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

Section 1115 Waiver Annual Report

Demonstration Reporting Period:
Demonstration Year: Fifteen (July 1, 2019 – June 30, 2020)

Table of Contents

Introduction: 4
General Reporting Requirements 8
- Item 8 of the STCs – Amendment Process 8
- Item 18 of the STCs – Post Award Forum 8
- Item 26 of the STCs – Monthly Calls 9
- Item 27 of the STCs – Demonstration Quarterly Reports 10
- Item 28b of the STCs – Primary Care Access Measures for Children 10
- Item 31 of the STCs – External Quality Review 12
- Item 33 of the STCs – Certified Public Expenditures (CPE) 12
- Item 34 of the STCs – Designated State Health Programs 12
- Item 37 of the STCs – Managed Care Expansions 13
- Item 38 of the STCs – Encounter Data Validation Study for New Health Plans 13
- Item 39 of the STCs – Submission of Encounter Data 14
- Item 41 of the STCs – Contracts 14
- Item 43 of the STCs – Network Adequacy 14
- Item 44 of the STCs – Network Requirements 15
- Item 45 of the STCs – Certification (Related to Health Plans) 16
- Item 58 of the STCs – 2016 CCS Pilot Update 17
- Items 69-73 of the STCs – Access Assessment 17
- Items 211-216 of the STCs – Evaluation of the Demonstration 18

Program Updates: **19**
California Children's Services (CCS) 19
Community-Based Adult Services (CBAS) 22
Coordinated Care Initiative (CCI) 38
Dental Transformation Initiative (DTI) 45
Drug Medi-Cal Organized Delivery System (DMC-ODS) 60
Global Payment Program (GPP) 71
Out-Of-State Former Foster Care Youth (OOS FFY) 74
Public Hospital Redesign And Incentives In Medi-Cal (PRIME) 77

Seniors And Persons With Disabilities (SPDs) 85
Whole Person Care (WPC) 89

INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 15 to the Centers for Medicare & Medicaid Services (CMS), in accordance with Item 28 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 15:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On November 10, 2016, DHCS submitted a waiver amendment proposal to CMS regarding the addition of the Health Homes Program (HHP) to the Medi-Cal managed care delivery system. Under the waiver amendment, DHCS would waive Freedom of Choice to provide HHP services to members enrolled in the Medi-Cal managed care delivery system. Fee-for-service (FFS) members who meet HHP eligibility criteria may

choose to enroll in a Medi-Cal managed care plan to receive HHP services, in addition to all other state plan services. HHP services will not be provided through the FFS delivery system. 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.

TIME PERIODS:

Demonstration Year

The periods for each demonstration year of the Waiver will consist of 12 months, except for DY 11 and DY 16, which will be 6 months respectively. The DY timeframes are indicated below:

- DY 11: January 1, 2016 through June 30, 2016
- DY 12: July 1, 2016 through June 30, 2017
- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020
- DY 16: July 1, 2020 through December 31, 2020

Annual Report

This report covers the period from July 1, 2019 through June 30, 2020.

GENERAL REPORTING REQUIREMENTS

Item 8 of the STCs – Amendment Process

Global Payment Program and Program of All-Inclusive Care for the Elderly Amendment

DHCS submitted an amendment to the STCs of the California Medi-Cal 2020 demonstration waiver, in February 2020, which allows DHCS to operate an additional six-month GPP program year (PY) for the service period of July 1, 2020, to December 31, 2020 (PY 6A). This amendment also allows Medicaid beneficiaries in Orange County at their election to be disenrolled from CalOptima, a county-organized health system (COHS), to be enrolled in the Program of All-Inclusive Care for the Elderly (PACE), if eligible. This amendment was approved by CMS on August 3, 2020. DHCS sent CMS California's official acceptance letter on September 25, 2020.

Item 18 of the STCs – Post Award Forum

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

In DY 15, DHCS hosted four SAC Meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- July 10, 2019
- October 29, 2019
- February 12, 2020
- May 27, 2020

Meeting information, materials, and minutes are available on the DHCS website at: http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx.

- Item 25 of the STCs – Contractor Reviews

Seniors and Persons with Disabilities (SPDs)

Under the authority of the Section 1115 Medicaid Demonstration Waiver titled "California Bridge to Reform Demonstration," California transitioned the SPD population from the Medi-Cal Fee-For-Service (FFS) delivery system into the managed care delivery system. This transition occurred between June 2011 and May 2012. In order to evaluate the success of California's Bridge to Reform Waiver, the Medi-Cal 2020 (Medi-Cal 2020) Demonstration Waiver requires the state to provide evaluations on several waiver programs, including the SPD program. The SPD program evaluation must include:

- An evaluation of the impact of the program on member experience as well as the impact of the state's administration of the program overall using measures that describe three specific content areas: access to care, quality of care, and costs of coverage.

- A focused evaluation on the specific health care needs of SPDs, including specific needs associated with multiple complex conditions.

DHCS has contracted with the Regents of the University of California on behalf of its Los Angeles campus (UCLA) to conduct the SPD program evaluation.[1] UCLA began its contracting work on July 1, 2018. The interim SPD evaluation report was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 18, 2019. The final SPD evaluation report is due to CMS by December 31, 2021 at the completion of the Medi-Cal 2020 Waiver.

Item 26 of the STCs – Monthly Calls

CMS and DHCS schedule monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. During DY 15, the conference calls were held on the following dates:

- July 8, 2019
- August 12, 2019
- September 9, 2019
- October 21, 2019
- November 18, 2019
- January 13, 2020
- February 10, 2020
- March 9, 2020
- April 13, 2020

[1] The SPD program evaluation design can be found on DHCS' website at: https://www.dhcs.ca.gov/provgovpart/Documents/SPDFinalEvalDesign.pdf.

- May 11, 2020
- June 8, 2020

The main discussion topics included: Whole Person Care program updates, Health Homes program updates, "Non-Waiver" Reporting, Financial Reporting, Draft Interim Evaluation Reports, 16% Threshold, GPP/PACE Waiver Amendment, and COVID-19.

Item 27 of the STCs – Demonstration Quarterly Reports

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 15, DHCS submitted three quarterly reports to CMS electronically on the following dates:

- Quarter 1 (July 1, 2019 – September 30, 2019): Submitted November 27, 2019
- Quarter 2 (October 1, 2019 – December 31, 2019): Submitted February 28, 2020
- Quarter 3 (January 1, 2020 – March 31, 2020) – Submitted May 28, 2020

Per CMS' guidance, the fourth quarterly reporting information have been folded into the annual reports beginning in this demonstration year.

Item 28b of the STCs – Primary Care Access Measures for Children

Each year, the Department of Health Care Services (DHCS) selects a set of performance measures, previously known as the External Accountability Set (EAS), to assess the quality of care Medi-Cal managed care health plans (MCPs) provide. For Measurement Year (MY) 2019 / Reporting Year (RY) 2020, DHCS selected a set of quality measures from the CMS Adult and Child Core Sets. The DHCS-selected measures are now known as the Managed Care Accountability Set (MCAS). For applicable measures, DHCS continues to utilize benchmarks from the National Committee for Quality Assurance Quality (NCQA) Compass, for setting the Minimum Performance Level (MPL) for MCP performance. As of MY 2019/RY 2020, DHCS increased the MPL from the 25th to the 50th percentile. DHCS contracts require MCPs to reach the MPL as a minimum, meaning they must perform at least as well as the bottom 50 percent of all Medicaid programs nationwide on each MCAS measure for which DHCS has identified a benchmark exists. The High-Performance Level (HPL) remains at the 90th percentile.

During DY 15, data for the relative RY 2020 included data from January 1, 2019 – December 31, 2019. The MCPs' MCAS included measures on rates for *Children and*

Adolescents' Access to Primary Care Practitioners. These measures were distributed by the following age groups:

- 12 - 24 months (Children and Adolescents' Access to Primary Care Practitioners [CAP]-1224),
- 25 months - 6 years (CAP-256),
- 7 - 11 years (CAP-711), and
- 12 - 19 years (CAP-1219).

Because the NCQA, the measure steward for the CAP measure, retired this CAP measure in 2019, DHCS chose not to hold MCPs to the MPL for this measure during RY 2020 and will not be including this measure in future annual waiver reports.

Item 30 of the STCs– Revision of the State Quality Strategy

The DHCS Comprehensive Quality Strategy (CQS) has been revised based on comments received, but finalization of the CQS has been delayed to allow inclusion of additional details related to COVID-19 and the resulting California Advancing and Innovating Medi-Cal (CalAIM) implementation delay. We plan on finalizing and submitting the final CQS to CMS in 2021.

The CQS report combines and updates the previous *Med-Cal Managed Care Quality Strategy Report* submitted to CMS on June 29, 2018 and the previous *DHCS Strategy for Quality Improvement in Health Care* report, which covers quality improvement activities in both DHCS managed care and fee for service delivery systems. The CQS outlines the Department's process for developing and maintaining a broader quality strategy to assess the quality of care that beneficiaries receive, regardless of delivery system, defines measurable goals, emphasizes CMS Core Set measures, and tracks improvement while adhering to regulatory managed care requirements of 42 Code of Federal Regulations (CFR) 438.340. The CQS describes DHCS' quality improvement infrastructure; development of the comprehensive quality strategy; managed care state standards, assessment, and evaluation requirements, including state-defined network adequacy standards; continuous program quality improvement and interventions; the state's plan to identify, evaluate, and reduce health disparities; the state's definition of "significant change"; and other quality improvement efforts in DHCS programs that are not part of the managed care delivery system. The report also highlights DHCS' coordinated delivery system reform efforts.

The CQS covers all Medi-Cal managed care delivery systems, including Medi-Cal managed care health plans, county mental health plans, drug Medi-Cal organized delivery systems, and dental managed care plans, as well as other non-managed care departmental programs.

Item 31 of the STCs – External Quality Review

Medi-Cal Managed Care

Every year, DHCS releases an External Quality Review (EQR) technical report to CMS and the public. These reports are compliant with federal regulations (Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E). The EQR technical report is usually released by the last day of April each year, but in 2020, due to COVID-19 impacts, DHCS obtained an extension from CMS to release the 2018-19 EQR technical report in July. This report is available on DHCS' Medi-Cal Managed Care – Quality Improvement & Performance Measurement webpage.[2]

Item 33 of the STCs – Certified Public Expenditures (CPE)

Nothing to report.

Item 34 of the STCs – Designated State Health Programs

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

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

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

Figure 1

[2] The EQR technical report is available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.

Payment	CPE	FFP	Service Period	Total Claim
(Qtr. 1 July - Sept)	$0	$0		$0
(Qtr. 2 Oct-Dec)	$0	$0		$0
(Qtr. 3 Jan-Mar)	$0	$0		$0
(Qtr. 4 Apr - Jun)	$0	$0		$0
Total	$0	$0		$0

In DY15 Q1-Q4, the Department claimed $0 FFP for DSHP-eligible services. DSHP claiming was placed on hold in DY14 Q2 due to the fact that DSHP claiming exceeded the non-federal share of amounts expended by the state for the DTI program. DHCS will resume DSHP claiming in state fiscal year 2020-21.

Item 37 of the STCs – Managed Care Expansions

Nothing to report.

Item 38 of the STCs – Encounter Data Validation Study for New Health Plans

DHCS annually performs an Encounter Data Validation (EDV) study with its contracted External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG). During each study, DHCS pulls encounter data from its Management Information System/Decision Support System (MMIS/DSS) and provides it to the EQRO. The EQRO then examines, through review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs.

In February 2020, DHCS published the DY 14 EDV Study, titled *SFY 2018-19 Encounter Data Validation Study Report*.[3] In the report, HSAG provided recommendations to DHCS to improve encounter data quality.

In early 2020, HSAG began work on the DY 15 EDV Study. HSAG has completed the study plan; data collection and sampling; and a portion of medical record procurements. In March 2020, DHCS temporarily paused the DY 15 EDV Study, including medical record procurement; efforts in order to minimize non-critical burdens on MCP provider networks during the COVID-19 Public Health Emergency (PHE). DHCS has set early 2021 as a tentative timeframe for resuming EDV. Depending on the state of the PHE,

[3] The EDV report is available on DHCS' website at: https://www.dhcs.ca.gov/Documents/2018-19-Encounter-Data-Validation-Study-Report.pdf

DHCS may further postpone EDV activities if appropriate. DHCS will work with its EQRO in order to identify the best method for resuming EDV study activities.

Item 39 of the STCs – Submission of Encounter Data

In May 2017, CMS approved DHCS to move into production for data transmission to the Transformed Medicaid Statistical Information System (T-MSIS), which replaced the Medicaid Statistical Information System. During DY 15, DHCS continued to work with CMS to identify and resolve concerns with its production encounter data transmissions through T-MSIS.

Item 41 of the STCs – Contracts

Nothing to report.

Item 43 of the STCs – Network Adequacy

DHCS performs extensive ongoing and scheduled monitoring activities as well as network certification and network readiness reviews when expansion occurs or when there is a significant change. DHCS annually submits network certification reports on the status of MCP network adequacy to CMS.

MCPs must obtain written approval from DHCS prior to making significant changes in their networks that would impact the availability or location of covered services or before they begin enrollment of new populations. MCPs are also required to submit provider data to DHCS on a monthly basis so that DHCS and MCPs can actively work together to resolve any network adequacy issues as they arise.

DHCS conducts comprehensive ongoing reviews of MCP networks and sends data analysis and inquiries to MCPs for responses and necessary resolutions. DHCS then evaluates MCP responses to identify any deficiencies or outliers to address during the next review of MCP networks. Network adequacy indicators, include, but are not limited to:

- Primary Care Provider (PCP) Capacity (PCPs accepting new members);
- PCP-to-member ratios;
- Physician-to-member ratios;
- Termination of contracts;
- PCP time and distance standards;
- Specialist time and distance standards;
- Mental health time and distance standards;
- Hospital time and distance standards;

- OB/GYN time and distance standards;
- Pharmacy time and distance standards;
- Timely access to PCPs, specialists, mental health providers, and ancillary providers;
- MCP alternative access standards (AAS);
- Out-of- network requests/approvals/denials;
- State Fair Hearings; and
- Independent Medical Reviews.

Beginning in DY 14, MCPs are required to submit comprehensive data to DHCS on an annual basis that reflects the MCP's entire contracted provider network for each service area. DHCS evaluates the data to confirm that each MCP's network is sufficient to meet the anticipated needs of its members with adequate availability and accessibility of services including an appropriate range of providers.

Item 44 of the STCs – Network Requirements

In DY 13, DHCS implemented new network adequacy standards, in addition to the existing network requirements. These standards consider elements specified in 42 CFR Sections 438.68, 438.206, and 438.207, Welfare and Institutions Code Section 14197, the Knox-Keene Health Care Service Plan Act of 1975, and the MCP contract. DHCS initially released its Network Adequacy Standards pursuant to the Medicaid Managed Care Final Rule on July 19, 2017; however, they were subsequently revised to account for changes pursuant to state law.[4]

In DY 13, DHCS issued All Plan Letter (APL) 18-005, *Network Certification Requirements*, to provide guidance to MCPs regarding annual network certification, other network reporting requirements, associated network adequacy standards, and AAS requirements. Then, in DY 14, DHCS released APL 19-002, *Network Certification Requirements*, which superseded APL 18-005. APL 19-002 clarified MCP responsibilities regarding 274 file submissions; DHCS' authority to determine significant changes to a network; the process for submitting AAS requests; DHCS' provider validation process; the use of telehealth; and out-of-network monitoring and oversight.[5] In DY 15, DHCS released APL 20-003*, Network Certification Requirements*, which superseded APL 19-002, to include provisions related to AAS required under Assembly Bill (AB) 1642 (Wood, Chapter 465, Statutes of 2019).[6] The APL also

[4] DHCS' Network Adequacy Standards are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacyStandards.aspx
[5] APLs, including APL 19-002, are available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[6] AB 1642 can be found at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1642.

clarifies the enforcement of time and distance standards and the DHCS validation process.

In DY 14, DHCS published two reports pertaining to the annual network certification on the DHCS website. The first report, titled *Approved Alternative Access Standards Report,* contains all MCP AAS requests that were approved by DHCS during the annual network certification of MCPs.[7] The second report, titled *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report*, identifies all MCPs that were subject to a Corrective Action Plan (CAP) due to non-compliance with network adequacy standards, as well as each MCP's response to the CAP.[8]

On June 28, 2019, DHCS submitted the report titled *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report* to CMS in accordance with 42 CFR 438.207(d). The report confirmed that MCPs contracting with DHCS are compliant with the network certification requirements set forth in 42 CFR Sections 438.206, 438.207, and 438.68.[8]

Item 45 of the STCs – Certification (Related to Health Plans)

DHCS updated statewide provider network adequacy standards in APL 20-003, *Network Certification Requirements* to guide the MCPs through the annual network certification process.[9] Based on DHCS' assessment, all MCPs contracted with DHCS have demonstrated the capacity to service the expected enrollment in each service area in accordance with standards for access to care pursuant to 42 CFR sSections 438.68, 438.206, and 438.207, and therefore meet all network certification requirements or have been deemed to meet the requirements for 2019.

DHCS continues to work with the MCPs to improve and automate the submission process. However, any changes to the submission process will not detract from the requirements placed on DHCS to report documentation to CMS that demonstrates each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and Long Term Services and Supports (LTSS) that is adequate for the anticipated number of members for the service area in compliance with 42 CFR, Sections

[7] https://www.dhcs.ca.gov/formsandpubs/Documents/AB_205_AAS_Report_2019.pdf.
[8] The *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report,* updated as of January 30, 2019, is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Documents/AB205ReportCAPsFinalADAMCQMD.pdf.
[8] The *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report* is available on DHCS' website at: https://www.dhcs.ca.gov/formsandpubs/Documents/AnnualNetCertReportJuly2019.pdf.
[9] APL 19-002 can be found on DHCS' website at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

438.68 (network adequacy standards) and 438.206 (c)(1) (availability of services);

- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area; and

- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and at any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services.

Item 58 of the STCs – 2016 CCS Pilot Update

As of June 2020, DHCS is working with CMS to finalize the CCS protocols. The report will meet the STCs' requirements and includes:

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

Items 69-73 of the STCs – Access Assessment

California's Section 1115(a) Medicaid Waiver Demonstration STCs required DHCS to contract with its EQRO, HSAG, to conduct a one-time assessment to care.

This assessment evaluated primary, core specialty, and facility access to care during 2017-18 for Medi-Cal managed care members based on requirements in the Knox-Keene Health Care Service Plan Act of 1975 and existing MCP contracts.

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

- Network Capacity;
- Geographic Distribution;
- Appointment Availability;
- Service Utilization; and

- Grievances and Appeals.

HSAG hosted a final access assessment advisory committee meeting in June 2019 to review the results and provide guidance to the committee for submitting its feedback to HSAG. DHCS and HSAG then presented an initial draft of the California 2017-18 Access Assessment Report for public comment.[10]

Summary of results:

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

The following activity completed this project:
- HSAG presented DHCS with a final report which DHCS submitted to CMS October 8, 2019. CMS confirmed receipt of the report October 10, 2019.

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

Detailed information about the CCS, DTI, GPP, SPD, PRIME, and WPC evaluations are available in their respective program updates provided below. Copies of the program evaluation designs are available on the DHCS website at:

http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

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

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

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

Accomplishments:

Figure 2: Pilot Accomplishments

Date	Pilot Accomplishment Items
September 19, 2016	The draft CCS evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at: https://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx
November 2017	DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and received the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.
Date	**HPSM Pilot Accomplishment Items**
October 2017 – November 2017	Submitted and received CMS approval of contract amendment A02.
October 2017 - Present	Preparing contract amendment A03 for signature.
June 2018	Transitioned CCS beneficiaries from demonstration pilot plan to managed care plan.
Date	**RCHSD Pilot Accomplishment Items**
July 1, 2018	RCHSD was implemented as a full risk plan. RCHSD began enrolling members into their plan.

Program Highlights:

RCHSD CCS DP

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.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

The monthly enrollment for RCHSD CCS DP is reflected in Figure 3 below. Eligibility data is extracted from the Children's Medical Services Network (CMS Net) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to RCHSD. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Figure 3: Monthly Enrollment for RCHSD CCS DP

Month	RCHSD Enrollment Numbers	Difference Prior Month
July 2019	363	-3
August 2019	356	-7
September 2019	351	-5
October 2019	350	-1
November 2019	351	+1
December 2019	349	-2
January 2020	352	+3
February 2020	348	-4
March 2020	346	-2
April 2020	348	+2
May 2020	351	+3
June 2020	371	+20

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

Regents of the University of California, San Francisco (UCSF) is currently leading the California Children's Services (CCS) evaluation that currently running from July 1, 2019, to December 31, 2021, and will be completed in two phases. Phase one includes Health Plan San Mateo (HPSM), and phase two includes Rady Children's Hospital of San Diego (RCHSD). To date, UCSF has completed interviews with key informant and families of CCS pilot patients; surveyed parents of CCS children in both Fee-for-Service and CCS pilot transition counties; and analyzed claims/encounter data and eligibility records. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to Centers for Medicare & Medicaid Services on August 31, 2020 as required. DHCS is in the process of posting the interim report on the website for public viewing.

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

With the delayed implementation of CalAIM due to the COVID-19 public health emergency (PHE), DHCS submitted a 12-month extension request to CMS for the Medi-Cal 2020 waiver, to extend the effective date to December 31, 2021.

Program Requirements

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria.

CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020; and 4) exhibit ongoing compliance with the requirements listed above.

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

determined by the MCP to be clinically appropriate. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment.

The State must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[11]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service 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 members in social and recreational activities, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist participants with Activities of Daily Living or Instrumental Activities of Daily Living.). If the participant is residing in a Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Program Highlights:

Beginning in March 2020, in response to the COVID-19 PHE, DHCS and CDA worked with stakeholders including the California Association for Adult Day Services (CAADS), CBAS providers, and the MCPs to develop and implement CBAS Temporary Alternative Services (TAS). CBAS TAS is a short-term, modified service delivery approach that grants CBAS providers time-limited flexibility during the COVID-19 PHE to reduce day-center activities and to provide services, as appropriate, via telehealth, live virtual video conferencing, or in the home (if proper safety precautions are taken and if no other option for providing services is able to meet the participant's needs).

In addition, as a result of stakeholder processes during 2015 and 2016, the California

[11] 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.

Department of Aging (CDA) and Department of Health Care Services (DHCS) in collaboration with CBAS providers, managed care plans and other interested stakeholders developed the following documents: (1) New CBAS Individual Plan of Care (IPC); (2) CBAS Quality Assurance and Improvement Strategy: A Five-Year Plan (dated October 2016); and (3) Revised CBAS Home and Community-Based (HCB) Settings Transition Plan (dated January 11, 2018).

These documents were developed in response to the following directives by CMS in the CBAS provisions of the 1115 Demonstration Waiver: (1) STC 48(c) and STC 49(c) requiring all CBAS settings to comply with the federal Home and Community-Based (HCB) Settings requirements (42 CFR 441.301(4)) and Person-Centered Planning requirements (42 CFR 441.301(c)(1)(2)(3)); and (2) STC 53 requiring the State to develop a quality strategy to assure the health and safety of Medi-Cal beneficiaries receiving CBAS. The following is an update on CBAS program activities during DY 15 related to each of these documents:

IPC

No update. New IPC implemented June 1. 2019.

CBAS Quality Assurance and Improvement Strategy

The CBAS Quality Assurance and Improvement Strategy (dated October 2016) is a five-year plan to assure CBAS participant health and safety by addressing the following: (1) the quality and implementation of the CBAS beneficiary's person-centered IPC, (2) provider adherence to state and licensure and certification requirements, (3) quality metrics for person- centered care/continuity of care, (4) clinical and program outcome measures/indicators, (5) CBAS center staff training on best practices and quality improvement, and (6) improved use of existing enforcement provisions for CBAS centers that do not meet licensing or certification standards. The *CBAS Quality and Improvement Strategy* is designed to assure federal partners, beneficiaries and the public that CBAS providers meet program standards while they continue to develop new approaches to improving service delivery.

CDA and DHCS continue to implement the goals and objectives of this report within specific timeframes in partnership with a CBAS Quality Advisory Committee comprised of CBAS providers, managed care plans, and advocates. The short- and medium-term objectives identified in Goals I and II guided CBAS program activities for DY15. For example, during DY 15, CDA achieved the following quality objectives: developed a listing of standardized/validated assessment/screening tools for specific status/conditions of CBAS participants to improve service delivery by promoting CBAS best practices; developed a list of organizations that provide (or link to) education and training via webinars, videos, fact sheets, and other materials on topics relevant to the needs/conditions of CBAS center participants to promote access to specialized

training of center staff; and convened triannual calls with MCPs that contract with CBAS providers to promote communication, provide updates on CBAS activities and policy directives, and request feedback on CBAS provider issues requiring CDA assistance.

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

All CBAS centers must comply with the federal HCB settings and person-centered planning requirements by March 17, 2023, and thereafter, or risk losing their CBAS Medi-Cal certification. The State submitted *California's Statewide Transition Plan (STP)* to the CMS on November 23, 2016, which included as an attachment the *Revised Draft CBAS HCB Settings Transition Plan* (dated November 23, 2016). CMS requested additional information from the State, which resulted in DHCS submitting revised STPs including revised CBAS Transition Plans on September 1, 2017 and January 11, 2018. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions to the STP and CBAS Transition Plan before it will grant final approval. California is planning to submit the Final STP to CMS in April 2021. The State continues to implement the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA is evaluating each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Qualitative and Quantitative Findings:

Enrollment and Assessment Information

Per STC 52(a), the CBAS Enrollment data for both MCP and FFS members per county for DY 15 represents the period of July 2019 to June 2020 as shown in the table entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.*" The table entitled "*CBAS Centers Licensed Capacity*" provides the CBAS capacity available per county, which is also incorporated into the table. Per the data presented, enrollment for CBAS has been consistent in DY 15 for Q1-Q3, with a decline in Q4.

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. Enrollment with County Capacity data identified in the table below, reflects data through July 2019 to June 2020.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY15-Q1		DY15-Q2		DY15-Q3		DY15-Q4	
	Jul - Sept 2019		Oct - De 2019		Jan -Mar 2020		Apr - Jun 2020	
County	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participant s (MCP & FFS)	Capacity Used
Alameda	513	78%	497	75%	487	74%	467	75%
Butte	30	30%	32	31%	30	30%	33	32%
Contra Costa	219	59%	203	54%	207	56%	223	57%
Fresno	646	46%	650	47%	634	46%	625	35%
Humboldt	85	22%	102	26%	101	26%	93	16%
Imperial	389	65%	381	63%	365	61%	335	56%
Kern	65	10%	57	8%	52	8%	74	11%
Los Angeles	21,994	60%	21,999	60%	21,610	60%	18,384	50%
Merced	95	51%	98	53%	98	53%	58	28%
Monterey	119	64%	116	62%	119	64%	116	62%
Orange	2,595	58%	2,611	58%	2,579	62%	2,360	57%
Riverside	538	44%	573	37%	576	37%	444	28%
Sacramento	503	49%	484	47%	443	46%	445	36%
San Bernardino	773	77%	777	78%	691	69%	586	59%
San Diego	2,630	70%	2,597	69%	2,362	59%	2,283	59%
San Francisco	679	43%	672	43%	723	46%	735	47%
San Joaquin	26	11%	38	16%	33	14%	35	15%
San Mateo	66	29%	67	29%	76	33%	80	35%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	617	47%	581	44%	582	44%	574	43%
Santa Cruz	102	67%	99	65%	101	66%	92	60%
Shasta	*	*	*	*	*	*	*	*
Ventura	931	65%	918	64%	901	63%	907	63%
Yolo	275	72%	279	74%	283	75%	273	72%
Marin, Napa, Solano	85	17%	81	16%	76	15%	61	12%
Total	**34,087**	**58%**	**33,963**	**58%**	**33,172**	**57%**	**29,309**	**49%**
FFS and MCP Enrollment Data 06/2020								

Figure 4: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS

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

The data provided in the previous table shows that while enrollment has decreased steadily throughout DY 15, there was a significant decline in Q4 due to the COVID-19 PHE. The data reflects ample capacity for participant enrollment into all CBAS Centers.

The overall decrease in Q4, in a significant amount of counties, was anticipated due to the COVID-19 PHE. Variations in the data between Q3 and Q4 indicate a significant decrease in the number of requests for CBAS as well as the number of members assessed for CBAS. CBAS eligibility determination assessments became a challenge, as previously they had been conducted face to face and providers were implementing new guidance around new participant enrollment during the COVID-19 PHE.

In Riverside County during Q2, there was a greater than five percent decrease of license capacity utilization compared to the previous quarter. A new CBAS center opened in Riverside County, which caused the overall license capacity to increase and accounts for the decrease in license capacity utilization. San Diego County experienced a significant decline between Q2 and Q3. During Q3, one CBAS Center opened prior to the declared PHE, and two CBAS Centers closed after the PHE, contributing to the overall license capacity utilization decrease as immediately following the Statewide Shelter in Place order there may have been delay in transitioning members to CBAS TAS. Although San Bernardino did not see any fluctuations in the number of centers in Q3, the variance in data is due to fluctuations in attendance. On March 15, 2020, Governor Newsom directed Californians 65 and older and those with chronic underlying health conditions to remain at home. Although CBAS centers were provided policy guidance for CBAS TAS to provide services to participants who remained at home, fluctuations in attendance were experienced. Fresno, Humboldt, Imperial, Los Angeles, Merced, Riverside, San Bernardino, Sacramento, and Santa Cruz all reported significant (greater than five percent) declines in the Q4 unduplicated participant data.

It is important to note that there were counties that maintained consistent enrollments that did not see fluctuations greater than five percent. These counties include Alameda, Butte, Contra Costa, Kern, Orange, San Francisco, San Joaquin, San Mateo, Santa Clara, Ventura, Yolo, and the combined counties of Marin, Napa, and Solano.

Additionally, Humboldt, Los Angeles, and Merced Counties all opened new CBAS centers in Q4, which increases capacity, thus decreasing the capacity utilization.

CBAS Assessments for MCPs and FFS Participants

Individuals who request CBAS services will be given an initial face-to-face assessment

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

Figure 5 below lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the table is reported by DHCS.

Figure 5: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY15-Q1 (07/01-09/30/2020)	2,449	2401 (98%)	48 (2.7%)	6	6 (100%)	0 (0%)
DY15-Q2 (10/01-12/31/2020)	2,095	2,031 (97%)	64 (2%)	3	3 (100%)	0 (0%)
DY15-Q3 (01/01-03/31/2020)	1,713	1,676 (97.8%)	37 (2.2%)	5	5 (100%)	0 (0%)
DY15-Q4 (04/01-06/30/2020)	438	419 (95%)	19 (5%)	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		Yes	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous table, for DY 15, 6,690 assessments were completed by the MCPs, of which 6,519 were determined to be eligible, and 171 were determined to be ineligible. For DHCS, it was reported that 14 participants were assessed for CBAS benefits under FFS and of these, all 14 were determined to be eligible. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

CBAS assessments in DY 15 Q4 declined due to the COVID-19 PHE, as CBAS providers temporarily halted in-center congregate services and transitioned to CBAS Temporary Alternative Services (TAS). During this transition providers were challenged with enrollment of new participants – some who were already in the process and were at varying levels of readiness to begin services and some who were brand new and for whom enrollment had yet to begin. All Center Letter (ACL) 20-11 was issued on May 13, 2020, providing requirements and guidance for provider assessment and enrollment of

new participants, to document enrollment steps, and to allow for CDA monitoring of CBAS TAS for participants not previously served by traditional CBAS.

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 table entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY15. As of DY15, the number of counties with CBAS Centers and the ADA of each center are listed below in figure 6. On average, the ADA at the 257 operating CBAS Centers is approximately 26,420 participants, which corresponds to 74 percent of total capacity. Provider-reported data identified in the table below, reflects data through July 2019 to June 2020.

Figure 6: CDA - CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	257
Non-Profit Centers	51
For-Profit Centers	206
ADA @ 257 Centers	26,420
Total Licensed Capacity	35,361
Statewide ADA per Center	74.7%

CDA - MSSR
Data 06/2020

Outreach/Innovative Activities: Stakeholder Process

During DY15 CDA issued 18 All Center Letters (ACLs) to CBAS providers pertaining to various topics including, but not limited to, CBAS training requirements and resources, Proposition 56 supplemental payments, and CBAS center operations during COVID-19. In addition, between March and June 2020, CDA provided multiple trainings sponsored by CAADS for CBAS providers and MCPs related to CBAS TAS requirements and implementation.

CBAS Beneficiary/Provider Call Center Complaints (FFS / MCP) (STC 52.e.iv)

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in Figure 7 entitled "*Data on CBAS Complaints*" and Figure 8 entitled "*Data on CBAS Managed Care Plan Complaints*." According to the table below, no complaints were submitted to CDA for DY 15.

Figure 7: Data on CBAS Complaints

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

CDA Data - Complaints 06/202

For complaints received by MCPs, the table below illustrates there were 11 beneficiary complaints and two provider complaints submitted for DY 15. The data reflects that for DY15, complaints decreased for both beneficiaries and providers. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 8: Data on CBAS Managed Care Plan Complaints

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY15-Q1 (Jul 1 - Sep 30)	8	0	8
DY15-Q2 (Oct 1 - Dec 31)	2	2	4
DY15-Q3 (Jan 1 - Mar 31)	0	0	0
DY15-Q4 (Apr 1 - Jun 30)	1	0	1

Plan data - Phone Center Complaints 06/2020

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Figure 9 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 15 grievances were filed with MCPs during DY 15. Seven of the grievances were solely regarding CBAS providers. One grievance was related to contractor assessment or reassessment. No grievances were related to excessive travel time to access CBAS services. Seven grievances were designated as "other". Overall, total grievances have decreased from the prior DY 14: 49 to 15. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Figure 9: Data on CBAS Managed Care Plan 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
DY15-Q1 (Jul 1 - Sep 30)	4	1	0	2	7
DY15-Q2 (Oct 1 - Dec 31)	3	0	0	4	7
DY15-Q3 (Jan 1 - Mar 31)	0	0	0	1	1
DY15-Q4 (Apr 1 - Jun 30)	0	0	0	0	0

Plan data - Grievances 06/2020

Figure 10: 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 CBAS	Other CBAS Appeals	Total Appeals
DY15 – Q1 (Jul 1 – Sep 30)	2	0	0	1	3
DY15 – Q2 (Oct 1 – Dec 31)	4	0	0	0	4
DY15 – Q3 (Jan 1 – Mar 31)	2	0	0	0	2
DY15 – Q4 (Apr 1 – Jun 30)	1	0	0	0	1

Plan data - Grievances 06/2020

During DY 15, Figure 10 entitled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 10 CBAS appeals filed with the MCPs. The table illustrates that nine of the appeals were related to "denial of services or limited services", and the other was categorized as "other CBAS appeals".

The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 15, there were two requests for hearings related to CBAS services, both from Los Angeles County. Of these two hearings, one was granted and the other was dismissed (Administrative Dismissal/Non-Jurisdictional).

Quality Assurance/Monitoring Activity

The CBAS Quality Assurance and Improvement Strategy, developed through a year- long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Figure 11 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 15. Quality Assurance/Monitoring Activity reflects data through July 2019 to June 2020.

Figure 11: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity						
	DY15-Q1 Jul-Sep 2019	DY15-Q2 Oct-Dec 2019	Percent Change Between Last Two Quarters	DY15-Q3 Jan-Mar 2020	DY15-Q4 Apr-Jun 2020	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	0.0%	390	**370**	- 5.1%	75%
Butte	60	60	0.0%	60	**60**	0.0%	32%
Contra Costa	220	220	0.0%	220	**220**	0.0%	57%
Fresno	822	822	0.0%	822	**1,062**	+29.2%	35%
Humboldt	229	229	0.0%	229	**349**	+52.4%	16%
Imperial	355	355	0.0%	355	**355**	0.0%	56%
Kern	400	400	0.0%	400	**400**	0.0%	11%
Los Angeles	21,492	21,522	+0.1%	21,412	**21,715**	+1.4%	50%
Merced	109	109	0.0%	109	**124**	+13.8%	28%
Monterey	110	110	0.0%	110	**110**	0.0%	62%
Orange	2,638	2,638	0.0%	2,438	**2,438**	0.0%	57%
Riverside	720	920	+27.8%	920	**935**	+1.6%	28%
Sacramento	609	609	0.0%	569	**729**	+2.8%	36%
San Bernardino	590	590	0.0%	590	**590**	0.0%	59%
San Diego	2,233	2,233	0.0%	2,383	**2,278**	+4.4%	59%
San Francisco	926	926	0.0%	926	**926**	0.0%	47%
San Joaquin	140	140	0.0%	140	**140**	0.0%	15%
San Mateo	135	135	0.0%	135	**135**	0.0%	35%
Santa Barbara	100	100	0.0%	100	**100**	0.0%	*
Santa Clara	780	780	0.0%	780	**780**	0.0%	43%
Santa Cruz	90	90	0.0%	90	**90**	0.0%	60%
Shasta	85	85	0.0%	85	**85**	0.0%	*
Ventura	851	851	0.0%	851	**851**	0.0%	63%
Yolo	224	224	0.0%	224	**224**	0.0%	72%
Marin, Napa, Solano	295	295	0.0%	295	**295**	0.0%	12%
SUM	34,603	34,833	+0.7%	34,633	**35,361**	+2.1%	49%

	CDA Licensed Capacity as of 06/2020

**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 previous table reflects that the average licensed capacity used by CBAS participants is 49% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of Alameda whose capacity is at 75%, but experienced a -5.1% capacity decrease between Q3 and Q4 (see below).. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. Alameda County experienced a decrease of more than 5 percent in licensed capacity, due to a closure of a CBAS Center that had a licensing capacity of 20.

Fresno, Humboldt, and Merced Counties experienced increases in licensed capacity. Fresno County opened up a new CBAS Center with a licensing capacity of 240, thus increasing the capacity by 29%. Humboldt County added another CBAS Center, increasing the licensing capacity by 120 (54% for the county), and Merced County increased capacity at an existing center from 60 to 75. This added another 13% to the capacity for the county. No other significant increases or decreases were noted over the last quarter. Over DY15, total licensed capacity has slightly and steadily increased statewide.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the first table for CBAS, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers.

Unbundled Services (STC 48.b.iii.)

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

closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY15, CDA had 257 CBAS Center providers operating in California. According to Figure 12 entitled "*CBAS Center History*," 11 CBAS Centers closed and 15 new centers were opened in DY 15.

Figure 12: CBAS Center History

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
June 2020	257	1	1	0	257
May 2020	256	0	1	1	257
April 2020	256	1	1	0	256
March 2020	257	4	3	-1	256
February 2020	257	1	1	0	257
January 2020	259	2	0	-2	257
December 2019	259	0	0	0	259
November 2019	259	0	0	0	259
October 2019	259	1	1	0	259
September 2019	256	0	3	3	259
August 2019	253	0	3	3	256
July 2019	252	0	1	1	253
June 2019	253	1	0	-1	252

The previous table shows there was no negative change of more than five percent in DY 15, from June 2019 to June 2020, so no analysis is needed to address such variances.

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.

- **Policy/Administrative Issues and Challenges:**

As previously identified in the Program Highlights section, DHCS and CDA implemented CBAS TAS beginning in March 2020, in response to the COVID-19 PHE. DHCS, through a disaster 1115 amendment, requested temporary flexibility for its 1115 waiver, to implement CBAS TAS and is awaiting CMS approval. DHCS and CDA continue to work with CBAS providers and MCPs to provide ongoing clarification regarding CBAS benefits, CBAS operations, and policy issues.

- **Progress on the Evaluation and Findings:**

Not applicable.

COORDINATED CARE INITIATIVE (CCI)

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income SPDs, including beneficiaries who are dually-eligible for Medi-Cal and Medicare (Duals). The CCI's aim is to achieve substantial savings by rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015), and SB 97 (Chapter 52, Statutes of 2017).

The three major components of the CCI are:

1. A Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs). Originally this was a three-year demonstration that has been extended to the end of 2022;
2. Mandatory Medi-Cal managed care enrollment for Duals (individuals eligible for Medicare and Medicaid); and
3. The inclusion of LTSS, with the exception of In-Home Supportive Services (IHSS), which has transitioned back to counties, as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal MediConnect.

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

Accomplishments:

Figure 13: CCI Pilot Accomplishments

Date	Pilot Accomplishments
Implementation of Streamlined Enrollment	
2018	Since DHCS implemented streamlined enrollment in August 2016, MMPs have been able to submit enrollment changes to DHCS on behalf of their members. This provides a simpler method for members to enroll in Cal MediConnect and has continued through DY 15 to contribute to a modest increase in enrollment for all MMPs.
Monthly Conference Calls	
2018	DHCS and CMS continue to support MMPs in simplifying enrollment for all services, including Managed Long Term Services and Supports (MLTSS) by holding bi-monthly conference calls.
Bi-Weekly Conference Calls	
2018	DHCS and CMS assist MMPs in resolving any enrollment or plan issues by holding bi-weekly conference calls.
Duals Plan Letters (DPLs) Released	
No DPLs were released during DY 15.	

Program Highlights:

In January 2019, DHCS requested stakeholder feedback on cost-neutral initiatives and activities to help improve Cal MediConnect. In total, DHCS received 23 sets of comments, representing 43 organizations and individuals. Stakeholders highlighted efforts to ensure members have appropriate access to durable medical equipment (DME). As a result, DHCS in collaboration with Aurrera Health Group focused on this feedback by creating a DHCS and MMP workgroup to review the challenges around accessing DME and to establish feasible solutions to identified barriers. The workgroup's efforts have been paused due to the COVID-19 PHE.

Qualitative and Quantitative Findings:

Enrollment

As of March 1, 2020, approximately 106,749 members were enrolled in MMPs across the seven participating CCI counties. Detailed enrollment information for each CCI county can be found below in Figure 14:

Figure 14: Enrollment Information for Each CCI County

County	Number of Members Enrolled
Los Angeles	29,734
Orange	13,838
Riverside	15,652
San Bernardino	15,111
San Diego	13,641
Santa Clara	10,304
San Mateo	8,469

DHCS updates the Cal MediConnect dashboard on a quarterly basis to include updated enrollment numbers and tables on key aspects of the Cal MediConnect program that assist MMPs in improving their performance and quality standards.[12]

Cal MediConnect Ombudsman Call Volume

From July 1, 2019, to June 30, 2020, the Cal MediConnect Ombudsman received approximately 4,851 calls from enrollees. Below is a breakdown of the Cal MediConnect Ombudsman call data by each county's corresponding Ombudsman service provider:

- Legal Aid Society of San Diego (San Diego): 994
- Neighborhood Legal Services (Los Angeles): 1,229
- Inland Counties Legal Services (San Bernardino and Riverside): 662
- Bay Area Legal Aid: 549
- Legal Aid Society of Orange County: 259
- Legal Aid Society of San Mateo: 39
- Other Health Consumer Alliance programs: 873
- Abandoned calls: 180

Continuity of Care Data

[12] The latest Cal MediConnect Performance Dashboard can be found at the following link: https://www.dhcs.ca.gov/services/Documents/MCQMD/CMCDashboard9-20.pdf.

DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. From Quarter 3 of 2019 to Quarter 2 of 2020, there was a total of 213 continuity of care requests. Overall, 97.2% of the requests were approved, 2.3% were denied, and 0.5% were in process. The continuity of care requests were denied due to reasons such as providers refusing to work with managed care, no relationship found between the enrollee and provider, and other reasons such as availability of a network provider.

Policy and Administrative Difficulties in the Operation of this DY:

Cal MediConnect continued to encounter the following difficulties that have continued since it began and during DY 15:

- The “unable to reach” reporting metric reached an all-time high for several MMPs;
- The resistance from providers to participate in the Cal MediConnect program; and
- The unknown future of the Cal MediConnect program.

MMPs have encountered a high level of “unable to reach” percentages for enrollees within Cal MediConnect due to several external factors. There are many possible reasons for this, such as enrollees moving, phones being disconnected, and enrollees not responding to attempted contacts. MMPs have attempted multiple workarounds to reach their enrollees for Health Risk Assessment and Individual Care Plan completion. However, negative reporting metrics remain high, and efforts have not been as successful as the MMPs had hoped. To respond, CMS and DHCS partnered with MMPs to first understand the extent of this issue and second, to conduct short-term focused quality improvement efforts.

Some providers continue to misunderstand Cal MediConnect and discourage enrollment in the program. This resistance has created difficulties maintaining enrollment in a few counties; however, most counties have been able to create positive relationships that assist members in accessing services in a collaborative manner.

Lastly, the unknown future and longevity of Cal MediConnect has created difficulties with gaining support and garnering enrollment growth. DHCS continues to provide education of MMPs to providers to allow them to understand Cal MediConnect and the benefits that it provides to their patients.

Progress on the Evaluation and Findings:

<u>Research Triangle Institute International</u>

CMS contracted with the Research Triangle Institute International (RTI) to monitor the implementation of demonstrations, including Cal MediConnect, under the federal Medicare-Medicaid Financial Alignment Initiative and to evaluate their impact on enrollee experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific

evaluations. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide.

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

MMPs are required to conduct a Medicare Advantage – Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, which is designed to measure important aspects of an individual's health care experience, including the accessibility to and quality of services. MMPs are also required to include supplemental questions as part of their annual survey in order to assist with RTI's independent evaluation. In January 2018, RTI added supplemental questions to the 2017 CAHPS survey and released the additional questions to the MMPs ahead of time to allow them to prepare appropriately. RTI assesses their questions as necessary to ensure they are gathering pertinent information to the demonstration. The first annual evaluation report provided by RTI, titled *Financial Alignment Initiative California Cal MediConnect: First Evaluation report,* was released on November 29, 2018.[13] The second annual evaluation report is not available at this time but will be provided in a future update.

The SCAN Foundation

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

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

[13] The report is available on the CMS website at: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf

The results of the sixth wave, released in October 2018, found that Cal MediConnect enrollees' confidence in navigating their healthcare increased.[3] This increase shows a large majority of enrollees express confidence that they know how to manage their health conditions (82%), how to get questions about their health needs answered (84%), and who to call if they have a health need or question (89%). In alignment with the first finding, a large majority of Cal MediConnect enrollees expressed satisfaction and confidence with their health care services, similar to the results in previous waves. Of particular note, between 10% and 16% of Cal MediConnect enrollees reported that they encountered problems with their health service. Cal MediConnect enrollees are also reporting longer relationships with their personal doctor. This is a key indicator of the care continuum that is especially important when transitioning to managed care.

In 2014, an evaluation team was formed comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health was formed. The evaluation team engaged stakeholder input and built upon the national evaluation conducted in 2014, by the University of California San Francisco Community Living Policy and the University of California Berkeley Health Research for Action Center to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects. The following evaluations, which often include data from previous years, were conducted for DY 14. These are outlined below.

In September 2018, TSF released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging to assess Cal MediConnect enrollees' experiences with care, including access, quality, and coordination over time.[14] A total of 2,100 Duals completed the first telephone survey in 2016. Of those, 1,291 enrollees completed a second survey in both 2016 and 2017. Key findings include:

- Very few people (less than 0.5%) changed MMPs or disenrolled from Cal MediConnect after one year in the program;
- Cal MediConnect satisfaction overall was very high (94%) with enrollees reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among Cal MediConnect enrollees compared to those who opted out or those in non-CCI counties;
- In both 2016 and 2017, one in five Cal MediConnect enrollees reported delays or problems in getting care or services. Of those, 61% reported the problems were unresolved;
- Primary care visits decreased among Cal MediConnect enrollees between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period;
- Two-thirds of Cal MediConnect enrollees used specialty care;

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[14] The evaluation, *Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey,* can be found at: https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf

- Over 70% of Cal MediConnect enrollees reported the ability to go to their hospital of choice all the time, and almost 90% of those hospitalized reported being ready to go home when discharged;
- One in five Cal MediConnect enrollees used behavioral health services, and a majority of those took medication for mental health conditions;
- Cal MediConnect enrollees took an average of six prescription medications. About two-thirds reported having paid out of pocket for prescriptions; this is lower than the out-of-pocket expenses reported by those who opted-out, of whom three-quarters reporting paying out of pocket;
- Less than one-third of Cal MediConnect enrollees reported having a care coordinator;
- Over three-quarters of Cal MediConnect enrollees said their PCP seemed informed and up-to-date about their care from specialists; and about 54% said their providers usually or always share information with each other;
- Compared to opt-outs, more Cal MediConnect enrollees reported getting a ride from their health plan to medical appointments;
- Half of non-English speaking Cal MediConnect enrollees reported they could “never” get a medical interpreter when they needed one;
- Among Cal MediConnect enrollees, those who need LTSS had lower satisfaction overall, and were almost four times more likely to rate their overall quality of care as fair or poor; and
- Approximately 37% of Cal MediConnect enrollees who needed help with routine needs (e.g., household chores, doing necessary business, shopping, and getting around outside the home) reported they needed more help, or got no help at all with those activities.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Given the importance of oral health to the overall well-being of an individual, the California Department of Health Care Services (DHCS) views improvements in dental care as a critical and interconnected component in achieving overall, better health outcomes, for all Medi-Cal beneficiaries, particularly children.

Through DTI, DHCS aims to:

- Improve the beneficiary experience by ensuring consistent and easy access to high-quality dental services that support achieving and maintaining good oral health;
- Implement effective, efficient, and sustainable health care delivery systems;
- Maintain effective, open communication, and engagement with our stakeholders; and,
- Hold itself, providers, plans, and other partners accountable for improved dental performance and overall health outcomes.

Medi-Cal beneficiaries are enrolled in one of the two dental delivery systems: Fee-for-Service (FFS) and Dental Managed Care (DMC). DMC plans are only in Sacramento and Los Angeles counties. The Geographic Managed Care (GMC) plans are mandatory in Sacramento. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, and those providing services through SNCs, can participate in all Domains of the DTI. DMC providers are allowed to participate in other Domains with the exception of Domain 3.

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

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

Overview of Domains

- *Domain 1 – Increase Preventive Services for Ages 20 and under*[14]

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

- *Domain 2 – Caries Risk Assessment (CRA) and Disease Management*[15]

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 twenty nine (29) counties currently participating in this Domain are: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare, Yuba, Merced, Monterey, Kern, Contra Costa, Santa Clara, Los Angeles, Stanislaus, Sonoma, Imperial, Madera, San Joaquin, Fresno, Orange, San Bernardino, Riverside, Ventura, Santa Barbara, and San Diego.

- *Domain 3 – Continuity of Care*[16]

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.

The thirty-six (36) counties currently participating in this Domain are: Alameda, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Imperial, Kern, Madera, Marin, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Ventura, and Yolo.

- *Domain 4 – Local Dental Pilot Projects (LDPPs)* [17]

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.

[14] DTI Domain 1
[15] DTI Domain 2
[16] DTI Domain 3
[17] DTI Domain 4

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.

Program Highlights

The State of California enacted a shelter in place mandate on March 11, 2020 to the slow the spread of Coronavirus Disease 2019 (COVID-19). A majority of counties implemented shelter-in-place for residents, businesses, non-essential personnel and dental offices were instructed by the American Dental Association to postpone all non-emergency services. This caused a cascading effect on dental utilization, and postponing various dental initiatives including California Advancing and Innovating Medi-Cal (CalAIM) to focus on the COVID-19 public health emergency. With the delay of CalAIM, DHCS intends to submit a request to Centers for Medicare and Medicaid Services (CMS) for a one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver, to include Domains 1-3 of the DTI program.

Domain 1

- DHCS issued incentive payments to providers in July 2019 which included, the second PY 3 payment and in January 2020 for the first PY 4 and final PY 3 payments.
- DHCS updated preventive services procedure codes to coincide with the Current Dental Terminology (CDT) 2019 update, which are noted in the table below:

Procedure Code	Procedure Code Description	Changes per CDT-19 Implementation	Effective/End Date
D1515	Space maintainer-fixed-bilateral	Removed	March 14, 2020
D1516	Space maintainer-fixed-bilateral, maxillary	New code replaced D1515	March 14, 2020
D1517	Space maintainer-fixed-bilateral, mandibular	New code replaced D1515	March 14, 2020
D1520	Space maintainer-removable-unilateral	Removed	March 14, 2020
D1525	Space maintainer-removable-bilateral	Removed	March 14, 2020
D1526	Space maintainer-removable-bilateral, maxillary	New code replaced D1525	March 14, 2020
D1527	Space maintainer-removable-bilateral, mandibular	New code replaced D1525	March 14, 2020
D1575	Distal shoe space maintainer-fixed – unilateral – per quadrant	New code	May 16, 2020

Domain 2

- As of June 2020, and following the expansion of the Domain 2 pilot counties on January 1, 2019, the total number of opted in providers increased from 209 to 2,896, resulting in an increase of 1,286 percent in the provider population.

- During the expansion of the Domain 2 program, effective January 1, 2019, DHCS worked with the Administrative Services Organization (ASO) contractor, Delta Dental, to conduct Domain 2 specific outreach to the expansion counties. DHCS has been successful in garnering increased provider participation in several of the expansion counties.

Domain 3

- DHCS issued incentive payments to providers in July 2020 which included the second and final payment of PY 3 for the 17 original counties and the first payment for PY 4 for all 36 participating counties.
- DHCS' ASO conducted DTI outreach and shared Domain 3 information with providers at stakeholder meetings, on-site enrollment visits, and dental societies.
- In DY 15, the ASO's outreach team visited/contacted 30 of the 36 pilot counties (Alameda, Butte, Contra Costa, El Dorado, Fresno, Imperial, Kern, Madera, Marin, Merced, Monterey, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sonoma, Solano, Stanislaus, Tehama, Tulare, Ventura, and Yolo).

Domain 4

- There are 13 total executed LDPP contracts and the contract status for each is available in the DTI DY 13 Annual Progress Report.
- During the last quarter of DY 15, LDPP's operations were severely impacted by the COVID-19 pandemic. Many of the LDPP's goals that included community and school based outreach components were halted. However, LDPPs were able to quickly shift strategies by utilizing teledentistry services, leveraging virtual platforms, performing educational outreach, as well as provide emergency services to patients in need.

Preventive Dental Services Utilization

Figure 15 summarizes the preventive dental service utilization during DY 15 for children statewide. The utilization showed a positive trend with an average of 47 percent through March 2020 and decreased in the last quarter due to COVID-19 and dental office closures.

Figure 15: Statewide Three Months Continuously Enrolled Medi-Cal Members Age 1-20 and the Preventive Dental Services Utilization[18]

Measure End Month	Measure Period	Numerator[19]	Denominator[20]	Utilization
Jul 2019	08/2018-07/2019	2,548,950	5,406,978	47.14%
Aug 2019	09/2018-08/2019	2,558,476	5,394,173	47.43%
Sep 2019	10/2018-09/2019	2,566,708	5,383,675	47.68%
Oct 2019	11/2018-10/2019	2,570,029	5,376,220	47.80%
Nov 2019	12/2018-11/2019	2,563,896	5,324,992	48.15%
Dec 2019	01/2019-12/2019	2,554,795	5,278,701	48.40%
Jan 2020	02/2019-01/2020	2,546,653	5,250,562	48.50%
Feb 2020	03/2019-02/2020	2,565,788	5,340,689	48.04%
Mar 2020	04/2019-03/2020	2,514,765	5,342,498	47.07%
Apr 2020	05/2019-04/2020	2,408,291	5,325,159	45.22%
May 2020	06/2019-05/2020	2,315,647	5,313,233	43.58%
Jun 2020	07/2019-06/2020	2,255,636	5,303,298	42.53%

Provider Enrollment

By the end of DY 15, the numbers of active FFS service offices increased from 5,848 to 5,985 and rendering providers increased from 10,829 to 11,534 constituting an increase of 2.3 percent and 6.5 percent in enrollment respectively. The numbers of active DMC (Geographic Managed Care (GMC) and Prepaid Health Plans (PHP)) service offices increased from 1,052 to 1,075 which is a 2.2 percent increase and rendering providers decreased from 1,896 to 1,743 which is a 8.1 percent decrease in enrollment. These numbers are per enrollment data and not based upon activity in rendering and billing for services. The numbers of SNCs who provided at least one dental service in the recent one year increased from 575 to 581. Figure 16 lists monthly provider counts across all delivery systems.

Figure 16: Statewide Active Dental Service Offices, Rendering Providers, and Safety Net Clinics[21]

[18] Data Source – DHCS Data Warehouse MIS/DS Dental Dashboard August 2020 update. Utilization does not include one-year full run-out allowed for claim submission.

[19] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (CDT codes D1000-D1999 or Current Procedural Terminology (CPT) code 99188 with 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.

[20] Denominator: 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.

[21] Active service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008M, PS-O-008N and DMC Plan deliverables of each month. This table does not indicate whether a provider provided services during the reporting month. Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net and LIBERTY.

Measure Month	FFS Offices	FFS Rendering	GMC Offices	GMC Rendering	PHP Offices	PHP Rendering	Safety Net Clinics
Jul 2019	5,848	10,829	127	283	925	1,613	575
Aug 2019	5,869	10,923	128	284	922	1,598	582
Sep 2019	5,877	10,992	149	287	922	1,614	576
Oct 2019	5,909	11,077	125	264	916	1,539	566
Nov 2019	5,919	11,149	135	273	916	1,581	567
Dec 2019	5,921	11,207	136	285	915	1,546	593
Jan 2020	5,888	11,242	138	286	916	1,569	598
Feb 2020	5,895	11,325	141	297	917	1,589	601
Mar 2020	5,889	11,353	144	301	914	1,618	599
Apr 2020	5,903	11,442	146	271	915	1,455	591
May 2020	5,952	11,477	147	271	913	1,456	589
Jun 2020	5,985	11,534	152	273	923	1,470	581

Outreach/Innovative Activities

- *Outreach Plans*

To increase the public awareness of DTI, DHCS presented the goals, incentive payments methodologies, implementation efforts, and outcomes in numerous events and meetings statewide. Figure 17 is a list of events and meetings where DHCS shared information on DTI during DY 15.

Figure 17: DTI Outreach Presentations

Date	DTI Outreach Presentations
July 30, 2019	National Academy for State Health Policy Webinar
August 1, 2019	Medi-Cal Dental Advisory Committee Meeting (agenda)
August 6, 2019	Child Health and Disability Prevention Statewide Oral Health Subcommittee Meeting
August 15, 2019	Los Angeles County Dental Stakeholder Meeting (agenda)
August 16, 2019	San Francisco City and County Department of Public Health Dental Access Collaborative Expert Meeting
October 17, 2019	Los Angeles County Dental Stakeholder Meeting (agenda)
October 18, 2019	Tribal and Indian Health Program Designee Follow Up Meeting

The count of Safety Net Clinics is based on encounter data from the DHCS Data Warehouse MIS/DSS as of September 2020. Only Safety Net Clinics who submitted at least one dental encounter within one year were included.

	(presentation)
November 5, 2019	Child Health and Disability Prevention Program Statewide Oral Health Subcommittee Meeting
November 19, 2019	California Department of Public Health's Office of Oral Health Project Directors Meeting
November 22, 2019	Statewide Taskforce on Oral Health for People with Disabilities and Aging Californians
December 5, 2019	Medi-Cal Dental Advisory Committee Meeting. Agenda is not available online for this meeting.
December 12, 2019	Los Angeles Dental Stakeholder Meeting (agenda)
February 4, 2020	Child Health and Disability Prevention Statewide Oral Health Subcommittee Meeting
February 27, 2020	Medi-Cal Dental Statewide Stakeholder Meeting (agenda)
April 2, 2020	Medi-Cal Advisory Committee Meeting (agenda)
April 16, 2020	Los Angeles Dental Stakeholder Meeting (agenda)
May 5, 2020	Child Health and Disability Prevention Statewide Oral Health Subcommittee Meeting

- *DTI Small Workgroup*

The objective of this meeting is to share updates on all DTI Domains and gather feedback from provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup meets on a bi-monthly basis, the third Wednesday of the month. When there are no agenda items for discussion, email updates are sent, which include information on incentive payments, provider participation, and LDPP visits. The following were the scheduled meetings during DY 15:

- July 22, 2019 – email sent in lieu of meeting.
- September 19, 2019 - discussions included dental initiatives in CalAIM, Mathematica's evaluation, and the regular DTI updates.
- November 21, 2019 – meeting was repurposed to focus on stakeholder education and feedback regarding the dental proposals in CalAIM.
- February 3, 2020 – email sent in lieu of meeting.
- March 11, 2020 – email sent in lieu of meeting.
- May 19, 2020 – email sent in lieu of meeting.

- *Domain 2 Subgroup*

The purpose of this subgroup is to report on the Domain's current activities, discuss ways to encourage providers who are eligible to participate in the Domain, and provide an open forum for questions and answers specific to this Domain. The subgroup did not meet during DY 15; however, e-mail updates were sent to the group on July 31, 2019, October 31, 2019, and April 7, 2020. The meetings are scheduled to convene once every quarter.

- *DTI Clinic Subgroup*

The clinic subgroup is still active and meets on an as needed basis. The subgroup did not meet during DY 15 as there were no changes to operations or policies prompting a need for the group to meet.

- *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 examine new correlations and data. Since the release of the DTI PY 2 Annual Report, stakeholders reviewed the report and shared written feedback with DHCS on March 13, 2019. The feedback included positive comments, follow up questions, and a suggestion to add previous years' Domain 1 statewide utilization to the DTI PY 3 Annual Report. DHCS responded to follow up questions, revised the report narrative for clarification, and agreed to incorporate the stakeholders' feedback in the DTI PY 3 Annual Report during the subgroup meeting on March 21, 2019. No additional comments were received.

- *Domain 4 Subgroup*

DHCS holds the bi-monthly teleconferences with the LDPPs as an opportunity to educate, provide technical assistance, offer support and address concerns. The purpose of the teleconferences expanded to include rotating presentations from one or two of the LDPPs to share their best practices, outcomes, and challenges with other lead entities. During DY 15, LDPP conference calls were held on the following dates:

- August 22, 2019
- September 23, 2019
- November 4, 2019
- December 18, 2019
- February 20, 2020
- April 30, 2020
- June 18, 2020

- *DTI Webpage*

During DY 15, webpage posting included the following:

- Domain 3 Incentive Payments for PY 1 and 2
- Final DTI Interim Evaluation Report and CMS Approval Letter.
- DHCS submitted DTI PY 3 Annual Report to CMS in late December 2019, which was published on the DTI Webpage on February 6, 2020.

- *DTI Inbox and Listserv*

DHCS regularly monitored its DTI inbox and listserv during DY 15. Figure 18 is the list of

inquiries received during each quarter of this DY with a total of eight hundred seventy-one (871) inquiries in the DTI inbox for Domains 1, 2, and 3. Most inquiries during this reporting period included, but were not limited to, the following categories: DTI program extension, county expansion, encounter data submissions, opt-in form submissions, payment status and calculations, check reissuances, resource documents, and Domain 2 billing and opt-in questions.

Figure 18: Number of DTI Inbox Inquiries by Domain

Domain	Q1 Inquiries	Q2 Inquiries	Q3 Inquiries	Q4 Inquiries
1	69	70	105	248
2	115	71	64	75
3	22	14	12	6
Total	**206**	**155**	**181**	**329**

Separately, the LDPP inbox for Domain 4 received a total of seven hundred twenty-four (724) inquiries in this DY, with questions related to budget revisions, quarterly reports, asset tagging, site visits, and reimbursement status.

Operational/Policy Developments/Issues

- *Domain 1*

  - Domain 1 providers are paid semi-annually at the end of January and July. The following payments were issued during DY 15:

    - The second PY 3 payment, $4,346,478.75, issued in July 2019.
    - The first PY 4 payment, $52,224,168.75, and final PY 3 payment, $1,530,795, issued in January 2020.
    - The second PY 4 payment, $3,852,981, issued in July 2020.

- *Domain 2*

  - FFS providers are paid weekly, whereas SNC and DMC providers are paid on a monthly basis. Figure 19 represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY 15, which totals $72,801,393.52 (for all Domain 2 benefits including CRA, Silver Diamine Fluoride and preventive services) paid to 2,896 providers who opted-in to Domain 2. Figure 20 represents incentive claims paid for FFS, SNC, and DMC providers from the beginning of the Domain 2 program until the end of DY 15, which equals $88,991,801.36.

Figure 19: Domain 2 Payments by County and Delivery System Paid in DY 15

County	FFS	DMC	SNC
Contra Costa	$870,168.25	$0	$0
Fresno	$3,641,910.20	$252.00	$17,528.00
Glenn	$2,268.00	$0	$0
Humboldt	$0	$0	$0
Imperial	$57,510.00	$0	$0
Inyo	$0	$0	$14,490.00
Kern	$4,617,315.93	$0	$0
Kings	$14,024.00	$0	$0
Lassen	$0	$0	$0
Los Angeles	$21,762,397.53	$276,199.00	$1,834,494.00
Madera	$662,136.00	$0	$0
Mendocino	$0	$0	$143,444.00
Merced	$558,615.85	$0	$0
Monterey	$2,844,139.35	$0	$0
Orange	$5,083,686.00	$126.00	$691,006.00
Plumas	$0	$0	$0
Riverside	$4,146,291.91	$126.00	$0
Sacramento	$618,814.65	$2,188,803.00	$0
San Bernardino	$3,794,727.70	$0	$0
San Diego	$5,562,046.19	$0	$795,479.00
San Joaquin	$1,574,647.55	$126.00	$18,322.00
Santa Barbara	$1,311,156.25	$0	$0
Santa Clara	$1,332,671.38	$0	$0
Sierra	$0	$0	$0
Sonoma	$194,102.00	$0	$705,540.00
Stanislaus	$2,093,151.90	$0	$0
Tulare	$2,459,938.55	$0	$0
Ventura	$2,365,740.33	$252.00	$547,747.00
Yuba	$0	$0	$0
Total	**$65,567,459.52**	**$2,465,884.00**	**$4,768,050.00**

Figure 20: Domain 2 Payments by County and Delivery System between February 2017 and June 2020 (End of DY 15)[22]

County	FFS	DMC	SNC
Contra Costa	$910,295.25	$0	$0
Fresno	$4,150,391.20	$252.00	$17,528.00
Glenn	$8,907.00	$0	$0
Humboldt	$70.00	$0	$126.00
Imperial	$65,664.00	$0	$0
Inyo	$0	$0	$43,218.00
Kern	$5,561,397.93	$0	$0
Kings	$30,372.50	$0	$0
Lassen	$0	$0	$0
Los Angeles	$24,602,118.83	$311,857.00	$1,869,774.00
Madera	$670,053.00	$0	$0
Mendocino	$0	$0	$532,367.00
Merced	$581,185.85	$0	$0
Monterey	$2,876,991.35	$0	$0
Orange	$5,770,763.00	$126.00	$691,006.00
Plumas	$0	$0	$0
Riverside	$4,496,505.91	$126.00	$0
Sacramento	$1,697,142.40	$4,393,543.00	$0
San Bernardino	$4,219,838.50	$126.00	$0
San Diego	$6,425,514.19	$0	$795,605.00
San Joaquin	$1,633,488.55	$126.00	$18,322.00
Santa Barbara	$1,640,193.25	$0	$0
Santa Clara	$1,575,600.38	$0	$0
Sierra	$0	$0	$0
Sonoma	$223,059.00	$0	$802,262.00
Stanislaus	$2,290,026.90	$0	$0
Tulare	$6,700,039.04	$0	$0
Ventura	$2,837,820.33	$252.00	$547,747.00
Yuba	$0	$0	$0
Total	**$78,967,438.36**	**$4,706,408.00**	**$5,317,955.00**

- *Domain 3*
    - The total number of SNCs participating in Domain 3 increased by 39 in DY 15, bringing the total to 120.
    - Incentive payments for Domain 3 are issued to providers once a year. In July 2020, DHCS issued the fourth payment of this Domain, which included the second and final payment of PY 3 for the 17 original counties and the first payment for PY 4 for all of the 36 participating counties. Figure 21 lists

[22] Data Source: ASO DTI Reports as of June 2020.

payments issued to counties for PY 3 and Figure 22 lists payments issued to counties for PY 4.

Figure 21: Domain 3 Payments by Delivery System and County for PY 3[23]

County	FFS	SNC	Total
Alameda	$1,218,110	$229,870	$1,447,980
Del Norte	$280	$0	$280
El Dorado	$128,530	$0	$128,530
Fresno	$2,077,620	$39,170	$2,116,790
Kern	$2,525,480	$89,580	$2,615,060
Madera	$383,690	$0	$383,690
Marin	$6,570	$0	$6,570
Modoc	$1,400	$7,980	$9,380
Nevada	$2,610	$0	$2,610
Placer	$260,400	$10,600	$271,000
Riverside	$3,935,860	$0	$3,935,860
San Luis Obispo	$324,700	$0	$324,700
Santa Cruz	$169,860	$252,790	$422,650
Shasta	$83,100	$0	$83,100
Sonoma	$303,790	$236,320	$540,110
Stanislaus	$1,241,040	$0	$1,241,040
Yolo	$61,800	$13,600	$75,400
Total	**$12,724,840**	**$879,910**	**$13,604,750**

Figure 22: Domain 3 Payments by Delivery System and County for PY 4[24]

County	FFS	SNC	Total
Alameda	$2,647,590	$770,260	$3,417,850
Butte	$225,700	$0	$225,700
Contra Costa	$1,445,300	$0	$1,445,300
Del Norte	$0	$0	$0
El Dorado	$153,120	$0	$153,120
Fresno	$5,231,540	$18,400	$5,249,940
Imperial	$373,300	$0	$373,300
Kern	$5,987,760	$27,560	$6,015,320
Madera	$837,790	$0	$837,790
Marin	$10,870	$0	$10,870
Merced	$879,600	$0	$879,600
Modoc	$2,580	$0	$2,580
Monterey	$2,769,000	$0	$2,769,000
Napa	$178,200	$181,500	$359,700

[23] Data Source: ASO DTI Reports as of June 2020.
[24] Data Source: ASO DTI Reports as of June 2020.

County	FFS	SNC	Total
Nevada	$5,750	$0	$5,750
Orange	$10,814,700	$295,500	$11,110,200
Placer	$644,090	$60,620	$704,710
Riverside	$8,788,020	$0	$8,788,020
San Bernardino	$8,805,100	$0	$8,805,100
San Diego	$7,191,200	$434,400	$7,625,600
San Francisco	$1,456,900	$0	$1,456,900
San Joaquin	$2,546,000	$16,000	$2,562,000
San Luis Obispo	$720,420	$0	$720,420
San Mateo	$1,051,900	$0	$1,051,900
Santa Barbara	$1,773,400	$0	$1,773,400
Santa Clara	$3,433,500	$0	$3,433,500
Santa Cruz	$384,290	$498,170	$882,460
Shasta	$174,930	$0	$174,930
Solano	$903,400	$17,100	$920,500
Sonoma	$628,330	$638,000	$1,266,330
Stanislaus	$2,913,670	$150,900	$3,064,570
Sutter	$1,423,700	$0	$1,423,700
Tehama	$0	$600	$600
Tulare	$2,374,200	$0	$2,374,200
Ventura	$3,230,200	$290,500	$3,520,700
Yolo	$105,830	$50,640	$156,470
Total	**$80,111,880**	**$3,450,150**	**$83,562,030**

- *Domain 4*

For DY 15, paid amounts for each LDPP are shown in Figure 23. DHCS paid a total of $33,318,567.

Figure 23: Domain 4 Payments by LDPP[25]

LDPPs	Total Paid
Alameda County	$4,753,626
California Rural Indian Health Board, Inc.	$621,827
California State University, Los Angeles	$4,239,597
First 5 San Joaquin	$1,512,354
First 5 Riverside	$2,487,274
Fresno County	$2,434,474
Humboldt County	$1,023,907
Orange County	$4,482,891
Sacramento County	$2,440,066

[25] Data Source: ASO Invoices as of August 2020.

San Luis Obispo County	$653,380
San Francisco City and County	$1,496,849
Sonoma County	$1,108,723
University of California, Los Angeles	$6,063,599
Total	**$33,318,567**

LDPPs are leveraging approximately half of the funds allocated for Domain 4. This may be due to staff turnover, delayed contract execution with partners and/or subcontractors, and issues developing partnerships. In addition, DHCS is monitoring LDPPs' self-selected performance metrics during the first two years of operation, which appear to be under performing.

Outreach Efforts

As a result of the COVID-19 pandemic, the ASO outreach team modified their approach by substituting routine, in person visits with emails and phone calls to participating providers in Domains 1, 2 and 3.

- *Domain 2*

During DY 15, Domain 2 enrollment increased by 1,001 providers, bringing the total from 1,895 to 2,896. The ASO continues to outreach to eligible providers during their regular course of business.

- *Domain 3*

Domain 3 outreach activities from the first three quarters of DY 15 are listed in the DY 15 Quarterly Progress Reports. During the last quarter, the ASO's outreach team visited/contacted twenty-four (24) of the thirty-six (36) pilot counties (Alameda, Butte, El Dorado, Contra Costa, Fresno, Kern, Madera, Merced, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura, and Yolo). The ASO outreach team offered a vast range of assistance and while networking with enrolled providers, they presented and discussed information about Prop 56 supplemental payments and dental student loan forgiveness as well as DTI. They also helped with renewing their enrollment paperwork. Visits to the Medi-Cal dental providers that are already enrolled in the program provide an opportunity to establish positive support, communication, and furthers efforts to encourage offices to accept new patients as a result of the additional coverage and performance incentives available to them.

- *Domain 4*

The LDPPs have utilized the email inbox to submit invoices electronically on a quarterly basis as well as communicate individual program concerns, share best practices,

request assistance, and inform their liaison of changes to their programs. During DY 15, DHCS conducted site visits represented in Figure 24 to observe the administrative and clinical initiatives as outlined in each LDPP's executed contract. Site visits are a way for the pilots to have in-person discussions with DHCS about their programs. These visits also provided DHCS with an immersive, firsthand experience of the services being offered in real time within the communities in which they serve.

Figure 24: Domain 4 Site Visits

Date	Sites
September 24, 2019	Humboldt County
September 25-26, 2019	San Luis Obispo County
September 27, 2019	Fresno County
November 6, 2019	First 5 Riverside
November 7, 2019	Orange County
January 21, 2020	Alameda County

Consumer Issues

Domain 1 providers expressed concerns regarding adjustments to benchmarks or payment calculations, and extensions to the DTI program, given the impacts of the COVID-19 pandemic.

Financial/Budget Neutrality Development/Issues

Please see the *Operational/Policy Developments/Issues* section for information on payments.

Quality Assurance/Monitoring Activities

There were no quality assurance issues or monitoring activities for this reporting period.

Evaluation

During DY 15, Mathematica, the DTI independent evaluator, finalized the DTI Interim Evaluation Report and other tasks associated with preparing for the final evaluation. Mathematica also participated in bi-weekly conference calls with DHCS. Mathematica is continuing to work on gathering and analyzing data for inclusion in the Final Evaluation Report.

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

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

The state DMC-ODS implementation is occurring in five phases: (1) Bay Area, (2) Kern and Southern California, (3) Central California, (4) Northern California, and (5) Tribal Partners. Thirty counties are currently approved to deliver DMC-ODS services, representing 94 percent of the Medi-Cal population statewide. As of July, 1, 2020, an additional seven counties collaborating with Partnership Health Plan of California have implemented an alternative regional model.

Program Highlights:

Please refer to previous quarterly reports for additional activities and details.

During DY15 UCLA conducted the following activities:

Administrative Data Analysis

- The evaluation makes use of various data sources including the California Outcomes Measurement System, Treatment (CalOMS-Tx), Drug Medi-Cal Claims, Medi-Cal Managed Care, Fee-For-Service (FFS) data, and client level-of-care data, as they become available to researchers. During this time period, UCLA presented a residential treatment, inpatient and emergency room utilization analysis using linked CalOMS-Managed Care and FFS data.

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. Statewide results for the 2019 survey period were prepared on February 27, 2020. Additional TPS information is available here:

http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html

County Administrator Survey

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

Provider Survey

- UCLA conducted surveys of providers in each waiver county throughout the state. Provider surveys are conducted at the care delivery unit level, referring to a treatment modality (e.g., inpatient, outpatient, methadone maintenance) at a specific site. Clinical directors are asked questions related to access (e.g., treatment capacity), quality (e.g., ASAM criteria, electronic health records) and coordination of care (e.g., partnerships with other treatment and recovery support providers, levels of integration with physical and mental health scare systems) in their treatment programs. UCLA continues to survey providers after they have implemented services once “Live” under the waiver, and concluded data collection for DY15 in March 2020. As of the end of this reporting period, 209 surveys have been completed.

Beneficiary Access Line Secret Shopper

- UCLA conducted secret shopper calls to evaluate access to counties’ beneficiary access lines. The purpose of these calls is to verify that the requirement of having a phone number available to beneficiaries is being met by counties that have started providing DMC-ODS services. Initiation of these secret shopper calls occurs soon after the county’s contract with DHCS is executed. As of the end of this reporting period, 261 calls were made to waivered counties’ beneficiary access lines. Each county receives feedback on their county’s beneficiary access line in the form of a written report.

Qualitative Interviews with Stakeholders

- UCLA conducted key informant interviews with county administrators and SUD provider programs administrators from counties participating in the DMC-ODS waiver to develop case studies on topics of particular interest to DHCS. Eight interviews were conducted April-June 2020 with county administrators and the analyses included in the Year 4 Evaluation report. These interviews were meant to gather data on successful strategies implemented by counties under the waiver.

Additional Technical Assistance (TA) provided to State and Counties

- UCLA provided TA related to TPS data to Santa Barbara, Santa Clara, Ventura, and San Joaquin.

- UCLA provided TA to Advocates for Human Potential (AHP) regarding clarification on Drug Medi-Cal billing to CA counties and providers who participated in a statewide webinar series: Sustainable Reimbursement of MAT Webinar Series; Session 2 Drug Medi-Cal, DMC-ODS & MAT Reimbursement. UCLA also provided feedback on the Q & A document following the webinar addressing provider questions about billing and coding for SUD treatment services under DMC-ODS.

In addition, following approval from DHCS, UCLA began the development of a new online survey for CA county administrators assessing statewide the impact of COVID-19 on SUD treatment delivery, access issues, needs of the community, and utilization of Telehealth. Dissemination and data collection across the state is scheduled for July 2020.

Qualitative Findings:

Outreach/Innovative Activities

DHCS staff conducted documentation training for DMC-ODS. The training included technical assistance for county management as well as general training for county staff. The focus of the training is to address requirements for all DMC-ODS treatment services and commonly identified deficiencies. The training details are as follows:

Figure 25: Documentation Training

County	Training Dates	Training Attendees
Stanislaus	August 27, 2019	52
Merced	August 29, 2019	12
Sacramento	September 9-10, 2019	45
Santa Cruz	October 8-9, 2019	12
El Dorado	November 13-14, 2019	15
Tulare	February 11-12, 2020	9

Please refer to previous quarterly reports for additional activities that occurred during DY 15. Recent activities including DMC-ODS guidance are listed below:

- April 2, 2020 – COVID-19 All County Weekly Call
- April 9, 2020 – COVID-19 All County Weekly Call
- April 14, 2020 – CalAIM Planning Kick-off

- April 16, 2020 – COVID-19 All County Weekly Call
- April 23, 2020 – COVID-19 All County Weekly Call
- April 30, 2020 – CCJBH Council Meeting
- April 30, 2020 – COVID-19 All County Weekly Call
- May 4, 2020 – BHIN DMC-ODS and IHCP Reimbursement Transition F/U
- May 7, 2020 – COVID-19 All County Weekly Call
- May 14, 2020 – COVID-19 All County Weekly Call
- May 18, 2020 – BHIN DMC-ODS and IHCP Reimbursement Transition F/U
- May 21, 2020 – COVID-19 All County Weekly Call
- May 27, 2020 – DHCS Behavioral Health Stakeholder Advisory Committee
- May 28, 2020 – COVID-19 All County Weekly Call
- June 4, 2020 – COVID-19 All County Weekly Call
- June 11, 2020 – COVID-19 All County Weekly Call
- June 18, 2020 – COVID-19 All County Weekly Call
- June 25, 2020 – COVID-19 All County Weekly Call
- June 26, 2020 – CCJBH Council Meeting

Quality Assurance/Monitoring Activities

DHCS conducted compliance monitoring reviews for the following Counties listed in Figure 26:

Figure 26: Compliance Monitoring Reviews

County	Date
Solano	January 2020
Monterey	January 2020
Sacramento	January 2020
Tehama	January 2020
Placer	February 2020
Colusa	February 2020
Del Norte	February 2020
Glenn	February 2020
San Diego	February 2020
Riverside	February 2020
San Bernardino	March 2020
Fresno	March 2020

Marin	March 2020
San Francisco	March 2020
Kern	March 2020
Stanislaus	March 2020
El Dorado	April 2020
Tulare	April 2020
Napa	April 2020
San Benito	April 2020
Alameda	May 2020
Contra Costa	May 2020
Imperial	May 2020
San Luis Obispo	May 2020

Consumer Issues

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

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 is as follows.

Figure 27: Grievance Data

Grievance							
County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
Alameda	4	3	1	-	-	3	11
Contra Costa	-	5	1	1	1	3	11
El Dorado	-	1	-	1	-	-	2
Fresno	4	1	1	1	-	2	9
Imperial	1	-	-	-	-	-	1
Kern	1	12	2	-	1	3	19
Los Angeles	11	3	14	9	2	16	55
Marin	-	1	2	-	6	2	11
Merced	-	-	-	-	-	2	2
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	1	1
Nevada	-	*	-	-	-	*	*
Orange	3	3	2	8	5	3	24
Placer	2	3	7	2	18	-	32
Riverside	2	11	-	-	-	3	16
Sacramento	-	1	-	-	2	1	4
San Benito	-	-	-	-	-	-	-
San Bernardino	1	25	2	-	-	2	30
San Diego	5	123	2	30	-	14	174
San Francisco	-	1	1	1	2	5	10
San Joaquin	1	3	-	-	-	9	13
San Luis Obispo	1	11	-	2	2	3	19
San Mateo	2	6	1	-	1	2	12
Santa Barbara	-	2	1	3	8	1	15
Santa Clara	1	1	7	-	1	2	12
Santa Cruz	-	6	2	-	2	2	12
Stanislaus	-	29	-	-	1	2	32
Tulare	-	-	-	-	1	-	1

Ventura	1	1	2	-	-	-	4
Yolo	1	3	2	1	3	-	10

**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.*

Figure 28 : Resolution and Transition of Care

	Resolution				Transition of Care		
Counties	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
Alameda	11	2	-	2	-	-	-
Contra Costa	10	-	-	-	-	-	-
El Dorado	2	1	1	-	-	-	-
Fresno	9	1	-	-	-	-	-
Imperial	1	-	-	-	-	-	-
Kern	12	-	-	-	-	-	-
Los Angeles	39	32	18	14	-	-	-
Marin	9	-	-	-	-	-	-
Merced	2	-	-	-	-	-	-
Monterey	-	1	-	1	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	*	-	-	-	-	-	-
Orange	19	5	1	3	-	-	-
Placer	31	2	1	1	-	-	-
Riverside	14	-	-	-	-	-	-
Sacramento	1	-	-	-	1	1	-
San Benito	-	-	-	-	-	-	-

San Bernardino	9	-	-	-	-	-	-
San Diego	140	17	16	6	-	-	-
San Francisco	10	-	-	-	-	-	-
San Joaquin	13	-	-	-	-	-	-
San Luis Obispo	14	5	2	3	-	-	-
San Mateo	9	-	-	-	-	-	-
Santa Barbara	10	1	1	-	-	-	-
Santa Clara	13	2	2	-	-	-	-
Santa Cruz	14	14	7	7	-	-	-
Stanislaus	33	3	3	-	3	2	1
Tulare	-	-	-	-	-	-	-
Ventura	4	-	-	-	-	-	-
Yolo	8	-	-	-	-	-	-

**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.*

Quantitative Findings:

Nothing to report.

Enrollment Information:

Figure 29: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total*
DY15-Q1	43,250	20,487	62,864
DY15-Q2	43,584	20,027	62,778
DY15-Q3	42,649	19,088	60,958
DY15-Q4	35,031	14,328	48,928

* Total is the unique client count for both populations. Beneficiaries can have more than 1 aid code and can be in more than 1 population.

Member Months:

Figure 30: DY 15 Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	32,473	32,877	32,848	DY15-Q1	43,250
	33,822	32,288	32,645	DY15-Q2	43,584
	32,877	32,774	31,151	DY15-Q3	42,649
	27,501	26,917	25,477	DY15-Q4	35,031
Non-ACA	16,640	16,823	16,905	DY15-Q1	20,487
	18,876	16,189	16,359	DY15-Q2	20,027
	15,976	15,026	14,445	DY15-Q3	19,088
	11,941	11,801	10,606	DY15-Q4	14,328

Financial/Budget Neutrality Developments/Issues:

Figure 31: Aggregate Expenditures: ACA and Non-ACA

DY15-Q1					
Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
ACA	2,885,923	$89,925,382.24	$77,282,983.37	$7,194,524.13	$5,447,874.74
Non ACA	1,649,935	$34,616,955.34	$17,462,973.25	$4,284,327.91	$12,869,654.18
DY15-Q2					
ACA	2,821,615	$91,901,709.45	$78,942,951.85	$7,387,876.58	$5,570,881.02
Non ACA	1,578,179	$33,874,436.71	$16,907,661.35	$4,369,980.12	$12,596,795.24
DY15-Q3					
ACA	2,777,267	$91,139,746.77	$75,962,274.83	$9,424,757.49	$5,752,714.45
Non ACA	1,426,842	$31,230,566.45	$15,580,179.02	$4,051,825.41	$11,598,562.02
DY15-Q4					
ACA	2,387,965	$74,128,801.99	$61,844,318.65	$7,442,073.95	$4,842,409.39
Non ACA	1,093,996	$23,911,084.15	$11,934,835.46	$2,964,783.98	$9,011,464.71

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 with DY 15-Q1 (FY 19-20), 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.

Operational/Policy Developments/Issues:

Please refer to previous quarterly reports for additional activities that occurred during DY 15.

DHCS continued to focus on minimizing the spread of COVID-19 and ensuring ongoing access to care by distributing guidance to stakeholders in support of maintaining the continuity of statewide essential services and operations. Further details can be found on the DHCS COVID-19 response webpage linked below.

https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx

In addition, the CalEQRO team has worked to record the impact of COVID-19 on operations and services of the DMC-ODS continuum of care and the availability and capacity of the programs to marshal resources to provide telehealth clinical care for clients through video, phone, and other platforms. Due to COVID distancing issues and challenges many of the DMC-ODS counties have asked for Technical Assistance to re-design PIPs that were initially designed for treatment programs built around group therapies, such as Seeking Safety and some Intensive Outpatient Programs with housing links as step-downs from residential.

Progress on the Evaluation and Findings:

The University of California Los Angeles' Integrated Substance Abuse Programs (UCLA-ISAP) submits Bi-Annual Evaluation Reports to DHCS detailing the activities it conducted during the specified time periods of January through June and July through December and UCLA-ISAP's overall progress towards the evaluation goals. The work is to be performed across two domains with objectives, deliverables and activities defined within each.

The first domain is to evaluate the impact of the DMC-ODS Waiver on SUD treatment access, coordination of care, quality, and placement in appropriate levels of care. Utilizing those evaluations, and comparing this data against the evaluations for the first three years of the DMC-ODS, UCLA-ISAP shall make recommendations to improve policies, practices, and data quality. The second domain is to provide its evaluation subjects and data sources with technical assistance to facilitate UCLA-ISAP's collection of data from those subjects and sources.

The Bi-Annual Evaluation Reports contains a summary of the efforts made toward collecting and analyzing administrative data, survey data, and qualitative data. The Bi-Annual Evaluation Reports also contain a summary of the progress made towards the overall evaluation goals and reporting on technical assistance on the SUD treatment

system. The most recent Bi-Annual Report was received by DHCS July 2020 in which UCLA provided an analysis on evaluation and technical assistance efforts for the time period of January 1, 2020 through June 30, 2020. Due to the COVID-19 Pandemic and the Emergency Shut Down/Shelter in Place requirements across the state and country, project activities were impacted to some degree.

Upon further review of the feasibility in creating an interim evaluation report, the State determined that the bi-annual evaluation reports, produced by UCLA-ISAP, provides evidence of the State's progress toward meeting the ultimate goals of the demonstration project using a variety of quantitative and qualitative measures. The data from these bi-annual reports will be used to inform subsequent 1115 Waiver Quarterly Progress Reports.

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 of 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 provided in inappropriate care settings for the type of illness.

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

Accomplishments:

The Department of Health Care Services (DHCS) successfully utilized the GPP Encounter Data Collection SharePoint Extranet site as a method of data transmission. Each PHCS submitted encounter level data on their uninsured services using excel templates provided in accordance with the Standard Terms and Conditions, Attachments EE and FF. DHCS extended the deadline to submit the GPP encounter level data reports to alleviate hospital workload resulting from the COVID crisis. The original due date was March 31, 2020. The encounter level data documents for Program Year (PY) 4 were submitted to DHCS on April 30, 2020.

Program Highlights:

Two Demonstration Year (DY) 15 final reports were due to DHCS from all participating GPP PHCS on April 30, 2020. Those reports were the PY 4 final year-end summary aggregate report, and the PY 4 encounter level data report. DHCS received all reports on time, conducted thorough evaluations of the reports, and completed the final reconciliation and redistribution process. PHCS were notified of the final reconciliation and redistribution process payment amounts and Intergovernmental Transfer (IGT) amounts on June 25, 2020.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

The SFY 2017-18 PY 3 Final Reconciliation occurred at the beginning of DY15 and DHCS recouped $13,823,060.00 in total funds from PHCS. The recoupment was a result of four PHCS that submitted final year-end reports with revisions to the interim report. The table below shows the PHCS requiring recoupment and their associated PY 3 Interim and Final reporting differences in the percent of GPP threshold met.

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

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

In SFY 2018-19 PY 4, DHCS recouped $4,970,672.00 in total funds from Ventura County Medical Center (VCMC). The recoupment was due to overpayment to VCMC. In PY 4, IQ 1 – 3 (July 1, 2018 – March 30, 2019), VCMC was paid 75% of its total annual budget. On August 15, 2019, VCMC submitted an interim year-end summary aggregate report. The threshold points earned for VCMC was 71% of GPP thresholds. The 71% is less than 75% of its total annual budget. Therefore, DHCS adjusted the payments previously made to VCMC for GPP PY 4 and recouped the difference in the amount of $4,970,672.00 from VCMC.

The payments table below shows the GPP payments made to the PHCS in the order that they were paid during DY 15.

Figure 32: Payments Table

Payment	FFP	IGT	Service Period	Total Funds Payment
PY 3 (July – June) Overpayment collection	($6,911,530.00)	($6,911,530.00)	DY 13	($13,823,060.00)
PY 3 Final Rec. (July – June)	$78,411,655.00	$78,411,655.00	DY 13	$156,823,310.00
PY 4 (July-March) Overpayment collection	($2,485,336.00)	($2,485,336.00)	DY 14	($4,970,672.00)
PY 4, IQ4 (April – June)	$252,547,934.00	$252,547,934.00	DY 14	$505,095,867.00
PY 5, IQ 1 (July – September)	$241,851,785.50	$241,851,785.50	DY 15	$483,703,571.00
PY 2 Final DSH GPP Round 6 (July – June)	$2,187,256.50	$2,187,256.50	DY 12	$4,374,513.00
PY 5, IQ 2 (October – December)	$367,989,408.50	$367,989,408.50	DY 15	$735,978,817.00
PY 5, IQ 3 (January – March)	$304,920,597.00	$304,920,597.00	DY 15	$609,841,194.00
Total	**$1,238,511,770.50**	**$1,238,511,770.50**		**$2,477,023,540.00**

Policy/Administrative Issues and Challenges:

In DY 15, GPP PY 5 IQ 2 and IQ 3 were impacted by the Families First Coronavirus Response Act which increases the Federal Medical Assistance Parentage (FMAP) to 56.2%, from 50%. Both quarters were initially processed utilizing the 50% FMAP, therefore these quarters will be reconciled to use the 56.2% FMAP when the IQ 4 payments are processed.

OUT-OF-STATE FORMER FOSTER CARE YOUTH (OOS FFY)

On August 18, 2017, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow the Department of Health Care Services (DHCS) to continue providing Medicaid coverage for former foster care youth under age 26, consistent with federal requirements for coverage of this population. Given the waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category. The evaluation design was approved on December 22, 2017, using the most current data representing 2015. The amendment authorized the OOS FFY 1115 Demonstration Waiver to start on November 1, 2017. This year's submission uses the most current data from 2018, as instructed by CMS.

DHCS submitted the Interim Evaluation Report for the OOS FFY Program to CMS on June 23, 2020. A request was also submitted to CMS on September 16, 2020 for a 12-month extension of the Medi-Cal 2020 Section 1115 Waiver Demonstration to to extend the Waiver to December 31, 2021.

Accomplishments:

California was the first state to have its 1115 Waiver approved by CMS to provide Medi-Cal eligibility to FFY who were in foster care in a state other than California and currently residing in California. Under the FFY Program, the OOS FFY under age 26 who qualify consistent with the federal requirements receive full scope benefits in Medi-Cal until they turn 26. These youths do not have to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

California continues to increase the number of FFY who are enrolled in the FFY Medi-Cal Program. Since 2016, California has added almost 6,000 FFY to the FFY Program under the HEDIS requirements of being enrolled for eleven out of twelve months in a year. An additional 2,400 FFY have utilized Ambulatory Care Visits demonstrating the progress in meeting the DHCS goal of improving health outcomes for FFY. FFY utilizations of Emergency Department Visits have also increased since 2016 by an additional 1,800 FFY. The remaining utilization measures in the FFY Waiver continue to show increases in FFY use.

Program Highlights:

California has increased total enrollment of FFY in Medi-Cal to 17,387, and of those, 66 are OOS FFY. These FFY meet the HEDIS requirements of being enrolled in Medi-Cal for eleven out of twelve months at any time in 2018. FFY continue to actively utilize the full scope Medi-Cal benefits available to them whether it is behavioral health visits, emergency department visits, inpatient stays or specific courses of treatment. Attachment QQ is based upon HEDIS requirements and provides the FFY data based

upon the number of FFY who remained enrolled in 2018 for eleven of the twelve months.

Qualitative Findings:

California continues to:

- use the current single-streamlined application that is used for all Insurance Affordability Programs within the state, including Medi-Cal, as applicable for OOS FFY;
- hold regular meetings with the counties to resolve issues that arise for the FFY;
- work closely with the California Department of Social Services to ensure the foster care youths are being transitioned seamlessly into the FFY Program without a break in Medi-Cal coverage, and;
- regularly meet with stakeholders for feedback on any concerns or issues.

Quantitative Findings:

According to the 2018 Enrollment, Utilization, and Health Outcomes evaluation (Attachment QQ), the FFY population continues to show greater use of Emergency Department (ED) visits, behavioral health visits and inpatient stays when compared to the 18-25 year old Medi-Cal population. Quality measures for Chlamydia Screening in Women (CHL) and Cervical Cancer Screening (CCS) also continue to be accessed more by the FFY group than the 18-25 year old Medi-Cal population.

Policy/Administrative Issues and Challenges:

FFY are a group of individuals who move often, and are accustomed to having their health care needs taken care of by the foster care system and/or caretakers. A youth new to California will have limited knowledge on where to access health care resources. They may also be unaware that California offers Medi-Cal for the former foster youth from ages 18 to 25 inclusive, until they are in need of services. Engagement with FFY stakeholders to convey information on access to services is conducted monthly.

Many FFY are also eligible for other programs that offer cash aid in addition to Medi-Cal. When these youths lose their eligibility for the cash aid programs, they are not always placed back into the FFY program, potentially creating a gap in their Medi-Cal coverage. California currently lacks the administrative ability to track OOS FFY entering or exiting the state or transitioning to other programs. To remedy this, DHCS is developing a system alert for counties to flag these cases, in an effort to ultimately prevent any gaps in Medi-Cal coverage. Due to the complexity of the project, the alert will be completed in stages. Completion of all stages is anticipated by 2022.

On October 24, 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Under Section 1001 of the SUPPORT Act "At-Risk Youth Medicaid Protection", eligibility for medical assistance for eligible juveniles may not be terminated because the juvenile is incarcerated. The definition of eligible juveniles includes FFY as described in Section 1902 of the Social Security Act (SSA) subsection of (a)(10)(A)(i)(IX). OOS FFY are not included in the current definition of FFY under SSA Section 1902.

Section 1002 of the SUPPORT Act extends Medicaid coverage for the OOS FFY regardless of the state they were in when they were in foster care. This amendment becomes effective for all foster youth who attain 18 years of age on or after January 1, 2023. Until January 1, 2023, OOS FFY over 21 may have their eligibility for medical assistance terminated while incarcerated. Thus, not all OOS FFY will be identified and re-enrolled in the FFY program upon leaving incarceration.

Progress on the Evaluation and Findings:

Please see OOS FFY - Attachment QQ

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

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

The PRIME Program aims to:

- Advance improvements in the quality, experience, and value of care that Designated Public Hospitals (DPH)/District/Municipal Public Hospitals (DMPH) provide

- Align projects and goals of PRIME with other elements of Medi-Cal 2020, avoiding duplication of resources and double payment for program work

- Develop health care systems that offer increased value for payers and patients

- Emphasize advances in primary care, cross-system integration, and data analytics

- Move participating 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 must select at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project. Participating DPH systems have implemented at least nine PRIME projects and participating DMPHs have implemented at least one PRIME project, as part of the participating PRIME entity's Five-year PRIME Plan.

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 improve physical and behavioral health outcomes or care delivery efficiency and patient experience by establishing or expanding fully integrated care with culturally and linguistically appropriate teams delivering coordinated comprehensive care for the whole patient.

The projects in Domain 2 – Targeted High-Risk or High-Cost Populations – focus on specific populations that would benefit most significantly from care integration and coordination: populations in need of perinatal care, individuals in need of post-acute

care or complex care planning, foster children, individuals who are reintegrating into society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

Projects in Domain 3 – Resource Utilization Efficiency – 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) by targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects 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 required the establishment of performance baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions.

Due to the difficult financial circumstances caused by the COVID-19 virus, the Centers for Medicare & Medicaid Services approved a 6.2 percent increase to the Federal Medical Assistance Percentage (FMAP) in order to provide financial relief to providers under the Families First Coronavirus Response Act. This adjustment was applied to the qualifying payments that occurred during the Calendar Year 2020.

Accomplishments:

DHCS received CMS approval of the PRIME Interim Evaluation report in February 2020. The approved report is posted on the DHCS PRIME website at the following link. Also during DY 15, DHCS completed the following payments to PRIME hospitals: DY13 High Performance Pools, DY14 Year End (YE) payments and DY 15 Mid-Year payments.

PRIME DY 15 was greatly impacted by the COVID-19 public health emergency. DHCS released DY15 benchmarks on July 3, 2019. These benchmarks were used to determine metric targets for DY 15 Mid-Year. For subsequent reporting periods, the public health emergency necessitated modifying these targets as well as the conventional PRIME target-setting methodology for the remainder of the year. For more information, please see the section below titled Policy/Administrative Issues and Challenges.

Program Highlights:

Total Funds payments, in the amount of $1,227,763,130.89, were made during DY 15 (Q1-Q4). These payments consisted of the following transactions:

- 3 DY 12 Annual Adjustments
- 2 DY 13 Annual Adjustments

- 34 DY 13 Supplemental payments
- 1 DY 14 Annual Adjustment
- 10 DY 14 Semi-Annual payments
- 51 DY 14 Annual payments
- 35 DY 15 Semi-Annual payments

General Program Webinars

On July 24, 2019, DHCS presented a webinar with NCQA to provide PRIME entities with an overview of the DY 15 YE Reporting Manual including changes to any of the metrics and updates to the manual.

On September 18, 2019, DHCS hosted a webinar on claiming unearned funds.

PRIMEd Annual Conference 2019

DHCS hosted the annual PRIME Learning Collaborative in-person conference in Sacramento on October 29-30, 2019. For a full description of this two-day event, please see the DY15-Q2 report.

Future Learning Collaborative Meetings

DHCS will host the 2020 PRIMEd Annual Conference, a virtual event starting on Monday, October 26, 2020 through Wednesday, October 28, 2020, which will consist of three half-day sessions.

On Monday, October 26, the topics will explore the COVID-19 pandemic and how it has influenced PRIME hospitals. The keynote speaker is Dr. Donald Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, who will speak on how health systems are navigating through COVID-19 challenges. The other presentation topics for this half day are Addressing COVID-19-Related Health and Health Care Disparities, and Trauma-Informed Practices to Address Stress Related to COVID 19.

On Tuesday, October 27, the topic will focus on developments in telehealth policies and expansion efforts during the pandemic. The session will end with presentations by PRIME entities about their hospital-level initiatives and changes.

The final day of the conference, Wednesday, October 28, will focus on PRIME programmatic updates, with a presentation on the interim evaluation results of the PRIME program, practical tips for sustaining quality improvement efforts, and next steps for mechanics of the new Quality Improvement Pool (QIP) Program.

As of October 5, 2020, there are 115 people registered to attend.

Additional Learning Collaborative Activities

DHCS continued to host Topic-Specific Learning Collaboratives (TLCs), which originally began in Q4 of DY 13. These TLCs created opportunities for PRIME entities to exchange ideas, engage in peer-to-peer learning and disseminate best practices in a collaborative effort to improve care delivery and meet project goals. Six TLC workgroups were selected for continuation throughout DY15.

TLCs meetings that occurred in prior DY15 quarters can be found at the following links: Q1, Q2 and Q3. During DY15-Q4, the six TLCs met on the following topics:

- Health Homes for Foster Children
    - June 2020, Dr. Heather Forkey from the Executive Committee of the American Pediatrics Council presented on Adverse Childhood Experiences for children in Foster Care, Dr. Forkey described ACEs and their potential outcomes for children in Foster Care. She also provided approaches for addressing trauma for these children, and approaches to empower caregivers to provide appropriate care for traumatized children.

- Reducing Health Disparities
    - June 2020, Dr. Seema Jain, COVID-19 Response Science Branch Director at the California Department of Public Health, shared and discussed California's COVID-19 data and notable disparities. Afterwards, PRIME entities shared the impact of COVID-19 in their hospitals.

- Care Transitions
    - June 2020, a PRIME entity presented on their homegrown data dashboard, including discussion of the process for collecting the data, building reports, distributing to stakeholders, and using the data to close gaps.

- Maternal and Infant Health
    - June 2020, the MIH TLC held a joint meeting with the Behavioral Health TLC on Caring for Women & Newborns Exposed to Opioids, featuring guest presenters from The Mother & Baby Substance Exposure Initiative.

- Tobacco Cessation (facilitated by the CA Quits Team)
    - April 2020, the PRIME health system participants learned about the importance and components of Tobacco/Smoke-Free workplace policy and Provider/Clinic Staff policy. In addition, the collaborative team

    members presented their health system's tobacco screening/assessment workflows and how COVID-19 impacted their workflow.
  - May 2020's topic was on Overview of Services: California Smokers' Helpline (CSH) by guest presenters from the CSH (Project Manager & Health Systems Outreach Coordinator). During this meeting, participants received an overview of the many services that the CSH provides, such as phone & online chat counseling, text program, mobile apps, and Amazon Alexa. The CSH presenters also share their new vaping cessation services, which was new and interesting to the tobacco collaborative team.
  - June 2020, the California Quits Project Director presented to the group on how to integrate Ask, Advise, Refer (AAR), what we know about smoking/vaping & COVID-19, and also E-cigarette use and E-cigarette Vaping Associated Lung Injury (EVALI). The collaborative team received the tobacco cessation intervention flyer, which goes over AAR and also has script to facilitate a conversation between health professional and patient.

- Behavioral Health
  - May 2020, the TLC featured a discussion around a previous webinar on battling the opioid crisis during COVID-19. An open discussion session followed to go over potential future topics and for hospitals to have an opportunity to share innovative practices for operational recovery and budget recovery.
  - June 2020, the TLC featured a joint meeting with the Maternal and Infant Health TLC to discuss cross-cutting issues related to substance use and pregnancy, featuring Dr. Helen DuPlessis, Health Management Associates, and Christina Oldini, Clinical Lead at the Mother and Baby Substance Exposure Initiative.

Qualitative Findings:

In accordance with DHCS' monitoring responsibilities, DY 14 Final YE Reports were due to DHCS from all participating PRIME entities on September 30, 2019. DHCS conducted its administrative reviews of all reports, and approved them for payment, appropriate to the demonstrated achievement values.

In DY15-Q3, a record-high number of entities requested a reporting extension because of COVID-19. For DY15 Mid-Year reporting, 12 DPHs and 11 DMPHs were approved for reporting extensions while 28 entities submitted their reports by the original reporting deadline, March 31, 2020. The deadline for those requesting extensions was May 30, 2020 and all 23 entities met their extended deadline.

Quantitative Findings:

Figure 33

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$96,999,522.24	$96,999,522.07	DY 12/13/14	$193,999,044.31
(Qtr. 2 Oct – Dec)	$296,463,620.76	$296,488,620.62	DY 13/14	$592,952,241.38
(Qtr. 3 Jan – Mar)	$50,838,172.66	$43,295,268.99	DY 14	$94,133,441.65
(Qtr. 4 Apr – Jun)	$193,249,750.43	$153,428,653.12	DY 14/15	$346,678,403.55
Total	$637,551,066.09	$590,212,064.80		$1,227,763,130.89

In DY15 Q1-Q4, 17 DPHs and 35 DMPHs received payments. In DY15 Q4, 9 DPHs and 26 DMPHs received their DY15 Semi-Annual payments, one DPH received a DY14 Annual payment, and one DPMH received a DY14 Annual Adjustment payment. During this quarter, DPHs and DMPHs received $193,249,750.43 in federal financial participation (FFP) for PRIME-eligible achievements instead of $173,339,201.80. The difference of **$19,910,548.63**, which is 6.2 percent in FFP above the normal rate of FFP, is due to the transactions qualifying for increased FMAP of 56.2 percent under the Families First Coronavirus Response Act.

Policy/Administrative Issues and Challenges:

The COVID-19 pandemic was the most difficult and complicated challenge of DY 15 and all years of PRIME. The COVID-19 pandemic greatly disrupted public hospital quality improvement and care delivery in the last two quarters of DY 15. Elective procedures, preventive care, and other primary care were all delayed in response to the pandemic. Hospitals anecdotally reported decreases in metric achievement based on preliminary data.

On April 3, 2020, DHCS submitted to the Centers for Medicare & Medicaid Services (CMS) a request for a waiver under Section 1115 of the Social Security Act seeking additional flexibilities to address the health care needs of California during the public health emergency. On July 27, 2020, CMS approved the proposal to modify the methodology for the distribution of incentive payments under the PRIME program to participating PRIME entities for DY 15 YE payments and DY 15 supplemental payments. The modifications are authorized by CMS' approval of revisions to the Medi-Cal 2020 Special Terms & Conditions (STCs), Attachment II – Program Funding and Mechanics Protocol. DHCS issued a PRIME policy letter notifying PRIME entities of these changes.

Progress on the Evaluation and Findings:

PRIME Evaluation – Interim Report Findings

As noted in the Accomplishments section, DHCS obtained CMS approval on the PRIME Interim Evaluation during DY15-Q3.

UCLA used a combination of qualitative and quantitative data sources in their interim evaluation analysis: surveys and key-informant interviews (qualitative data), PRIME hospital self-reported data (deemed by evaluator as qualitative), Medi Cal enrollment and encounter data from the DHCS MIS/DSS (quantitative), and patient discharge data from California's Office of Statewide Healthcare Planning and Development (quantitative).

The overview on metric achievements thus far (DYs 11 through 13) demonstrates hospitals' metric payment attainment declined by project domain. Domain 1 had the highest rate of metric payments attained and Domain 3, the least. This pattern was observed for both DPHs and DMPHs. The evaluator observed that this could be attributable to the high number of process-oriented metrics in Domain 1, whereas hospitals have less control over outcomes-based metrics more prevalent in Domain 2, and provider practice pattern metrics in Domain 3.

A Difference in Difference (DinD) analysis examined the achievements of PRIME hospitals in comparison to non-PRIME hospitals using administrative data provided by the state. PRIME hospitals achieved greater progress in the process measures in Domains 1 and 2 indicating greater improvements in the delivery of preventive and prenatal services for patients of DPHs and DMPHs than their respective comparison groups. Over this time period, the DinD analysis did not show improvement in outcome measures when examining achievements in PRIME hospitals versus comparison hospitals.

Limitations of the Interim Evaluation

The report is an interim PRIME evaluation, which limits quantitative data conclusions and conclusive lessons learned. As indicated within the report, PRIME will be more comprehensively assessed for success in the Final Evaluation.

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

Care enrollees were included in UCLA’s analysis if they met PEP 1 criteria, but not included if they only met PEP 2 criteria.

PRIME Evaluation – Preliminary Summative Evaluation

The preliminary draft is currently under review by DHCS and will be submitted to CMS by the December 27, 2020 deadline.

PRIME Evaluation – Draft Summative Evaluation

DHCS and UCLA are carefully reviewing the CMS feedback received on the Interim Evaluation to ensure the Draft Summative Evaluation addresses CMS concerns. The Draft Summative Evaluation is due to CMS on August 31, 2021

SENIORS AND PERSONS WITH DISABILITIES (SPDs)

The "mandatory SPD population" consists of Medi-Cal only members with certain aid codes who reside in all counties operating under the Two-Plan and Geographic Managed Care (GMC) models of managed care. The "existing SPD population" consists of members with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Duals 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 members 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 members 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.

Figure 34: DY 15 Total Member Months for Mandatory SPDs by County

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Alameda	82,544	81,834	80,596	80,096	325,070
Contra Costa	50,953	50,545	50,295	50,289	202,082
Fresno	72,119	71,875	71,301	70,570	285,865
Kern	58,924	59,033	58,701	58,122	234,780
Kings	8,134	8,171	8,153	8,133	32,591
Los Angeles	538,801	537,078	534,233	531,855	2,141,967
Madera	7,051	7,074	7,058	7,008	28,191
Riverside	107,702	107,716	107,394	106,959	429,771
San Bernardino	106,033	105,615	105,001	104,259	420,908
San Francisco	117,144	117,091	116,129	115,760	466,124
San Joaquin	117,485	117,118	116,563	116,486	467,652
Santa Clara	40,774	40,287	39,779	39,391	160,231
Stanislaus	48,770	48,240	47,773	47,759	192,542
Tulare	64,218	64,051	63,861	64,425	256,555
Sacramento	34,750	34,597	34,277	33,805	137,429
San Diego	32,056	32,213	32,204	32,133	128,606
Total	1,487,458	1,482,538	1,473,318	1,467,050	5,910,364

Figure 35: DY 15 Total Member Months for Existing SPDs by County

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Alameda	69,954	71,783	72,632	72,788	287,157
Contra Costa	33,056	33,682	34,022	34,449	135,209
Fresno	43,263	43,743	44,000	44,200	175,206
Kern	31,180	32,142	32,486	32,760	128,568
Kings	4,510	4,585	4,610	4,700	18,405
Los Angeles	1,021,821	1,023,823	1,021,809	1,022,368	4,089,821
Madera	4,610	4,663	4,623	4,659	18,555
Marin	19,372	19,332	19,201	19,377	77,282
Mendocino	17,866	17,773	17,442	17,242	70,323
Merced	49,584	49,820	49,722	49,556	198,682
Monterey	49,045	48,700	48,559	48,489	194,793
Napa	15,049	15,156	15,194	15,305	60,704
Orange	339,815	340,415	340,310	340,062	1,360,602
Riverside	118,165	118,248	117,598	117,694	471,705
Sacramento	69,994	71,497	72,735	73,216	287,442
San Bernardino	114,900	114,800	113,989	113,530	457,219
San Diego	193,981	193,594	192,744	193,145	773,464
San Francisco	47,509	48,449	49,028	49,292	194,278
San Joaquin	30,093	30,566	30,569	30,898	122,126
San Luis Obispo	25,081	25,341	25,196	25,122	100,740
San Mateo	41,480	41,243	41,380	41,133	165,236
Santa Barbara	47,186	47,390	47,229	47,278	189,083
Santa Clara	124,882	125,034	124,037	122,907	496,860
Santa Cruz	32,064	32,145	32,070	32,095	128,374
Solano	61,213	61,446	61,179	60,876	244,714
Sonoma	53,010	52,693	52,112	51,719	209,534
Stanislaus	18,138	18,617	18,877	19,064	74,696
Tulare	20,217	20,571	20,887	21,149	82,824
Ventura	88,626	88,980	88,983	89,163	355,752
Yolo	26,069	26,082	25,966	25,997	104,114
Total	**2,811,733**	**2,822,313**	**2,819,189**	**2,820,233**	**11,273,468**

Figure 36: DY 15 Total Member Months for SPDs in Rural Non-COHS Counties

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Alpine	49	47	44	39	179
Amador	1,093	1,078	1,069	1,089	4,329
Butte	17,674	17,422	17,191	16,826	69,113
Calaveras	1,682	1,657	1,661	1,622	6,622
Colusa	826	815	816	808	3,265
El Dorado	5,218	5,159	5,104	5,096	20,577
Glenn	1,703	1,675	1,621	1,619	6,618
Imperial	11,074	11,132	11,057	10,874	44,137
Inyo	478	474	468	466	1,886
Mariposa	718	732	744	722	2,916
Mono	175	168	167	161	671
Nevada	3,173	3,205	3,151	3,117	12,646
Placer	10,172	10,200	10,219	10,294	40,885
Plumas	1,084	1,039	996	990	4,109
San Benito	366	345	348	359	1,418
Sierra	115	115	112	107	449
Sutter	6,055	6,083	6,017	6,015	24,170
Tehama	5,255	5,256	5,244	5,210	20,965
Tuolumne	2,560	2,541	2,518	2,500	10,119
Yuba	6,234	6,262	6,266	6,290	25,052
Total	**75,704**	**75,405**	**74,813**	**74,204**	**300,126**

Figure 37: DY 15 Total Member Months for SPDs in Rural COHS Counties

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Del Norte	8,140	8,156	8,067	7,999	32,362
Humboldt	26,463	26,478	26,461	26,207	105,609
Lake	19,828	19,766	19,510	19,426	78,530
Lassen	4,455	4,505	4,374	4,328	17,662
Modoc	2,137	2,140	2,152	2,185	8,614
Shasta	40,624	40,516	40,143	40,027	161,310
Siskiyou	11,203	11,234	11,241	11,214	44,892
Trinity	2,713	2,693	2,678	2,744	10,828
Total	**115,563**	**115,488**	**114,626**	**114,130**	**459,807**

WHOLE PERSON CARE (WPC)

The Whole Person Care (WPC) pilot is a five-year program authorized under the Medi-Cal 2020 Waiver. 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 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 expand access to supportive housing options for these high-risk populations.

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

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

Eighteen LEs began implementing 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 fifteen WPC pilot applications the second round.

The WPC evaluation report, required pursuant to the STCs 127 of the Medi-Cal 2020 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 avoidable utilization.

The midpoint report, which was submitted to CMS in December 2019, included an assessment of the population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, though only preliminary outcome data was 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 for specific target populations. The

final report will also include assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

Accomplishments:

Figure 38: Pilot Accomplishments

Date	Pilot Accomplishments
STC 117 & 130 WPC Payments	
June 2020	All twenty-five LEs received WPC payments totaling $562,045,678.82 in DY 15.
	DY 12-15 total-to-date payments of $961,354,378.35 represent payments made through June 30, 2020 and 65% of the $3 billion allocated for WPC over the 5 years of the program until December 31, 2020. Due to the COVID-19 PHE, LEs were allowed a one-month extension to submit their invoices; therefore, the majority of the originally planned payments for June 2020 were made in July 2020. The July 2020 payments of approximately $193 million will be counted in the DY 16 report. There are two scheduled payments remaining, 2020 Program Year (PY) 5 mid-year and 2020 PY 5 annual. Payments are anticipated to be released October 21, 2020, for mid-year PY 5 activities.
STC 118 Housing and Supportive Services	
June 2020	Twenty-five LEs are providing a range of housing services including individual housing and tenancy sustaining services and individual housing transition services. These housing services include tenant screening, housing assessments and individualized housing support plans, work with property owners, identification of community resources, and training tenants to maintain housing once it is established. As of June 30, 2019, LEs reported 51% (69,910) of WPC members were homeless.
STC 119 Lead and Participating Entities	
June 2019	Participating entities have increased from 350 to more than 478 for the 25 LEs since program implementation began in 2017.
STC 123 Learning Collaborative	
July 2019-June 2020	The Learning Collaborative (LC) supports the WPC LEs with the following goals: • Enhance the permanent capacity of providers to effectively care for high-risk, high-utilizing populations targeted by the WPC LEs; • Inform state oversight and policy making relevant to the WPC pilot, their target populations, and related delivery system reforms; and • Grow and sustain a peer network among LEs to encourage the continued spread of best practices. The LC structure includes a variety of learning activities, such as webinars, in-person convenings, and access to a resource portal as a means to address the topics and questions from LEs.

	The LC has consistently hosted monthly Advisory Board meetings, unless there were no agenda items for a specific month. The focus of these meetings was on the implementation of California Advancing and Innovating Medi-Cal (CalAIM) and, starting in February 2020, the meetings shifted focus to the LE's response to the COVID-19 PHE.
September 2019	DHCS, in collaboration with the LC, held an in-person convening for all WPC pilots on September 10, 2019. More than 160 people attended, including representatives from all 25 pilots. The agenda focused on WPC sustainability and discussion on different strategies on how LEs can sustain WPC services post 2020. The convening included time for LEs to network and meet with DHCS for one-on-one discussions on operational issues and program activities.
STC 125 Progress Reports	
September 2019	Twenty-five LEs submitted the PY 4 mid-year report for 2019.
May 2020	Twenty-five LEs submitted the PY 4 annual report for 2019.
STC 126 Universal and Variant Metrics	
September 2019	Twenty-five LEs submitted their baseline PY 4 mid-year variant and universal metric reports.
May 2020	Twenty-five LEs submitted their PY 4 annual variant and universal metric reports.
STC 127 Mid-Point and Final Evaluations	
September 2019	UCLA submitted the draft WPC interim evaluation to DHCS on September 30, 2019. The WPC interim evaluation report was submitted to CMS on December 18, 2019.

Program Highlights

On September 10, 2019, DHCS, in collaboration with the LC, held an in-person convening for all WPC pilots. More than 160 people attended, including representatives from all 25 pilots. The agenda focused on WPC lessons sustainability and discussion on different strategies for how LEs can sustain WPC services post 2020. The convening included time for LEs to network and meet with DHCS for one-on-one discussions on operational issues and program activities.

On November 21, 2019, the LC hosted a webinar on CalAIM. The LC collected questions ahead of time to ensure the presentation was responsive to LE's questions and allowed participants to ask questions in real time. Ninety-eight participants called into the webinar and every pilot was represented. The webinar's focus was on providing an overview of CalAIM and its impact on WPC.

During DY 15, DHCS held a total of nine technical assistance (TA) teleconferences with LEs. The teleconferences focused on administrative topics and technical assistance, allowing the LEs to ask questions about DHCS' guidance and various operational

issues such as deliverable reporting, timelines, budget adjustments, sustainability, transition of CalAIM, COVID-19 impacts and flexibilities, and overall DHCS expectations.

During DY 15 Quarter 4, all LEs submitted the following reports:

- PY 4 Quarter 4 (Q4) quarterly enrollment and utilization (QEU) report;
- Revised PY 4 Quarters 1 (Q1), 2 (Q2), 3 (Q3) and Q4 QEU report (optional);
- PY 4 Annual Narrative, Invoice, and Plan Do Study Act;
- PY 4 Annual Variant and Universal Metrics report;
- PY 4 first quarter Enrollment & Utilization; and
- PY 5 Midyear Budget Adjustment.

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, metrics 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.

The COVID-19 PHE affected the LE's report submission timelines to DHCS. To allow flexibility for the LE's reporting timelines, DHCS allowed a one-month extension for LEs to submit their PY 4 annual reports. The extended due date resulted in a delay in DHCS' annual report processing, and thus a delay in data submission to WPC evaluators. A majority of WPC payments were made after the end of the 2019-2020 fiscal year.

By way of background, after two rounds of applications, the WPC program consists of 25 LEs with 18 legacy LEs that implemented on January 1, 2017 and 7 LEs (counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma, the City of Sacramento, and the Small County WPC Collaborative (SCWPCC), which includes San Benito and Mariposa Counties) that implemented on July 1, 2017. Eight of the legacy LEs (Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura) continued their original programs and were approved to expand their programs with additional or expanded target populations, services, and administrative/delivery infrastructure to support the expansions in the second round. By June 30, 2020, WPC touched more than 190,689 unique lives with more than 2,188,337 member months.

Qualitative and Quantitative Findings

DHCS uses the mid-year and annual narrative reports, quarterly enrollment and utilization reports, and invoices to monitor and evaluate the programs and to verify invoices for payment.

In DY 14, seven LEs that required more time to enroll members and fully develop their programs have met in-person with DHCS' management and developed CAP as needed to increase enrollment, maximize expenditures, and/or increase the provision of services. Program implementation for several LEs, Sonoma in particular, was impacted by the devastating effects of multiple fires. DHCS has closed six of the seven CAPs by May 31, 2019 except for Kern County, which closed in DY 15 (September 2019). DHCS continues to monitor LEs closely and provide technical assistance.

Enrollment Information

The data reported below in Figure 39 reflects the most current unique new beneficiary enrollment counts available including updated data files submitted by LEs after the publishing date of the prior quarterly report. Enrollment data is updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly enrollment counts reflect the cumulative number of unique new beneficiaries enrolled during Q1 to Q4 of DY 15. The total-to-date column reflects the cumulative number of unique new beneficiaries enrolled from the beginning of the program, DY 12 (January 2017), to the end of the reporting period for DY 15 – Q4 (April – June 2020). The DY 15 Q1 – Q4 data is point-in-time as of September 15, 2020.

Figure 39: Quarterly Enrollment Counts

Lead Entity	DY 15 Q1 (July – Sept. 2019)	DY 15 Q2 (Oct. – Dec. 2019)	DY 15 Q3 (Jan. – Mar. 2020)	DY 15 Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total to Date
Alameda	559	449	3,041	5,330	19,703
Contra Costa	3,059	2,446	3,193	2,455	47,250
Kern	250	187	167	162	1,857
Kings*	71	82	84	46	692
LA	5,251	4,088	5,113	2,551	58,672
Marin*	183	137	176	39	1,783
Mendocino*	18	78	3	4	391
Monterey	53	79	129	34	601
Napa	79	45	24	40	568
Orange	935	619	504	198	11,708
Placer	76	24	24	20	464
Riverside	728	580	666	235	6,940
Sacramento*	209	170	175	117	2,023

Lead Entity	DY 15 Q1 (July – Sept. 2019)	DY 15 Q2 (Oct. – Dec. 2019)	DY 15 Q3 (Jan. – Mar. 2020)	DY 15 Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total to Date
San Bernardino	89	74	68	122	1,236
San Diego	124	101	122	103	839
San Francisco	1,397	956	959	455	19,232
San Joaquin	178	188	303	139	2,006
San Mateo	110	69	72	53	3,675
Santa Clara	816	457	427	339	5,886
Santa Cruz*	14	47	24	23	556
SCWPCC*	22	9	3	8	138
Shasta	35	32	33	32	429
Solano	11	21	22	12	240
Sonoma*	328	341	280	193	2,521
Ventura	43	33	46	31	1,279
Total	**14,638**	**11,312**	**15,658**	**12,741**	**190,689**

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

The data provided in the figure above shows the count of unduplicated members has steadily increased since implementation began in 2017. The program began with 11,286 unduplicated members by March of 2017 and has increased by more than tenfold with 190,689 unduplicated members as of June 30, 2020. Additionally, the data reflects continued outreach and engagement to increase enrollment as disenrollment occurs on a monthly basis.

Member Months

The data reported below in Figure 40 reflects the most current member month counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months are updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly member month counts reflect the number of member months from Q1 to Q4 of DY 15. The cumulative total-to-date column reflects the cumulative number of member months from the beginning of the program, DY 12 (January 2017), to the end of the reporting period for DY 15 – Q4 (April – June 2020). Member months are extracted from the LE's self-reported QEU reports. The DY 15 – Q4 data is point-in-time as of September 15, 2020.

Figure 40: Member Months Counts

Lead Entity	DY 15 Q1 (July – Sept. 2019)	DY 15 Q2 (Oct. – Dec. 2019)	DY 15 Q3 (Jan – Mar. 2020)	DY 15 Q1 (Apr. – June 2020)	Jan. 2017 – June 2020 Cumulative Total to Date
Alameda	27,219	27,704	32,712	47,442	242,309
Contra Costa	40,669	39,919	39,807	38,460	517,287
Kern	3,650	4,276	4,140	5,116	25,019
Kings*	583	581	538	575	4,240
LA	51,131	50,587	55,202	55,731	488,405
Marin*	3,958	4,315	4,778	4,989	26,167
Mendocino*	317	507	553	422	4,699
Monterey	668	678	650	636	4,699
Napa	730	776	779	781	6,388
Orange	14,202	13,494	9,673	7,080	125,369
Placer	427	440	402	413	4,607
Riverside	13,819	15,751	17,690	18,482	94,170
Sacramento *	2,543	2,657	2,833	2,803	20,737
San Bernardino	1,506	1,571	1,553	1,485	16,365
San Diego	1,055	1,168	1,265	1,385	7,662
San Francisco	28,491	29,539	30,615	30,290	327,693
San Joaquin	2,908	3,173	3,822	4,007	23,477
San Mateo	6,672	6,361	6,256	6,141	88,514
Santa Clara	10,697	11,366	10,965	10,294	102,350
Santa Cruz*	1,111	1,219	1,304	1,337	11,970
SCWPCC**	199	199	171	141	1,342
Shasta	227	229	254	237	2,615
Solano	253	181	220	175	2,912
Sonoma*	2,122	3,106	3,908	4,248	17,529
Ventura	1,753	1,712	1,702	1,671	21,812
Total	**216,910**	**221,509**	**231,792**	**244,341**	**2,188,337**

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

The data provided in the figure above shows the count of member months has dramatically increased since implementation began in 2017 as the unduplicated members and enrollment increased. The program began with 28,974 member months by March of 2017, and has increased to 2,188,337 member months as of June 30, 2020. It is important to note that the number of member months plays a significant role in the utilization of services.

Payments

As shown below in Figure 41, DHCS released WPC payments for DY 15 to all 25 LEs, in accordance with the WPC payment schedule. WPC received $281,022,839.41 in Federal Financial Participation (FFP) and $281,022,839.41 in Intergovernmental Transfers (IGT), for a total of $562,045,678.82 in payments to the LEs.

DY 15 Q4, only seven LEs received WPC payments totaling $323,903,550.00 and the remaining 18 LEs received WPC payments of approximately $193 million in the first month of DY 16. Although the payment schedule indicated that PY 4 annual invoices were due on April 1, 2020, with payments scheduled for May 2020, due to the COVID-19 PHE, DHCS extended the due date for PY 4 annual invoice submittals to May 1, 2020. After DHCS reviewed and approved the PY 4 annual invoices, payments were made in June 2020 and July 2020.

Figure 41: WPC Payments for DY 12 to DY 14 for all 25 LEs

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 3 (Jan. 1 – Mar 31)	$216,787,499.88	$216,787,499.88	DY 12 (PY 1)	$433,574,999.75
Qtr 4 (Apr. 1 – June 30)	$22,206.521.50	$22,206.521.50	DY 12 (PY 1)	$44,413,043.00
DY 13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr 1 (Jul. 1 – Sept. 30)	$9,730,650.50	$9,730,650.50	DY 13 (PY 1)	$19,461,301.00
Qtr 2 (Oct. 1 – Dec. 31)	$63,309,652.68	$63,309,652.68	DY 13 (PY 2)	$126,619,305.36
Qtr 3 (Jan. 1 – Mar 31)			DY 13 (PY 2)	
Qtr 4 (Apr. 1 – June 30)	$116,574,244.78	$116,574,244.78	DY 13 (PY 2)	$233,148,489.56

DY 14 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 1 (Jul. 1 – Sept. 30)	$0	$0	DY 14 (PY 3)	$0
Qtr 2 (Oct. 1 – Dec. 31)	$101,981,216.28	$101,981,216.28	DY 14 (PY 3)	$203,962,432.56
Qtr 3 (Jan. 1 – Mar. 31)	$0	$0	DY 14 (PY 3)	$0
Qtr 4 (Apr. 1 – June 30)	$169,064,564.15	$169,064,564.15	DY 14 (PY 3)	$338,129,128.30
Total	**$699,654,349.77**	**$699,654,349.77**		**$1,399,308,699.53**

Figure 42: WPC Payments for DY 15 for all 25 LEs

DY 15 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 1 (Jul. 1 – Sept. 30)	$0	$0	DY 15 (PY4*)	$0
Qtr 2 (Oct. 1 – Dec. 31)	$119,071,064.41	$119,071,064.41	DY 15 (PY4*)	$238,142,128.82
Qtr 3 (Jan. 1 – Mar. 31)	$0	$0	DY 15 (PY4*)	$0
Qtr 4 (Apr. 1 – June 30)	$161,951,775.00	$161,951,775.00	DY 15 (PY4*)	$323,903,550.00
Total**	$281,022,839.41	$281,022,839.41		$562,045,678.82

**PY 4 is from January 2019 to December 2019.*

*** Due to the COVID19 PHE, LEs were allowed a one month extension to submit their invoice; therefore, the majority of the originally planned payments in June 2020 were made in July 2020. The July 2020 payments of approximately $193 million will be counted in the DY 16 report.*

Operational/Policy Developments/Issues:

During the Q3 and Q4 of DY 15, DHCS completed approval of both the optional budget adjustment and rollover requests from LEs. The budget adjustment process allowed adjustments to future PY budgets within each LE budget, while the rollover process allowed an LE to move unspent budgeted funds from PY 4 to PY5. The budget adjustment and rollover enable the LE to overcome operational challenges and barriers.

Furthermore, these processes allow LEs the flexibility to more fully maximize funding integral to the success of the WPC and support the activities aligned with WPC goals and objectives, including the expansion of services and enrollment, sustainability efforts in preparation for the CalAIM, and COVID-19 PHE response.

DHCS, along with the WPC LC, communicated with the LEs through phone calls and emails to understand the issues that are of most interest and concern to guide DHCS' TA and LC content. The LC structure includes a variety of learning activities, such as in-person convening, webinars, teleconferences, and access to a resource portal as a means to address the topics and questions from LEs.

During this reporting period, DHCS held a total of nine TA teleconferences with LEs. The teleconferences focused on administrative topics and technical assistance, allowing the LEs to ask questions about DHCS' guidance and various operational issues such as deliverable reporting, timelines, budget adjustments, sustainability, transition of CalAIM, COVID-19 PHE impacts and flexibilities, and overall DHCS expectations. TA teleconferences in Q4 focused on the PY 4 annual reports and invoice submission, impacts due to the COVID-19 PHE, the postponed implementation timeline of CalAIM, and updates on DHCS' request of an additional PY for the WPC pilot program. During Q4, DHCS provided budget guidance to LEs, since many pilots have expressed major impacts on staffing shortage, limited in-person service capabilities, and meeting health outcome metrics due to the COVID-19 PHE.

During this reporting period, the LC Advisory Board held a total of seven meetings. The first half of the RY, the focus was on WPC services suitability and how the LC can support the LEs as they transition to the enhanced care management (ECM) benefit and In-Lieu-of Services (ILOS) under the CalAIM initiative, as the pilot program will be ending at the end of 2020. However, toward the end of Q3 and into Q4 of DY 15, the LC Advisory Board focused on how the LC can support the LEs through the COVID-19 PHE. In Q4 DY15, attendance was limited as Advisory Board members prioritized their county's COVID-19 PHE responses. The Advisory Board members that were able to attend the meeting requested support to better help them understand available housing resources and telehealth flexibilities.

The LC did not host an in-person meeting or any webinars in Q4 DY 15. All in-person meetings are on-hold due to restrictions on large gatherings caused by the COVID-19 PHE.

The LC has drafted a “Promising Practices” summary paper that crosswalks the ECM benefits and ILOS proposed under CalAIM. The LC has submitted the summary paper to DHCS for review, and once DHCS provides an approval, the LC plans to post it on the WPC portal.

COVID-19 Public Health Emergency:

WPC target populations are at the highest risk if exposed to COVID-19. WPC target populations include, but are not limited to, individuals who have underlying health conditions and are currently homeless or at risk of becoming homeless; therefore, they are more susceptible and unable to isolate themselves from exposure. WPC services are vital to ensure clients are able to receive care coordination and housing support, during this PHE.

DHCS continued to support LEs and their response to the COVID-19 PHE. DHCS provided guidance to LEs to ensure the safety of their clients as well as, to continue to provide WPC services as safely as possible. DHCS has allowed LEs to adjust their PY 5 budget to add needed infrastructure such as hygiene pods, personal protective supplies, and telehealth equipment, and refocus on previously approved activities that support COVID-19 identified needs, to ensure the health and safety of both clients and staff.

Progress on the Evaluation and Findings:

During DY 15, DHCS' independent evaluator, UCLA:

- Submitted the draft WPC interim evaluation to DHCS in September 2019.
- Completed qualitative data analysis software coding to include challenges, successes, and lessons learned related to (1) identifying, engaging, and enrolling clients, (2) care coordination, (3) data sharing, (4) outcomes and sustainability, and (5) biggest barriers to implementation as discussed by LEs in PY 4 mid-year narrative reports. Preliminary analysis was completed.
- Tested modifications to the difference-in-difference model used in the interim evaluation report to improve analysis for the final report. The difference-in-difference model examines the change in trends from pre-WPC to post-WPC and between the treatment group and control group. As compared to the previous analysis, which examined change in the average metric rate in the pre-WPC and post-WPC periods, this analysis will improve the ability to assess whether WPC changed the trajectory of key outcome metrics.
- Developed refined service categories to better understand services provided to WPC beneficiaries. These new categories were incorporated into the secondary LE survey, along with the recent list of per-member-per-month and FFS categories from the QEU reports, in order to get more up-to-date data for the WPC final evaluation report.
- Continued to refine the "report card" template, which will compare WPC pilots based on outcome metrics by target populations, alongside key descriptive elements and metrics, including beneficiary demographics, care coordination elements, implementation measures, and service availability. Key elements of the report card will come from the updated infrastructure, implementation, and

service details in the LE survey, as well as enrollment and population descriptive elements. The new model will rank and target population outcome metrics.

- Continued the development of a shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final report.
- Conducted a COVID-19 rapid-response survey in April 2020 with LEs to measure: (1) how WPC infrastructure and integrated care delivery approach may have helped with local response to COVID-19; and (2) the impact of the COVID-19 PHE on WPC enrollment, staffing, policies/procedures, and services.
- Initiated conversations with DHCS around anticipated COVID-19 PHE impact on Medi-Cal claims data and subsequent UCLA analysis.
- Published an article in Health Affairs in April 2020, which explored challenges, successes, and best practices of WPC implementation. As a follow-up to this article, UCLA published a blog post on the Health Affairs website exploring how WPC infrastructure and processes facilitated WPC counties in their response to COVID-19.

Administered the final LE survey in June 2020. Key content areas include data sharing infrastructure, perceived pilot impact on better health, better care, and cost savings, and plans for sustainability of critical WPC components. UCLA also administered a survey to partners and frontline workers directly involved in WPC care coordination efforts.