthly Calls
- Indian Health Program Organized Delivery System (IHP-ODS) Bi-Monthly Calls
- DHCS Opioid Workgroup Meetings
- January 17, 2019: Coalition of Alcohol & Drug Associations (CADA) and DHCS DMC-ODS Workgroup
- January 24, 2019: Council on Criminal Justice and Behavioral Health (CCJBH) January Council Meeting
- January 24, 2019: Opioid Treatment Task Force Meeting
- January 24, 2019: California Department of Corrections and Rehabilitation Meeting regarding Narcotic Treatment Programs
- January 25, 2019: Quarterly DHCS, Behavioral Health Concepts (BHC), and UCLA Meeting

- January 31, 2019: DHCS, Harbage Consulting, and CHCF: Strategy Session on communication efforts for 2019
- January 31, 2019: DHCS Medi-Cal Mental Health, and SUDs Estimate Briefing
- February 12, 2019: DHCS, Public Health Institute (PHI), and CHCF Meeting
- February 13, 2019: DHCS Webinar for Residential Treatment Facilities
- February 14, 2019: Treatment Starts Here: CHCF MAT Advisory Group
- February 14, 2019: County Behavioral Health Directors Association Governing Board Meeting
- February 26, 2019: Statewide Opioid Safety Workgroup
- February 27, 2019: Collaborative Justice Courts Advisory Committee Meeting
- March 13, 2019: Joint Informational Hearing Senate and Assembly Health Committees: Increasing Access to Treatment and Services in Response to the Opioid Crisis
- March 14, 2019: Joint Meeting SAMHSA Tribal Technical Advisory Committee and IHS National Tribal Advisory Committee on Behavioral Health
- March 27, 2019: Collaborative Justice Courts Advisory Committee Meeting

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

County	County/Provider Staff Training Dates	County/Provider Staff Training Attendees
Monterey County	January 16, 2019	8
Placer County	February 21, 2019	10
San Bernardino County	March 13, 2019	22

Operational/Policy Developments/Issues:

During this reporting period, CMS continued to assist DHCS with program and fiscal questions on Attachment BB for the IHP-ODS.

Financial/Budget Neutrality Developments/Issues:

Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY13-Q4					
ACA	948,048	$31,536,794.00	$27,526,105.13	$2,616,875.43	$1,393,813.44
Non-ACA	539,422	$11,949,676.86	$6,050,704.76	$1,665,381.49	$4,233,590.61

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY14-Q1					
ACA	1,670,850	$45,760,294.47	$40,102,747.44	$3,375,811.23	$2,281,735.80
Non-ACA	949,300	$18,394,692.05	$9,283,312.25	$2,472,546.72	$6,638,833.08
DY14-Q2					
ACA	1,559,775	$44,536,735.21	$39,149,835.35	$3,181,138.28	$2,205,761.58
Non-ACA	864,538	$17,562,631.65	$8,867,750.90	$2,659,811.80	$6,035,068.95
DY14-Q3					
ACA	1,084,436	$28,876,003.52	$24,989,396.96	$2,257,104.42	$1,629,502.14
Non-ACA	580,251	$11,487,477.80	$5,802,412.50	$1,349,306.20	$4,335,759.10

ACA and Non-ACA Expenditures by Level of Care

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

There are now 26 counties participating in the DMC ODS waiver as of April 1, 2019, with 15 new counties implementing the waiver in DY 14. Of the 15 counties, eight started providing services in Q1, three counties in Q2, and three counties in Q3. (One county started on April 1, 2019, and is included in the total count.)

Because of the six month lag in claiming, DY13-Q4 and DY14-Q1 represent a more complete billing perspective in comparison to DY14-Q2 and Q3. To date, approved claims for the four quarters equal $210,104,306. In these four quarters, claims for Methadone dosing and Residential 3.5 comprise 20% and 18%, respectively, of the $210 million in approved claims.

Consumer Issues:

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

Grievances

Grievance	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals
Alameda	0	2	2	0	0	0	**4**
Contra Costa	0	0	0	0	0	1	**1**
Imperial	0	0	0	0	0	0	**0**
Kern	0	1	1	0	0	0	**2**
Los Angeles	4	4	4	2	1	7	**22**
Marin	0	0	0	0	0	0	**0**
Monterey	0	0	0	0	0	0	**0**
Napa	0	0	0	0	0	0	**0**
Nevada	0	0	0	0	0	0	**0**
Orange	0	3	1	0	2	0	**6**
Placer	0	0	0	0	0	0	**0**
Riverside	1	5	0	0	0	0	**6**
San Bernardino	0	0	0	0	0	3	**3**
San Diego	2	13	0	3	0	8	**26**
San Francisco	0	0	0	0	0	0	**0**
San Joaquin	0	0	1	0	0	0	**1**
San Luis Obispo	0	1	0	5	0	0	**6**
San Mateo	0	0	1	0	0	0	**1**
Santa Barbara	0	0	0	0	1	1	**2**
Santa Clara	0	2	2	1	1	0	**6**
Santa Cruz	1	0	0	0	0	0	**1**
Ventura	0	0	0	0	0	0	**0**
Yolo	0	0	0	0	0	0	**0**

Resolutions

County	Grievances	Appeal	Appeal Resolved in Favor of Plan/County	Appeal Resolved in Favor of Beneficiary
Alameda	0	0	-	-
Contra Costa	1	1	1	-
Imperial	0	0	-	-
Kern	2	0	-	-
Los Angeles	14	0	-	-
Marin	1	0	-	-
Monterey	0	0	-	-
Napa	0	0	-	-
Nevada	0	0	-	-
Orange	6	0	-	-
Placer	0	0	-	-
Riverside	5	1	1	-
San Bernardino	0	0	-	-
San Diego	27	0	-	-
San Francisco	1	0	-	-
San Joaquin	0	0	-	-
San Luis Obispo	10	0	-	-
San Mateo	2	0	-	-
Santa Barbara	2	0	-	-
Santa Clara	3	2	-	2
Santa Cruz	2	0	-	-
Ventura	0	0	-	-
Yolo	0	0	-	-

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

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

Los Angeles: In DY14-Q2, Los Angeles County reported 100 grievances. DHCS and Los Angeles County have determined that investigations not related to the DMC-ODS network of providers such as complaints regarding Driving Under the Influence (DUI) and homeless advocacy programs have been submitted. DHCS and Los Angeles

County are reviewing reports to determine the actual number of grievances for the second quarter. Corrections will be reported in the fourth quarter report.

For DY14-Q3, Los Angeles County is reporting 22 grievances. DHCS has reviewed the available reports and is satisfied with the outcomes. DHCS will continue to work closely with Los Angeles County until all inaccuracies are corrected.

San Diego: In DY14-Q2, San Diego County reported 24 grievances. DHCS reviewed the reports and is satisfied with the outcomes. For DY14-Q3, San Diego reported 26 grievances and DHCS has reviewed and is satisfied with the outcomes. Also in this quarter, DHCS conducted an Intergovernmental Agreement compliance monitoring review and discussed the grievance process with the Quality Assurance Officer and the Behavioral Health Administrator.

Quality Assurance/Monitoring Activities:

DHCS conducted compliance monitoring reviews for the following Counties:

County	Date
San Mateo	January 8, 2019
Monterey	January 9-11, 2019
Placer	February 14-15, 2019
San Diego	February 26-28, 2019
Imperial	March 12-15, 2019
Santa Clara	March 25-27, 2019

Evaluation:

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

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

UCLA's approved evaluation plan is available online at: www.uclaisap.org/ca-policy/assets/documents/DMC-ODS-evaluation-plan-Approved.pdf

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

During this reporting period UCLA conducted the following activities:

Treatment Perceptions Survey (TPS):

- The Treatment Perceptions Survey (TPS) is used to measure client satisfaction under the DMC-ODS waiver. As part of the waiver evaluation, counties are required to have their network of providers administer the TPS. UCLA completed the preparation of county- and program-level summary reports for the TPS October 2018 survey period for all 20 counties, and updated resource materials on the TPS website (e.g. frequently asked questions and answers, checklist for county administrators/providers).

County Administrator Survey:

- UCLA conducts a survey of county SUD program administrators on an annual basis to obtain information and insights from all SUD administrators in the state. UCLA revised the survey and prepared for distribution in April 2019.

Secret Shopper:

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

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP/LIHP

Designated State Health Program

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

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

Payment	FFP	CPE	Service Period	Total Claim
(Qtr. 1 July-Sept)	$18,718,589	$37,437,178	DY 13	$18,718,589
(Qtr. 2 Oct-Dec)	$0	$0	DY 13	$0
(Qtr. 3 Jan-Mar)	$0	$0	DY 13	$0
Total	**$18,718,589**	**$37,437,178**		**$18,718,589**

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

Low Income Health Program

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

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

GLOBAL PAYMENT PROGRAM (GPP)

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

The total amount available for the GPP is a combination of a portion of the State's Disproportionate Share Hospital (DSH) allotment that would otherwise be allocated to the PHCS and the amount associated with the Safety Net Care Uncompensated Care Pool under the Bridge to Reform demonstration.

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY4-IQ2 (October - December)	$301,281,907	$301,281,907	DY 14	$602,563,814
Total	**$301,281,907**	**$301,281,907**		**$602,563,814**

DY14-Q3 reporting includes GPP payments made on January 11, 2019. The payment

made during this time period was for PY 4, Interim Quarter (IQ) 2 (October 1, 2018 – December 31, 2018).

In PY4-IQ2, the PHCS received $301,281,907 in federal fund payments and $301,281,907 in IGT for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

The RAND Corporation continues to assess the final year-end aggregate data and encounter level data. The data analysis will be incorporated for finalizing the analysis of the GPP Final Evaluation Report that is due to the Centers for Medicaid and Medicare Services on June 30, 2019.

All 12 PHCSs submitted responses to final written survey evaluations by February 15, 2019. The survey measured the effectiveness of the GPP and the services provided to the beneficiaries. The survey results include an analysis of PHCS experiences they have undertaken through GPP regarding the reorganization of care teams, better use of data collection, the expansion of non-traditional services, and additional investments in infrastructure to support improvements in care delivery.

In addition, RAND conducted telephone interviews with each of the 12 PHCSs. The interviews supplemented the written survey responses. The interviews were conducted between February 14, 2019, and February 26, 2019. The 30-minute discussions focused on how each PHCS responded to GPP's experiences and goals of:

1. Delivering care in more appropriate settings, and
2. Improving patient experiences.

Both the final survey evaluations and the interviews will be incorporated in the Final Evaluation Report. The Final Evaluation Report will determine whether, and to what extent, changing the payment methodology resulted in a more patient-centered system of care. The report will also include a summary assessment of the various aspects of the program including infrastructure and improvements in care, an overview of the opportunities and challenges of the program and the effects of the GPP on care delivery and cost. Additionally, the report will focus on three research questions:

1. Was the GPP successful in driving a shift in provision of services from inpatient to outpatient settings (including non-traditional services) over the course of the GPP?
2. Did GPP allow PHCS to leverage investments in primary care, behavioral health, data collection and integration, and care coordination to deliver care to the remaining uninsured?

3. Did the percentage of dollars earned, based on non-inpatient, non-emergency services, increase across PHCS?

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

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

The PRIME Program aims to:

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

PRIME Projects are organized into 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 implement at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project.

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

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

Projects in Domain 3 – Resource Utilization Efficiency will reduce unwarranted variation in the use of evidence-based, diagnostics, and treatments (antibiotics, blood or blood products, and high-cost imaging studies and pharmaceutical therapies) targeting

overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services.

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

In DY14-Q3, DHCS launched the 2019 PRIMEd Learning Collaborative activities. This year's plan consists of two in-person meetings and web-based topic-specific learning collaborative (TLC) meetings. These TLCs will occur semi-monthly for six TLC topics; Care Transitions, Tobacco Cessation, Health Homes for Foster Children, Behavioral Health, Health Disparities, and Maternal & Infant Health. All six TLC workgroups launched kickoff meetings in Q3 or in the following quarter.

DHCS hosted a webinar on March 26, "Preventing Heart Attacks and Strokes," with a speaker from the Million Hearts Initiative and also hosted a webinar on March 19, "Patient Safety and Transparency," conducted by Zuckerberg San Francisco General Hospital.

DHCS planned an optional in-person learning collaborative meeting to take place on May 31, 2019 in Sacramento. As of March 14, 2019, there were 74 PRIME entity representatives registered to attend. DHCS also began to plan for the 2019 PRIMEd Annual Conference, an in-person learning collaborative to be held in Sacramento in October 2019.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$9,471,663.13	$9,471,663.13	DY 13	$18,943,326.26
(Qtr. 2 Oct – Dec)	$330,002,762.77	$330,002,762.77	DY 13	$660,005,525.54
(Qtr. 3 Jan – Mar)	$67,339,773.15	$67,339,773.14	DY 13	$134,679,546.29
Total	**$406,814,199.05**	**$406,814,199.04**		**$813,628,398.09**

In DY14-Q3, four DPHs and nine DMPHs received payments.

This quarter, DPHs and DMPHs received $67,339,773.15 in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

In DY14-Q3, of the 52 PRIME entities, 47 submitted their DY 14 Mid-Year reports to DHCS on or before March 31, 2019. There were five PRIME entities, one DPH and four DMPHs, which requested a reporting extension into DY14-Q4.

Evaluation:

The University of California Los Angeles Center for Health Policy Research (UCLA CHPR) is the PRIME external evaluator. In DY14-Q3, UCLA CHPR received OSHPD inpatient discharge data, and they have used this data to create metrics on which to base their analysis. Their draft interim PRIME evaluation report is due to DHCS on August 29, 2019, and they are on target to meet this contractual requirement.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

Enrollment Information:

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

Total Member Months for Mandatory SPDs by County

County	Total Member Months
Alameda	55,174
Contra Costa	34,246
Fresno	46,879
Kern	37,624
Kings	5,223
Los Angeles	377,723
Madera	4,612
Riverside	70,041
San Bernardino	71,625
San Francisco	75,573
San Joaquin	78,019
Santa Clara	27,551
Stanislaus	32,768
Tulare	43,637
Sacramento	23,135
San Diego	20,553
Total	**1,003,383**

Total Member Months for Existing SPDs by County

County	Total Member Months
Alameda	43,636
Contra Costa	20,671
Fresno	27,220
Kern	18,912
Kings	2,807
Los Angeles	678,513
Madera	2,794
Marin	12,700
Mendocino	11,686
Merced	32,177
Monterey	31,831
Napa	9,841
Orange	220,239
Riverside	76,466
Sacramento	43,874
San Bernardino	73,885
San Diego	126,011
San Francisco	29,604
San Joaquin	18,979
San Luis Obispo	16,270
San Mateo	26,811
Santa Barbara	30,541
Santa Clara	80,303
Santa Cruz	20,640
Solano	39,769
Sonoma	35,038
Stanislaus	11,221
Tulare	12,576
Ventura	56,922
Yolo	17,039
Total	**1,828,976**

Total Member Months for SPDs in Rural Non-COHS Counties

County	Total Member Months
Alpine	36
Amador	727
Butte	12,108
Calaveras	1,066
Colusa	539
El Dorado	3,389
Glenn	1,104
Imperial	7,011
Inyo	339
Mariposa	443
Mono	122
Nevada	2,021
Placer	6,569
Plumas	710
San Benito	194
Sierra	84
Sutter	3,952
Tehama	3,410
Tuolumne	1,719
Yuba	4,062
Total	**49,605**

Total Member Months for SPDs in Rural COHS Counties

County	Total Member Months
Del Norte	5,333
Humboldt	17,225
Lake	12,941
Lassen	2,799
Modoc	1,404
Shasta	26,449
Siskiyou	7,258
Trinity	1,785
Total	**75,194**

WHOLE PERSON CARE

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

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

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

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

Eighteen LEs began implementing and enrolling WPC members on January 1, 2017. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. DHCS received and approved 15 WPC pilot applications in the second round including the following:

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

The 15 second round LEs began implementation on July 1, 2017, with the addition of seven new LEs for a total of 25 LEs with WPC programs. The eight existing LEs continued their original programs and implemented the new aspects from the second round.

Enrollment Information:

Quarterly enrollment counts are the cumulative number of unique new members enrolled for the reported quarter with year-to-year totals reflected in the table below. The total-to-date column includes all previously submitted data beginning with DY 12 and includes the DY14-Q2 (October-December) data. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (E/U) Reports. The current DY14-Q2 data reported is point-in-time as of April 10, 2019. Enrollment data is updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported below reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY14-Q2 (Oct-Dec 2018) Unduplicated	Jan 2017-Dec 2018 Total to Date (Unduplicated)
Alameda	4,431	8,511
Contra Costa	3,701	30,916
Kern	318	570
Kings*	79	254
LA	3,581	29,029
Marin*	656	743
Mendocino*	16	261
Monterey	1	98
Napa	43	319
Orange	60	5,763
Placer	7	273
Riverside	956	2,696
Sacramento*	173	902
San Bernardino	65	829
San Diego	72	239
San Francisco	1,141	13,070
San Joaquin	462	840
San Mateo	53	3,096
Santa Clara	243	3,413
Santa Cruz*	31	407
SCWPCC*	15	74
Shasta	22	236
Solano	12	156

Lead Entity	DY14-Q2 (Oct-Dec 2018) Unduplicated	Jan 2017-Dec 2018 Total to Date (Unduplicated)
Sonoma*	291	608
Ventura	102	1,045
Total	**16,531**	**104,348**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in the availability of data, DY14-Q3 data will be reported in the next quarterly report.*

Member Months:

Quarterly and cumulative year-to-date member months are reflected in the table below. The cumulative year-to-date column includes all previously submitted data beginning with DY 12 and includes the DY14-Q2 data. Member months are extracted from the LE's self-reported Quarterly E/U Reports. The current DY14-Q2 data reported is point-in-time as of April 10, 2019. Member months are updated during the reporting period to reflect retroactive changes to enrollment status and may not match prior reports. The data reported below reflects the most current data available including updated data files submitted by LEs after the publishing date of the prior quarterly report.

Lead Entity	DY14-Q2 (Oct–Dec 2018)	Jan 2017-Dec 2018 Cumulative Total to Date
Alameda	15,679	51,749
Contra Costa	43,938	277,746
Kern	1,238	2,893
Kings*	354	1,035
LA	33,797	181,604
Marin*	1,593	2,092
Mendocino*	571	1,957
Monterey	172	1,002
Napa	462	2,082
Orange	10,281	54,914
Placer	351	2,311
Riverside	2,818	6,343
Sacramento*	1,790	5,679
San Bernardino	1,550	7,095
San Diego	641	1,290
San Francisco	25,494	155,395
San Joaquin	2,022	4,628

Lead Entity	DY14-Q2 (Oct–Dec 2018)	Jan 2017-Dec 2018 Cumulative Total to Date
San Mateo	6,456	49,312
Santa Clara	7,282	47,676
Santa Cruz*	1,034	4,745
SCWPCC*	117	344
Shasta	231	1,243
Solano	267	1,546
Sonoma*	486	993
Ventura	2,503	9,911
Total	**161,127**	**875,585**

**Indicates one of seven new LEs that implemented on July 1, 2017. Due to a delay in the availability of data, DY14-Q3 data will be reported in the next quarterly report.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

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

The LC advisory board met on January 17 and February 21, 2019, and focused on developing the agendas for the April 3-4 Los Angeles LE site visit and Spring Convening.

The LC hosted two webinars this quarter:

- March 1, 2019: *Early Housing Successes*. Sacramento, Monterey, and Marin counties presented on their successful strategies in placing members of their target populations in permanent housing and the linkage between health and housing. 52 people attended the webinar.
- March 19, 2019: *WPC Respite & Sobering Center Webinar.* San Francisco and Santa Clara counties presented on their efforts to implement sobering and respite centers through their pilot. 72 people attended the webinar.

On January 28 and March 6, 2019, DHCS held monthly teleconferences with LEs

focused on administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various contract issues such as reporting, reporting templates, timeliness, and expectations. The calls included the following topics: annual invoicing guidance, annual report, budget adjustment, rollovers, Quarterly E/U Reports, and program spotlight on Alameda, Riverside, and Sonoma counties.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

During this quarter, no WPC payments were made. This is in accordance with the WPC payment schedule. PY 3 annual invoices are due on April 2, 2019, and payments are scheduled for May 2019.

In March, DHCS approved 20 budget adjustment requests and anticipates approving the remaining three budget adjustments in the next quarter after questions regarding requests for budget items are resolved.

DHCS is reviewing 23 LE rollover requests that allow an LE to move budgeted funds from the current year to the next year's budget. DHCS anticipates approving rollover requests in the next quarter.

Quality Assurance/Monitoring Activities:

During the third quarter, LEs submitted the following:

- Second quarter PY 3 Quarterly E/U Report; and
- Optional PY 4 budget rollover requests

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

During the second quarter, DHCS evaluated the budgetary expenditures, enrollment, and service delivery for the LEs and placed seven LEs under a Corrective Action Plan (CAP). These seven LEs were required to develop and submit a CAP detailing how the LE would meet its contractual obligations. DHCS established biweekly TA meetings to discuss LEs' activities and progress toward completing milestones in addition to monthly enrollment reporting. During the third quarter, DHCS determined that five LEs successfully met their CAP requirements triggering closure of their CAPs. Two LEs did

not complete their CAP requirements and will continue under a CAP during the next quarter.

Evaluation

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

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

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

- Developed a preliminary propensity score model and model specifications to develop a control group. UCLA used this model to match WPC enrollees with controls. This protocol was performed by LEs to account for significant differences between enrollees from the various WPC pilots. UCLA is now making further refinements to improve match results and to account for significant differences between enrollees from the various LEs.
- Replicated universal and variant metrics using Medi-Cal data, when possible. Additional utilization measures have been identified, which will provide further understanding of the impact of WPC. These utilization measures will be tested on the second round of Medi-Cal data, once received.
- Finalized analysis of the LE and partner questionnaires to better understand concepts such as motivation for participation in WPC, communication and decision-making processes, performance monitoring, and inter-agency collaboration with partner organizations.
- Began preliminary coding of leadership/key management staff and frontline care coordination interviews to inform the care coordination case studies and qualitative data report. Coding aims to systematically capture key program components (e.g., care coordination model, LE-identified barriers and facilitators, and critical success factors).
- Completed qualitative coding of PY 2 mid-year, PY 2 annual, and PY 3 mid-year narrative reports in order to identify themes related to: 1) identifying, engaging, and enrolling clients, 2) care coordination, 3) data sharing, 4) preliminary outcomes and sustainability plans; and 5) biggest barriers to implementation. An

additional round of coding was conducted to identify and quantify specific subthemes within the data.