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

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Section 1115 Waiver
Demonstration Year (DY) 17
Annual and Final Report

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INTRODUCTION:

Overview

The California Department of Health Care Services (DHCS) submits this combined Annual Demonstration Report for Demonstration Year (DY) 17 and Final Report to the Centers for Medicare & Medicaid Services (CMS), in accordance with Items 28 and 29 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). The combined report format was agreed upon by CMS and DHCS during technical assistance correspondence on Medi-Cal 2020 reporting conducted during late 2021 and early 2022. California's Annual Demonstration Report for DY 16 covered the period from July 1, 2020 to June 30, 2021, which includes a portion of DY 17. Therefore, this joint report covers new data from the remainder of DY17 that was not previously reported on (i.e., July 1, 2021 to December 31, 2021) as well as reflects on the State's experiences over the course of DY 17 (or calendar year 2021) more generally as the State prepared to transition certain elements of Medi-Cal 2020 to either the Medi-Cal State Plan or the amended and renewed California Advancing and Innovating Medi-Cal (CalAIM) Section 1915(b) waiver. This combined report addresses the following areas:

- General program and reporting requirements;
- Demonstration program updates, including:
    - Successes and accomplishments,
    - Program highlights,
    - Qualitative findings,
    - Policy/administration issues and challenges,
    - Progress on evaluation and findings, and
    - Opportunities for improvement and approach for transitioning activities concluding under the 1115 demonstration; and
- Budget neutrality and financial reporting.

The Medi-Cal 2020 Section 1115 demonstration was originally approved on December 30, 2015 for a five-year period and implemented January 1, 2016 through December 31, 2021, including a 12-month extension CMS approved on December 29, 2020.

While a number of longstanding Medi-Cal 2020 features transitioned to the CalAIM Section 1115 demonstration, during DY17 (January 1, 2021 – December 31, 2021), DHCS prepared to transition a number of Medi-Cal 2020 demonstration initiatives to the Medi-Cal State Plan and/or CalAIM Section 1915(b) waiver. Other elements of the Medi-Cal 2020 demonstration sunset at the end of DY 17.

The shift from Medi-Cal 2020 to CalAIM enables the State to move to a statewide population health approach that prioritizes prevention and addresses social drivers of health across the Medi-Cal population. The CalAIM framework authorized across the

Section 1115 demonstration and other authorities builds on lessons learned from the Medi-Cal 2020 Section 1115 demonstration, including the primary goals to:

- Identify and manage comprehensive needs through whole person care approaches and social drivers of health;
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform; and
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

To achieve these goals, DHCS conducted a robust public comment period and stakeholder engagement prior to submitting Section 1115 and Section 1915(b) applications to CMS on June 30, 2021 to continue components of the Medi-Cal 2020 Section 1115 demonstration and request new features. CMS approved the CalAIM Section 1115 demonstration and Section 1915(b) waiver on December 29, 2021. Over the course of 2021, DHCS also worked with CMS to conduct public notice and secure Medi-Cal State Plan approval to continue components of the Medi-Cal 2020 demonstration, as described below.

Throughout DY 17, DHCS worked to ensure a smooth transition of Medi-Cal 2020 initiatives to CalAIM. For example, DHCS leveraged the Medi-Cal 2020 Section 1115 demonstration's Whole Person Care (WPC) pilots and Health Homes Program (HHP) to launch the statewide Enhanced Care Management (ECM) and Community Supports programs under CalAIM. As part of the transition from WPC/HHP to ECM and Community Supports, DHCS worked closely across stakeholders to provide notices to Medi-Cal members impacted by the change and ensure a smooth handoff across programs.

Medi-Cal 2020 Features & Amendments

Through the Medi-Cal 2020 Section 1115 demonstration, the State aimed to transform and improve the quality of care, access, and efficiency of health care services for Medi-Cal enrollees. The Medi-Cal 2020 demonstration built on the successes of the State's prior Bridge to Reform Section 1115 demonstration and represented the State's ongoing commitment to partner with CMS to realize the full potential of the Affordable Care Act (ACA) in pursuit of better care and improved health equity and outcomes. The focus of the Medi-Cal 2020 demonstration was to continue driving the transformation of the Medi-Cal program, ensuring ongoing support for the safety net in California, and safeguarding the long-term viability of the program and Medi-Cal expansion. The demonstration aimed to continue financing innovation in developing sources of the non-federal share of Medi-Cal matching funds as California had done in prior years through partnerships with the federal government and other public entities and partners. In addition, the demonstration complemented other delivery system and payment transformation efforts the State was undertaking, including implementing the ACA Section 2703 Health Home Option, leveraging frontline workers, and advancing Accountable Communities for Health.

The Medi-Cal 2020 demonstration continued Bridge to Reform Section 1115 demonstration initiatives, including the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and Coordinated Care Initiative (CCI). Building off of the successes of the Bridge to Reform demonstration, Medi-Cal 2020 initiatives continued to improve the quality and value of care for Medi-Cal enrollees.

The Medi-Cal 2020 demonstration initiatives included:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program,** which improved the quality and value of care provided by California's safety net hospitals and hospital systems.
- **Global Payment Program (GPP)**, which streamlined funding sources for care for California's remaining uninsured population and created a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services.
- **WPC Pilot Program,** which supported local and regional efforts to integrate systems and improve care provided to Medi-Cal's most high-risk beneficiaries.
- **Dental Transformation Initiative (DTI),** which improved access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.

On December 8, 2016, California received approval of an amendment to the demonstration to expand the definition of a WPC pilot lead entity to include federally recognized tribes and tribal health programs operated under a Public Law 93-638 contract with the Federal Indian Health Services.

On January 6, 2017, the State received CMS approval of an amendment to the demonstration to revise the methodology for determining the baseline metrics for purposes of receiving incentive payments for new and existing dental service office locations under DTI. California also sought authority to provide incentive payments for specified dental services delivered at provider service office locations at two levels: a 37.5% above the State's Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet at least a one percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children served in the previous year with a preventive dental service; and a 75% above the State's SMA incentive payment for service office locations that meet or exceed a two percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the predetermined baseline number of children receiving a preventive dental service in the previous year.

On December 19, 2017, CMS approved the State's request to amend the demonstration to provide coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they "aged out" of foster at age 18 (or a higher age as elected by the state) and were enrolled at Medicaid at the time. California submitted an amendment on November 10, 2016, as a companion to

the HHP State Plan Amendment (SPA) 16-007, to request a waiver of freedom of choice in the non-county organized health systems (COHS) counties in order to provide the HHP services through the Medi-Cal Managed Care (MCMC) delivery system to beneficiaries enrolled in managed care. Managed care plans (MCPs) were responsible for the overall administration of the HHP, which was structured as a HHP network with members functioning as a team to provide care coordination. Fee-For-Service (FFS) members who meet the eligibility criteria for HHP could choose to voluntarily enroll in a MCP to receive HHP services along with other State Plan services provided through MCPs. HHP services were not provided through a FFS delivery system; therefore, beneficiaries in FFS in non-COHS counties had to enroll in a MCP to receive HHP services.

On August 3, 2020, California received CMS approval to permit the GPP to continue from July 1, 2020 to December 31, 2020 and to permit eligible Medi-Cal beneficiaries in Orange County to elect to disenroll from CalOptima (a COHS including CalOptima PACE), to be enrolled in a Program of All-Inclusive Care for the Elderly (PACE) organization not affiliated with CalOptima.

On December 29, 2020, CMS approved the State's September 16, 2020 request for a one-year temporary extension of the State's Section 1115 demonstration, in order to allow the State and CMS to continue working together on approval of a longer-term renewal of this demonstration by December 31, 2021. This temporary extension continued most elements of the Medi-Cal 2020 Section 1115 demonstration unchanged pending a full renewal and included an additional authorization for the GPP program, WPC Pilots, and DTI. The extension included the removal of the authority for the State's Designated State Health Programs (DSHP) and the conclusion of PRIME, with eligible public hospitals able to qualify to receive managed care directed payments through the Quality Incentive Program (QIP) as of July 1, 2020.

CalAIM Amendment & Renewal

On June 30, 2021, California submitted a renewal request for the CalAIM Section 1115 demonstration. This Section 1115 demonstration requested a five-year renewal of components of the Medi-Cal 2020 Section 1115 demonstration to continue improving health outcomes and reducing health disparities for individuals enrolled in Medi-Cal and other low-income populations in the State. In tandem, DHCS requested authority through a renewal of the State's longstanding Specialty Mental Health Services (SMHS) Section 1915(b) waiver to implement delivery system reforms and transition learning from the Medi-Cal 2020 Section 1115 demonstration to a statewide delivery system, as described below.

The overview below outlines 1) Medi-Cal 2020 Section 1115 demonstration initiatives renewed in the CalAIM Section 1115 demonstration; 2) new CalAIM Section 1115 demonstrations initiatives; and 3) Medi-Cal 2020 Section 1115 demonstration initiatives continued via the Medi-Cal State Plan or Section 1915(b) waiver.

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Renewed in the CalAIM Section 1115 Demonstration:**
    - **GPP** to renew California's statewide pool of funding for care provided to California's remaining uninsured populations, including streamlining funding sources for California's remaining uninsured population with a focus on addressing social needs and responding to the impacts of systemic racism and inequities.
    - **Substance Use Disorder (SUD) Institutions for Mental Disease (IMD)** authority to continue short-term residential treatment services to eligible individuals with a SUD in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
    - **Coverage for Out-of-State Former Foster Care Youth** to continue Medi-Cal coverage for this population during the renewal period, up to age 26.
    - **Community Based Adult Services (CBAS)** to continue to authorize CBAS services for eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.
    - **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.
- **CalAIM Initiatives Newly Authorized in the CalAIM Section 1115 Demonstration:**
    - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
    - **Providing Access and Transforming Health (PATH) Supports** expenditure authority to (1) sustain, transition, and expand the successful WPC pilots and HHP services initially authorized under the Medi-Cal 2020 demonstration as they transition to become ECM and Community Supports and (2) sustain justice-involved pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.
    - **Contingency Management** to offer Medi-Cal beneficiaries, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral health treatments.
    - **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, in order to provide this service in DMC-ODS and Drug Medi-Cal counties and county mental health plans (MHPs).
- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**

- **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authority** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
- **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to 109 to 138% of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan.
- **DTI** authority as outlined under the Med-Cal 2020 Section 1115 demonstration transitioned into a new, statewide dental benefits for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

The WPC Pilots and HHP, which were implemented under the Medi-Cal 2020 Section 1115 demonstration, concluded on December 31, 2021 following approval of the CalAIM Section 1115 demonstration renewal. Under CalAIM, California launched new ECM and Community Supports services that built on the successes of the WPC Pilots and HHP. ECM is authorized through Medi-Cal managed care authority, and the Community Supports are authorized through a combination of CalAIM Section 1115 demonstration authority and Medi-Cal managed care authority as effectuated through the Section 1915(b) waiver.

DHCS continues to negotiate with CMS on a number of CalAIM Section 1115 demonstration initiatives that were requested as part of the Section 1115 renewal but not yet approved by CMS. These key initiatives include authority to provide select Medi-Cal services to individuals involved in the justice system as well as authority to provide Traditional Healers and Natural Helper services to DMC-ODS beneficiaries.

GENERAL REPORTING REQUIREMENTS

The General Reporting Requirements Section describes how the state fulfilled the general program and reporting requirements detailed in Medi-Cal 2020 demonstration, as required by Item 28 of the Medi-Cal 2020 demonstration Special Terms and Conditions (STCs). This section focuses on reporting data from July 1, 2021 through December 31, 2021 that was not previously reported on as part of prior Annual Demonstration Reports. (Note: The DY 2016 Annual Report covered the period from July 1, 2020 through June 30, 2021.[1]) The section includes detail on the following program and reporting requirements outlined in the Medi-Cal 2020 STCs:

- Post Award Forum (Item 18)
- Budget Neutrality and Title XXI Allotment Neutrality (Item 23)
- Accounting Procedure (Item 24)
- Contractor Reviews (Item 25)
- Monthly CMS Calls (Item 26)
- Demonstration Quarterly Reports (Item 27)
- DSHP Appropriation Details (Item 28a)
- Primary Care Access Measures for Children (Item 28b)
- Revision of the State Quality Strategy (Item 30)
- External Quality Review (Item 31)
- Certified Public Expenditures (Item 33)
- DSHP (Item 34)
- Supplemental Payments to IHS and 638 Facilities (Item 35)
- Managed Care Expansions (Item 37)
- Encounter Data Validation Study for New Health Plans (Item 38)
- Submission of Encounter Data (Item 39)
- Contracts (Item 41)
- Network Adequacy (Item 42)
- Network Requirements (Item 44)
- Certification (Related to Health Plans) (Item 45)
- Concurrent Operation of the MSSP 1915(c) HCBS Program (Item 46)
- 2016 CCS Pilot Update (Item 58)
- Repayment of PMS Negative Account Balance (Item 164)

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

[1] Medi-Cal 2020 demonstration years included two 6-month demonstration "years" – one at the beginning of the approval (DY 11) and one at the end of the originally 5-year demonstration period (DY16). DY16 comprises the period July 1, 2020-December 31, 2020. The temporary extension period, DY17, comprises the period January 1, 2021-December 31, 2021.

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 DY17, DHCS hosted two SAC meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- July 29, 2021
- October 21, 2021

DHCS agenda items for the two SAC meetings included: Approved FY 2022 State Budget and Implications for DHCS; HCBS Spending Plan; Medi-Cal Rx; CalAIM Implementation; CalAIM 1115 and 1915b Waiver Processes; COVID-19 Vaccination Disparities in Medi-Cal; Managed Care Procurement; Children and Youth Behavioral Health Initiative; and Comprehensive Quality Strategy and Equity Roadmap.

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

Item 23 of the STCs – Budget Neutrality and Title XXI Allotment Neutrality

The State has complied with all reporting requirements for monitoring budget neutrality set forth in these STCs for DYs 11-15, and is providing an updated budget neutrality worksheet with this report for DYs 11-15. The State is currently working with CMS to develop a functional BN workbook for DYs 16-17 reporting purposes.

Item 24 of the STCs – Accounting Procedure

The State submitted and CMS approved accounting procedures for the Medi-Cal 2020 to ensure oversight and monitoring of demonstration claiming and expenditures. The approved procedures are included as Attachment H in the STC's.

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. DHCS contracted with the Regents of the University of California on behalf of its Los Angeles campus (UCLA) to

conduct the SPD program evaluation.[2] The Final SPD evaluation report was submitted to CMS on December 31, 2021.

California Children's Services (CCS) Demonstration Pilot

Under the authority of the Section 1115 Medicaid Demonstration Waiver titled, "California Bridge to Reform Demonstration," the State of California piloted two models of care delivery for children enrolled in the CCS program, a provider-based Accountable Care Organization (ACO), Rady Children's Hospital-San Diego, and an existing Medi-Cal Managed Care Plan (MCP), Health Plan of San Mateo. The overarching goal of the CCS pilot project was to test two integrated delivery models for the CCS population that results in achieving desired outcomes related to improved access to care; improved patient and family satisfaction; increased provider satisfaction with the delivery of and the reimbursement of services; high quality care; improved care coordination by reducing inpatient and emergency room care; and reduced total cost of care.

DHCS contracted with the Regents of the University of California on behalf of it San Francisco campus (UCSF) to conduct the CCS Evaluation.[3] The Final CCS evaluation report will be submitted to the Centers for Medicare and Medicaid Services (CMS) on December 31, 2022.

Item 26 of the STCs – Monthly CMS Calls

CMS and DHCS schedule monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. During DY17, many waiver monitoring conference calls were canceled due to lack of agenda items from both CMS and DHCS. However, 1115 waiver items were discussed, as needed, in separately held meetings between CMS and DHCS with key subject matter experts in attendance.

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 DY17, DHCS submitted two quarterly reports to CMS electronically on the following dates:

- Quarter 1 (July 1, 2021 – September 30, 2021): Submitted November 16, 2021
- Quarter 2 (October 1, 2021 – December 31, 2021): Submitted February 24, 2022

[2] DHCS Website, SPD Program Evaluation Design, November 2017, https://www.dhcs.ca.gov/provgovpart/Documents/SPDFinalEvalDesign.pdf

[3] DHCS Website, CCS Demonstration Pilot Evaluation Design, https://www.dhcs.ca.gov/provgovpart/Documents/CCSFinalEvalDesign.pdf

Per CMS' guidance, the fourth quarterly reporting information has been folded into the annual reports beginning in DY15.

Item 28a – DSHP Appropriation Detail

According to the original Medi-Cal 2020 approval, the annual FFP limit the State may claim for DSHP during each demonstration year is $75 million for a five-year total of $375 million. The STCs further limit the federal funding received for DSHP expenditures such that funding may not exceed the non-federal share of amounts expended by the state for the Dental Transformation Initiative (DTI) program. CMS's December 2020 temporary extension of Medi-Cal 2020 did not authorize DSHP expenditures during DY 17.

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

DHCS continues to utilize benchmarks from the NCQA Compass for setting the Minimum-Performance Level (MPL) for MCP performance. As of MY 2020/RY 2021, the MPL is considered 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% of all Medicaid programs nationwide on each Managed Care Accountability Set (MCAS) measure for which DHCS has identified a benchmark exists. The High-Performance Level (HPL) remains at the 90th percentile.

There were several plans that fell below DHCS's MPL, given the NCQA benchmark of 50th percentile. For RY 2020, 16 MCPs performed below the MPL for all four of the Children and Adolescents' Access to Primary Care Practitioners (CAP) measure stratifications for 12 - 24 months (CAP-1224), 25 months - 6 years (CAP-256), 7 - 11 years (CAP-711), and 12 -19 years (CAP-1219). However, the overall rates as well as national benchmarks demonstrated higher rates as compared to RY 2017 rates. Nevertheless, in efforts to improve overall rates, DHCS has begun working with CMS's infant well-child affinity group workshop to improve rates. Additionally, DHCS has made children's preventive care a clinical focus in the 2022 Comprehensive Quality Strategy report. Further detail is below.

For reporting year (RY) 2020, 16 out of 25[4] MCPs did not meet the Minimum Performance Level for CAP-1224, CAP-256, CAP 711, and CAP-1219. (All the MCPs/reporting units listed below performed below the MPL on all CAP measures).

MCP	County
1. Aetna Better Health of California	Sacramento County
2. Alameda Alliance for Health	Alameda County

[4] Kaiser No. & Kaiser So. Counted as separate MCPs.

MCP	County
3. Blue Cross of California Partnership Plan	Alameda County Contra Costa County Fresno County Kings County Region 2 Sacramento County San Benito County San Francisco County Santa Clara County
4. Blue Shield of California Promise Health Plan	San Diego County
5. California Health & Wellness Plan	Region 1 Region 2
6. CalViva Health	Fresno County Kings County
7. Gold Coast Health Plan	Ventura County
8. Health Net Community Solutions, Inc.	Ventura County Kern County Los Angeles County Sacramento County San Diego County San Joaquin County Stanislaus County
9. Health Plan of San Joaquin	San Joaquin County Stanislaus County
10. Inland Empire Health Plan	Riverside/San Bernardino Counties
11. Kern Health Systems	Kern County
12. L.A. Care Health Plan	Los Angeles County
13. Molina Healthcare of California	Imperial County Riverside/San Bernardino Counties Sacramento County San Diego County
14. Partnership Health Plan of California	Northeast Northwest Southeast
15. San Francisco Health Plan	San Francisco County
16. United Healthcare Community Plan	San Diego County

For reporting year (RY) 2020, 3 out of 25[5] MCPs met the Minimum Performance Level for CAP-1224, CAP-256, CAP 711, and CAP-1219. (All the MCPs/reporting units listed below performed above the MPL on all CAP measures).

MCP	County

[5] Kaiser No. & Kaiser So. Counted as separate MCPs.

1. CenCal Health	San Luis Obispo County Santa Barbara County
2. Community Health Group Partnership Plan	San Diego County
3. Kaiser SoCal (KP Cal, LLC)	San Diego County

For reporting year (RY) 2020, 6 out of 25[6] MCPs met the Minimum Performance Level for at least one CAP measure (CAP-1224, CAP-256, CAP 711, and CAP-1219). (All the MCPs/reporting units listed below performed above the MPL on at least one CAP measures).

MCP	County	CAP-1224	CAP-256	CAP-711	CAP-11219
1. CalOptima	Orange County	**Did not meet MPL**	Met MPL	Met MPL	**Did not meet MPL**
2. Central California Alliance for Health	Merced County	**Did not meet MPL**	Met MPL	**Did not meet MPL**	Met MPL
	Monterey/Santa Cruz Counties	Met MPL	Met MPL	Met MPL	Met MPL
3. Contra Costa Health Plan	Contra Costa County	Met MPL	Met MPl	**Did not meet MPL**	**Did Not Meet MPL**
4. Health Plan of San Mateo	San Mateo County	Met MPL	Met MPL	Met MPl	**Did not meet MPL**
5. Kaiser NorCal (KP Cal, LLC)	KP North	Met MPL	**Did not meet MPL**	**Did not meet MPL**	Met MPL
6. Santa Clara Family Health Plan	Santa Clara County	**Did not meet MPL**	Met MPL	**Did not meet MPL**	**Did not meet MPL**

The chart below indicates how the remainder of the MCP's reporting units performed in CAP measures (CAP-1224, CAP-256, CAP 711, and CAP-1219). Please note that these MCPs are listed under the category of having reporting units perform below the MPL in all CAP measures however, there were some reporting units that performed above the MPL in at least one CAP measure.

MCP	County	CAP-1224	CAP-256	CAP-711	CAP-11219
1. Blue Cross of California Partnership Plan	Madera County	**Did not meet MPL**	Met MPL	Met MPL	Met MPL
	Region 1	**Did not meet MPL**	Met MPL	**Did not meet the MPL**	**Did not meet the MPL**

[6] Kaiser No. & Kaiser So. Counted as separate MCPs.

MCP	County	CAP-1224	CAP-256	CAP-711	CAP-11219
	Tulare County	Met MPL	Met MPL	Met MPL	Met MPL
2. California Health & Wellness Plan	Imperial County	Met MPL	Met MPL	**Did not meet MPL**	**Did not meet MPL**
3. CalViva Health	Madera County	Met MPL	Met MPL	Met MPL	Met MPL
4. Health Net Community Solutions, Inc.	Tulare County	Met MPL	Met MPL	Met MPL	Met MPL
5. Partnership Health Plan of California	Southwest	**Did not meet the MPL**	Met	**Did not meet the MPL**	**Did not meet the MPL**

Data for MY 2021 is not yet available to review or interpret due to data reporting lags, thus is not included in this report. DHCS is committed to taking steps to ensure children in California have access to high quality health care. Recognizing quality and health equity as the center of DHCS' mission and vision, in February 2021 DHCS created a new position, the Chief Quality Officer (CQO), to oversee the overall quality, equity, and population health management strategy. The CQO is responsible for centralizing and standardizing all health equity, quality, and population health management functions across all DHCS programs. The Deputy Director for Quality and Population Health Management (QPHM) will support the CQO in advancing this vision.

The new organizational structure standardizes and supports capacity building for quality and health equity improvement, compliance, and monitoring with all efforts rooted in LEAN and Results Based Accountability frameworks. The central QPHM program will also standardize and support Quality Assurance and Performance Improvement (QAPI) initiatives across all managed care programs, lead public reporting and dashboard development, and centralize and oversee the external quality review management process for ongoing feedback. The organizational changes to centralize quality changes will be complete by March 2022, with training and process standardization to be completed by 2023.

In DY 17, DHCS also completed a deep review of the Preventive Services Report, which is a report DHCS uses to monitor appropriate utilization of preventive services for children in Medi-Cal. The measures bulleted below, are further stratified by various demographics and compared to national benchmarks, and the findings are then used by DHCS to implement targeted improvement strategies that can lead to positive change to include access to care. Primary care access for children specific measures in the report include:

- Well-Child Visits in the First 30 Months of Life
- Well-Child Visits in the First 15 Month
- Six or More Well-Child Visits and Well-Child Visits for Age 15 Months to 30 Months

Lastly, DHCS launched Medi-Cal's Strategy to Support Health and Opportunity for Children and Families in March 2022**,** a forward-looking policy agenda for children and families enrolled in Medi-Cal**.** This Medi-Cal strategy will unify the common threads of existing and newly proposed child and family health initiatives, and will solidify DHCS' accountability and oversight of children's services. Medi-Cal's Strategy to Support Health and Opportunity for Children and Families outlines key policy developments, new strategies, and how they fit together to establish greater accountability for the care provided to children, capturing key areas to support children and families. Given Medi-Cal's reach, DHCS views Medi-Cal's Strategy to Support Health and Opportunity for Children and Families as critical to the health and well-being of California's children and families, and foundational for the long-term health and wellness of all Californians.

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

DHCS wrote and posted the revised Draft DHCS Comprehensive Quality Strategy (CQS) to the DHCS website for public comment at the end of December 2021. This draft addressed the significant impact caused by of the COVID-19 pandemic, as well as additional details related to the CalAIM implementation. In February 2022, DHCS submitted the final version of the 2022 DHCS CQS report to CMS. The CQS report incorporated stakeholder feedback received during the 30-day public comment and tribal review process that ended on January 27. It provided a summary of the extensive work being done to assess and improve the quality and equity of health care covered by DHCS, as well as its vision for the future of quality and health equity in Medi-Cal. This report serves as an update to the previously published 2018 Medi-Cal Managed Care Quality Strategy Report, which was limited to managed care programs. The revised Comprehensive Quality Strategy serves as a broader quality strategy to encompass all DHCS quality activities, while meeting the requirements of the Code of Federal Regulations (CFR) at 42 CFR 438.340, as amended, under the managed care rule. The revised strategy:

- Provides an overview of all DHCS healthcare, including managed care, fee-for-service and other programs.
- Includes overarching quality and health equity goals with program-specific objectives.
- Reinforces DHCS's commitment to health equity throughout all program activities.
- Provides a review and evaluation of the effectiveness of the 2018 Quality Strategy.

Incorporated into report are details about DHCS' California Advancing and Innovating Medi-Cal (CalAIM) five-year policy framework which encompasses broader delivery system, program and payment reform across the Medi-Cal program. While conceived with extensive stakeholder engagement prior to the COVID-19 PHE, CalAIM's goals are even more relevant as we emerge from the pandemic. They have been strengthened with additional historic investments in the Governor's 2021-2022 budget and the Home and

Community Based Services spending plan. While not required as a part of the Comprehensive Quality Strategy, these transformational initiatives will support DHCS' efforts to drive quality outcomes and reduce health disparities, and are interwoven with our quality strategy.

Item 31 of the STCs – External Quality Review

Every year, the DHCS releases an External Quality Review (EQR) technical report to the CMS and the public, in compliance with Federal regulations (Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E)[7]. The EQR technical report is generally available by the last day of April each year; however, there were delays in 2020 due to COVID-19 impacts. DHCS obtained an extension from CMS, to release the 2018-19 EQR technical report in July 2020; and in 2021, DHCS resumed publishing EQR technical reports by the last day of April, per federal guidance.

Managed care annual EQR technical reports are available on DHCS' Medi-Cal Managed Care: Quality Improvement webpage.[8] Over the course of the Medi-Cal 2020 Demonstration, DHCS expanded EQR analyses and reports each year, to gain knowledge and apply improvements in multiple program areas:

- Network adequacy improvements included the identification of disparities based on region.
- Improvements to the provision of preventive services for pediatric members, included increased administration of blood lead screenings,[9] the identification of health disparities by language, race, and ethnicity; and
- An expansion of performance standards, to begin incorporating Core Set measures.[10]

DHCS will continue to apply EQR recommendations as part of its ongoing commitment to make data-driven policy improvements under the new CalAIM 1915(b) Waiver.[11]

[7] Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E can be found in the following link: OLRC Home (house.gov)
[8] The Medi-Cal Quality Improvement Reports page for Managed Care can be accessed at this link: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx
[9] The Preventive Services report provides in-depth analyses of several existing DHCS measures as well as new administrative measures that DHCS developed with its managed care EQRO to capture utilization of services by pediatric Medi-Cal managed care members, see the main report, as well as the Blood Lead addendum, at this link: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx
[10] Expansion of performance measures across years can be viewed by accessing the External Accountability/ Managed Care Accountability Sets at this link: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx
[11] For more details on DHCS' long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory, please see the information linked here: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

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) were expenditures for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State received federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures were claimed in accordance with CMS-approved claiming protocols; the Medi-Cal 2020 Demonstration STCs allowed the State to claim Federal Financial Participation (FFP) using the certified public expenditures of approved DSHPs.

Costs associated with providing non-emergency services to non-qualified aliens were unable to be claimed against the Safety Net Care Pool. To implement this limitation, 13.95% of total certified public expenditures for services to uninsured individuals was treated as expended for non-emergency care to non-qualified aliens.

The state claimed the following during the period of January 1, 2016 – December 31, 2020:

MC-2020	FFP Claimed
DY11	$ 75,000,000
DY12	$ 75,000,000
DY13	$ 18,718,589
DY14	$ 50,031,480
DY15	$ 142,750,864
DY 16	$ 13,499,067
Total	**$ 375,000,000**

As noted above, CMS's December 2020 temporary extension of Medi-Cal 2020 did not authorize DSHP expenditures during DY17.

Item 35 of the STCs – Supplemental Payments to IHS and 638 Facilities

DHCS made supplemental payments to Indian Health Service (IHS) and 638 facilities for the duration of Medi-Cal 2020 in accordance with Standard Terms and Conditions (STC) 35, for Demonstration Years (DY) 11-16, January 1, 2016 through December 31, 2020. Supplemental payments were computed based on the uncompensated costs for certain benefits that were eliminated from Medi-Cal coverage in July 2009 pursuant to SPA 09-001. Prior to Medi-Cal 2020, psychology benefits were restored in Medi-Cal and thus not claimable under this program for the entirety of Medi-Cal 2020. During Medi-Cal 2020,

acupuncture, audiology, dental, optician/optical lab, podiatry, and speech therapy benefits were restored in Medi-Cal and thus no longer claimable under this program for portions of Medi-Cal 2020. Chiropractic benefits are the only remaining services approved to be covered by this program and were claimable for the entirety of Medi-Cal 2020.

Throughout the duration of Medi-Cal 2020, supplemental payments for IHS did not exceed the annual total computable (TC) limit of $1,550,000 per DY, as stipulated in STC 35. Total actual claiming for the duration of Medi-Cal 2020, DY11-16 was $3,995,000 TC. This program has one additional payment related to DY16 that will be made for Medi-Cal 2020 eligible services. The additional payment is projected to be in the amount of $127,000 TC. Therefore, the total actual payments plus the projected payment will amount to $4,122,000 TC for Medi-Cal 2020.

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).

In February 2020, DHCS published the DY 14 EDV Study, titled "*State Fiscal Year (SFY) 2018-19 Encounter Data Validation Study Report*." 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; however, in March 2020, DHCS halted all DY 15 EDV study activities, including medical record procurement efforts, in order to minimize non-critical burdens on MCPs and their network providers during the COVID-19 Public Health Emergency (PHE). Prior to the PHE, HSAG complete the following: a study plan; data collection and sampling; and a portion of medical record procurements. Due to the continuation of the PHE into 2021, DHCS extended the cancellation of EDV study activities into DY 16. In lieu of the DY 15 and 16 EDV Studies, DHCS and HSAG developed an administrative data analysis using encounter, provider, member demographic, and member eligibility data to measure the completeness and accuracy of DHCS' encounter data for dates of service in calendar years 2018 and 2019. This study, known as the 2020–21 Encounter Data Administrative Profile (EDAP), will coincide with the resumption of the 2021–22 EDV activities and includes measures for the assessment of duplication, the completeness and accuracy of key data elements, member data referential integrity, and provider data referential integrity. The EDAP study will conclude in July 2022.

DHCS resumed EDV activities for DY 17 including medical records procurement. We anticipate the DY 17 EDV Study, covering dates of service between January 1, 2020 and December 31, 2020, will publish on DHCS' webpage in early 2023.

Item 39 of the STCs – Submission of Encounter Data

In May 2017, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Care Services (DHCS) plan to move into production, for data transmission, to the Transformed Medicaid Statistical Information System (T-MSIS), which replaced the Medicaid Statistical Information System. In DY 15 (2019), DHCS continued to work with CMS to identify and resolve concerns with its production encounter data transmissions through T-MSIS. In DYs 16 and 17 (2020 and 2021), DHCS submits eligibility and encounter data on a monthly basis, that allows data linkages according to CMS requirements for T-MSIS. DHCS continues to work with CMS on the data quality issues in T-MSIS submissions.

Item 41 of the STCs – Contracts

Nothing to report.

Item 42 of the STCs – Network Adequacy

DHCS performs extensive ongoing and scheduled network monitoring activities at various intervals throughout the year. DHCS conducts a network certification annually and network readiness reviews when there is a significant network change, which include program expansion and population transitions. DHCS submits to CMS the results of these reviews in its annual network certification.

Through the annual network certification process, MCPs must submit comprehensive data to DHCS that reflects the MCP's entire contracted provider network for each service area and its ability to meet network certification components:

- Primary Care Physician(PCP)-to-member ratios;
- Physician-to-member ratios;
- PCP time or distance standards;
- Specialist time or distance standards;
- Mental health time or distance standards;
- Hospital time or distance standards;
- Obstetrics/Gynecology (OB/GYN) specialist time or distance standards;
- Timely access to PCPs, specialists, mental health providers, and ancillary providers; and
- MCP alternative access standards (AAS)

MCPs must submit geographic accessibility analyses and narratives, if applicable, to demonstrate compliance with time or distance standards for each of their service areas, by ZIP code, to account for current and anticipated service utilization. If the MCP is unable to meet time or distance standards and has exhausted all reasonable contracting efforts with closer providers, the MCP must request DHCS' approval for an alternative access standard (AAS). The AAS request is by ZIP code, provider type and details the specific reasons demonstrating the need for the AAS. It can also include telehealth and mail order pharmacy when appropriate for the member's health condition and supported by justification that in-person care is not available. All AAS findings are posted on the DHCS website.[12]

In order for an AAS request to be approved, DHCS assesses whether the MCP[13] is contracted with the closest provider based on the availability of Medi-Cal providers, taking into consideration the geographic region that could require additional miles or minutes as well as justifiable reasons for the MCP's inability to contract with closer providers such as quality of care issues, the provider's refusal to contract, and/or the provider no longer accepting Medi-Cal. If DHCS finds a closer provider based on its own research of nearby providers, DHCS will deny the request.

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, a change in their service or benefits 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.

On a quarterly basis, DHCS conducts comprehensive ongoing reviews of MCP networks, and sends data analyses 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 provider networks. Network adequacy indicators, include, but are not limited to the following:

- Primary Care Physician(PCP)-to-member ratios;
- Physician-to-member ratios;
- Termination of contracts;
- Out-of-network requests;
- State Fair Hearings; and
- Independent Medical Reviews.

[12] July 2021 & January 2022 Annual Network Certification Alternative Access Standards for Medi-Cal
[13] Managed Care Health Plans can be accessed at:
https://www.dhcs.ca.gov/formsandpubs/Documents/July-2021-Jan-2022-AAS-Report.pdf

Item 44 of the STCs – Network Requirements

Network adequacy standards for primary care, including standards for primary care time or distance standards, are codified in California Welfare and Institutions Code 14197. DHCS assesses the primary care provider network annually through DHCS' network certification and provides the results of this certification to CMS through the annual assurances of compliance as required by 42 CFR 438.207 and on quarterly basis to ensure MCP compliance with PCP ratios. DHCS also utilizes monitoring indicators such as grievances and appeals to assess whether there are access to care concerns. DHCS contractually requires cultural competency training for network providers and ensures that providers are aware of the right to interpretation services for members. Further, DHCS conducts an annual Timely Access Survey and provides the results of the survey quarterly to each MCP so that they can rectify any performance concerns. As part of the Timely Access Survey, DHCS tests provider compliance with interpretation services to ensure that they are aware of the members' right to interpretation services and are providing accurate information to members pertaining to this benefit.

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

DHCS evaluated and certified each MCP's compliance with contractual, State, and Federal requirements related to network adequacy standards. This evaluation includes reviewing all MCP reported data through DHCS' monthly provider file and additional MCP submissions that demonstrate compliance with provider to member ratios, mandatory provider types, time or distance standard requirements, and other network adequacy components.

DHCS submits its Assurance of Compliance Report to CMS to demonstrate network adequacy of MCPs. DHCS assesses network adequacy standards compliance in accordance with CFR sections 438.68, 438.206 and 438.207 and corresponding state law and policy guidance. DHCS received an extension from CMS to submit documentation of assurances in Demonstration Year (DY) 17, and submitted materials on November 1, 2021 for the 2021 Annual Network Certification. DHCS will provide all Annual Network Certification (ANC) documentation collected by DHCS from each MCP to CMS, upon request.

Item 46 of the STCs – Concurrent Operation of the MSSP 1915(c) HCBS Program

Payment for the MSSP 1915(c) waiver services were included in the plan capitation payments from the State starting July 1, 2014. Eligible beneficiaries in the seven CCI counties who are participating in the MSSP waiver were allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in a plan. The Cal MediConnect plans and Medi-Cal only managed care plans (MCPs) were required to contract with MSSP providers to ensure ongoing access to MSSP waiver services for MSSP enrolled beneficiaries at the time of transition through December 31, 2021. MSSP waiver providers

continued to provide the same services to MSSP Waiver participants/clients; however, they received payment for MCP members from the MCPs. These requirements were outlined in the MCP and MSSP Waiver provider contracts. Effective with the January 1, 2022, implementation of CalAIM, MSSP was carved out of the CCI counties, reverting MSSP to a fee-for-service waiver program operating as it did prior to the implementation of CCI. The MCPs and MSSP providers are required to continue coordinating care for their mutual members/participants.

Item 58 of the STCs – 2016 CCS Pilot Update

DHCS contracted with the University of California, San Francisco (UCSF) Institute for Health Policy Studies to conduct the CCS evaluation from July 1, 2019, to December 31, 2022. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to CMS on August 31, 2020 as required.

Item 164 of the STCs – Repayment of PMS Negative Account Balance

As of February 10, 2022, the total of all Medicaid and CHIP negative subaccount balances through Federal Fiscal Year 2021 for the State of California is $74,280,816.87. DHCS is waiting for CMS to release $74,433,798 on the Q3 2021 Finalization letter which will bring all the accounts to balance and clear all negative balances.

PROGRAM UPDATES:

The Program Updates Section describes key activities and data across Medi-Cal 2020 program initiatives from the remainder of DY 17 that was not previously reported on in prior reports (i.e., the period from July 1, 2021 to December 31, 2021), as well as reflects on the State's experiences over the course of DY17 (or calendar year 2021) more generally as the State prepared to transition certain elements of Medi-Cal 2020 to either the Medi-Cal State Plan or the amended and renewed CalAIM Section 1915(b) waiver. This Section includes requirements outlined across Items 28 and 29 of the Medi-Cal 2020 demonstration STCs. For each program area, this Section describes program requirements, recent deliverables, success and accomplishments, program highlights, qualitative and quantitative findings, progress on evaluation findings, and opportunities for DHCS to build on success as the State continues programs under the CalAIM 1115 demonstration or transitions programs to other federal authorities. Key program areas described in this Section include:

- **Medi-Cal 2020 Initiatives Continuing Under the CalAIM 1115 Demonstration:**
    - Community Based Adult Services (CBAS)
    - Drug Medi-Cal Organized Delivery System (DMC-ODS)
    - Global Payment Program (GPP)
    - Out of State Former Foster Care Youth (OOS-FFY)
- **Medi-Cal 2020 Initiatives Not Continuing Under the CalAIM 1115 Demonstration:**
    - Access Assessment
    - Health Home Program (HHP)
    - Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
    - Whole Person Care (WPC)
    - Dental Transformation Initiative (DTI)
    - California Children's Service (CCS) Demonstration Pilot
    - Coordinated Care Initiative (CCI) Program Experience of Dual Eligibles
    - Seniors or Persons with a Disability (SPD)

MEDI-CAL 2020 INITIATIVES CONTINUING UNDER THE CALAIM SECTION 1115 DEMONSTRATION:

COMMUNITY BASED ADULT SERVICES (CBAS)

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

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

DHCS submitted California's 1115(a) "Medi-Cal 2020" waiver to CMS which was approved on December 30, 2015, for a five-year term through December 31, 2020. Due to the COVID-19 public health emergency (PHE), DHCS received approval from CMS for a 12-month extension of the "Medi-Cal 2020" waiver through December 31, 2021.
On June 30, 2021, after an extensive stakeholder process and public comment period, DHCS submitted the CalAIM Section 1115 Demonstration Waiver application to CMS requesting a five-year renewal and amendment. CMS approved California's 1115(a) CalAIM Demonstration Waiver with an effective date of January 1, 2022, through December 31, 2026. CBAS will continue as a Medi-Cal managed care benefit in the CalAIM Demonstration Waiver.

Program Requirements:

CBAS is an outpatient, facility-based program, located at ADHC centers licensed by the California Department of Public Health (CDPH). CBAS providers are certified by CDA to participate in the Medi-Cal program. CBAS providers deliver skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to Medi-Cal managed care beneficiaries age 18 and older who meet CBAS eligibility criteria and are enrolled in certified CBAS programs. CBAS participants have chronic medical, cognitive, mental health and/or intellectual/developmental disabilities and are at risk of needing institutional care.

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

Initial eligibility for the CBAS benefit is traditionally 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. Note: Due to the COVID-19 public health emergency (PHE), a face-to-face assessment is not required at this time. On October 9, 2020, CMS granted approval of DHCS' disaster 1115 Attachment K, effective March 13, 2020, through March 12, 2021, which allowed flexibilities for the delivery of CBAS Temporary Alternative Services (TAS) and permitted CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (if proper safety precautions are implemented). CMS extended these flexibilities from March 13, 2021, until six months post declaration of the end of the federal PHE. DHCS submitted a proposal to CMS on March 5, 2022, to phase out the CBAS TAS flexibilities by June 30, 2022, transitioning to the new ongoing CBAS emergency remote services (ERS) service delivery option included in the CalAIM 1115 Waiver renewal. The proposal remains under CMS review at the time of submission of this report.

Deliverables:

Although the Medi-Cal 2020 Waiver does not identify specific deliverables or require evaluation findings for the CBAS program, the State demonstrated that the CBAS benefit could be delivered successfully as a Medi-Cal managed care benefit. The termination and transition of ADHC services from an optional State Plan benefit to a managed care benefit required extensive collaboration among State partners and with CBAS providers, managed care plan representatives, and other stakeholders. These collaborative efforts informed the development of ongoing policies and procedures specific to the issues/challenges experienced during the Medi-Cal 2020 Waiver period, the establishment of new center application and certification processes that continue to evolve, the formation and facilitation of time-limited workgroups and standing committees, the initiation of multiple methods of ongoing communication with all partners/stakeholders,

and the provision of ongoing training to ensure that eligible CBAS participants receive the CBAS benefit as directed by CMS in the waiver demonstration.

Successes/Accomplishments:

During the Medi-Cal 2020 Waiver period, January 1, 2016, through December 31, 2021, CDA accomplished the following in compliance with the Waiver's CBAS Special Terms and Conditions (STCs):

- CBAS Transition Plan (STC 48c): CDA and DHCS convened a series of stakeholder meetings in 2015 with CBAS providers, managed care plans and interested stakeholders to develop the initial CBAS Home and Community-Based (HCB) Settings Transition Plan (*CBAS Transition Plan*) which would be included as an attachment to the DHCS *Statewide Transition Plan (STP)*. The *CBAS Transition Plan* is a blueprint to transition all CBAS providers into compliance with the federal HCB Settings requirements by March 17, 2023, and on an ongoing basis thereafter. CDA validates CBAS provider compliance with the HCB Settings requirements during CDA's biennial Medi-Cal certification survey process for all CBAS centers. CBAS providers must comply with these federal requirements to be certified to participate in the Medi-Cal program. The HCB Settings requirements are to ensure that CBAS participants have access to community services and the benefits of community living to the same degree as non-Medi-Cal beneficiaries. The *CBAS Transition Plan* identifies the policies, procedures, and tools that CDA developed in collaboration with DHCS, CBAS providers and other stakeholders to assist CBAS providers in complying with these requirements on an ongoing basis and to enable CBAS survey staff to validate CBAS provider compliance. The *STP* and *CBAS Transition Plan* will be submitted to CMS for final approval in 2022.

- Individual Plan of Care (STC 49c): CDA, in collaboration with DHCS, CBAS providers, managed care plans and interested stakeholders through a stakeholder workgroup process, developed a new Individual Plan of Care (IPC) to ensure compliance with the federal HCB Person-Centered Planning Requirements as specified in the CBAS provisions of the Medi-Cal 2020 Waiver. The new IPC requires that CBAS services are planned and delivered according to person-centered planning processes and principles to address the assessed and expressed needs of CBAS participants and includes the identification of risk factors and social determinants of health that place an individual at risk for hospitalization and/or institutionalization. The federal HCB Person-Centered Planning requirements ensure that the CBAS participant has an active role in the development of their care plan, including the services and supports to be provided that address the participant's expressed needs. CDA validates compliance with the federal HCB person-centered planning principles and processes during CDA's biennial onsite Medi-Cal certification survey of all CBAS centers, which includes a review of CBAS participants' IPCs. CDA has provided training to CBAS providers

and CBAS survey staff on the federal person-centered planning requirements and on completing the new IPC.

- CBAS Quality Assurance and Improvement Strategy (STC 53): CDA, in collaboration with DHCS, CBAS providers, managed care plans and interested stakeholders, convened a workgroup to develop the *CBAS Quality Assurance and Improvement Strategy (2016)* which has two primary goals: 1) assure CBAS provider compliance with program requirements through improved State oversight, monitoring, and transparency activities, and 2) improve service delivery by promoting CBAS best practices, including person-centered and evidence-based care. CDA established the CBAS Quality Advisory Committee comprised of CBAS providers, managed care plans, and representatives from the California Association for Adult Day Services (CAADS) and DHCS. CDA convenes triannual meetings with the Quality Advisory Committee to review/evaluate progress on achieving the Quality Strategy's original goals and objectives and to identify new ones that will support and promote the delivery of quality CBAS services. This is a continuous quality improvement effort designed to support CBAS providers in meeting program standards while continuing to develop and promote new approaches to improving service delivery.

  The following are examples of the CBAS Quality Advisory Committee's accomplishments during the Medi-Cal 2020 Waiver Period: 1) development of a resource document for CBAS providers on Assessment/Screening Tools to promote the use of standardized/validated assessment/screening tools for specific status/conditions of CBAS participants to improve service delivery by promoting best practices; 2) compilation of Education and Training Resources for CBAS providers on topics relevant to the needs/conditions of CBAS center participants which can assist providers in complying with ADHC/CBAS program requirements for ongoing staff training; 3) development of Center Assessment Tools to assist CBAS providers in understanding CBAS program requirements such as staff responsibilities, staff training, proper medication storage and administration, and multidisciplinary team and person-centered planning process requirements. Additional resources/tools will be developed and updated as needed.

- Managed Care Plan Meetings (Supports STCs 51 and 53)
  CDA convened triannual meetings with MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) provide an update on CBAS policy directives and other issues impacting CBAS providers, (3) discuss CBAS data collection activities and the number, location, and approval status of new center applications, and (4) request feedback from MCPs on any CBAS provider issues requiring CDA assistance. These meetings have been essential for discussing any challenges faced by CBAS providers and MCPs over the past five years, particularly related to the COVID-19 PHE and implementing the CBAS TAS flexibility. In addition, during the Medi-Cal 2020 Waiver period, CDA attended and

continues to attend the monthly MCP meetings convened by the California Association for Adult Day Services (CAADS) which includes CBAS providers. This meeting provides an additional opportunity to discuss any issues or concerns expressed by CBAS providers and MCPs.

- CBAS Application Pre-Screening Process for Prospective New CBAS Providers (Supports STC 52)
  Starting in 2015, CDA developed a new CBAS application pre-screening process that is required for prospective new CBAS providers. This pre-screening process helps to prepare prospective providers to understand CBAS program requirements before opening a new center. In addition, this process enables CDA to determine the need for the prospective center in the location proposed, which can help to promote CBAS access and capacity in places where there are no CBAS centers or an insufficient number of centers to address unmet needs of specific underserved populations. This pre-screening application process continues to be improved and is now electronic to expedite the application submission and review process. However, CDA is facing challenges in determining which CBAS centers should be approved in requested locations where there may be an abundance of existing CBAS centers, but which may not address the needs of specific underserved populations. This requires data and a methodology to identify where there are unmet needs (underserved CBAS-eligible individuals) to determine where a prospective new center may be needed to improve access and equity for persons eligible for CBAS services. Refer to Section 6 (Policy/Administrative Issues and Challenges)

- CBAS Training (Supports STCs 49, 52 and 53)
  CDA provided ongoing training via webinars and at CAADS conferences throughout the Medi-Cal 2020 Waiver period to assist CBAS providers, managed care plans, and interested stakeholders in understanding/implementing CDA policy directives in CDA All Center Letters (ACLs). This training focused on the provision of CBAS services in accordance with state laws and regulations, and federal requirements; CDA reporting and documentation requirements; implementation of CBAS TAS and related COVID-19 PHE requirements, and more. CDA provided specific webinars on ADHC/CBAS Program Requirements, CBAS Initial ADHC/CBAS Certification Requirements, HCB Settings and Person-Centered Planning Requirements, and the new CBAS IPC. All CDA training is recorded and posted on the CDA website. CDA will continue to provide training to support the delivery of CBAS services in accordance with state and federal requirements.

Program Highlights:

The following are highlights of several key program activities:

- Guidance to CBAS Providers on COVID-19 PHE and CBAS TAS

Since March 2020, CDA in collaboration with DHCS and CBAS providers has developed policy guidance to CBAS providers in response to ever-changing conditions and public health guidance with the goal of ensuring the health and safety of CBAS participants and CBAS providers. DHCS, through a disaster 1115 Attachment K, received approval from CMS to implement CBAS TAS. CBAS TAS is a short-term, modified service delivery approach that grants CBAS providers time-limited flexibility 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.) These temporary flexibilities have been approved by CMS through six months after the federal PHE ends.

Oversight of the implementation of CBAS TAS amidst fluctuations in public health guidance has been the primary focus of CDA, in collaboration with DHCS. CDA activities included the following: 1) issued All Center Letters (ACLs) providing policy guidance to CBAS providers related to the PHE, the delivery of remote services and in-center individual services, and public health guidance/requirements; 2) provided CBAS webinars to address CBAS ACL policy guidance and answer questions; 3) met weekly with CBAS provider members of the California Association for Adult Day Services (CAADS) and the leadership of CAADS to formulate policy guidance prior to issuing ACLs and other policy directives; 4) distributed CBAS Updates newsletters to keep CBAS providers and interested stakeholders informed of CBAS activities including state and federal guidance related to COVID-19 and the delivery of CBAS TAS; and 5) convened calls with MCPs and participated in MCP calls coordinated by CAADS to keep them informed of CDA policy guidance and to address questions.

Toward the end of 2021, the State indicated a likely end to the ADHC licensing flexibilities effective March 31, 2022, which would impact the provision of CBAS TAS remote services. In anticipation of the termination of CBAS TAS remote services on June 30, 2022, CDA in collaboration with DHCS, CBAS providers, and managed care plans are in the process of drafting policy guidance for the return of CBAS participants to in-center services who are able and choose to return, and instructions for the discharge and referral to alternative services of participants who are not able or choose not to return to in-center services. The State is also in the process of drafting policy guidance for the ongoing CBAS ERS option included in the CalAIM Waiver renewal. CDA has been providing guidance to CBAS providers to prepare for the unwinding of CBAS TAS, but the uncertainties of the PHE created challenges in providing a definitive timeline.

- <u>CBAS Quality Improvement and Assurance Strategy</u>
  During DY17, the CBAS Quality Advisory Committee recommended continuation of the CBAS Quality Strategy Plan beyond October 2021, to (1) continue work on previously identified long-term objectives that have not yet been completed, (2)

identify completed objectives which require ongoing evaluation and monitoring, and (3) identify new objectives that will promote and support the quality of CBAS services such as collecting more participant characteristic data to post on the CDA website, collecting more center characteristic information to help individuals/families and managed care plans find centers to meet beneficiaries' needs, identifying obsolete licensing and Medi-Cal regulations that have been replaced with new laws, training providers on end of life care best practices that support participants and families, and looking at quality objectives through the lens of equity, access and inclusion, and streamlining the new center application process that can increase access to CBAS services.

The CBAS Quality Advisory Committee has been focusing on the need to collect more information from the CBAS IPC to better understand who is receiving CBAS services and the complexity of their needs, what IPC data would best identify this complexity, how are CBAS centers addressing their needs (e.g., quality of care). The committee has been discussing who the target audiences would be for the data collected and for what purpose, what questions would CDA be trying to address with the data collected, and what data should be published on the CDA website. In addition, the Committee has been discussing the development of a consumer guide for prospective CBAS participants and their family caregivers to assist them in selecting a CBAS center that would meet their needs—medical, social, linguistic, cultural. Collecting and publishing more information/data about specific centers and who they serve would be helpful to multiple audiences. These projects will continue into 2022.

Qualitative Findings:

Outreach Activities

CDA provides ongoing outreach and CBAS program updates to CBAS providers, MCPs, CAADS, the Alliance for Education and Leadership (ALE), and other interested stakeholders via multiple communication strategies such as the *CBAS Updates* newsletter, CBAS All Center Letters (ACLs), CBAS News Alerts (a new communication tool to distribute time-sensitive information relevant to CBAS center operations), CBAS webinars, CAADS conferences, CAADS and ALE webinar presentations, triannual meetings with MCPs that contract with CBAS centers, and triannual meetings with the CBAS Quality Advisory Committee. In addition, CDA responds to ongoing written and telephone inquiries sent to the CBAS Mailbox by CBAS providers, MCPs, and other interested stakeholders.

These outreach strategies inform CBAS stakeholders about (1) CBAS policy directives and their implementation particularly regarding the PHE and CBAS TAS and (2) CBAS program and reporting requirements such as Monthly Statistical and Summary Reports, Incident Reports, Discharge Summary Reports, Participant Characteristics Reports, Plans of Corrections, CDA Certification/Recertification Processes, Compliance with the federal

HCB Settings and Person-Centered Planning Requirements, and other issues that impact CBAS providers and the delivery of CBAS services.
The following are CDA's outreach activities during FY17 (July 1, 2021 through December 31, 2021):

- CBAS Updates newsletters (four);
- ACLs (six);
- CBAS News Alerts (27);
- CBAS webinars (four);
- CAADS conference presentations (two);
- MCP meetings (one);
- CBAS Quality Advisory Committee meetings (one); and
- Responses to CBAS Mailbox Inquiries (257).

These outreach activities focused primarily on the following issues: (1) CBAS program operations including clarification of CDA ACLs and the continued implementation of CBAS TAS flexibilities amidst the changing PHE; (2) planning for the transition to full in-center services when CBAS remote flexibilities end, including the hesitancy of some CBAS participants to return to in-center services and CBAS staffing shortages due to COVID-19 infections; (3) public health guidance related to COVID-19 and PHE including the implementation of public health practices to mitigate the risks of COVID-19 infection at the CBAS center; (4) clarification of public health vaccination and testing requirements for CBAS staff, and the need for more testing kits at CBAS centers; and (5) preparation for the implementation of CBAS Emergency Remote Services (ERS) which are included in the CBAS STCs of the CalAIM Demonstration Waiver, effective January 1, 2022.

Quantitative Findings:

Enrollment and Assessment Information
Per STC 52(a), the CBAS Enrollment data for both MCP and FFS members per county for DY16 represents the period of July 2020 to June 2021 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 is consistent in calendar year 2021 with a minor dip in the last quarter.

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 data through January 2021 to December 2021.

Figure 1: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data With County Capacity of CBAS

County	DY16-Q3 Jan - Mar 2021		DY16-Q4 Apr - Jun 2021		DY17-Q1 Jul - Sept 2021		DY17-Q2 Oct - Dec 2021	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	445	71%	451	72%	454	72%	464	74%
Butte	31	31%	31	31%	28	28%	24	24%
Contra Costa	165	44%	155	42%	140	38%	134	36%
Fresno	812	42%	903	47%	856	45%	867	39%
Humboldt	93	16%	84	14%	84	14%	90	15%
Imperial	288	48%	284	47%	276	46%	270	45%
Kern	212	21%	162	16%	187	18%	171	17%
Los Angeles	24,337	61%	24,169	59%	25,029	61%	24,545	59%
Merced	119	57%	120	57%	125	60%	111	53%
Monterey	132	71%	101	54%	112	60%	100	54%
Orange	2,469	54%	2,503	55%	2,545	56%	2,672	61%
Riverside	520	33%	534	34%	526	33%	523	30%
Sacramento	483	42%	512	44%	498	43%	525	46%
San Bernardino	667	67%	668	67%	663	66%	690	69%
San Diego	2,587	64%	2,619	81%	2,006	66%	1,842	57%
San Francisco	826	53%	901	57%	857	55%	841	54%
San Joaquin	48	20%	56	24%	38	16%	25	11%
San Mateo	73	32%	63	62%	68	67%	68	67%
Santa Barbara*	21	12%	13	8%	**	**	**	**
Santa Clara	618	47%	628	48%	607	46%	585	44%
Santa Cruz	0	0%	79	52%	75	49%	75	49%
Shasta*	39	27%	44	31%	**	**	**	**
Ventura	926	64%	924	62%	921	61%	819	55%
Yolo	255	67%	245	65%	241	64%	235	62%
Marin, Napa, Solano	63	13%	70	14%	83	17%	79	16%
Total	**36,315**	**57%**	**36,319**	**57%**	**36,432**	**57%**	**35,766**	**55%**
FFS and MCP Enrollment Data 12/2021								

The data provided in the previous table demonstrate fairly static enrollment in the second half of DY16 and DY17 Q1. While total enrollment decreased during DY17 Q2 by approximately 600 participants it does not represent a significant overall decrease in unduplicated participants or capacity used. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Orange County experienced an increased capacity utilization from DY17 Q1 to Q2 of greater than 5%. Orange County's increased capacity utilization was due to the closure of a CBAS Center during DY17 Q2, resulting in the county's licensed capacity decreasing and an increase in licensed capacity utilization.

A majority of counties maintained consistent enrollment and capacity utilization that did not experience fluctuations greater than 5%. These counties include Alameda, Butte, Contra Costa, Humboldt, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Clara, Santa Cruz, Yolo, and the combined counties of Marin, Napa, and Solano, Fresno, Monterey, San Diego, San Joaquin, and Ventura County all experienced a greater than 5% negative change related to capacity utilization. The Fresno County drop in capacity used is attributed to an opening of a CBAS Center. Although unduplicated participants increased, the addition of a new center resulted in an overall increase in licensed capacity and decrease in licensed capacity utilized in the county. The remaining counties have fluctuations likely as a result of declines in participation. Enrollment fluctuations in counties with fewer participants cause greater percentage variations.

Overall, there is a 2% decrease of capacity utilization statewide as many counties throughout California demonstrate fairly static enrollment in unduplicated participants throughout calendar year 2021, with a slight dip in participants in DY17 Q2.

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 2, on the next page, 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 2: 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
DY16-Q3 (Jan – Mar 2021)	2,844	2,793 (98.2%)	51 (1.8%)	0	0 (0%)	0 (0%)
DY16-Q4 (Apr-Jun 2021)	2,645	2,581 (97.6%)	64 (2.4%)	0	0 (0%)	0 (0%)
DY17-Q1 (Jul-Sept 2021)	2,534	2,481 (97.9%)	53 (2.1%)	1	1 (100%)	0 (0%)
DY17-Q2 (Oct-Dec 2021)	2,779	2,688 (96.7%)	91 (3.3%)	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous table, for 2021, 10,802 assessments were completed by the MCPs, of which 10,534 were determined to be eligible, and 259 were determined to be ineligible. For DHCS, it was reported that one participant was assessed for CBAS benefits under FFS and was 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 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 licensed and enrollment capacity while conversely new CBAS Center openings increase licensed and enrollment capacity. 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 DY17. As of DY17 Q2, 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 270 operating CBAS Centers is approximately 33,987 participants, which corresponds to 88.8% of total capacity. Provider-reported data identified in the table below, reflects data through December 2021.

Figure 3: 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	270
Non-Profit Centers	48
For-Profit Centers	222
ADA @ 270 Centers	33,987
Total Licensed Capacity	38,253
Statewide ADA per Center	88.8%
CDA - MSSR Data 12/2021	

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 in Figure 7 entitled "*Data on CBAS Complaints"* and Figure 8 entitled "*Data on CBAS Managed Care Plan Complaints*." According to the table on the next page, no complaints were submitted to CDA for DY17 Q2.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q3 (Jan - Mar 2021)	0	0	0
DY16-Q4 (Apr - Jun 2021)	0	0	0

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY17-Q1 (Jul - Sep 2021)	0	0	0
DY17-Q2 (Oct – Dec 2021)	0	0	0
CDA Data - Complaints 12/2021			

For complaints received by MCPs, the table below illustrates there were 20 beneficiary complaints and two provider complaints submitted for 2021. The data reflects that for DY17 Q2, no complaints were submitted. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q3 (Jan - Mar 2021)	11	1	12
DY16-Q4 (Apr - Jun 2021)	9	1	10
DY17-Q1 (Jul - Sept 2021)	0	0	0
DY17-Q2 (Oct – Dec 2021)	0	0	0
Plan Data - Phone Center Complaints 12/2021			

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 6 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 36 grievances were filed with MCPs during 2021. Twenty 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. Fifteen grievances were designated as "other". Overall, total grievances

increased from the prior year. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Figure 6: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY16-Q3 (Jan–Mar 2021)	2	1	0	2	5
DY16-Q4 (Apr–Jun 2021)	6	0	0	4	10
DY17-Q1 (Jul–Sept 2021)	6	0	0	4	10
DY17-Q2 (Oct–Dec 2021)	6	0	0	5	11
Plan Data - Grievances 12/2021					

Figure 7: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CBAS	Other CBAS Appeals	Total Appeals
DY16-Q3 (Jan–Mar 2021)	1	0	0	0	1
DY16-Q4 (Apr–Jun 2021)	3	1	0	1	5
DY17–Q1 (Jul–Sept 2021)	2	0	0	0	2

Demonstration Year and Quarter	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CBAS	Other CBAS Appeals	Total Appeals
DY17 – Q2 (Oct – Dec 2021)	3	0	1	0	4
Plan Data – Appeals 12/2021					

During 2021, Figure 7 entitled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 12 CBAS appeals filed with the MCPs. The table illustrates that nine of the appeals were related to "denial of services or limited services", one was categorized as "denial to see requested provider", one as "excessive travel times" and one 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. CDSS reports the Fair Hearings/Appeals data to DHCS. For CY 2021, there were two requests for hearings related to CBAS services.

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 8 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table on the next page also illustrates overall utilization of licensed capacity by CBAS participants statewide for 2021. Quality Assurance/Monitoring Activity reflects data through January 2021 to December 2021.

Figure 8: CBAS Centers Licensed Capacity

See next page.

County	CBAS Centers Licensed Capacity					
	DY16-Q3 Jan-Mar 2021	DY16-Q4 Apr-Jun 2021	DY17-Q1 Jul-Sept 2021	DY17-Q2 Oct-Dec 2021	Percent Change Between Last Two Quarters	Capacity Used
Alameda	370	370	370	**370**	0.0%	74%
Butte	60	60	60	**60**	0.0%	24%
Contra Costa	220	220	220	**220**	0.0%	36%
Fresno	1132	1,132	1,132	**1,297**	+12.8%	39%
Humboldt	349	349	349	**349**	0.0%	15%
Imperial	355	355	355	**355**	0.0%	45%
Kern	610	610	610	**610**	0.0%	17%
Los Angeles	23,636	24,211	24,371	**24,371**	0.0%	59%
Merced	124	124	124	**124**	0.0%	53%
Monterey	110	110	110	**110**	0.0%	54%
Orange	2,678	2,678	2,678	**2,603**	-2.9%	61%
Sacramento	680	680	680	**680**	0.0%	46%
San Bernardino	590	590	590	**590**	0.0%	69%
San Diego	2,383	1,903	1,903	**1,903**	0.0%	57%
San Francisco	926	926	926	**926**	0.0%	54%
San Joaquin	140	140	140	**140**	0.0%	11%
San Mateo	135	60	60	**60**	0.0%	67%
Santa Barbara	100	100	100	**100**	0.0%	5%
Santa Clara	780	780	780	**780**	0.0%	44%
Santa Cruz	90	90	90	**90**	0.0%	49%
Shasta	85	85	85	**85**	0.0%	1%
Ventura	851	886	886	**886**	0.0%	55%
Yolo	224	224	224	**224**	0.0%	62%
Marin, Napa, Solano	295	295	295	**295**	0.0%	16%
SUM	37,858	37,913	38,073	**38,253**	+.5%	55%
CDA Licensed Capacity as of 12/2021						

The previous table reflects that the average licensed capacity used by CBAS participants is 55% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of Alameda. Alameda is at 74% capacity. Licensing Capacity 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 -5% change from quarter to quarter in CBAS provider

licensed capacity per county and an analysis that addresses such variance. Orange County Licensing capacity went down 2.9 due to a CBAS Center closure, while licensed capacity in Fresno County increased 12. 8% due to the opening of a new CBAS Center. Riverside County data reflects increased capacity that took effect in May of 2021, but was not reflected in the data until November of 2021. No other significant increases or decreases were noted over the last quarter. Over 2021, 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 2021, CDA had 270 CBAS Center providers operating in California. According to Figure 12 entitled “*CBAS Center History*,” 5 CBAS Centers closed and 10 new centers were opened in 2021.

Figure 9: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
December 2021	270	0	0	0	270
November 2021	270	0	0	0	270
October 2021	270	1	1	0	270
September 2021	270	0	0	0	270
August 2021	270	0	0	0	270
July 2021	269	0	1	1	270
June 2021	269	0	0	0	269
May 2021	269	1	1	0	269
April 2021	269	2	2	0	269
March 2021	268	0	1	1	269
February 2021	266	0	2	2	268
January 2021	265	1	2	1	266

Figure 9 shows there was no negative change of more than 5% in from January 2021 to December 2021, so no analysis is needed to address such variances.

Policy/Administrative Issues and Challenges:

- CBAS Access and Equity and Need for Data Collection/Sharing

Access and Equity

The State is to ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012, which can include eligible participants receiving 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 is insufficient CBAS Center capacity to satisfy the demand.

In addition, CBAS participant eligibility requirements in the waiver include the parameters of their residing within a geographic service area in which the CBAS benefit was available as of

April 1, 2012, and are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers.

These CBAS provisions in the Medi-Cal 2020 Waiver, which continues in the CalAIM Demonstration Waiver, restrict the delivery system of the CBAS benefit and who has access to CBAS services. CBAS centers are located in 27 of the 58 counties which limits access to CBAS services including for underserved populations.

Data Collection/Sharing

Historically, it was not clear what data needed to be collected to identify unmet need for CBAS, underserved populations eligible for CBAS, and equity in access to CBAS in order to address it. Establishing benchmarks for this data and defining the methodology and strategies to improve access and equity are needed. These issues have implications for CDA CBAS program activities moving forward particularly since the CBAS Quality Assurance and Improvement Strategy Committee has been discussing these issues and external organizations have requested CBAS data that reflects access and equity. In response to this need, utilizing the Money Follows the Person (MFP) planning and capacity supplemental funding grant, a Contractor, on behalf of DHCS, plans to conduct a Gap Analysis and Multiyear Roadmap to identify and close existing gaps within California's HCBS and Managed Long Term Services and Supports (MLTSS) programs and provider networks and build broader MLTSS capabilities. A component of this effort includes recommendations for demographic, utilization, access, quality, and equity measures to include as part of the state's long-term services and supports (LTSS) data dashboard. Through identification of statewide unformed performance measures, the state will be able to identify and close existing gaps in access, equity, health disparities, and reaching underserved populations for CBAS.

Related, a component of the CBAS new center pre-screening process is to determine where new CBAS centers are needed to address access and equity, and if a proposed new CBAS center for a specified location will meet that need. There are no current standardized methodologies and data available to inform this determination. CDA has contracted with the University of California, Los Angeles (UCLA), to assist CDA in determining where there are unmet needs for CBAS eligible beneficiaries. Challenges remain in accessing/collecting statewide needs assessment data to improve equity in access to CBAS services for underserved populations. The data collection issue to improve access and equity in accessing services and reducing disparities will continue to be a focus for CDA in collaboration with DHCS.

Lastly, there is a need for more data sharing across HCBS programs, and between CBAS and MCPs for better coordination and provider oversight. For example, such data can be used to determine what Medi-Cal services CBAS participants use other than CBAS such as In-Home Supportive Services (IHSS), county behavioral health services, 1915(c) HCBS waiver services, Regional Center services, etc., rather than relying on self-reported information.

Progress on the Evaluation and Findings:

This section is not applicable to CBAS since there is no evaluation project/design specified in the CBAS STCs of the Medi-Cal 2020 Waiver requiring outcomes/findings.

Opportunities for Improvement:

Access to Remote Services

As a result of the COVID-19 PHE and the provision of CBAS TAS remote services, CDA, CBAS providers, and MCPs have learned the benefit of the availability of flexible remote services to meet participants needs, preferences, and choice under specified conditions/circumstances and emergency situations. This experience will help CDA, in collaboration with DHCS, CBAS providers and MCPs, implement the CMS-approved CBAS Emergency Remote Services (ERS) included in the CalAIM Demonstration Waiver.

ERS is to be used to address participant needs under specified circumstances such as (1) qualified emergencies (state or local disasters such as wildfires and power outages to allow for services prior to the official declaration of a formal PHE as determined by DHCS or its contractors), and (2) personal emergencies (time-limited illness/injury, crises, or care transitions that temporarily on a time-limited basis prevents or restrict enrolled CBAS participants from receiving services, in-person, at the CBAS center.

Access to remote services in specified emergency situations enables Home and Community-Based Services (HCBS) programs such as CBAS to be more responsive to participant needs and choice which aligns with the intent of HCBS. This may require the adoption of more flexible state laws and regulations to enable the approval and delivery of remote services when needed, particularly for facility-based programs such as CBAS, and not be delayed by a cumbersome flexibility approval process on a case-by-case basis at the time of the emergency.

Performance Measures

CDA recommends having performance measures to evaluate if the specified timeframes for certain services are being met such as the eligibility determination and authorization of services by managed care plans. CBAS providers have indicated that there are delays beyond the specified waiver timeframes which impacts a center's ability to address the service needs of potential CBAS participants in a timely manner. The issue of presumptive eligibility for CBAS may be appropriate in certain situations where a delay in service authorization/provision may have serious negative consequences. The CalAIM Demonstration Waiver requires performance measures for several waiver requirements which may be helpful for any waiver requirement that has an associated timeframe for completion.

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

In 2015, CMS approved a request from the DHCS to initiate an innovative demonstration pilot program called DMC-ODS. The DMC-ODS program provided an evidence-based benefit design covering the full continuum of substance use disorder (SUD) care. It required providers to meet industry standards of care, had a strategy to coordinate and integrate across systems of care, and created utilization controls to improve care and efficient use of resources. DMC-ODS called for reporting specific quality measures, and ensured necessary program integrity safeguards and benefits management strategies. The DMC-ODS allowed 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) Criteria for SUD treatment services, including recovery support services.

This included treatment placement and planning based on a multidimensional assessment of the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources, and support structure. The DMC-ODS program added or expanded DMC coverage of residential treatment services, case management, and recovery support services. It enabled selective provider contracting, supported coordination with managed care health plans, facilitated quality improvement, utilization management, and evidence based practices, and promoted use of a licensed workforce.

CMS required all residential providers participating in the DMC-ODS to meet ASAM requirements and obtain a DHCS-issued Level of Care (LOC) Designation (see DHCS LOC Designation (ca.gov) for details), or the equivalent national ASAM designation. The DMC-ODS included residential treatment services for all DMC Beneficiaries in facilities with no bed limits.

DMC-ODS implementation occurred on a county-by-county basis, and the first counties began delivering services in February 2017. On July 1, 2020, seven counties collaborated with the Partnership Health Plan of California (PHC) as an alternative regional model. By December 31, 2021, there were 37 counties, including PHC, approved to deliver DMC-ODS services, representing 94% of the Medi-Cal population statewide.

DHCS received approval from CMS on December 29, 2021 to restructure the DMC-ODS program (BHIN 21-075) via the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

Successes/Accomplishments:

The DMC-ODS waiver demonstration project has been successful at improving treatment access, quality, and coordination/integration of care. DMC-ODS implementation occurred in three main phases: Start-up Activities (2017-2020); Transition to Quality Focus (2018-2021); and Focus on Quality, Integration, and Expansion (2019-2021). In the first phase, DMC-ODS plans concentrated on establishing core infrastructure, building an adequate provider network,

and obtaining Medi-Cal certification and DMC-ODS licensing to provide required clinical services. DHCS implemented contracts with counties and provided DMC-ODS trainings, technical assistance, information notices, and readiness reviews.

During the second implementation phase, plans shifted their focus to streamlining systems, refining the system of care, improving individualized treatment program models and curriculums, and increasing focus quality of care. Many manual workflows were automated as plans began to consider new or expanded EHRs to include utilization by their contract provider networks, improve service coordination, and make data exchange more efficient. In the third phase, plans continued to expand their client-centered DMC-ODS focusing on innovation, addressing outcomes and transitions in care. Counties identified a need for continued expansion of non-methadone access points, added 3.7 and 4.0 ASAM LOC where possible, worked to improve case management services, and incorporated more activities supporting integration with physical and mental health.

It is important to note that DMC-ODS counties launched in a staggered fashion. The COVID-19 pandemic affected DMC-ODS plans in both the second and third phases of implementation, causing a rapid shift from in-person services to telehealth. Both counties and patients reported high satisfaction with telehealth. In addition, early data suggest flexibilities related to Narcotic Treatment Program (NTP) take-home medications may have increased retention among patients in methadone treatment without increasing fatal overdoses. Throughout these phases, DHCS increased engagement and oversight through DMC-ODS monitoring reviews, review of network adequacy and timely access submissions, implementation of corrective action plans for deficiencies, and provision of technical assistance to ensure resolution of deficiencies.

DMC-ODS was initially authorized as part of the state's Medi-Cal 2020 1115 waiver for a five-year term from January 2016 to December 2020. In 2018, DHCS began stakeholder engagement and research to understand the successes and opportunities for improvement within the DMC-ODS pilot to date. DHCS conducted extensive stakeholder engagement throughout 2019 and 2020, proposing and refining updates to the DMC-ODS program, some of which were incorporated into the 1115 waiver extension for calendar year 2021, which was approved on December 29, 2020. Findings from research and stakeholder engagement formed a central part of behavioral health policies in the CalAIM, the package of Medi-Cal reforms implemented through the 1915(b) and 1115 waiver submissions in the fall of 2021. On October 8, 2021, SPA 21-0058 was released; on December 17, 2021, BHIN 21-075 was published; and DHCS received approval on December 29, 2021, to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver, accomplishing an innovative integration of the State's Medi-Cal delivery systems.

Program Highlights:

DHCS oversight of the DMC-ODS program standards include annual county compliance monitoring reviews, starting in 2017 for the first six counties entering the program. As new counties joined, DHCS conducted compliance reviews within their first 12 months of participation.

From 2017 to 2021, DMC-ODS participants developed a framework for an SUD continuum of care which has continued to evolve and thrive over time. DMC-ODS counties have made substantial progress in expanding their continuum of care in breadth of services and in service capacity. They have worked well with their provider networks, most of whom are contracted, to adopt a more client-centered approach to the delivery of treatment, ancillary services, and care coordination using case management systems and enhancing communication. They have made strides with their networks to incorporate a more science-based set of practices as prescribed by the Waiver STCs, including the use of a wider range of medications for addiction treatment (also known as medication-assisted treatment or MAT).

Access systems among DMC-ODS plans continue to grow, with counties adding services over time, with utilization growing year by year, other than the expected drop early in the pandemic, due to the impact of the public health emergency (PHE). Compliance with state timely access standards has also continued to improve incrementally throughout the duration of the Waiver. While workforce and capacity challenges have been exacerbated by the pandemic, DHCS continues to see growth in services and utilization since the start of the program. In FY 2020-21, considerable progress was observed in launching DMC-ODS continuums of new and expanded clinical services, information/billing systems, and quality systems. DMC-ODS counties are in various stages of implementing their electronic health records (EHRs), and many counties are collaborating on a statewide EHR in preparation for coding updates and payment reform, which launches in July 2023.

Telehealth has been an invaluable tool for providing SUD services during the PHE, allowing access to services for clients with transportation barriers and supporting retention and recruitment of the behavioral health workforce, with high overall satisfaction. In response to the positive experience, DHCS has proposed to continue the PHE telehealth policy after the PHE ends, allowing ongoing reimbursement of services by telephone, video, and store-and-forward (for e-consults between providers). The telehealth policy for DMC-ODS is aligned with the telehealth policy for Medi-Cal managed care and specialty mental health services.

In 2021 DHCS obtained approval of SPA 21-0058, ultimately leading to the inclusion of DMC-ODS services in the Medicaid state plan and CalAIM approval on December 29, 2021. For more information about the program activities involving the CalAIM initiatives and stakeholder engagement process, please visit the CalAIM homepage and CalAIM 1115 Demonstration & 1915(b) Waiver webpage.

Qualitative Findings:

As of December 2021, 37 counties are participating in the DMC-ODS program, and DHCS conducted annual compliance monitoring reviews for all counties throughout the waiver period. A portion of the DMC-ODS Evaluation activities include stakeholder interviews conducted by the University of California, Los Angeles (UCLA). Activities for DY17 continue to be evaluated, and will be posted in the DMC-ODS 2021 Evaluation Report on the California DMC-ODS Evaluation webpage.

DHCS contracts with an External Quality Review Organization (EQRO) to monitor quality and access, and the EQRO conducts consumer and family member focus groups. Throughout the duration of the DMC-ODS Waiver, focus group commentary contained overwhelmingly positive feedback, focused on the quality of care, improvements in access to care, and the impact of services on their lives. Suggestions for improvements included more information and guidance about MAT, guidance and support regarding housing and employment (particularly for those in residential treatment and adults with families), additional family supports and help navigating personal relationships, and more time with case management, including assistance with community services and re-entry into community living. Respondents felt all of the above areas were significantly improved compared to services prior to the Waiver.

Additional information specific to DY17 can be found in the DY17-Q1 and Q2 reports.

Quantitative Findings:

County administrator and provider surveys covered a broad array of topics and results are integrated into each of the annual UCLA evaluation reports. The most recent county administrator survey was completed in 2021, and the most recent provider survey was completed in 2020.

Treatment Perceptions Survey (TPS)

In 2021, all DMC-ODS counties conducted the TPS during the week of September 21-25, 2021, through paper (11,096 surveys), online (5,216 surveys), and an automated phone version (316 calls) for both adults and youth, totaling 16,628 respondents statewide. This was the fifth administration of the annual survey under the waiver. Results from the final report suggest ratings remain high for youth and adult satisfaction with services. Over the course of these five annual surveys, ratings for all domains have remained high across time (scores over 4.0 on a scale from 1 to 5). Tables A and B below show mean scores for each of the domains for Adults and Youth, respectively, since the TPS was initiated in California.

Table A

Scores by domain (ADULT)	Mean 2017	Mean 2018	Mean 2019	Mean 2020	Mean 2021
Access	4.27	4.25	4.26	4.30	4.29
Quality	4.40	4.41	4.42	4.44	4.42
Care Coordination	4.23	4.27	4.27	4.30	4.24
Outcome	4.31	4.33	4.32	4.35	4.32
General Satisfaction	4.43	4.44	4.44	4.45	4.43

Table B

Scores by domain (YOUTH)	Mean 2018	Mean 2019	Mean 2020	Mean 2021
Access	4.01	4.14	4.13	4.13
Quality	4.09	4.16	4.19	4.26
Therapeutic Alliance	4.26	4.42	4.41	4.53
Care Coordination	4.11	4.22	4.17	4.26
Outcome	3.99	4.26	4.06	4.14
General Satisfaction	4.10	4.22	4.28	4.25

Enrollment Information:

Prior DYs have been updated based on new claims data. For DY17, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Figure 10: Demonstration Yearly Report Beneficiaries with FFP Funding

Year	ACA	Non-ACA	Total*
DY12*	3,127	1,182	4,309
DY13	32,946	15,805	48,751
DY14	34,545	16,528	51,702
DY15	43,499	20,597	64,097
DY16	44,067	23,454	67,521

**This DY contains less than 12 months of data.*

Member Months:

Figure 11: Member Enrollment

Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Demonstration Year	Total Enrollees
ACA	-	-	2,389	3,865	DY12*	3,127
	14,073	14,705	17,699	19,673	DY13	32,946
	28,824	31,586	37,414	40,355	DY14	34,545
	44,293	44,542	44,316	40,846	DY15	43,499
	42,810	43,341	44,429	45,688	DY16	44,067
	45,569	39,642	5,466	-	DY17*	30,226
Non-ACA	-	-	948	1,416	DY12*	1,182
	8,695	8,685	9,451	10,088	DY13	15,805
	14,383	15,321	17,715	18,691	DY14	16,528
	21,105	21,075	21,264	18,945	DY15	20,597
	24,233	24,048	22,928	22,606	DY16	23,454
	58,264	50,861	6,980	-	DY17*	38,702

**This DY contains less than 12 months of data.*

A decline in member months and expenditures in the two most recent quarters of DY17 are attributable to the timing of the data run. Counties have six months to submit their DMC claims, which can lead to lower reported numbers when data is pulled prior to the claiming deadline. Accurate enrollment numbers are updated and provided in subsequent quarterly report cycles.

Financial/Budget Neutrality Developments/Issues:

Figure 12: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY12*					
ACA	282,100	$11,627,007.27	$10,302,795.18	$986,480.42	$337,731.67
Non ACA	117,858	$3,227,312.80	$1,635,096.76	$794,337.60	$797,878.44
DY13					
ACA	5,621,142	$159,089,177.38	$141,069,835.36	$11,893,478.50	$6,125,863.52
Non ACA	3,461,676	$66,451,499.85	$33,476,557.73	$10,222,809.30	$22,752,132.82

DY14					
ACA	10,358,657	$304,645,640.47	$264,900,840.75	$23,697,000.34	$16,047,799.38
Non ACA	5,634,953	$115,787,353.60	$58,699,932.01	$15,854,076.59	$41,233,345.00
DY15					
ACA	11,981,969	$395,497,826.63	$336,489,533.27	$35,718,854.14	$23,289,439.22
Non ACA	6,462,491	$146,821,856.90	$74,661,537.58	$20,062,301.89	$52,098,017.43
DY16					
ACA	12,502,471	$486,999,194.81	$407,341,713.72	$49,356,463.14	$30,301,017.95
Non ACA	6,978,981	$213,614,751.91	$118,707,968.94	$33,470,307.78	$61,436,475.19
DY17*					
ACA	5,444,224	$237,336,600.00	$198,541,628.09	$25,070,641.44	$13,724,330.47
Non ACA	7,067,068	$291,606,626.85	$228,957,911.58	$34,751,121.98	$27,897,593.29

**This DY contains six months of data.*

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'. A delta in expenditure levels is attributable to the timing of the data run. Counties have up to six months to submit their DMC claims, which can lead to lower reported expenditures when data is pulled within six months of the date of service.

Additional information specific to DY17 can be found in the DY17-Q1 and Q2 reports.

Policy/Administrative Issues and Challenges:

Beginning in March 2020, DMC-ODS counties experienced novel challenges in providing services due to the PHE. Due to safety concerns and staffing challenges faced by the counties as they were responding to COVID-19 case surges, DHCS made adjustments to its review schedules and compliance monitoring protocols, shifting onsite reviews to virtual reviews via WebEx. Allowing virtual review improved efficiency and reduced administrative burden on the counties, allowing them to focus on treating beneficiaries affected by the pandemic, without sacrificing oversight rigor. In addition, DHCS implemented several flexibilities through CMS waivers, guidance from the Drug Enforcement Agency (DEA), and Governor's executive orders, including waivers of informed consent written documents, adaptions to documentation requirements, allowance of telehealth services, and allowance for methadone take-home medications, among others.

CalAIM, and its associated 1915b and 1115 waiver proposals, were initially proposed to launch in January 2021, but were delayed due to the PHE. In response to a DHCS request, CMS approved a one-year extension to the 1115 waiver, mentioned above.
In addition, DHCS solicited feedback from providers and counties to understand the impact of the PHE and which flexibilities were needed. In response, CMS approved modifications to the STCs for California's section 1115(a) demonstration, including the following flexibilities:

- Suspending the following limits on residential treatment for participating DMC-ODS pilots with respect to DMC-ODS beneficiaries impacted by the COVID-19 emergency:
    - Modification to the STCs to suspend the limitation on 2 non-continuous 90-day regimens per year.
    - Modification to the STCs to suspend the current 30-day (for adolescents) and 90-day (for adults) maximums for a single residential stay.
- Modifying the rate-setting methodology of the DMC-ODS Certified Public Expenditure (CPE) protocol in Attachment AA.
- Modifying the settings in which services may be provided to include locations recognized by the state as temporary extensions of qualified residential settings where covered rehabilitative services may be provided.
- Suspending the minimal clinical service hour and disallowance requirements for intensive outpatient and residential SUD treatment, as long as care is consistent with the individual care plan.

In addition, DHCS provided guidance to counties and Medi-Cal providers to assist in providing medically necessary services for beneficiaries impacted by the PHE. DHCS was granted authority to grant flexibility for certain requirements through Executive Order N-43-20 and N-55-20. Guidance for counties participating in the DMC-ODS included the following:

- Starting March 1, 2020, through the duration of the emergency, the initial clinical diagnostic assessment, determination of medical necessity, and level of care may be conducted by telephone. These services may be provided by telehealth or in person, independent of the emergency.
- Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
- Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's Medicaid State Plan does not require that all components of these services be provided in-person. (An example could include services via telephone for a patient quarantined in their room in a residential facility due to illness).
- DMC-ODS individual counseling services that a provider determines to be clinically appropriate can be provided via telehealth and telephone. Beginning on March 1, 2020, and for the duration of the public health emergency, group counseling services can also be provided via telehealth and telephone.
- DMC-ODS counties that have NOT previously authorized services via telehealth in their program should allow providers to bill for services provided via telehealth during the period of heightened COVID-19 concern; DHCS approval is not required.
- No additional billing code (e.g. modifier) is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.
- With the exception of the Narcotic Treatment Program intake/physical for methadone maintenance, the required physical exam can be conducted via telehealth. When a

physical exam cannot be secured within 30 days, it is acceptable to list the physical exam as a goal on the treatment plan. For options regarding the physical exam, please see the Intergovernmental Agreement.

Additional details can be found on the DHCS COVID-19 response webpage.

Many counties continue to experience staffing challenges due to the demands of responding to the emergency. To adapt to these challenges, counties have expanded telehealth services, and DHCS is proposing to continue a robust telehealth policy after the PHE. DHCS is also exploring the option to continue the take-home methadone flexibilities, as long as allowed by the DEA.

DHCS also responded to PHE-related challenges in specific counties. For example, as a result of significant staffing shortages during the PHE, a Narcotic Treatment Provider (NTP) in Santa Cruz County began the practice of issuing Notice of Adverse Benefit Determinations (NOABD) in batches for beneficiaries noncompliant with program requirements. After technical assistance, the NTP has discontinued this practice and continues to be in compliance with NOABD timelines. DHCS is working with the Santa Cruz County to verify that beneficiaries were not negatively impacted by the process the NTP was using. The county will be submitting copies of the NOABDs for DHCS to analyze. The County/Provider Operations and Monitoring Branch aims to complete the analysis by March 15, 2022.

Many counties experienced natural disasters, in addition to the pandemic, and requested extensions to their scheduled monitoring reviews. DHCS adjusted to meet the needs of the counties and ensured that each review was completed timely. Despite the various challenges that have been faced by DHCS and the counties due to the pandemic and other emergencies, DHCS consistently completed the annual compliance monitoring reviews of each County during each year of the waiver period.

As mentioned above, DHCS engaged stakeholders to identify challenges and problems in Medi-Cal behavioral health, resulting in a set of policy updates as part of CalAIM:

- Administrative Behavioral Health Integration: Approximately half of individuals with a serious mental illness have co-occurring substance use and would benefit from integrated treatment. DHCS proposes to integrate mental health and SUD treatment into one county contract as of January 2027.

- Behavioral Health Payment Reform: effective July 1, 2023, DHCS will transition counties from a cost-based reimbursement methodology to a rate schedule, and will require all counties to update their coding to include CPT codes for licensed providers, and a more comprehensive set of HCPCS codes for counselors and other staff.

- Behavioral Health Policy Reforms: DHCS updated criteria for specialty mental health services, clarified criteria for SUD treatment (including allowing services prior to

diagnosis, and allowing youth to receive prevention and early engagement services), and reformed provider documentation standards.

To incentivize counties to implement these reforms, DHCS created the CalAIM Behavioral Health Quality Improvement Program (BHQIP), an incentive payment program to support counties in CalAIM implementation. Counties will be required to achieve certain CalAIM implementation milestones to earn incentive payments. Additional information on BHQIP can be found in the CalAIM BH-QIP Program Implementation Plan.

Progress on the Evaluation and Findings:

On February 28, 2022, UCLA submitted its final DMC-ODS evaluation report which is in the process of being posted to UCLA Evaluation reports. This report summarizes findings for both the most recent year and the full duration of the DMC-ODS Waiver from 2017-2021 in fulfillment of the requirements and timelines outlined in the approved evaluation design. This is the sixth annual report on DMC-ODS. Previous evaluation reports can be found at on the DMC-ODS Evaluation webpage. Recent reports are also available on the DHCS website. In the coming months, the evaluation team plans to conduct additional cost analyses to supplement the submitted reports.

There were no major challenges encountered for the 2017-2021 evaluation; a new evaluation plan will be prepared for DMC-ODS under the new CalAIM waiver. Please see the following brief descriptions of the UCLA Evaluation's interim findings:

- Access to care: Overall, DMC-ODS increased the number of people receiving Medicaid-funded treatment as well as the number of people receiving treatment under any funding source by about 25%. County administrators and patients alike provided high ratings for treatment access under the DMC-ODS waiver. However, treatment need has recently grown even faster than the growth in access, which will require continuing capacity expansion. Fentanyl overdoses, particularly among American Indian/Alaska Natives and Black/African-American populations, and staffing shortages were identified as challenges.

- Quality of care: Overall patient satisfaction remained high, and county administrators have reported that the DMC-ODS waiver has had a positive impact on quality improvement efforts. Use of ASAM Criteria-based screenings and assessments has been widespread, and the majority of patients who received ASAM-based screenings and assessments were successfully connected to care within 30 days in CY 2020. On other indicators of care quality such as treatment engagement, readmissions to withdrawal management, and patient satisfaction with treatment, data suggest the state continued to provide high-quality services to Medi-Cal beneficiaries in CY 2020 despite challenges created by the COVID-19 pandemic.

- Integration and coordination of care: County administrators have reported that the DMC-ODS waiver has had a positive impact on the integration of mental health, physical health, and SUD services. Still, progress has been uneven. Provider surveys indicated that SUD programs are more integrated with mental health than physical health services. Referrals from mental and physical health to SUD services also remained low overall, but county administrators reported that referrals from emergency departments with Care Navigators were rising. A number of challenges to better coordination of services remain, but progress is expected to continue under CalAIM, as many of CalAIM policies facilitate better integration and coordination of services.

The upcoming report and past reports have also covered a variety of special topics including the impact of COVID-19 and telehealth, residential length of stay, what non-waiver counties would need to join DMC-ODS, lessons learned for future regional models, stimulants, homelessness, and a cost analysis of residential treatment.

Opportunities for Improvement:

Looking ahead, the transition to the CalAIM initiative will significantly shape California's SUD treatment landscape. CalAIM policies will streamline access, improve quality, support integration and care coordination, and scale innovations statewide through new policies including: Enhanced Care Management, Community Supports, Providing Access and Transforming Health (PATH) Supports, Supporting Coordination and Integration for Dual Eligibles, Global Payment Program, and California's proposed justice in-reach and re-entry proposal.

Essentially, CalAIM will shift Medi-Cal to a population health approach that prioritizes prevention and addresses social drivers of health to better serve communities. It advances treatment for individuals with substance use disorder, including evidence-based contingency management to reduce the use of stimulants, peer support specialists to promote recovery and prevent relapse, and short-term residential treatment when necessary to advance treatment for enrollees. CalAIM's approach will reduce health disparities through improved community partnerships, member engagement, and a broader focus on identifying and addressing unmet health and health-related social needs.

Enclosures/Attachments:

The attachment listed below contains the Enrollment data, Member Year data, and Aggregate Expenditures data referenced in this report. Additionally, the attachment contains the ACA and Non ACA Expenditures parsed by level of care for DY12-DY17
1115 Waiver Report DY12-17 by Demonstration Year-3-4-22.xlsx

Also attached for CMS reference is Enrollment data, Member Month data, and Aggregate Expenditures data by demonstration year, including the ACA and Non ACA Expenditures parsed by level of care.

1115 Waiver Report DY12 PER QUARTER.xlsx
1115 Waiver Report DY13 PER QUARTER.xlsx
1115 Waiver Report DY14 PER QUARTER.xlsx
1115 Waiver Report DY15 PER QUARTER.xlsx
1115 Waiver Report DY16 PER QUARTER.xlsx
1115 Waiver Report DY17 PER QUARTER.xlsx

GLOBAL PAYMENT PROGRAM (GPP)

The GPP Program assists public health care systems (PHCSs) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. GPP supports PHCSs in their key role of providing services to California's remaining uninsured and promotes the delivery of more cost-effective and higher-value care to the uninsured. Under the GPP, participating PHCSs 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 funding for GPP is a combination of a portion of California's federal Disproportionate Share Hospital (DSH) funds and Uncompensated Care Pool (UC Pool) funding previously allocated to Designated Public Hospitals.

Successes/Accomplishments:

DHCS instituted and conducted bi-weekly conference calls with the California Association of Public Hospital and Health Systems to discuss implementation activities and issues, trends in reported data on metrics, and budgets.

CMS authorized $472 million annually in total computable (TC) funds for the UC Pool component of the GPP for each Program Year (PY) 2 through 7 (Formerly 6B). For the six-month period of PY6 (Formerly 6A), the UC Pool was approved for $236 million.

GPP implemented point value revaluation to four categories of services in accordance with Attachment FF. From PYs 1 through 7 (formerly 6B), the point value change was made at 5.5% for OP ER and mental health ER/crisis stabilization, and 3.3% for IP med/surg and IP mental health.

DHCS successfully developed aggregate reporting templates, encounter data manuals and revisions in accordance with STC Attachment EE, GPP Funding and Mechanics. In addition to this, DHCS successfully utilized the GPP Encounter Data Collection SharePoint Extranet site as a method of data transmission. Each PHCS submitted PYs 2 through 6 encounter-level data on their uninsured services using Excel templates provided in accordance with STC Attachment EE. PY7 (Formerly 6B) encounter-level data will be submitted by September 30, 2022.

On September 17, 2017, DHCS announced the Notice of Intent to Award the RAND Corporation a contract to conduct two evaluations of the GPP to assess the degree to which the program achieved the intended goals and improved care for uninsured patients accessing care in California's PHCSs. Both evaluations were completed in accordance with STC 177, Evaluations of Provider Expenditures and Activities under the GPP.

On August 3, 2020, DHCS received CMS approval to extend the GPP, allowing DHCS to operate an additional six-month GPP PY6 (formerly 6A) for the service period of July 1, 2020, to December 31, 2020. On December 29, 2020, CMS approved a one year extension of the Medi-Cal 2020 Waiver, to allow for the continuation of the GPP under PY7 (formerly 6B) for the service period of January 1, 2021, to December 31, 2021.

On December 29, 2021, CMS approved California's 1115(a) "CalAIM" Demonstration. The approval is a part of the state's larger CalAIM initiative and authorizes the continuation of GPP for the period of January 1, 2022 through December 31, 2026. Under CalAIM, GPP is adding services that aim to address health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries. Such alignment of services across populations seeks to facilitate addressing health disparities.

Program Highlights:

GPP originated as a fiscal year program aligning with the state fiscal year, however, GPP began operating as a calendar year program as of January 1, 2021. In order to align federal fiscal year DSH allotment amounts with the conversion to a calendar year, GPP PYs 7 through 12 are funded with 50% of the Adjusted DSH for the FFY beginning prior to the first GPP PY, and 50% of the Adjusted DSH for the FFY commencing during the GPP PY.

Prior to the beginning of each GPP PY, DHCS determined the initial adjusted DSH component and submitted a report to CMS in accordance with STC Attachment NN, DSH Coordination Methodology. GPP made interim quarterly payments, based on 25% of a PHCS' annual global budget. The payments occurred 15 days after the end of each of the first three quarters of the PY. The fourth quarterly payment occurred three and a half months after the end of the quarter and utilized interim hospital reporting to determine the amount that each PHCS earned. The final reconciliation and redistribution payment round redistributed funds according to final data reports received from the PHCSs and allocated any unclaimed GPP funds to those hospitals that exceeded their system threshold budgets.

PY final closeout activities took place for PYs 1 and 2 after CMS published the final federal fiscal year (FFY) 2016 and 2017 DSH allotments to the Federal Register. DHCS determined the amount earned by each PHCSs in accordance with the final reconciliation and redistribution process and completed round 6 final DSH GPP payment rounds. Final closeout activities for PY3 through 7 (formerly 6B) will occur upon publish of the final FFY 2018 – 2021 DSH allotments.

DHCS submitted payment summary reports to CMS following 30 days of payment date. The payment summary reports summarized all GPP transactions, such as interim payments, final payments, and recoupments for all PHCSs. CMS released adjusted FFY 2020, 2021, and 2022 DSH allotments as a result of the American Rescue Plan Act of 2021 (ARPA). GPP made

catch-up payments for PY5, PY6 (formerly 6A), and 7 (formerly 6B) as a result of the increased allotments.

Qualitative Findings:

DHCS reviewed and approved PY2 through 6 (formerly 6A) encounter-level data on PHCS uninsured services submitted. DHCS reviewed encounter-level data for accuracy, completeness, reasonability, timeliness, and compliance using the GPP Encounter Data Manuals, and performed tests for reasonableness. Where necessary and appropriate, DHCS worked with PHCSs to correct or improve data.

The RAND Corporation conducted interviews with PHCS representatives about the trends in behavioral health care utilization in ERs, outpatient, and inpatient settings among other topics, to better understand PHCS operations. The interviews gained more insight into PHCS views of the benefits and challenges of providing non-traditional services. Additionally, the interviews provided the opportunity to explore factors that influenced real or observed changes in service utilization.

DHCS received signed certifications of voluntary contributions to non-federal share of Medicaid expenditures from all PHCSs with their intergovernmental transfers (IGT) payments. The IGT certification process includes DHCS providing an IGT notification and payment memos, IGT receipts, payment amount, and payment date notifications.

DHCS created and manages a GPP webpage. The webpage content contains the 1115 Waiver STCs, funding and annual limits, payments made for all PYs, and the midpoint and final evaluation reports. In addition to GPP webpage, DHCS created and utilizes a GPP e-mailbox, GlobalPaymentProgram@dhcs.ca.gov, to manage correspondence for stakeholder engagement and PHCSs inquiries.

Quantitative Findings:

For each GPP PY, DHCS determined the funding and annual limits consistent with the STCs. The annual limit is the sum of the Adjusted DSH allotment, the UC Pool, and the applicable intergovernmental transfer component. For GPP PYs 1 through 7, the following TC payments were made to PHCS:

DY11 GPP PY1: $2.2 billion
DY12 GPP PY2: $2.2 billion
DY13 GPP PY3: $2.3 billion
DY14 GPP PY4: $2.4 billion
DY15 GPP PY5: $2.4 billion
DY16 GPP PY6 (Formerly 6A): $1.2 billion
DY17 GPP PY7: (Formerly 6B): $1.5 billion paid to date as of February 2022. The total annual budget for PY7 is $2.5 billion.

All eligible GPP services were assigned a point value related to the cost of the service, the relative benefit to the patient for that service, and the impact on the delivery system through future health care cost. In aggregate, PHCSs met their PYs 1, 3, and 4 system thresholds. However, during PYs 5 and 6 (formerly 6A), specific PHCSs were unable to meet their historical threshold points earned due to the public health emergency (PHE) and the impact to the delivery of GPP services. In response, CMS approved the reduction of GPP thresholds for PY5 and PY6 (formerly 6A). PY5 PHCS thresholds were reduced by 10%, and PY6 (formerly 6A) PHCS thresholds were reduced by 29%. PY7 (formerly 6B) data is currently being reviewed to determine if an additional reduction is warranted.

In PYs 1 through 4, the total number of GPP units of service increased by 2% on average. In PY5, the total number of GPP units of service decreased by 5%, in comparison to the prior year, PY 4. The decrease was largely due to the PHE. Likewise, PY6 (formerly 6A) was also affected by the PHE and GPP units of service decreased by 16%, in comparison to the prior year, PY5.

Policy/Administrative Issues and Challenges:

In PY2, PHCSs did not earn the full GPP global budget of $2.2 billion, and instead earned 97% of the GPP global budget. As a result, PHCS were unable to claim $29M in FFP for an unclaimed TC amount of $58 million.

The Families First Coronavirus Response Act (FFCRA) federal medical assistance percentage (FMAP) increase of 6.2% went into effect on January 1, 2020 as a result of the Public Health Emergency (PHE). The increased FMAP period began with the GPP PY5 IQ 2 payment, resulting in an increase from 50% to 56.2% FMAP. The FMAP increase created administrative challenges with GPP payment methodologies, timing of payments, and state program and hospital budgeting. The preliminary DSH allotments prior to the FFCRA FMAP increase and ARPA-adjusted allotments differed from the originally provided amounts, which affected prior payments made to the PHCSs. DHCS made adjustments and additional payment rounds for the FMAP increase and ARPA-adjusted allotments.

The Affordable Care Act (ACA) requires a reduction in DSH allotments and was originally scheduled to take effect on October 1, 2013. On December 27, 2020, House of Representatives 133 (2020) was enacted which eliminated the DSH reductions for FFY 2021 through FFY 2023, lowered the overall aggregate national reduction to $32 billion, and postponed the implementation until FFY 2024. The postponement of the implementation of the DSH reduction affected GPP payments that were previously made using reduced amounts. Furthermore, the postponement added additional rounds of payments to reflect repayment of previously reduced amounts.

Progress on the Evaluation and Findings:

In accordance with STC 177, DHCS conducted two evaluations of provider expenditures and activities under the GPP. Both evaluations examined the purpose and aggregate impact of the

GPP, care provided by the PHCSs and patients' experience, with a focus on understanding the benefits and challenges of the GPP payment approach. DHCS contracted with the RAND Corporation and conducted a midpoint and final evaluation of the GPP to assess the degree to which the program achieved its intended goals of more cost-effective and higher-value care for uninsured patients.

On June 18, 2018, the Midpoint Evaluation Report was submitted to CMS. The midpoint report used utilization data from PYs 1 and 2 and was designed to assess early trends and describe infrastructure investments made by California's PHCS. The Evaluation found that PHCSs have built and strengthened primary care, data collection and integration, and care coordination to deliver care to the remaining uninsured. The majority of PHCSs improved the utilization of non-inpatient non-emergent services.

On June 18, 2019, the Final Evaluation Report was submitted to CMS. The Evaluation found that PHCSs reported building and strengthening infrastructure to support the goals of the GPP. Utilization data showed a continued increase in outpatient non-emergent non-behavioral health services for most PHCSs. PHCSs also reported that the strategies and services being delivered having a positive impact on GPP outcomes.

Opportunities for Improvement:

Per STCs, final DSH GPP payments cannot be made until CMS publishes the final FFY DSH allotments. Because final allotments have not been published beyond FFY 2017, DHCS has been unable to close out any PYs other than PY1 and 2. Improvement can be achieved by making an adjustment to the GPP Funding and Mechanics Protocol to allow final GPP payments to be made upon CMS notification of the final CA DSH allotment.

For IQ payments in GPP PYs 7 (formerly 6B) through 12, PHCSs can extend their IGT due date to July 1 and payment date to July 30. Doing this allows IQ 2 payments to occur 30 days after the end of the service period, whereas IQ 1 and 3 payments occur 15 days after end of service period. The extension of the IGT due date will allow for PHCSs to submit their IGTs and receive payment within the same fiscal year. This change can alleviate PHCSs cash flow issues that PHCSs face at Fiscal Year-End.

Schedule C:

For the DY 11 – DY 15 budget neutrality (BN) submission on July 12, 2021, the State utilized the December 9, 2020, version of the Schedule C report. For this DY 11 – DY 15 submission, the State has utilized the November 2, 2021 version of the Schedule C report from the Medicaid Budget & Expenditure System (MBES) to populate the 'C Report' tab of the BN workbook. Any adjustment applied outside of MBES is reflected on the 'Total Adjustments' tab of the BN workbook.

Program Spending Limits:

The State added dollar amounts to the program spending limit cells for DY 16 and DY 17 within this tab so that expenditures could flow through the BN workbook. The Global Payment Program, IHS Uncompensated Care, DSHP, DTI, and Whole Person program limits were blank in the CMS-provided template for DY 16 and DY 17, thus anticipated amounts were included.

Enrollment:

Actual member months (MMs), by applicable DY, were extracted on November 9, 2021, from the State's Medi-Cal Management Information System/Decision Support System (MIS/DSS) data warehouse. Using the eligibility data within the MIS/DSS warehouse, MMs were mapped to the applicable Medicaid Eligibility Groups (MEGs). See the attached aid code mapping file for reference (*2020 Waiver BN Aid Code Mapping 070921.xlsx*). Additional criteria, which are not reflected in the attached file, were applied to account for dual status, rural/urban distinctions, Coordinated Care Initiative (CCI)/Non-CCI distinctions, and Waiver Model type. The State can provide the full data query logic/code to CMS upon request.

Projected MMs were included for a portion of DY 17 as the time period was incomplete at the time of the data query. Enrollment for DY 17 includes actual MMs through the September 2021 service period and MMs for the last quarter of DY 17 were assumed at the monthly average of the prior nine months. In other words, the State annualized the nine-month actual DY 17 enrollment to project the final 3 months of DY 17.

Manual Adjustments:

Within the BN workbook, the 'Total Adjustments' tab allows the State to manually adjust the Schedule C reported expenditures. The State has determined it necessary to apply adjustments for DY 11 – DY 17 (July 1, 2015 through December 31, 2021 reporting period). By doing so, expenditures flow to the appropriate waiver categories for the BN calculation. Both negative (decrease in expenditures) and positive (increase in expenditures) adjustments have been applied to each DY.

Broadly, the starting point for this BN calculation is Schedule C data as of November 2, 2021, which is derived from data queried from the State's capitation payment system. As previously communicated by the State to CMS, the State has identified and is working to resolve various system mapping challenges to refine and improve the mapping of expenditures from the State's capitation payment system to the appropriate waiver categories. As the system updates are still in process, the State applied refined mapping logic to more appropriately categorize expenditures across the waiver categories via the 'Total Adjustments' tab. The manual adjustments primarily shift expenditures between waiver categories but also produce some changes in total expenditures that are needed better to represent actual expenditures under the waiver.

Although the State continues to apply manual adjustments to account for system mapping issues, as described above, significant progress has been made in updating the capitation payment system since the prior Medi-Cal 2020 Waiver BN submission in July 2021. As such, the Schedule C report used for this submission more closely aligns with actual expenditures and the State has applied fewer manual adjustments than in the prior submission. As is understood with CMS, manual adjustments for expenditures beyond the two-year timely claim filing timeframe are not reflected on the Schedule C report.

The aggregate adjustments applied to each wavier category by DY are reflected within the 'Total Adjustments' tab of the BN workbook. Please refer to the file *2020 Waiver BN Manual Adjustments Detailed Crosswalk 040122.xlsx* for an itemized list and additional detail of these adjustments.

Adjustments to the November 2, 2021, Schedule C expenditures are described below.

- Expenditures for the **Out-of-State (OOS) Foster Care Youth** hypothetical population are not specifically tracked for reporting within Schedule C. Using expenditure data pulled from MIS/DSS for OOS Foster Care Youth aid codes, a portion of expenditures included with the Medicaid Per Capita MEGs were reallocated to the OOS Foster Care Youth Hypothetical 4 Aggregate category.
- Expenditures for the **Community-Based Adult Services (CBAS)** hypothetical service category are not specifically tracked for reporting within Schedule C. Using expenditure data pulled from MIS/DSS for the CBAS rate increment, a portion of expenditures included within the Medicaid Per Capita MEGs and New Adult Group Hypothetical 2 Per Capita category were reallocated to the CBAS Hypothetical 1 Aggregate category.
- Expenditures for the **Health Homes Program (HHP)** hypothetical service category are not specifically tracked for reporting within Schedule C. As HHP expenditures are independently identified in the MIS/DSS under a distinct Invoice Type, all HHP invoice expenditures were reallocated to the HHP Hypothetical 5 Aggregate category.
- Expenditure reductions due to **Adult Expansion Medical Loss Ratio (AE MLR) calculations** were not reported within Schedule C. A manual adjustment is necessary to reflect the portion of Schedule C reported expenditures for the New Adult Group Hypothetical 2 Per Capita category that were returned by Medi-Cal managed care plans to the State due to the AE MLR calculations.
- **Pharmacy rebates** were allocated to Medicaid Per Capita categories in proportion to the actual expenditures by waiver category. These adjustments were not reflected in the capitation expenditures, so a manual adjustment was necessary.
- **Other Adjustments (not otherwise captured)** were necessary to adjust the Schedule C reported expenditures in light of the system mapping challenges noted above. As the system updates are still in process, the State applied refined mapping logic to more appropriately categorize expenditures across the waiver categories.

Please see the table below that summarizes the aggregate level adjustments for each DY. For a more detailed breakdown, see the file *2020 Waiver BN Manual Adjustments Detailed Crosswalk 040122.xlsx*.

Figure 13: Aggregate Level Adjustments for DY 11-16

	11	12	13	14	15
Medicaid Per Capita	$ (1,919,657,035)	$ (1,750,162,747)	$ (608,844,688)	$ 758,909,228	$ 538,883,532
Medicaid Aggregate	$ -	$ -	$ -	$ -	$ -
Medicaid Aggregate (WW only)	$ (796,230)	$ (17,264,872)	$ 18,389,872	$ -	$ -
CBAS	$ 457,814,635	$ 477,625,639	$ 472,617,810	$ 319,113,136	$ (13,987,660)
New Adult Group	$ (2,108,326,632)	$ (1,384,118,126)	$ (814,865,947)	$ 225,944,381	$ 572,694,076
DMC-ODS	$ -	$ -	$ -	$ -	$ -
OOS Foster Care Youth	$ -	$ -	$ 282,252	$ 472,488	$ 534,414
HHP	$ -	$ -	$ -	$ 9,255,328	$ 46,156,140
Total	**$ (3,570,965,263)**	**$ (2,673,920,106)**	**$ (932,420,701)**	**$ 1,313,694,560**	**$ 1,144,280,503**

	16	17	Total
Medicaid Per Capita	$ 298,617,739	$ (2,157,369,856)	$ (4,839,623,826)
Medicaid Aggregate	$ -	$ -	$ -
Medicaid Aggregate - WW only	$ -	$ -	$ 328,770
CBAS	$ (10,608,182)	$ (51,572,812)	$ 1,651,002,566
New Adult Group	$ 358,473,865	$ (1,021,829,434)	$ (4,172,027,817)
DMC-ODS	$ -	$ -	$ -
OOS Foster Care Youth	$ 254,371	$ 346,203	$ 1,889,727
HHP	$ 29,288,943	$ 23,040,232	$ 107,740,642
Total	**$ 676,026,736**	**$ (3,207,385,667)**	**$ (7,250,689,937)**

Projections:

Within the BN workbook, the 'WW Spending Projected' tab allows the State to add projected expenditures to the Schedule C reported expenditures. The State has determined it necessary to include projections for DY 11 – DY 17.

The aggregate projections applied to each wavier category by DY are reflected within the 'WW Spending Projected' tab of the BN workbook. The projections are estimated amounts for anticipated payments and recoupments that are not yet reflected in either the Schedule C data or the manual adjustments described above. In the managed care delivery system, it is not uncommon for expenditures to change retroactively due to the time and data runout required for various special payment arrangements, risk corridors and other retrospective financial calculations, and other factors.

Fiscal best-estimates were leveraged to determine the appropriate amounts to project. The estimates were reviewed and applicable expenditures under the waiver were included within the BN workbook by DY and waiver category. Estimated amounts that were developed in aggregate across the managed care delivery system were allocated to waiver categories using the best available information for each projection.

Examples of noteworthy projections are listed below. Please refer to the file *2020 Waiver BN WW Spending Projections Detailed Crosswalk 040122.xlsx* for an itemization of the projections as well as amounts and distribution by MEG and DY.

- Estimates for a portion of **DY 17 base expenditures** are included as projections. This includes monthly capitation payments (for August through December 2021), supplemental payments, directed payments, and other health care financing mechanisms.
- Estimates of **CCI risk corridor calculations** for DYs 11, 12, and 13 are included as projections. Due to the retroactive nature of the risk corridor calculations, which have not been completed at this time, the State relied on Medi-Cal managed care plan reported data to develop the estimated impacts. Anticipated recoupments are allocated across the applicable CCI-related MEGs: MLTSS Duals - TPM/GMC, Cal-Medi-Connect - TPM/GMC, MLTSS Duals - COHS, and Cal-Medi-Connect - COHS.
- Estimates of CMS-approved **directed payment expenditures** for DY 15 – DY 17 are included as projections. These directed payments are paid retrospectively based on actual utilization of services and actual performance on quality measures, respectively. Data from the applicable rating period, once reasonably complete, is used to calculate and issue the final payments. The estimated total expenditures were allocated across applicable MEGs.
- **Medicaid Aggregate With Waiver (WW) expenditures** are best estimates as of November 2021 by each programmatic area within the State responsible for implementing the associated programs.

Please see the table below summarizing the projections for each DY.

Figure 14: Projections for DY 11-17

	11	12	13	14	15
Medicaid Per Capita	$ (41,911,031)	$ (13,678,925)	$ (13,713,654)	$ (145,510,732)	$ 390,451,934
Medicaid Aggregate	$ (1,205,694,385)	$ 127,008,475	$ (71,170,678)	$ (177,626,188)	$ 219,467,367
CBAS	$ -	$ -	$ -	$ -	$ -
New Adult Group	$ -	$ -	$ (33,129,619)	$ (68,060,718)	$ 285,526,171
DMC-ODS	$ -	$ 23,716,402	$ 26,340,226	$ 17,797,144	$ 11,389,730
OOS Foster Care Youth	$ -	$ -	$ -	$ -	$ -
HHP	$ -	$ -	$ -	$ -	$ -
Total	**$ (1,247,605,416)**	**$ 137,045,952**	**$ (91,673,725)**	**$ (373,400,494)**	**$ 906,835,203**

	16	17	Total
Medicaid Per Capita	$ 1,358,778,881	$ 15,542,966,200	$ 17,077,382,674
Medicaid Aggregate	$ 587,565,391	$ 3,230,594,505	$ 2,710,144,487
CBAS	$ -	$ 199,229,354	$ 199,229,354
New Adult Group	$ 1,312,253,881	$ 9,632,353,770	$ 11,128,943,485
DMC-ODS	$ 46,827,120	$ 522,811,786	$ 648,882,408
OOS Foster Care Youth	$ -	$ 158,003	$ 158,003
HHP	$ -	$ 103,407,546	$ 103,407,546
Total	**$ 3,305,425,273**	**$ 29,231,521,163**	**$ 31,868,147,956**

All projections are point-in-time best estimates and subject to change as additional information and/or actuals become available. Anticipated payments and recoupments for which an amount was not reasonably estimable are not included. These include but are not limited to expenditure changes due to:

- Corrections not reflected in the State's capitation payment system, except as described above;
- Certain retrospective risk corridor, financial reconciliation, and withhold calculations for which the magnitude and direction of results is unknown.

Additional Notes:

WW expenditures reflect actual and projected managed care expenditures under the waiver including any changes in managed care covered benefits. As previously communicated by the State to CMS, during DY 11 – DY 17, certain services or programs were carved in to or carved out from the managed care delivery system, or were modified, without corresponding updates to Without Waiver PMPMs. Examples include but are not limited to: acupuncture services (added effective July 1, 2016), nonmedical transportation services (added effective July 1, 2017), Proposition 56-funded supplemental payments (added effective July 1, 2017), and In-Home Supportive Services (removed effective January 1, 2018).

In instances where information was not available at the beneficiary level to allow accurate mapping to particular waiver categories, broader assumptions or allocations were used to shift Schedule C reported expenditures between waiver categories, or to appropriately increase or decrease total expenditures. Assumptions and allocations are viewed to be reasonable best estimates of the beneficiary-level distributions.

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

On August 18, 2017, CMS approved an amendment to Medi-Cal 2020 1115 Demonstration Waiver (Medi-Cal 2020) to allow the DHCS to continue providing Medicaid coverage for Out-of-State (OOS) Former Foster Youth (FFY) 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 (Attachment QQ of the Medi-Cal 2020 STCs) was approved on December 22, 2017, using the most current data from 2015. CMS agreed that the OOS FFY population was statistically insignificant for comparison in the evaluation design. Any statistical comparisons in Attachment QQ were to be between the FFY population and the Medi-Cal population age 18 to 25, inclusive. The waiver amendment authorized Medi-Cal 2020 to include OOS FFY starting on November 1, 2017. The DY17 report and Attachment QQ uses the most current data for FFY from 2020.

DHCS submitted the Interim Evaluation Report for the OOS FFY portion of Medi-Cal 2020 to CMS on June 23, 2020. The State of California also submitted a request to CMS on September 16, 2020 to extend Medi-Cal 2020 to December 31, 2021. On December 29, 2020, CMS approved a temporary extension of Medi-Cal 2020 to December 31, 2021. As described in more detail below, during DY17, the State again requested the extension of this authority as part of the CalAIM renewal, and the authority was granted.

The final report on the Medi-Cal 2020 waiver and the data for DY17 is due to CMS within 120 days of December 31, 2021. Data for DY17 for the OOS FFY is included with the report as Attachment QQ.

Successes/Accomplishments:

California was the first state to have its 1115 Waiver approved by CMS to provide Medi-Cal eligibility to OOS 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 Program. From 2016 through 2019, California added over 6,500 FFY to the FFY Program under the HEDIS requirements of being enrolled for eleven out of twelve months in a year. Under the Public Health Emergency (PHE) in 2020, California added nearly 10,000 FFY to the FFY Program.

Program Highlights:

Under the PHE, California increased total enrollment of individuals in the FFY Program to 28,257 and of these 174 are OOS FFY. In 2019, California had total enrollment of FFY in Medi-

Cal of 18,153, and of these 81 were OOS FFY. These FFY meet the HEDIS requirements of being enrolled in Medi-Cal for eleven out of twelve months at any time in 2019 and 2020. FFY continue to actively utilize the full scope Medi-Cal benefits available to them whether it is behavioral health visits, ambulatory care visits, inpatient stays or specific courses of treatment. Attachment QQ submitted with this report is based upon HEDIS requirements and provides the FFY data based upon the number of FFY who remained enrolled in 2020 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 and FFY;
- hold regular meetings with the counties to resolve issues that arise for the FFY;
- collaborate with our county partners in the development of a flag in the Medi-Cal Eligibility Data System (MEDS) to allow counties to track FFY eligibility in one system location, accessible to all counties, to simplify tracking youths for eligibility purposes as they change residence from one county to another;
- 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;
- regularly meet with stakeholders for feedback on any concerns or issues, and;
- collaborate closely with our county partners to prepare for the lifting of the PHE.

Quantitative Findings:

According to the 2020 Enrollment, Utilization, and Health Outcomes evaluation (DY17 Attachment QQ), during the PHE the FFY utilization changed, reflecting the concerns of the PHE. There was a greater percentage use of ambulatory care 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), Initiation and Engagement of Alcohol and Other Drug Treatment (IET) and Follow-Up After Hospitalization for Mental Illness (FUH) continue to be accessed more by the FFY group than the 18-25 year old Medi-Cal population. The OOS FFY quality measures are insufficient to allow for disclosure due to Data De-Identification Guidelines.

In 2020, measure specifications for the data collected changed for assessing utilization and quality measures to more accurately reflect the current HEDIS measures. Since those measure specifications changed, it is not recommended to compare 2019 data regarding utilization and quality measures to 2020 data regarding utilization and quality measures.

Policy/Administrative Issues and Challenges:

FFY are a group of individuals who move often, and are accustomed to having their health care needs met 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 FFY 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 FFY transitioning from foster care to programs other than the FFY Program. To remedy this, DHCS is developing a MEDS field for counties to track youths eligible for the FFY Program in an effort to prevent any gaps in Medi-Cal coverage. This field will also identify the location where the youth was in foster care, whether in California or out of state. Due to the complexity of the project, the new MEDS field is being completed in stages. Completion of all stages is anticipated in 2022.

On October 24, 2018, Congress passed H.R. 6, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

Under H.R. 6, 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 initial definition of eligible juveniles included FFY as described in Section 1902 of the Social Security Act (SSA) subsection of (a)(10)(A)(i)(IX). OOS FFY were excluded in this initial definition and therefore were not eligible for the coverage under Section 1001 of the SUPPORT Act.

CMS published additional guidance on January 19, 2021 that redefined ““eligible juvenile” to include “beneficiaries eligible under the state plan and/or under a section 1115 demonstration project for whom expenditures are regarded as expenditures under the state plan, including individuals under age 26 who were enrolled in both Medicaid and in foster care under the responsibility of another state upon attaining age 18 or higher applicable age.”

Under the revised definition of “eligible juvenile” OOS FFY are eligible for coverage under Section 1001 of the SUPPORT Act.

During the PHE, once an individual is enrolled in Medi-Cal, they cannot be terminated from the program until the PHE ends. California enrolls FFY immediately upon self-attesting application and then verifies their eligibility for the FFY Program. Due to the PHE, individuals who were verified as not eligible remain in Medi-Cal until the PHE is lifted. When the PHE is lifted, counties will fully reassess the youths in the FFY Program who have been determined not eligible for the Program to determine if they are eligible for any other Medi-Cal program.

Once the FFY are fully reassessed, the number of eligible youths remaining in the FFY Program is expected to be lower.

Progress on the Evaluation and Findings:

Former Foster Youth (FFY) Demonstration Results (2016 – 2019)
Through this demonstration California has continued to provide Medicaid coverage for FFY who aged out of foster care under the responsibility of another state while enrolled in Medicaid and have now applied for Medi-Cal in California where they reside. The demonstration results show increasing and strengthening overall coverage of FFY and improving health outcomes for these youth.

DHCS has gathered and compared FFY data from 2016 to 2019 to assess how the FFY are accessing eight specific categories of age appropriate health care services and to demonstrate a positive health outcome for the FFY.

The data is set out below:

Medi-Cal 2020 has provided continuous health insurance coverage for the OOS FFY. Beneficiaries are continuously enrolled for 12-month periods until they reach 26 years of age. (Beneficiaries are considered “continuously enrolled” during the measurement year if enrolled in January and not age 26 by December 31st of measurement year.)
Beginning in 2016, 10,764 FFY beneficiaries were continuously enrolled for a 12-month period with a total of 22,720 FFY enrollments. In 2019, enrollment increased to a total of 17,422 FFY continuously enrolled for a 12-month period with a total of 29,004 FFY enrollments.

From 2016 to 2019, FFY beneficiaries accessed emergency, behavioral health visits and hospital services more often than their peers, and accessed ambulatory care at a lesser rate under the Medi-Cal program. During the PHE in 2020, FFY beneficiaries accessed ambulatory care more often than their peers and accessed emergency care at lesser rate under the Medi-Cal program reflecting the changing needs of the PHE.

From 2016 to 2019, the health outcomes for beneficiaries show the rates for chlamydia (CHL) and cervical cancer (CCS) screening are similar to their peers, as is initiation of treatment of substance use disorders (IET). FFY do not do as well on AMM, or for follow up after hospitalization for mental illness (FUH 30 day).

FFY beneficiaries utilized health services in the following ways:

- Ambulatory Care: In 2016, there were 5,269 FFY who had ambulatory care visits compared to a total of 11,572 FFY beneficiaries. In 2019, there were 8,206 FFY who had ambulatory care visits compared to a total of 18,153 FFY beneficiaries. The percentage of FFY utilization of ambulatory care visits varied from 46% in 2016 to 45% in 2019.

- Behavioral Health Visits: In 2016, there were 1,610 FFY who had behavioral health visits compared to a total of 11,572 FFY beneficiaries. In 2019, there were 2,543 FFY who had behavioral health visits compared to a total of 18,153 FFY beneficiaries. The percentage of FFY utilization of behavioral health visits remained the same at approximately 14% each year.
- Emergency Department (ED) Visits: In 2016, there were 4,877 FFY who had ED visits compared to a total of 11,572 FFY beneficiaries. In 2019, there were 7,066 FFY who had ED visits compared to a total of 18,153 FFY beneficiaries. The percentage of FFY utilization of ED visits decreased slightly from approximately 42% in 2016 to 39% in 2019.
- Inpatient Stay: In 2016, there were 422 FFY who had inpatient stays compared to a total of 11,572 FFY beneficiaries. In 2019, there were 684 FFY who had inpatient stays compared to a total of 18,153 FFY beneficiaries. The percentage of FFY utilization of inpatient stays remained the same at approximately 4% each year.

FFY beneficiaries utilized health services in the following ways:

- Chlamydia screening in women (CHL): The total number of FFY beneficiaries who received CHL screening in 2016 was 1,851 whereas the total number of FFY beneficiaries who received CHL screening in 2019 was 2,782. The percentage of FFY beneficiaries who received CHL screenings rose slightly from approximately 69% in 2016 to 72% in 2019.
- Initiation and Engagement of Alcohol and Other Drug Treatment (IET): The total number of FFY beneficiaries who received IET treatment in 2016 was 298 whereas the total number of FFY beneficiaries who received IET treatment in 2019 was 304. The percentage of FFY beneficiaries who received IET treatment decreased from approximately 53% in 2016 to 30%in 2019.
- Cervical Cancer Screening (CCS): The total number of FFY beneficiaries who received CCS screening in 2016 was 516 whereas the total number of FFY beneficiaries who received CCS screening in 2019 was 1,276. The percentage of FFY beneficiaries who received CCS screenings increased from approximately 34% in 2016 to 40% in 2019.
- Antidepressant Medication Management (AMM) – Continuous Phase: The total number of FFY beneficiaries who received AMM in 2016 was 26 whereas the total number of FFY beneficiaries who received AMM in 2019 was 59. The percentage of FFY beneficiaries who received AMM rose from 11% in 2016 to 14% in 2019.
- Follow-up after Hospitalization for Mental Illness (FUH): The total number of FFY beneficiaries who received FUH in 2016 was 148 whereas the total number of FFY beneficiaries who received FUH in 2019 was 181. The percentage of FFY beneficiaries who received FUH rose from approximately 69% in 2016 to 71% in 2019.
- Use of Opioids at High Dosage (OHD): The total number of FFY beneficiaries who received OHD in 2016 and 2019 was suppressed in accordance with California DHCS De-identification Guidelines due to the size of the population.

- Medication Management for People with Asthma (MMA): The total number of FFY beneficiaries who received MMS in 2016 was suppressed in accordance with California DHCS De-identification Guidelines due to the size of the population. 2016 was the last year MMA was being tracked.
- Asthma Medication Ratio for People with Asthma (AMR): The original category to be tracked was Medication Management for People with Asthma (MMA). AMR was being reported in place of MMA, since MMA was no longer being tracked. The total number of FFY beneficiaries who received AMR in 2019 was 39. The percentage of FFY beneficiaries who received AMR in 2019 was 34%.
- Annual Monitoring for Patients Eligible for Persistent Medication (MPM) – Angiotensin converting 6enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): The total number of FFY beneficiaries who received MPM in 2016 and 2019 was suppressed in accordance with California DHCS De-identification Guidelines due to the size of the population.

Opportunities for Improvement:

Under H.R. 6, Section 1002 of the SUPPORT Act, "Health Insurance for Former Foster Youth", Medicaid coverage was extended to provide Medicaid eligibility to all OOS FFY regardless of the state they were in when they were in foster care. Therefore, with the implementation of Section 1002, any foster care youth who exits foster care at 18 or older on or after January 1, 2023, is eligible for Medicaid regardless of the state in which they were in foster care. However, OOS FFY who exited foster care in a state other than California before January 1, 2023 and apply for Medi-Cal must still be covered under a waiver.

To remedy the potential gap in coverage for the OOS FFY, California included the OOS FFY in its request for an amendment and five-year renewal of the CalAIM Section 1115 Demonstration. The request was approved on December 29, 2021 with a requested effective date of January 1, 2022. Since OOS FFY were included in the new CalAIM Section 1115 Demonstration request, those FFY who exited foster care before January 1, 2023 will have their Medi-Cal eligibility maintained for the next five years under the CalAIM Waiver.

With the implementation of Section 1002, it is anticipated that the OOS FFY population eligible for Medi-Cal under the CalAIM Waiver will begin to decline since any OOS FFY exiting foster care on or after January 1, 2023 will be covered under Section 1002 and any resulting proposed SPAs.

Under 42 CFR 435.150 the currently approved California SPA limits eligibility to those FFY who "were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program." California anticipates a new SPA will be necessary due to the language implemented under H.R. 6, Section 1002 of the SUPPORT Act "Health Insurance for Former Foster Youth". The new language will provide eligibility to those

FFY who “were in foster care under the responsibility of a State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii)…”

Sometime in 2022, the FFY MEDS Flag project is expected to be completed. This flag will allow DHCS to identify youths who are eligible for the FFY Program regardless of the Medi-Cal program they are placed in when exiting foster care. It will facilitate identification of individuals when they change counties or programs to prevent gaps in Medi-Cal coverage.

Enclosures/Attachments:

The attachment listed below contains 2019-2020 FFY Enrollment, Utilization, and Health Outcomes.

Attachment QQ_FFY Enrollment_2019-2020

MEDI-CAL 2020 INITIATIVES NOT CONTINUING UNDER THE CALAIM 1115 DEMONSTRATION:

ACCESS ASSESSMENT

In 2016 DHCS contracted with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct a one-time assessment to evaluate primary, core specialty, and facility access to care for Medi-Cal managed care members enrolled in managed care during 2017/18 based on access requirements in the Knox-Keene Health Care Service Plan Act of 1975 and existing MCP contracts.

As part of the assessment, DHCS formed an advisory committee, which included representatives from consumer advocacy organizations, providers, provider associations, Medi-Cal managed care health plans (MCPs), health plan associations, and legislative staff.

DHCS 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. DHCS sought public comment on the draft report and reviewed the results with the committee prior to finalizing. The final report identified that although some MCPs did not meet all standards, no single MCP consistently performed poorly. DHCS submitted the final report to CMS on October 8, 2019 and continues to work on network and data quality improvement efforts to support the ongoing analysis of MCP networks and member experience.[14]

[14] DHCS Website, *An initial draft of the CA 2017-18 Access Assessment Report,* 2018, https://www.dhcs.ca.gov/provgovpart/Pages/mc2020accessassessment.aspx.

HEALTH HOME PROGRAM (HHP)

The Federal authority for California's (CA) HHP was initially through an amendment to CA's 1115 Medi-Cal 2020 waiver, as well an amendment to California's State Plan; both of which were effective December 19, 2017. Through these authorities, CMS granted DHCS approval for a freedom of choice waiver, allowing the state to provide HHP services strictly through the Medi-Cal managed care delivery system to members enrolled in managed care. Eligibility for the HHP is limited to individuals who are: (1) enrolled in a Medi-Cal managed care plan (MCP); have certain chronic health or mental health conditions, such as diabetes, asthma, Substance Use Disorders (SUDs), or serious mental illness, among others; and (3) meet certain acuity/complexity criteria, one of which is chronic homelessness.

MCPs serve as the foundation of the HHP infrastructure and are responsible for developing and overseeing a network of health care and social service providers that collaborate and function as a team to provide HHP services. The six core HHP services are comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social supports.

During the reporting period, DHCS began planning efforts with MCPs to sunset the HHP, and therefore submitted SPA 21-0018 and 21-0043 to terminate CA's HHP. DHCS led planning and implementation efforts for the new Enhanced Care Management (ECM) benefit, which sought to seamlessly transition members enrolled in HHP to ECM, effective January 1, 2022. CMS granted approval for the transition of HHP enrollees to ECM in December 2021. DHCS aims to provide expanded services to additional populations considered high-need and high-cost, who would benefit from receiving similar intensive care coordination and care management services.

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

The 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) and District/Municipal Public Hospitals (DMPH) provide.

Accomplishments and Program Highlights:

- During DY16, DHCS and the PRIME external evaluator, University of California Los Angeles, Center for Health Policy Research (UCLA), worked extensively on the PRIME Final Summative Evaluation. The draft report was submitted to CMS August 19, 2021.
- CMS provided recommendations for draft revisions in December 2021, and DHCS and UCLA revised the report to incorporate all feedback. The Final Summative Evaluation is currently under review with DHCS leadership and will be submitted to CMS on March 14, 2022.
- Effective July 1, 2020, DHCS began transitioning PRIME to a Medi-Cal Managed Care Directed Payment program, the Quality Incentive Pool (QIP) program, and successfully completed the transition effective January 1, 2021.

Progress on the Evaluation and Findings:

Prior Findings

Initial assessment of PRIME hospitals' efforts was conducted and described in the released in August 2019. Collectively, the findings indicate substantial improvements in the fundamental infrastructure needed to implement PRIME projects both system-wide and for specific projects with advances in administrative capacity and increased Electronic Health Record (EHR) functionality.

A second assessment of progress in PRIME by the end of the program was described in the Preliminary Summative Evaluation Report completed in August 2020. Through surveys, hospitals rated the extent to which they achieved the goals of their PRIME projects. Hospitals perceived that the highest impact of PRIME was on the quality of care followed by patient health outcomes and cost containment.

Final Summative Evaluation

The draft Final Summative Evaluation Report was developed in DY16 using statewide patient discharge data (California's Office of Statewide Healthcare Planning and Development data

through 2019) and Medi-Cal enrollment, claims, and encounter data (through June 30, 2020). The report also utilized qualitative data from survey and key-informant interviews, as well as a new 2020 survey about the impact of COVID in the last 6 months of PRIME. DY15 YE was not included in the hospital-reported metric trend analysis due to COVID-19 impacts on measure performance. The Final Summative Evaluation assessed the achievement of the five PRIME overarching goals: (1) increase provision of patient-centered, data-driven, team-based care; (2) improve provision of point of care services, complex care management, population health management, and culturally competent care; (3) improve population health and patient experience in Medi-Cal; (4) integrate physical and behavioral health and coordinate care for vulnerable populations; and (5) transition public hospitals to value-based care. In this report, ample evidence indicated achievement of the overarching goals of PRIME, particularly success in reducing hospitalizations and emergency department visits that were likely unnecessary, and an overall reduction in Medi-Cal payments attributable to the program. The Final Summative Evaluation Report provided evidence that the COVID-19 pandemic disrupted implementation of PRIME projects but hospitals used innovation and modifications to mitigate this disruption.

Transition of Initiatives:

Effective July 1, 2020, DHCS began transitioning PRIME to a Medi-Cal Managed Care Directed Payment program, the Quality Incentive Pool (QIP) program, and successfully completed the transition effective January 1, 2021. Most of the participating PRIME hospitals successfully transitioned into the new program.

The QIP program will advance the state's Quality Strategy through the use of targeted performance measures that align with departmental priorities to drive public health system improvement. In order to receive QIP payments, health systems must achieve specified targets and establish relationships with Medi-Cal managed care plans. The QIP program will continue the quality improvement infrastructure and activities that started in PRIME and continue to promote access, value-based payment, and tie funding to quality outcomes, while at the same time further aligning state, MCP, and hospital system goals.

WHOLE PERSON CARE (WPC)

The WPC pilot was a five-year program authorized under the Medi-Cal 2020 Demonstration. In December 2020, the Centers for Medicare and Medicaid Services (CMS) approved a temporary extension of the Medi-Cal 2020 Waiver, which was set to expire on December 31, 2020, to operate an additional year from January 1, 2021 to December 31, 2021.

WPC provided, through more efficient and effective use of resources, an opportunity to test local initiatives that coordinated physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple health care systems and who have poor health outcomes.

The local WPC pilots identified high-risk, high-utilizing target populations; shared data between systems; provided comprehensive care in a patient-centered manner; coordinated care in real time; and evaluated individual and population health progress. Additionally, WPC pilots may have chosen to focus on homelessness and expanding access to supportive housing options for these high-risk populations.

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

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

Eighteen LEs implemented and began enrollment of WPC beneficiaries on January 1, 2017. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. DHCS approved fifteen WPC pilot applications in the second round. The second round LEs implemented on July 1, 2017.

Program Years (PY) 1 through PY 5 (2015-2020) consisted of 25 LEs operating WPC pilots.

- Ten LEs were from the initial eighteen LEs. These LEs continued to implement their originally approved pilots that began on
  January 1, 2017.

- Eight LEs were also part of the initial eighteen LEs. These eight reapplied during the second round and expanded their existing pilots. These eight LEs implemented their originally approved pilots on January 1, 2017, as well as new aspects that were approved during the second round on July 1, 2017.
- Seven new LEs approved in the second round implemented and began enrollment on July 1, 2017.

WPC PYs	1115 Waiver DYs
PY1 Application Period (January 1 – December 31, 2016)	11 (January 1 - June 30, 2016) and 12 (July 1 - December 31, 2016)
PY2 (January 1 – December 31, 2017)	12 (January 1 - June 30, 2017) and 13 (July 1 – December 31, 2017)
PY3 (January 1 – December 31, 2018)	13 (January 1 - June 30, 2018) and 14 (July 1 - December 31, 2018)
PY4 (January 1 – December 31, 2019)	14 (January 1 - June 30, 2019) and 15 (July 1 - December 31, 2019)
PY5 (January 1 – December 31, 2020)	15 (January 1 - June 30, 2020) and 16 (July 1 - December 31, 2020)
PY6 (January 1 – December 31, 2021)	16 (January 1 - June 30, 2021) and 17 (July 1 - December 31, 2021)

PY6, also known as the extension year from January 1, 2021, to December 31, 2021, consisted of 23 LEs operating a WPC Pilot. Additionally:

- Two of the original twenty-five LEs opted out of operating the extension PY in 2021 due to service provider contractual limitations, inconsistent staffing retention, and a limited availability to secure matching funds for the local match portion of the Intergovernmental Transfer (IGT) payment. The Small County Whole Person Care Collaborative (SCWPCC) and Solano County no longer operated as of January 1, 2021, and successfully transitioned all of their beneficiaries to other modes of care.

LEs submitted regular reporting deliverables over the length of the WPC Pilot program. Enrollment and utilization reporting were due quarterly, which captured new enrollment information, client information, populations of focus, and service utilizations. Midyear reports were due 60 days after June 30 each year and annual reporting was due 90 days after December 31 each year. The midyear and annual reports captured narrative updates, Plan-Do-Study-Act projects, metric outcomes, and invoice expenditures for payment.

DHCS Midpoint Evaluation Report submitted to CMS on December 2019, which 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 Evaluation Report, due to CMS in December 2022, 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 Evaluation Report will also include an assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

As CalAIM ECM and Community Supports are being implemented, major WPC Program elements such as services, delivery infrastructure, information technology infrastructure, and partnerships that have been built in the past 5 program years will be leveraged for the new CalAIM initiatives. Many services that had successfully impacted beneficiaries will continue and be offered through the MCPs. WPC Pilots worked to provide adequate notifications to beneficiaries, ensure seamless transitions of beneficiaries to their MCPs, and provide additional support to beneficiaries to other resources if the beneficiaries were not being transitioned. Beneficiaries that were receiving care coordination from WPC will continue to receive ECM through their MCPs. A menu of Community Support services, similar to WPC housing support services, transitions services, medical respite, and sobering centers, will be available for beneficiaries that qualify. The vulnerable populations that WPC served will continue to get services through an expansive and more robust system in CalAIM.

Figure 15: Pilot Successes/Accomplishments

Date	Pilot Accomplishments
STC 117 & 130 WPC Payments	
December 2021	All LEs received WPC payments totaling $230,307,319.49 in DY17.
	DY 12-17 total-to-date payments of $3,114,921,650.57 represent payments made through December 31, 2021 and 87% of the $3.6 billion allocated for WPC over the 6 years of the program until December 31, 2021. Three LEs submitted their PY 6 Midyear invoices late or have been working through data discrepancies; their payments will process in early 2022, or along with their PY 6 Annual invoicing process. The PY 6 Annual invoicing process implemented on April 1, 2022, and the payments process will occur in the following month. The final PY6 annual payment amount is anticipated to be approximately $390 million, which would increase the total payment for WPC across 6 program years to be 98% of the allocated $3.6 billion.
STC 118 Housing and Supportive Services	
December 2021	All LEs provided a range of housing services which include individual housing and tenancy sustaining services and individual housing transition services. These housing services included 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 December 2020, LEs reported 49% (106,775) of WPC members were homeless.
STC 119 Lead and Participating Entities	

June 2020	Participating entities increased from 350 to more than 558 for the 25 LEs since program implementation began in 2017.
STC 123 Learning Collaborative	
December 2021	The Learning Collaborative (LC) supported the WPC LEs with the following goals: • Enhanced the permanent capacity of providers to effectively care for high-risk, high-utilizing populations targeted by the WPC LEs; • Informed state oversight and policy making relevant to the WPC pilot, their target populations, and related delivery system reforms; and • Grew and sustained a peer network among LEs to encourage the continued spread of best practices. Over the past 6 program years, the LC hosted and facilitated a variety of learning activities which included 11 webinars, over 30 technical assistance (TA) calls, and developed a resource portal, which was visited over 5,600 times. The resource portal served as a singular location for LEs to download reporting templates, retrieve previous agenda materials, previous Power Point presentations, project resources, and other LE contact information to encourage collaboration. The LC hosted monthly Advisory Board meetings directly with the LEs, which consisted of approximately 35 meetings total. The meetings focused on learning collaborative strategies, general feedback, and the development of agenda items for in-person meetings. Board members were selected based on past participation on LE calls and willingness to commit. Membership also reflected the diversity of rural/urban and small/large pilots. In 2018, the LC launched Affinity Groups initiative, which focused on five topic-specific affinity groups based on LE feedback and discussions with the LC advisory board. These affinity groups focused on the following areas: data, care coordination, sustainability, housing, and re-entry. Each affinity group was led by LC staff who were responsible for working with their group to understand the challenges LEs were faced in each area, then helped the LEs share best practices, lessons learned, and work toward finding solutions. LEs were encouraged to have frontline staff and pilot partners participate in groups relevant to their role in WPC. Prior to the COVID-19 pandemic and safety precautions, the LC hosted six in-person convening's over the course of three program years with an average attendance of 150 participants at each event. Attendees included representatives from each LE, program presenters, associations, and DHCS staff. On December 9, 2020, the LC hosted the WPC Appreciation Event. The event was recommended by the Advisory Board as an opportunity for DHCS to acknowledge the hard work of the WPC Pilots, especially throughout 2020 where Pilots experienced the stresses of the COVID-19 public health emergency and uncertainty surrounding the extension of the WPC program. The event drew in 148 attendees. Keynote speakers included DHCS' Medicaid Director and Chief Deputy Director of Health Care, Jacey Cooper, and CHCF's Associate Director, Catherine

	Teare. Pilots from Riverside County, Santa Cruz County, San Diego County, and San Francisco City and County presented their program highlights. Pilots nominated and awarded “Unsung Hero” awards to select members of their staff. DHCS provided closing remarks. The focus of the LC changed multiple times throughout the WPC program to meet the changing needs of the LEs. In the early program years, the LCs provided administrative and programing support to assist LEs with pilot implementation, building data collection infrastructure, addressing workforce development, expanding partnership amongst CBOs and health plans for enrollment and service support. In 2018, the LC conducted one-on-one calls with all LEs to determine how the LC can be helpful. The LC then shifted their focus to help build a sustainability mind frame for LEs to enhance their current services and enrollment strategies by documenting promising practices to share amongst all pilots and publicly. The LC’s focus shifted once again due to the impact of the COVID-19 public health emergency (PHE) and more recently in 2021, on the implementation of California Advancing and Innovating Medi-Cal (CalAIM). The LC in combined efforts with DHCS, structured TA activities, developed resources, and continued to meet directly with LEs to ensure support was available.
STC 125 Progress Reports	
September 2021	Twenty-three LEs submitted the PY6 mid-year report for 2021.
April 2022	Twenty-three LEs will submit the PY6 annual report for 2021.
January 2017 – December 2021	Over the course of each program year, all LEs have been successful in meeting the mid-year and annual reporting requirements.
STC 126 Universal and Variant Metrics	
September 2021	Twenty-three LEs submitted their baseline PY6 mid-year variant and universal metric reports.
April 2022	Twenty-three LEs will submit their PY6 annual variant and universal metric reports.
January 2017 – December 2021	Over the course of each program year, all LEs have been successful in meeting the midyear and annual reporting requirements.
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 submitted to CMS on December 18, 2019. The final evaluation will be submitted to CMS in December 2022.

Program Highlights:

By June 30, 2017, DHCS has completed two rounds of applications, chose twenty-five

LEs and all WPC agreements executed. The WPC program consisted of eighteen legacy LEs (first round applicants) that implemented on January 1, 2017 and seven new LEs (second round applicants) that implemented on July 1, 2017. Eight of the legacy LEs were approved to expand their programs with additional or expanded target populations, services, and administrative/delivery infrastructure in the second round. By June 30, 2018, approximately one-and-a-half-year post implementation, approximately 73,000 unique lives were touched and with more than 535,000 member months.

By January 2018, the majority of LEs had submitted their first Budget Adjustment request for their PY 3 program budget. Budget Adjustment requests were optional for LEs. The changes captured in the request assisted the LEs to overcome identified barriers during ramp-up and early implementation efforts. Many LEs continued to take part in this optional flexibility over each program year 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.

On April 30, 2018, DHCS, in collaboration with the LC, held the largest attended meeting in Sacramento, with approximately 200 participants. The agenda focused on addressing challenges in care coordination, planning for sustainability, and housing limitations. The convening included time for LEs to network and meet with DHCS staff to discuss operational issues and program activities.

On April 3, 2019, approximately 100 participants attended the Los Angeles WPC site visit hosted by DHCS and the LC. The site visit consisted of overviews of the Los Angeles WPC pilot including Substance Use Disorder Engagement/Navigation and Overdose Prevention, WPC Mental Health Programs focused on WPC members with Serious Mental Illness, Reentry Care Coordination, Community Health Worker-driven Complex Care Management Model, and Housing Transition of Care Programs.

On April 4, 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 twenty-five pilots. The agenda focused on WPC lessons learned, promising practices and pilot accomplishments. The convening included time for LEs to network and meet with DHCS for one-on-one discussions on operational issues and program activities.

On April 19, 2019, the LC partnered with the California Health Care Foundation (CHCF) to hold a webinar sharing findings from a CHCF-funded paper by Intrepid Ascent about opportunities and challenges surrounding data sharing entitled: Catalyzing Coordination: Technology’s Role in California’s Whole Person Care Pilots. The webinar included an overview of common challenges and critical decisions encountered by WPC pilots as they seek to implement technology solutions including how to design data-sharing agreements and whether to adapt existing technologies or procure new ones.

On September 10, 2019, DHCS, in collaboration with the LC, held the last in-person convening for all WPC pilots. More than 160 people attended, including representatives from all 25 pilots. The agenda focused on WPC lessons learned 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. Ninety-eight participants called into the webinar and every pilot was represented. The webinar focused on providing an overview of CalAIM and its impact on WPC.
By December 31, 2020, two of the twenty-five LEs opted out of operating the additional PY due to service provider contractual limitations, inconsistent staffing retention, and limited availability to secure matching funds for the local match portion of the Intergovernmental Transfer payment. With DHCS' approval, Small County Collaborative Whole Person Care (SCCWPC) and Solano County discontinued their pilot programs as of January 1, 2021, and successfully transitioned all of their beneficiaries to other modes of care.

By March 17, 2021 DHCS restructured the bi-weekly TA calls to focus on CalAIM Enhanced Care Management (ECM) and Community Supports transition and implementation process. The LC hosted the bi-weekly ECM and Community Supports TA calls in partnership with DHCS and Manatt, DHCS' CalAIM implementation consultants.

On October 31, 2021, LEs had developed their Closeout and Transition plan of their pilot program transition to ECM and/or Community Supports. LEs provided a detailed narrative on the process for data exchange with their Medi-Cal Managed Care Plan (MCPs), notification to partners and WPC beneficiaries, notification to the public, identified providers and programs for WPC beneficiaries who would not transfer into ECM/Community Supports, and acknowledgement of WPC Close-Out and final reporting requirements.

During DY 16, 17, and post the conclusion of the program, DHCS continued to hold bi-weekly TA teleconferences with LEs. The teleconferences focused on administrative topics and provided the opportunity for LEs to ask questions about DHCS' guidance and various operational issues such as deliverable reporting, timelines, budget adjustments, COVID-19 impacts and flexibilities, CalAIM ECM/Community Supports implementation, ECM Community Supports member transition, and overall DHCS expectations.

In preparation for the sunset of the WPC Pilot Program, DHCS worked closely with LEs to ensure WPC members eligible for ECM and Community Supports were transitioned. DHCS utilized the Data Mapping reports to provide a list of WPC enrollees that would transition to services provided by the MCPs on January 1, 2022. DHCS continued to update the Data Mapping reports in DY 17, including updated WPC enrollment. WPC

pilots sent a 30-day notice to WPC enrollees who were not transitioning to ECM and/or Community Supports in advance of the pilot ending, and care coordinators worked closely with enrollees to transition them to other modes of care if applicable.

Qualitative and Quantitative Findings:

DHCS utilized the mid-year and annual narrative reports, quarterly enrollment and utilization reports, and invoices as a tool to monitor and evaluate the programs and to verify invoices for payment. Over the six program years, DHCS developed communication strategies to monitor program progress, identified budget flexibilities to support innovative approaches for LEs to increase enrollment and service utilization, and developed individual program milestones for LEs that needed additional support.

DHCS had begun to provide guidance and work with LEs on an optional Budget Adjustment and Budget Rollover process in PY 3 (2018). Budget Adjustments allowed LEs to restructure existing budget categories, while Budget Rollover allowed the LEs to carry over unspent funds from the previous program year into the next program year. The budget adjustments assisted the LEs in overcoming identified barriers during ramp-up and early implementation efforts. Many LEs continued to use this flexibility across each PY to build innovative outreach and engagement efforts, adjust and expand services to meet higher than originally anticipated complex needs of WPC beneficiaries, and secure IT and delivery infrastructures that would be sustainable past the sunset of the pilot program.

In PY 3 (2018), DHCS had identified seven LEs that had significant challenges in enrollment and the full development of their service programs. DHCS management held in-person meetings with the identified LEs and developed corrective action plans (CAPs) 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 during program implementation). All CAP milestones were successfully achieved and CAPs closed by September 2019. DHCS continued to monitor LEs closely and provided TA.

DHCS monitored LE activities through the close out of the program. Over the past six program years, LEs submitted routine mid-year and annual narrative reports, Plan Do Study Act reports, Universal and Variant Metric reports, and Invoices. LE have continued to submit their quarterly enrollment and utilization reports. The submission templates and guidance for these reports have slightly changed and matured over the program years due to feedback received from the LEs. DHCS worked with internal data specialists to develop more robust data guidelines, simplified reporting templates, and provided continual data reporting expectations on TA calls. LEs received one-on-one TA support as requested, and DHCS supported LEs through their final PY 6 Annual reporting deliverables. The following deliverables were submitted by LEs on April 1, 2022:

- PY 6 Annual Narrative, Invoice, PDSAs, Universal & Variant Metric Report
- PY 6 Quarter 1 – Quarter 4 Enrollment and Utilization Report Revisions (Optional)

Accurate reporting was fundamental to the success of WPC. These reports were tools for LEs and DHCS to assess the degree to which the LEs achieved their goals. Additionally, DHCS utilized these reports to monitor and evaluate the WPC Pilot Programs and to verify invoices for payment purposes.

Enrollment Information:

The data reported below in Table 14 reflects the most current unique new beneficiary enrollment counts available across all program years, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Enrollment data was updated each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Enrollment counts reflect the cumulative number of unique new beneficiaries enrolled in each program year from PY 1 through PY 6. The total-to-date column reflects the cumulative number of unique new beneficiaries enrolled from beginning of the program, PY 2 (January 1, 2017 – December 31, 2017), to the end of the program, PY 6 (January 1, 2021 – December31, 2021). The data presented for PY 6 may change due to the revision flexibility LEs may take advantage, to revise any PY 6 Quarterly Enrollment and Utilization (QEU) reports, in April of 2022. Enrollment data was extracted from the LE's self-reported QEU reports. The data reported is point-in-time as of February 14, 2022.

Figure 16: New Beneficiary Enrollment Counts

LE	PY2 Jan. – Dec. 2017	PY3 Jan. – Dec. 2018	PY4 Jan. – Dec. 2019	PY5 Jan. – Dec. 2020	PY6 Jan. – Dec. 2021	Jan. 2017 – Dec. 2021 Cumulative Total to Date
Alameda	1,872	7,089	2,371	13,169	6,315	30,816
Contra Costa	16,600	14,315	10,687	10,376	5,412	57,390
Kern	88	486	954	669	290	2,487
Kings*	29	219	314	200	58	820
LA	13,752	16,389	20,867	13,444	11,815	76,267
Marin*	12	727	829	277	81	1,926
Mendocino*	21	241	122	44	38	466
Monterey	44	52	342	249	137	824
Napa	116	164	224	103	134	741
Orange	3,150	4,214	3,642	1,802	667	13,475
Placer	158	114	148	55	25	500
Riverside	153	2,968	2,918	1,815	818	8,672
Sacramento*	236	666	829	478	151	2,360
San Bernardino	334	372	340	315	167	1,528
San Diego	NR	243	371	262	73	949
San Francisco	8,211	4,878	4,729	2,774	1,843	22,435
San Joaquin	145	688	731	862	226	2,652

LE	PY2 Jan. – Dec. 2017	PY3 Jan. – Dec. 2018	PY4 Jan. – Dec. 2019	PY5 Jan. – Dec. 2020	PY6 Jan. – Dec. 2021	Jan. 2017 – Dec. 2021 Cumulative Total to Date
San Mateo	2,454	642	454	307	267	4,124
Santa Clara	1,981	822	2,317	1,505	806	7,431
Santa Cruz*	202	203	104	72	21	602
SCWPCC**	DD	71	53	16	NR	140
Shasta	102	134	128	131	68	563
Solano**	79	77	50	48	NR	254
Sonoma*	NR	605	1,443	1,314	598	3,960
Ventura	458	590	154	129	129	1,460
Total	**50,197**	**56,969**	**55,121**	**50,416**	**30,139**	**242,842**

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

***Indicates the LE has closed out their WPC Pilot Program as of December 31, 2020.*
"NR" indicates not reportable, as the LE did not implement in PY2, or was no longer implementing in PY6.

The data reflects continued outreach and engagement from the start of pilot to the start of ECM and Community Supports transition. Enrollment data is de-identifiable accordingly to the expert determination methodology provided under the HIPAA Privacy Rule. Therefore, SCWPCC has de-identified data represented by "DD" in their PY2 report, as their data suppresses enrollment numbers less than 11.

The data provided in the figure above shows that the count of unduplicated members has steadily increased since implementation began in 2017. The program began with 11,286 unduplicated members reported in March of 2017, and increased to 242,842 unduplicated members as of December 31, 2021.

Member Months:

The data reported below in Table 15 reflects the member month counts across all program years, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months were updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. PY and cumulative total-to-date member months are in the table below. The cumulative total-to-date column reflects the cumulative number of member months from the beginning of the program, PY 2 (January 1, 2017 – December 31, 2017), to the end of the program, PY 6 (January 1, 2021 – December 31, 2021). The data presented for PY 6 may have changed due to the revision flexibility LEs may take advantage, to revise any PY 6 Quarterly Enrollment and Utilization (QEU) reports in April 2022. Member month

data is extracted from the LE’s self-reported QEU reports. The data reported is point-in-time as of February 14, 2022.

Figure 17: Member Month Counts

LE	PY2 Jan. – Dec. 2017	PY3 Jan. – Dec. 2018	PY4 Jan. – Dec. 2019	PY5 Jan. – Dec. 2020	PY6 Jan. – Dec. 2021	Jan. 2017 – Dec. 2021 Cumulative Total to Date
Alameda	10,283	44,957	106,915	199,658	282,389	644,202
Contra Costa	93,640	184,107	161,273	154,317	127,000	720,337
Kern	265	2,636	12,862	21,089	13,799	50,651
Kings*	59	976	2,092	2,306	541	5,974
LA	66,140	120,929	190,403	213,321	224,180	814,973
Marin*	17	2,072	14,311	19,866	10,243	46,509
Mendocino*	21	1,936	1,767	1,805	1,360	6,889
Monterey	286	717	2,410	2,719	1,634	7,766
Napa	490	1,711	2,627	3,027	2,253	10,108
Orange	15,326	40,507	52,783	33,818	10,248	152,682
Placer	791	1,521	1,480	1,491	914	6,197
Riverside	248	6,716	51,034	76,533	44,877	179,408
Sacramento*	369	5,311	9,421	11,330	7,476	33,907
San Bernardino	986	6,153	6,188	6,153	4,515	23,995
San Diego	NR	1,288	3,724	4,956	2,154	12,122
San Francisco	60,903	94,603	111,282	123,041	93,808	483,637
San Joaquin	403	4,235	11,010	17,269	10,424	43,341
San Mateo	23,948	25,818	26,351	25,275	16,249	117,641
Santa Clara	15,242	27,311	38,538	38,170	28,062	147,323
Santa Cruz*	1,102	3,655	4,572	5,427	4,566	19,322
SCWPCC**	DD	342	685	548	NR	1,575
Shasta	348	870	906	926	598	3,648
Solano**	387	1,159	971	669	NR	3,186
Sonoma*	NR	993	8,380	19,958	20,185	49,516
Ventura	1,213	9,232	7,994	6,495	4,469	29,403
Total	**292,467**	**589,755**	**829,979**	**990,167**	**911,944**	**3,614,312**

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

***Indicates the LE has closed out their WPC Pilot Program as of December 31, 2020.*
"NR" indicates not reportable, as the LE did not implement in PY2, or was no longer implementing in PY6.

The data provided in the figure above shows the count of member months dramatically increased since implementation began in 2017 as the unduplicated members and

enrollment increased. The program began with 28,974 member months reported in March of 2017 and increased to 3,614,312 member months as of December 31, 2021. It is important to note that the number of member months played a significant role in the utilization of services. Member months for PY 6 may change due to the revision flexibility LEs may take advantage, to revise any PY 6 Quarterly Enrollment and Utilization (QEU) reports in April of 2022.

Financial/Budget Neutrality Developments/Issues:

The figure below for Table 16 outlines the WPC payments released from DY 12 to DY 17. Midyear invoices were due 60 days after June 30 of the program year and annual invoices are due 90 days after December 31 of the program year. Therefore, PY 6 annual payments will begin to process in April 2022, when annual reports are due. Payments are made through the IGT process. The total payment anticipated through the end of the fiscal year June 30, 2022, for PY 6 annual expenditures is estimated at approximately $454,000,000. The total estimated payments for the WPC is approximately $3.6 billion. The total estimated $1.9 billion represent the Federal Financial Participation (FFP) share and estimated $1.7 billion represent the local non-federal IGT share of the total program.

Figure 18: WPC Payments for DY12 to DY17 for all 25 LEs

DY12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 3 (Jan. 1 – Mar 31)	$216,787,499.88	$216,787,499.88	DY12 (PY1)	$433,574,999.75
Qtr. 4 (Apr. 1 – June 30)	$22,206.521.50	$22,206.521.50	DY12 (PY1)	$44,413,043.00
DY13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$9,730,650.50	$9,730,650.50	DY13 (PY1)	$19,461,301.00
Qtr. 2 (Oct. 1 – Dec. 31)	$63,309,652.68	$63,309,652.68	DY13 (PY2)	$126,619,305.36
Qtr. 3 (Jan. 1 – Mar 31)	$0	$0	DY13 (PY2)	$0
Qtr. 4 (Apr. 1 – June 30)	$116,574,244.78	$116,574,244.78	DY13 (PY2)	$233,148,489.56
DY14 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$0	$0	DY14 (PY3)	$0
Qtr. 2	$101,981,216.28	$101,981,216.28	DY14	$203,962,432.56

(Oct. 1 – Dec. 31)			(PY3)	
DY14 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 3 (Jan. 1 – Mar. 31)	$0	$0	DY14 (PY3)	$0
Qtr. 4 (Apr. 1 – June 30)	$169,064,564.15	$169,064,564.15	DY14 (PY3)	$338,129,128.30
DY15 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$0	$0	DY15 (PY4)	$0
Qtr. 2 (Oct. 1 – Dec. 31)	$119,071,064.41	$119,071,064.41	DY15 (PY4)	$238,142,128.82
Qtr. 3 (Jan. 1 – Mar. 31)	$0	$0	DY15 (PY4)	$0
Qtr. 4 (Apr. 1 – June 30)	$161,951,775.00	$161,951,775.00	DY15 (PY4)	$323,903,550.00*
Total	**$980,677,189.18**	**$980,677,189.18**		**$1,961,354,378.35**

** Due to the COVID19 PHE, LEs got a one-month extension to submit their PY4 Annual invoice; therefore, the majority of the June 2020 payments processed in July 2020. The July 2020 payments of approximately $193 million are in the DY16 report.*

DY16 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$96,573,902.01	$96,573,902.01	DY16 (PY5)	$193,147,804.02*
Qtr. 2 (Oct. 1 – Dec. 31)	$177,791,520.89	$138,563,498.50	DY16 (PY5)	$316,355,019.41
Qtr. 3 (Jan. 1 – Mar. 31)	$0	$0	DY16 (PY5)	$0
Qtr. 4 (Apr. 1 – June 30)	$236,709,327.89	$183,887,958.44	DY16 (PY5)	$420,597,286.32
Total	**$511,074,750.79**	**$419,025,358.95**		**$930,100,109.75**

DY17 Payment	FFP	IGT	Service Period	Total Funds Payment
Q1 (July 1 - Sept 30)	$13,015,831.75	$10,144,011.22	DY16 (PY5)	$23,159,842.97
Q2 (Oct 1 – Dec 31)	$129,432,713.55	$100,874,605.94	DY17 (PY6)	$230,307,319.49
Total	**$142,448,545.30**	**$111,018617.16**		**$253,467,162.46**

Anticipated Payments	FFP	IGT	Service Period	Total Funds Payment
June 30, 2022	$255,148,000.00	$198,852,000.00	DY17 (PY6)	$454,000,000.00

Operational/Policy Developments/Administrative Issues:

DY13:
Due to a combination of factors, such as slow program implementation ramp-up and second round implementation beginning mid-year, some LEs expressed concerns regarding meeting continuous enrollment requirements and metric objectives. To help mitigate these issues and concerns, DHCS revised the WPC Universal and Variant Metrics Technical Specifications to allow for changes to the length of enrollment and enrollment data type for several of the metrics. These changes facilitated successful LE report outcomes based on actual program experienced during PY 2.

During the third and fourth quarters, 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 budgeted funds from the current year to the next year's budget. The changes assisted LEs to overcome identified barriers during ramp-up and early implementation efforts. Furthermore, these processes allowed LEs the flexibility to 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.

According to narrative reports, LEs experienced a few common challenges early into implementation of WPC, such as: difficulty identifying and enrolling eligible Medi-Cal beneficiaries, concerns regarding data sharing, development of inter-organizational collaboration, and hiring staff.

DHCS held discussions on these challenges during the bi-weekly technical assistance calls, encouraged sharing of tools developed by LEs, and worked with the LC to hold webinars on these topics to assist LEs in dealing with these challenges. Additionally, LEs developed their collaborative efforts with partners and all levels of leadership. Subsequently, LEs had success in the development of the following:

- Usage of shared data to identify target population
- Data sharing agreements and consent forms
- Purchase and development of technology
- Leadership and governance structure

Common successes included strengthening relationships between community partners, development of policy, practices, or other infrastructure, provision of enrollee services, and improved outcomes of care.

DY14:
During the third and fourth quarters of DY 14, 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 budgeted funds from the current year to the next year's budget. The budget adjustment and rollover enabled the LE to overcome operational challenges and barriers. Furthermore, these processes allowed LEs the flexibility to 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. Additionally, LEs were able to add new services to their program, which CMS approved and were successful in other WPC programs during these processes.

According to the LE narrative reports, most challenges were associated with:

- Difficulty identifying, engaging, and enrolling eligible target populations;
- Issues implementing care coordination related to limited availability of needed services such as housing, staffing issues and engaging appropriate interdisciplinary partners; and
- Concerns regarding data–sharing due to legal and cultural barriers to data sharing, implementing data sharing systems, and implementing data sharing agreements

DHCS has held discussions on these challenges during monthly, as well as one-on-one, technical assistance calls, encouraged sharing of tools developed by LEs, and worked with the LC to hold webinars on these topics to assist LEs in dealing with these challenges. Subsequently, LEs had the following successes:

- Establishing referral pathways into the WPC program;
- Identifying and assessing eligibility of prospective enrollees;

- Increasing WPC enrollment;
- Maintaining enrollment by preventing gaps in Medi-Cal eligibility;
- Employing other pilot-specific strategies to facilitate and improve enrollment processes;
- Implementing new or improved care coordination delivery services;
- Establishing partnerships to overcome silos;
- Using data systems to support care coordination activities; and
- Developing new software/platform/repository.

DY15:
In response to the COVID-19 public health emergency, DHCS provided budget flexibility to WPC programs that allowed counties to adapt their WPC models in response to the COVID-19 pandemic. The Budget Alternative request was optional and supported activities aligned with existing WPC pilot goals and objectives.

DHCS increased the frequency of communication with LEs due to the impact of the COVID-19 PHE. DHCS continued to provide regular TA, through virtual meetings, email and one-on-one calls.

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 PY 5. The budget adjustment and rollover enabled the LE to overcome operational challenges and barriers. Furthermore, these processes allowed LEs the flexibility to 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 structured 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 the reporting period, DHCS held 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 expressed major impacts on staffing shortage, limited in-person service capabilities, and meeting health outcome metrics due to the COVID-19 PHE.

During the reporting period, the LC Advisory Board held seven meetings. The first half of the DY, focused on WPC services suitability and how the LC could support the LEs through the transition to the enhanced care management (ECM) benefit and Community Supports under the CalAIM initiative, as the pilot program was expected to sunset 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 could support the LEs through the COVID-19 PHE. In Q4 DY 15, attendance was limited as Advisory Board members prioritized their county's COVID-19 PHE responses. The Advisory Board members requested support for understanding 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 were on-hold due to restrictions on large gatherings caused by the COVID-19 PHE. The LC drafted a "Promising Practices" summary paper that cross walked the ECM benefits and Community Supports proposed under CalAIM. The LC submitted the summary paper to DHCS for review to post to the WPC Portal.

DY16:

The extension of the Medi-Cal 2020 Waiver included an additional $600 million allocation to the WPC Pilot Program. This additional program year allocation, paired with roll over funds from the previous program year, allowed LEs to sustain their program activities and provide needed services to their enrollees. DHCS finalized all PY 6 budgets in September 2021.

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 while the rollover process allowed an LE to move unspent budgeted funds from the previous PY to the current PY. The budget adjustment and rollover enabled the LEs to overcome operational challenges and barriers. Furthermore, these processes allowed LEs the flexibility to fully maximize funding. LEs utilized the flexibility to strengthen service delivery and information technology for coordinated care, which was integral to the success of the WPC and supported 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 LC, communicated with the LEs through phone calls, video conferencing and emails to understand the issues that are of most interest and concern to guide DHCS' TA and LC content. The LC structured a variety of learning activities, such as webinars, teleconferences, and access to a resource portal, as a means to

address the topics and questions from LEs.

During the reporting period, DHCS held nine TA teleconferences with LEs. The teleconferences focused on administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various operational issues such as deliverable reporting, timelines, budget adjustments, sustainability, COVID-19 PHE impacts and flexibilities, ECM/Community Supports service transition, ECM/Community Supports client transition mapping, CalAIM implementation, and overall DHCS expectations. TA teleconferences in Q4 focused on the PY 5 annual reports and invoice submission, PY 6 allocation budgets, PY 6 contract amendments, WPC services transitioning into CalAIM, and mapping WPC beneficiaries into eligible ECM/Community Supports services. During Q4, DHCS focused primarily on the assistance of LEs' transition into CalAIM, the ECM/Community Supports timeline, populations of focus, performance incentives to assist LEs, and data exchange processes between LEs and MCPs.

During the reporting period, the LC Advisory Board held seven meetings. The first half of DY 16, the focus was the COVID-19 PHE and the uncertainty of an additional PY. The second half of DY 16, the LC Advisory Board focused on supporting LEs for the transition into CalAIM, especially joint TA opportunities with MCPs and other stakeholders.

The LC did not host an in-person meeting or any webinars in DY 16. All in-person meetings were on-hold due to restrictions on large gatherings caused by the COVID-19 PHE.

The LC drafted a "Promising Practices" summary paper that cross walked the ECM benefits and Community Supports services proposed under CalAIM. The paper is available to LEs in the WPC portal and publicly on the DHCS WPC webpage.

The LC developed a year-long TA plan to support the LE's transition to CalAIM. This plan developed in coordination with other DHCS efforts to support the LEs, and included several activities (such as statewide webinars on topics of interest, development of FAQs, and other opportunities for pilots to learn from each other as they navigate the transition). In March 2021, the LC hosted the bi-weekly ECM and Community Supports TA calls in partnership with DHCS and Manatt.

DY17:
During DY17 DHCS, along with the WPC Learning Collaborative (LC), communicated with the LEs through webinars, virtual conference meetings, phone calls, and emails to understand the issues that are of most interest and concern to guide DHCS' technical assistance (TA) and LC content. There was a hold placed on all in-person meetings, due to restrictions on large gatherings given the COVID-19 Public Health Emergency (PHE).

The LC held bi-weekly virtual conference meetings with LEs focusing on the new Medi-Cal benefits and services under the state's CalAIM initiative, including the new Enhanced Care Management (ECM) benefit and Community Supports. The LC and DHCS provided robust TA to the LEs to support the sunset of the WPC Pilot Program, the close out process and expectations, WPC member transition into ECM and Community Supports, and ECM/Community Supports policies and guidance. Bi-weekly virtual meetings during the reporting period were held on October 13, October 27, November 10, November 24, December 8, and December 22. The following topics were discussed:

- WPC close out process and expectations
- Member Transition Notice and Template
- ECM/Community Supports WPC-Health Homes Program Transition and Reporting
- Final Member Transition List
- ECM/Community Supports Go-Live expectations
- Late enrollee data sharing
- ECM/Community Supports monitoring, data sharing, and reporting guidance
- ECM/Community Supports Justice-involved population model of care updates
- Additional funding opportunities that support WPC migration into CalAIM ((Providing Access and Transforming Health (PATH), Incentive Payment Program, Behavioral Health Quality Improvement Program))
- DHCS technical assistance structure in 2022

DHCS fully executed 23 contract amendments that have confirmed LEs would be operating Pilot Programs through the end of 2021, as CMS approved the extension of the Medi-Cal 2020 Demonstration through December 31, 2021. DHCS worked with the Office of Legal Services to draft appropriate language for the WPC contract amendments. DHCS anticipates all contracts fully executing by the next quarterly report.

The LC Advisory Board met on October 5, 2022 to discuss feedback on TA needs related to ECM/Community Supports. The Advisory Board urged for timely policy guidance and consistent messaging between WPC LEs and Medi-Cal managed care health plans (MCPs). DHCS engaged Manatt Health to ensure LEs and MCPs receive coordinated messaging. The WPC Advisory Board will not remain in place beyond December 2021. DHCS will provide TA going forward and the LC will provide support through the CalAIM ECM/Community Support capacity.

<u>COVID-19 Public Health Emergency:</u>
WPC target populations are at the highest risk if exposed to COVID-19. WPC target populations included, but was not limited to, individuals who have underlying health conditions and are homeless or at risk of becoming homeless, and therefore, more

susceptible and unable to isolate themselves from exposure. WPC services were vital to ensure enrollees received care coordination and housing support during the PHE.

DHCS' supported LEs and their response to the COVID-19 PHE, which included guidance to LEs to ensure the safety of their staff and enrollees, as well as opportunities for budget flexibilities to address the PHE. In August 2020, DHCS allowed optional budget flexibilities in a COVID-19 budget alternative to:

- Expand care coordination services for individuals at risk of contracting COVID-19, individuals that have contracted COVID-19, and individuals recovering from COVID-19;
- Provide an opportunity for Medi-Cal beneficiaries to isolate and quarantine if their home setting is not a viable option; and
- Incentivize development of a COVID-19 referral process with local health departments.

Seventeen LE's modified their budgets to address the impacts of the COVID-19 PHE.

Progress on the Evaluation and Findings:

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

The midpoint report submitted to CMS in December 2019 included an assessment of population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, although only preliminary outcome data was available. The final report, due to CMS in 2022, will provide the complete assessment of care and outcome improvements, including an assessment of the impact of the various packages of interventions on specific target populations. The final report will also include an assessment of reduction of avoidable utilization of emergency and inpatient services, and associated costs, challenges and best practices, and assessments of sustainability.

Due to the COVID-19 PHE, DHCS' independent evaluator, the University of California, Los Angeles (UCLA) would include the impacts of the PHE on program implementation and outcomes, adjusting evaluation methods as appropriate. Resulting from conversations between DHCS and UCLA, the final report will include analyses restricted to the period prior to COVID-19 along with separate analyses of the period impacted by COVID-19.

During the second quarter of DY17, UCLA:

- Merged data on refined service categories with the QEU reports utilization data to understand the distribution of service types within and across LEs. UCLA will update this analysis with new QEU report data as available. Analysis will be included in the final report.
- Refined shadow pricing methodology, to analyze the cost impact of WPC in the final report.
- Developed a policy brief that focused on the impact of COVID-19 on WPC infrastructure, implementation, enrollment, and service use. The final report will utilize the findings from the policy brief as context to assist explanation of utilization trends during the COVID-19 pandemic.
- Cleaned survey data, and conducted preliminary analysis of final LE survey administered early in 2021, the analysis will be in the final report.
- Completed thematic coding of semi-structured interviews with program level management, front line staff, and supervisors. Data will be in final report.
- Received PY6 midyear narrative reports from DHCS in November, and reviewed/redacted to prep for qualitative coding. Systematic analysis will be present in the PY6 midyear narrative report, due to DHCS by March 2022.
- Finalized template for Pilot specific “mini case studies” to be included in the final report.
- Completed a homelessness or at-risk-of-homelessness analysis using administrative and publicly available data.
- Incorporated the PY4 and PY5 Pilot-reported metrics with the previously reported Pilot-reported metric in order to update that analysis. UCLA further developed templates to compile data with PY6 reports once available. These data updates will be in the final report.
- Developed an updated data request plan for the Medi-Cal enrollment and claims data needed for the final evaluation. This plan includes a multi-step pull that will reduce the burden on DHCS’ data team and enable UCLA to meet the September deadline with data running through 2021.
- Examine trends in the evaluation process, utilization and outcome measures of the Medi-Cal data through 2020.
- Finalized a timeline for sharing chapters of the final evaluation report with DHCS in August and September 2022

Opportunities for Improvement:

Throughout the past six years of the WPC program, WPC Pilots have tested interventions to coordinate physical, behavioral and social services in a patient-centered manner, including interventions that addressed Social Determinants of Health (SDOH) such as improving access to housing and supportive services, and built significant infrastructure to ensure local collaboration for improved outcomes.

ECM and Community Supports developed from WPC program lessons learned, as well as MCP and Provider experience, in the WPC Pilots and Health Homes Program (HHP). Both WPC and HHP led the way in providing a set of intensive care coordination services that spanned multiple delivery systems to provide a person-centered approach to care. These initiatives pushed the boundaries of a traditional health care delivery approach to begin formally considering the impact of SDOH on health outcomes and experience of care in California's Medicaid program.

The list of pre-approved Community Supports are drawn in part from the foundational work done as part of the WPC Pilots and HHP. A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. Community Supports will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs

On January 1, 2022, ECM and Community Supports implemented in all WPC counties. MCPs were required to authorize and transition individual Members enrolled in WPC, who identified by the WPC Lead Entity in the county as receiving Care Coordination services in the pilot. DHCS strongly encouraged MCPs to offer appropriate Community Supports to these Members beginning on January 1, 2022. MCPs operating in WPC Pilot counties were required to describe in their Model of Care (MOC) how they would sustain WPC services through a combination of ECM and Community Supports.

DHCS' adoption of ECM and Community Supports on a statewide scale will support the highest-need MCP Members, with the provision of ECM and ILOS anchored in the community, where services can be delivered in an in-person manner by community-based ECM and Community Supports Providers, to the greatest extent.

DENTAL TRANSFORMATION INITIATIVE (DTI)

Given the importance of oral health to the overall well-being of an individual, the 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.

All providers enrolled in Fee-for-Service (FFS), and those providing services through Safety Net Clinics (SNC), can participate in all Domains of the DTI. Dental Managed Care (DMC) providers are allowed to participate in other Domains with the exception of Domain 3, as DMCs have existing contract requirements to maintain continuity of care for members.

The Medi-Cal 2020 Section 1115 Demonstration Waiver (Medi-Cal 2020 Waiver) was originally approved by CMS on December 30, 2015 through December 31, 2020. Following the end of the waiver period, DHCS intended to implement CalAIM a multi-year initiative to support DTI goals. However, with the delay in implementation of CalAIM due to the 2019-Novel Coronavirus (COVID-19) public health emergency (PHE), DHCS submitted a one-year extension of the Medi-Cal 2020 Waiver to CMS on September 16, 2020, which CMS approved on December 29, 2020, with an additional demonstration year for PY6 ending on December 31, 2021. The extension included DTI Domains 1, 2, and 3.

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 under the age of 20 who receive a preventive dental service by at least ten percentage points over a five-year period.

[14] DTI Domain 1

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.

There are twenty nine (29) counties currently participating in this Domain. Initially eleven (11) counties participated in this domain: Glenn, Humboldt, Inyo, Kings, Lassen, Mendocino, Plumas, Sacramento, Sierra, Tulare and Yuba. In January 2019, additional eighteen (18) counties were added to the domain. They are: Contra Costa, Fresno, Imperial, Kern, Los Angeles, Madera, Merced, Monterey, Orange, Riverside, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Sonoma, Stanislaus and Ventura.

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.

Initial 17 counties participating in Domain 3 were: Alameda, Del Norte, El Dorado, Fresno, Kern, Madera, Marin, Modoc, Nevada, Placer, Riverside, San Luis Obispo, Santa Cruz, Shasta, Sonoma, Stanislaus and Yolo. On January 1, 2019, Domain 3 expanded from 17 to 36 pilot counties. The extended counties currently participating in this Domain are: Butte, Contra Costa, Imperial, Merced, Monterey, Napa, Orange, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Solano, Sutter, Tehama, Tulare and Ventura. The added counties became effective beginning in program year 4.

Domain 4 – Local Dental Pilot Projects (LDPPs) [17]
Since Domain 4 was not included in the one-year extension of the Medi-Cal 2020 Waiver, operations for these efforts concluded on December 31, 2020. The LDPPs have submitted all their final reports and invoices relative to PY5. Final payments have all been processed as of June 2021. While active, the LDPPs supported the aforementioned Domains through thirteen (13) innovative pilot programs to test alternative methods to increase preventive

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

services, reduce early childhood caries, and establish and maintain continuity of care. The LDPPs were required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

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

Successes/Accomplishments:

During DY17, DHCS continued to successfully issue DTI payments to providers and increase utilization from the previous DY, which was heavily impacted by the PHE. Data is not yet available to fully evaluate DY17's success and accomplishments because claims runout for calendar year 2021 is in progress. However, as mentioned in previous DTI program year final reports, utilization of preventive services by children increased annually during the demonstration period until calendar year 2020, which decreased due to the PHE, leaving members slowly regaining comfort in receiving dental services in person. Nonetheless, utilization remained positive from the baseline years for domains 1, 2, and 3. In addition, children received CRAs and designated risk levels, which contributed to the increased preventive services versus children who received CRA for the first time and were less likely to obtain preventive services.

DHCS is working closely with an external contractor, Mathematica, to complete a comprehensive evaluation of DTI, which will provide detailed insights on successes and accomplishments with qualitative and quantitative findings. The report is due to CMS by December 31, 2022.

Program Highlights:

Program highlights during DY17 included incentive payments to providers in July 2021 for Domain 1, which was the second payment for PY5 (CY 2020) for $2.02 million. Domain 2 added 176 participating providers totaling 3,512 opted-in providers. Domain 2 paid approximately $28.4 million during the DY17 period, totaling $230.5 million for services rendered throughout PY2 – PY6 (Jan 1, 2017-Dec 31, 2021). There were no Domain 3 or 4 payments issued during this reporting period. Moreover, DHCS completed the DTI Program Year 5 (Calendar Year 2020) Final Report. In general, utilization in 2020 was lower than previous program years due to impacts of the PHE; however, utilization remains positive from the baseline years.

During DY17, the Administrative Services Organization (ASO) outreach team modified their approach by substituting routine, in-person visits with emails, phone calls, and virtual meetings to participating providers in Domains 1, 2 and 3. The outreach efforts included

information on dental benefits, DTI, Proposition 56 supplemental payments and the Proposition 56 student loan repayment program, and online resources. In addition, ASO representatives offered Medi-Cal Dental training for staff, shared materials and online resources, and encouraged the dental offices to accept new patients. For Domain 3, the ASO's outreach team contacted providers in the 34 of the 36 pilot counties.

Qualitative Findings:

DHCS' external contractor, Mathematica, will be doing a qualitative analysis via administrative and survey data to analyze all Domains, pre-implementation and throughout the demonstration years, which will compare participating and nonparticipating Medi-Cal dental providers. In-depth qualitative interviews over the phone and web-based will be directed at a sample set of dental providers, dental managed care organizations, DHCS, and other stakeholders to gather their experiences with and perceptions of DTI including contextual and other factors influencing the implementation and outcomes of the demonstration. In addition, qualitative interviews will be conducted via survey of a large sample of providers and parents or caregivers of targeted children in order to analyze quantitative trends and impacts of the DTI on outcomes targeted by the demonstration. The evaluation report will also include findings from case studies of a sample of Domain 4 pilot projects to explore local strategies for advancing DTI goals and extract lessons learned to inform future efforts to improve oral health outcomes for children. In DY17, Mathematica mostly conducted data analysis in preparation for completing the final evaluation report.

Quantitative Findings:

Since dental utilization measures the number of members who received a dental service over a 12 month period, it is difficult to quantify utilization within a six month period for DY17. Therefore, Figure 19 shows preventive services utilization for children over a rolling 12 month period, which averages 43.45% utilization.

Figure 19: Statewide Three Months Continuously Enrolled Medi-Cal Members Age 1-20 and the Preventive Dental Services Utilization[18]

[18] Data Source – DHCS Data Warehouse MIS/DS Dental Dashboard January 2022 update. Utilization does not include one-year full run-out allowed for claim submission.

Measure End Month	Measure Period	Numerator[19]	Denominator[20]	Utilization
Jul 2021	08/2020-07/2021	2,310,661	5,344,367	43.24%
Aug 2021	09/2020-08/2021	2,336,464	5,358,205	43.61%
Sep 2021	10/2020-09/2021	2,342,175	5,370,197	43.61%
Oct 2021	11/2020-10/2021	2,344,411	5,388,817	43.51%
Nov 2021	12/2020-11/2021	2,352,193	5,401,042	43.55%
Dec 2021	01/2021-12/2021	2,337,426	5,411,211	43.20%

Figure 20 summarizes the preventive dental service utilization from CY 2014 to CY 2021 for children ages one through twenty statewide. Dental utilization increased throughout the years since the implementation of DTI, but decreased in CY 2020 due to the PHE compared to previous CYs; however, utilization is showing a positive trend since March 2021. Note that the utilization is based on preliminary data and is expected to increase as DHCS receives more claims for 2021 dates of services.

Figure 20: Statewide Three Months Continuously Enrolled Medi-Cal Members Age 1-20 and the Preventive Dental Services Utilization CY 2014 – CY 2021

Measure End Month	Measure Period	Numerator[21]	Denominator[22]	Utilization
Dec 2014	01/2014-12/2014	2,173,965	5,570,505	39.03%
Dec 2015	01/2015-12/2015	2,465,407	5,794,087	42.55%
Dec 2016	01/2016-12/2016	2,464,575	5,783,806	42.61%
Dec 2017	01/2017-12/2017	2,580,623	5,648,992	45.68%
Dec 2018	01/2018-12/2018	2,545,379	5,507,592	46.22%
Dec 2019	01/2019-12/2019	2,577,057	5,374,280	47.95%

[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] 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.
[22] 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.

Measure End Month	Measure Period	Numerator[21]	Denominator[22]	Utilization
Dec 2020	01/2020-12/2020	2,043,289	5,271,973	38.76%
Dec 2021	01/2021-12/2021	2,337,426	5,411,211	43.20%

Provider Enrollment:

During the DY17 reporting period, the number of enrolled FFS service offices increased by 92 offices and 330 rendering providers. The number of DMC (Geographic Managed Care (GMC) and Prepaid Health Plans (PHP)) service offices increased by 61 and rendering providers decreased by 96. These numbers are per enrollment data and not based upon billing activity. The number of SNCs who provided at least one dental service in the recent one year increased by 10. Figure 21, on the next page, lists monthly provider counts across all delivery systems.

Figure 21: Statewide Enrolled Dental Offices, Rendering Providers, and Safety Net Clinics[23]

Measure Month	FFS Offic-es	FFS Render-ing	GMC Offic-es	GMC Render-ing	PHP Offic-es	PHP Render-ing	Safety Net Clinics
Jul 2021	5,966	12,071	161	356	910	1,455	558
Aug 2021	5,967	12,149	157	358	911	1,469	559
Sep 2021	5,936	12,186	157	353	898	1,437	561
Oct 2021	5,873	12,190	143	334	890	1,436	572
Nov 2021	5,925	12,238	142	334	891	1,440	570
Dec 2021	6,058	12,401	160	336	972	1,379	568

Domain Payments:

Domain 1 providers are paid semi-annually at the end of January and July. In DY17, DHCS issued a second payment for PY5 in August 2021 for the following: FFS $851,322.75, DMC $549,313.50, and SNC $621,924.75, totaling $2,022,561.00.

[23] Enrolled 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. The count of Safety Net Clinics is based on encounter data from the DHCS Data Warehouse MIS/DSS as of January 2022. Only Safety Net Clinics who submitted at least one dental encounter within one year were included.

For Domain 2, FFS providers are paid weekly; whereas, DMC and SNC providers are paid on a monthly basis. Figure 22 on the next page represents Domain 2 (CRA, Silver Diamine Fluoride (SDF), and preventive services) claim payments for FFS, DMC, and SNC providers during DY17, which total $28,442,323.

Figure 22: Domain 2 Payments by County and Delivery System Paid in DY17[24]

County	FFS	DMC	SNC
Contra Costa	$435,069	$0	$0
Fresno	$1,108,811	$0	$0
Glenn	$252	$0	$0
Humboldt	$0	$0	$0
Imperial	$16,960	$0	$0
Inyo	$0	$0	$5,670
Kern	$1,566,977	$0	$2,646
Kings	$3,944	$0	$0
Lassen	$0	$0	$0
Los Angeles	$9,017,247	$143,670	$130,402
Madera	$200,894	$0	$0
Mendocino	$0	$0	$37,658
Merced	$369,367	$0	$0
Monterey	$899,363	$0	$0
Orange	$2,368,363	$0	$0
Plumas	$0	$0	$0
Riverside	$2,306,744	$0	$0
Sacramento	$117,026	$942,941	$0
San Bernardino	$2,264,530	$0	$21,602
San Diego	$2,035,148	$61	$3,677
San Joaquin	$644,388	$0	$0
Santa Barbara	$495,906	$0	$0
Santa Clara	$531,392	$0	$0
Sierra	$0	$0	$0
Sonoma	$52,349	$0	$156,377
Stanislaus	$857,209	$0	$0
Tulare	$692,241	$126	$0
Ventura	$821,159	$126	$192,028
Yuba	$0	$0	$0
Total	**$26,805,339**	**$1,086,924**	**$550,060**

[24] Data Source: ASO DTI Reports as of July 2021.

Figure 23 below represents claim payments for FFS, DMC, and SNC providers from the beginning of the Domain 2 program through the end of DY17, which total $230,508,517.56.

Figure 23: Domain 2 Payments by County and Delivery System between February 2017 and December 2021 (End of DY17)[25]

County	FFS	DMC[26]	SNC
Contra Costa	$3,089,373	$0	$0
Fresno	$10,261,298	$252	$85,816
Glenn	$11,475	$0	$0
Humboldt	$70	$0	$126
Imperial	$155,328	$0	$0
Inyo	$0	$0	$57,960
Kern	$13,778,853	$126	$4,032
Kings	$54,066	$0	$0
Lassen	$0	$0	$0
Los Angeles	$69,952,727	$750,817	$2,643,898
Madera	$1,602,504	$0	$0
Mendocino	$0	$0	$917,222
Merced	$2,173,247	$0	$0
Monterey	$7,576,863	$0	$0
Orange	$17,612,412	$252	$714,024
Plumas	$0	$0	$0
Riverside	$15,069,915	$126	$61,755
Sacramento	$2,679,860	$7,477,705	$0
San Bernardino	$13,952,672	$252	$63,224
San Diego	$17,281,498	$187	$1,475,936
San Joaquin	$4,973,618	$504	$103,298
Santa Barbara	$4,086,551	$0	$0
Santa Clara	$4,342,465	$0	$28,875
Sierra	$0	$0	$0
Sonoma	$474,985	$0	$1,368,536
Stanislaus	$6,908,507	$126	$0
Tulare	$10,465,900	$126	$0
Ventura	$7,051,489	$630	$1,196,785
Yuba	$0	$252	$0
Total	**$213,555,676**	**$8,231,355**	**$8,721,487**

There were no Domain 3 payments issued during this reporting period as Domain 3 payments are made annually in June. The total number of SNCs participating in Domain

[25] Data Source: ASO DTI Reports as of July 2021.
[26] Counties are associated with the providers' county code in MIS/DSS.

3 remained the same in DY17, with a total of 123.

For Domain 4, Figure 24 below shows payments in DY17 for each LDPP, which total $42,514,660.

Figure 24: Domain 4 Payments to LDPP[27] for DY17

LDPPs	Total Paid
Alameda County	$5,286,963
California Rural Indian Health Board, Inc.	$598,366
California State University, Los Angeles	$6,680,242
First 5 San Joaquin	$1,766,333
First 5 Riverside	$3,708,265
Fresno County	$2,282,437
Humboldt County	$1,480,950
Orange County	$7,750,430
Sacramento County	$4,218,315
San Luis Obispo County	$813,026
San Francisco City and County	$1,707,721
Sonoma County	$912,680
University of California, Los Angeles	$5,308,932
Total	**$42,514,660**

For all DYs, Figure 25 below shows paid amounts for each LDPP, which total $108,546,404.

Figure 25: Domain 4 Payments to LDPP[28] for all DYs

LDPPs	Total Paid
Alameda County	$16,252,324
California Rural Indian Health Board, Inc.	$1,911,233
California State University, Los Angeles	$15,218,815
First 5 San Joaquin	$4,487,937
First 5 Riverside	$8,422,689
Fresno County	$8,231,086
Humboldt County	$3,515,891
Orange County	$15,495,453
Sacramento County	$9,315,478

[27] Data Source: ASO Invoices as of December 2021.
[28] Data Source: ASO Invoices as of December 2021.

LDPPs	Total Paid
San Luis Obispo County	$1,643,747
San Francisco City and County	$4,219,835
Sonoma County	$3,284,941
University of California, Los Angeles	$16,546,975
Total	**$108,546,404**

A broader analysis of the quantitative data for each of the Domains will be included in the preliminary DTI Program Year 6 report for calendar year 2022, due to CMS by June 30, 2022, and final report due to CMS by December 31, 2022.

Policy/Administrative Issues and Challenges:

DHCS did not have any policy/administrative issues or challenges in DY17.

Progress on the Evaluation and Findings:

Given that DTI has been extended for one additional year (PY6), Mathematica, the DTI independent evaluator, has been directed to include data from PY6 in the final evaluation of the DTI Program. Accordingly, the due date by which Mathematica must submit the final evaluation to DHCS has been extended for one additional year, due to DHCS on October 31, 2022. During DY17, DHCS executed an amendment to extend its contract with Mathematica, to reflect the extension of the DTI. Mathematica continued to complete tasks associated with the final evaluation of the DTI Program, and remained on schedule with timelines outlined in the approved Evaluation Design. Per the quarter two (October 2021-December 2021) progress report received, Mathematica has completed all beneficiary interview transcripts; completed analysis of the beneficiary survey data; completed programming of additional descriptive analyses that include CY 2018, 2019, and 2020 administrative data, that accounted for the expansion of Domain 2 and Domain 3; completed summarizing preliminary results from impact analysts of Domains 1, 2, and 3; began development of specification and programs for the analyses and outcomes for descriptive and impact analysis; and completed stakeholder interviews and analyzed the interview transcripts. Mathematica reported there were two planned stakeholder interviews that did not occur; one because the target organization did not follow DTI, and the other because of non-response despite outreach to multiple potential organizations. Additionally, Mathematica will continue to participate in bi-weekly conference calls with DHCS and gather and analyze data for inclusion in the Final Evaluation Report.

Opportunities for Improvement:

Through DTI, DHCS was able to validate the effectiveness incentive payments had on providers to serve more Medi-Cal children and increase dental services utilization in the piloted counties. DHCS used DTI data, stakeholder feedback, lessons learned, and LDPP's experience to identify opportunities for improvement and developed new oral health policies that would garner statewide provider and member participation in the Medi-Cal program. As a result, DHCS implemented two new pay-for-performance initiatives and two new dental benefits as part of the CalAIM with federal support through the State Plan Amendment 21-0019. CalAIM offers performance payments for preventive services and continuity of care, as well as, CRA and SDF as statewide benefits. Performance payments are based upon services rendered and not baselines or benchmarks as required for DTI incentive payments. In addition, CalAIM payments are more frequent than DTI, such that payments are part of the FFS providers' weekly check write and monthly check write for SNC providers; whereas, DMC plans are required to comply with the approved SPA 21-0019 and issue directed payments to their network providers.

Upon conclusion of DTI on December 31, 2021, CalAIM went into effect on January 1, 2022. Although the transition was instant, providers were kept apprised of DTI run out activities as well as CalAIM implementation efforts through various stakeholder engagement forums and provider bulletins throughout 2021. A new CalAIM Dental webpage was created to house details on all the CalAIM oral health initiatives including forms and frequently asked questions. Providers were also able to submit questions directly to the Medi-Cal dental email inbox and receive direct responses. Although DHCS has seen an increase in correspondence from providers with questions regarding CalAIM, DHCS has responded to all emails timely and will be evaluating responses for opportunities to improve on the information posted to the CalAIM Dental website and Frequently Asked Questions to avoid similar questions being submitted.

DTI Not Continuing Under the CalAIM Section 1115 Demonstration:

DHCS is closing out the remaining DTI Domains 1, 2, and 3. Similar policies were implemented as part of the CalAIM oral health initiatives with state plan authority and not under CalAIM Section 1115 Demonstration. DTI Domain 1 concentrated on increasing preventive services for children, which expanded to children and adults statewide under CalAIM. As compared to DTI, CalAIM includes six additional preventive services procedure codes for children and added procedure codes for adults. CalAIM payments to providers are not based upon baseline and benchmarks; instead, are a flat rate performance payment based upon rendering preventive services. CalAIM payments are processed as part of the normal provider payments and are issued weekly to FFS providers and monthly to safety net clinics for dates of service starting on January 1, 2022, versus twice a year under DTI. Also, DMC plans are issuing directed payments for

preventive services to their network providers instead of DHCS issuing CalAIM payments as done under DTI.

For Domain 2, motivational interviewing did not carry over as a benefit under CalAIM and as a result is not part of the CalAIM CRA bundle; changes to the caries-arresting medicament (known as SDF) criteria were also implemented. The CRA bundle, inclusive of nutritional counseling for children ages 0-6, continues to offer increased frequencies of preventive treatments based on corresponding CRA risk levels low, moderate, and high. Under DTI Domain 2, SDF was applicable every 6 months only on high risk children ages 0-6; whereas, CalAIM enabled SDF for children ages 0-6 and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include individuals in a Skilled Nursing Facility/Intermediate Care Facility or who are part of the California Department of Developmental Services population. All providers can receive payment for these benefits through their normal Medi-Cal dental claims processes and respective rates available through the delivery system they participate in.

Domain 3’s continuity of care tiered incentive payments for the specified 36 counties concluded, however; CalAIM continued DHCS’ focus on continuity of care by expanding statewide to all Medi-Cal members (adults and children) and offering flat rate performance payments to providers who maintain continuity of care. CalAIM payments are issued to FFS providers weekly and safety net clinics monthly with dates of service starting on January 1, 2022. As under DTI, DMC plans are contractually required to maintain continuity of care; therefore, their network providers will not receive continuity of care performance payments from DHCS. All CalAIM oral health initiatives were effective and implemented on January 1, 2022 with no breaks in payments for dates of services after DTI concluded on December 31, 2021.

CALIFORNIA CHILDREN'S SERVICE DEMONSTRATION PILOT (CCS)

Although the CCS Demonstration Pilot will not continue under the CalAIM Section 1115 Demonstration the final evaluation report due date is 12/31/2022 and thus only interim findings are presented below.

The CCS Demonstration Pilot provided 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 Demonstration Pilot was 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 focused on improving care provided to childrenin 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 piloted two (2) health care delivery models of care for children enrolled in the CCS Program. The two demonstration models included 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 are being evaluated to measure the effectiveness of focusing on the whole child, not just the CCS condition. The evaluation looks to answer the following questions:

- What is the impact of the CCS DP on client's access to CCS services?
- What is the impact of the CCS DP on client satisfaction?
- What is the impact of the CCS DP on providers' satisfaction/assessment of the delivery of and the reimbursement of services?
- What is the impact of the CCS DP on the quality of care received?
- What is the impact of the CCS DP on care coordination?

The pilots also helped create 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 ACO
- Medi-Cal MCP (existing)

In addition to HPSM, DHCS contracted with RCHSD, an ACO beginning in FY 2018.

DHCS contracted with the University of California, San Francisco (UCSF) Institute for Health Policy Studies to conduct the CCS evaluation from July 1, 2019, to December 31, 2022. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to CMS on August 31, 2020 as required.

Success/Accomplishments:

Figure 26: 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 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.
December 31, 2021	Upon sunset of RDHSD, DHCS successfully transferred members to Fee-for-Service or other

Date	Pilot Accomplishment Items
	Managed Care Plans in San Diego County.

Program Highlights:

HPSM CCS Pilot Program
On April 1, 2013, the Health Plan of San Mateo (HPSM), in partnership with the San Mateo County Health System, became the first operational CCS Demonstration Pilot under the Waiver. The HPSM provided comprehensive health care to approximately 1,400 CCS eligible clients, and managed and coordinated a full range of health care services for the "whole" child including periodic health assessments, immunizations, primary health care services not related to the CCS eligible medical condition and specialty health care services. In June 1, 2018, HPSM transitioned CCS beneficiaries from the demonstration pilot plan to managed care plan.

Rady Children Hospital San Diego (RCHSD) CCS Demonstration Pilot
RCHSD also known as California Kids Care – San Diego pilot demonstration was implemented on July 1, 2018. This program covered beneficiaries with full scope Medi-Cal and 5 (five) CCS eligible medical conditions: cystic fibrosis, sickle cell, diabetes types I and II, acute lymphoblastic leukemia, or hemophilia. During their time as a managed care plan in San Diego County, RCHSD oversaw approximately 400 members. DHCS worked closely with the county and neighboring managed care plans to ensure a smooth transition of the population. On December 31, 2021, the RCHSD Pilot terminated. DHCS worked closely with other plans in San Diego County to ensure members were transferred smoothly to other managed care plans or Fee-For- Service.

Qualitative Findings:

UCSF conducted Qualitative Parent/Guardian Interviews to capture data respond to the evaluation research questions related to client satisfaction. The interviews are based on the following domains: Access to Care, Client Satisfaction Quality of Care, Care Coordination, and Total Cost of Care. Fourteen qualitative one-on-one interviews were conducted with parents/guardians of CCS DP clients who have been transitioned to HPSM and RCHSD. Interviews will gather in-depth, qualitative data on their experiences with the transition of CCS services in the areas of satisfaction, perceived quality, access to care, and coordination of care. These qualitative data from parents/guardians will also be used to inform the development of the telephone survey instrument as well as help with the interpretation of quantitative results. At the time of the interim report, 14 parent/guardian interviews were completed in total. No conclusions can be drawn until the final data is analyzed. Final qualitative results will be available in the Final Report due to CMS on 12/31/2022.

Quantitative Findings:

Enrollment

The monthly enrollment for RCHSD CCS DP is reflected in Figure 27 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 27: 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	349	-3
March 2020	346	-3
April 2020	349	+3
May 2020	352	+3
June 2020	372	+20
July 2020	372	+0
August 2020	373	+1
September 2020	374	+1
October 2020	375	+1
November 2020	371	-4
December 2020	372	+1
January 2021	371	-1
February 2021	373	+2

Month	RCHSD Enrollment Numbers	Difference Prior Month
March 2021	383	+10
April 2021	381	-2
May 2021	382	+1
June 2021	384	+2
July 2021	384	+0
August 2021	384	+0
September 2021	383	-1
October 2021	382	-1
November 2021	379	-3
December 2021	342	-37

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

The evaluation began on July 1, 2019. Since then the UCSF research team:

- Obtained Institutional Review Board (IRB) approval from both UCSF and the state of California. (See Appendices F and G.)
- Worked with DHCS programmers to accomplish a schedule of data pulls and transfers to UCSF. The tables/results contained in this section reflect frequencies of the data transferred to UCSF. UCSF has been working with DHCS to obtain the data listed in Sections C and D, including all claims and encounters for the CCS population from 2011 to 2019. As of this report, UCSF has received all data from MIS-DSS for the study period as well as data from CMS Net. UCSF is still waiting for the California Department of Health Care Access and Information (HCAI) PDD and ED files for hospitalization and emergency use data. All data in this current report regarding hospitalizations and emergency room visits have been obtained through claims; UCSF will further investigate hospitalizations and ED visits through HCAI data when those datasets are received. In addition, UCSF is working with DHCS and the CCS DPs to attain clinical data (e.g., HbA1c, depression screening data) in

order to answer the quality of care questions posed in the 1115 waiver evaluation. At the time of writing this report, these data are still being queried.
- Completed 16 key informant interviews with CCS DP health plan staff, CCS county staff, and other expert stakeholders.
- Completed 14 qualitative interviews with parents and guardians of CCS DP clients.
- Developed and finalized a telephone survey instrument with the input of the advisory group, DHCS, and consumers who participated in pilot testing.
- Collected 1,449 telephone survey responses from CCS DP and Traditional CCS parent/guardians to date.

Opportunities for Improvement:

The final evaluation report due date is December 31, 2022 and thus conclusions, lessons learned and opportunities for improvement are not currently available and will be included in the final evaluation report.

COORDINATED CARE INITIATIVE PROGRAM EXPERIENCE OF DUAL ELIGIBLES

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (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. The CCI is authorized by Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), SB 94 (Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015) and SB 97 (Chapter 52, Statutes of 2017).[29]

The CCI initially included the following three major components in seven counties[30]:

1. Cal MediConnect (CMC), which combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through Medicare-Medicaid Plans (MMPs);
2. Mandatory Medi-Cal managed care enrollment for all Duals for their Medi-Cal benefits; and
3. The integration of all Long-Term Services and Supports (LTSS) into Medi-Cal managed care.

Accomplishments:

Figure 28: Cal MediConnect Accomplishments 2019-2021

Date	Pilot Accomplishments
Implementation of Streamlined Enrollment for Cal MediConnect	
2019 - 2021	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 CMC and has continued through DY15 to contribute to a modest increase in enrollment for all MMPs.
MMP Monthly Conference Calls	
2019 - 2021	DHCS and CMS continue to support MMPs in simplifying enrollment for all services, including Managed Long Term Services and Supports by holding monthly Contract Management Team conference calls.
MMP Bi-Weekly Conference Calls	

[29] California legislation authorizing the CCI is searchable here: http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml.
[30] The seven CCI counties are Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara.

2019 - 2021	DHCS and CMS assist MMPs in resolving any enrollment or plan issues by holding bi-weekly conference calls.
MMP Duals Plan Letters (DPLs) Released	
No DPLs for MMPs released from 2019 to present.	

Cal MediConnect Program Highlights:

In January 2019, DHCS requested stakeholder feedback on cost-neutral initiatives and activities to help improve CMC. 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 were paused due to the COVID-19 PHE, but re-launched in 2020. The final output of this group was the development of member and provider education in the form of two factsheets.[31]

Qualitative and Quantitative Findings:

Cal MediConnect Enrollment

As of December 1, 2021, approximately 114,052 members enrolled in MMPs across the seven participating CCI counties. Detailed Cal MediConnect enrollment information for each CCI county is below in Figure 14:

Figure 29: Cal MediConnect Enrollment Information for Each CCI County

County	Number of Cal MediConnect Members Enrolled
Los Angeles	31,219
Orange	14,753
Riverside	17.060
San Bernardino	16,466
San Diego	14,039
Santa Clara	11,705

[31] Cal MediConnect Member and Provider Education Fact Sheets:
The Cal MediConnect member DME fact sheet can be found at the following link:
https://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder%20documents/DME-Member-Fact-Sheet.pdf
The Cal MediConnect provider DME fact sheet can be found at the following link:
https://www.dhcs.ca.gov/provgovpart/Documents/Duals/stakeholder%20documents/DME-Provider-Fact-Sheet.pdf

County	Number of Cal MediConnect Members Enrolled
San Mateo	8,810

DHCS updates the CMC Performance Dashboard on a quarterly basis to include updated enrollment numbers and tables on key aspects of the CMC program that assist MMPs in improving their performance and quality standards. [32]

Cal MediConnect Ombudsman Call Volume

From July 1, 2020, to December 31, 2021, the CMC Ombudsman received approximately 9,482 calls from Cal MediConnect enrollees. Below is a breakdown of the CMC Ombudsman call data by each county's corresponding Ombudsman service provider:

- Legal Aid Society of San Diego (San Diego): 1,371
- Neighborhood Legal Services (Los Angeles): 2,829
- Inland Counties Legal Services (San Bernardino and Riverside): 506
- Bay Area Legal Aid: 1,028
- Legal Aid Society of SoCal: 551
- Legal Aid Society of San Mateo: 100
- Other Health Consumer Alliance programs: 2,881
- Abandoned calls: 216

MLTSS Medi-Cal Continuity of Care Data

DHCS began to collect Medi-Cal continuity of care data for dual eligibles not enrolled in Cal MediConnect on a quarterly basis beginning the first quarter of 2015. From Quarter 3 of 2020 to Quarter 4 of 2021, there were 661 continuity of care requests. Overall, 95.2% of the requests approved, 3.9% denied, and 0.5% were in process. From Quarter 3 to Quarter 4 of 2021, there were 255 continuity of care requests. Overall, 98.0% of the requests approved, 1.2% denied, and 0% were still in process. The continuity of care request denials were due to reasons such as providers refusing to work with managed care and other reasons such as availability of a network provider and request for a non-covered service.

Cal MediConnect Policy and Administrative Issues and Challenges:

CMC continued to encounter the following difficulties that have continued since it began and during DY17:

- The "unable to reach" reporting metric reached an all-time high for several MMPs;

[32] The latest Cal MediConnect Performance Dashboard can be found at the following link: https://www.dhcs.ca.gov/Documents/MCQMD/CMC-Dashboard-12-21.pdf

- The resistance from providers to participate in the CMC program; and

MMPs have encountered a high level of “unable to reach” percentages for enrollees within CMC due to several external factors. There are many possible reasons for this, such as enrollees moving, phones 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 collaborated with MMPs to first understand the extent of this issue and second, to conduct short-term focused quality improvement efforts that resulted in CMS and DHCS continuing to require several of the MMPs to report on their Performance Improvement Projects to address their inability to reach rate targets.

Progress on the Evaluation and Findings of Cal MediConnect:

Research Triangle Institute International
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 measures 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:* released on November 29, 2018*,* and the *Second Evaluation report,* released in summer 2021.[33]

The SCAN Foundation

The SCAN Foundation (TSF) funded two evaluations of CMC: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of CMC, 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 CMC enrollees with Duals who are eligible for CMC but are not participating, or live in a non-CCI county within California.

The results of the sixth wave, released in October 2018, found that CMC enrollees' confidence in navigating their healthcare increased. 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 CMC 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 CMC enrollees reported that they encountered problems with their health service. CMC 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 formation comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health. 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 included data from previous years, conducted in DY14, as outlined below.

[33] The report is available on the CMS website at: https://innovation.cms.gov/data-and-reports/2021/fai-calif-prelim-er2

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 CMC enrollees' experience with care; including access, quality, and coordination over time.[34] Approximately 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 CMC after one year in the program;
- CMC satisfaction overall was very high (94%) with enrollees reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among CMC enrollees compared to those who opted out or those in non-CCI counties;
- In both 2016 and 2017, one in five CMC enrollees reported delays or problems in getting care or services. Of those, 61% reported the problems were unresolved;
- Primary care visits decreased among CMC enrollees between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period;
- Two-thirds of CMC enrollees used specialty care;
- Over 70% of CMC 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 CMC enrollees used behavioral health services, and a majority of those took medication for mental health conditions;
- CMC 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 CMC enrollees reported having a care coordinator;
- Over three-quarters of CMC 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 CMC enrollees reported getting a ride from their health plan to medical appointments;
- Half of non-English speaking CMC enrollees reported they could "never" get a medical interpreter when they needed one;
- Among CMC 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

[34] 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

- Approximately 37% of CMC 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.

In May 2019, TSF released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging that described the findings of the 2018 wave of the Cal MediConnect (CMC) Rapid Cycle Polling Project, a tracking survey that included over 2,900 interviews with older adults and people with disabilities who were dually eligible for Medicare and Medi-Cal.[35] CMC health plans integrate all Medicare and Medi-Cal benefits, including long-term services and supports (LTSS), in seven California counties. Since 2015, almost 10,000 CMC enrollees completed surveys about their experiences with the program.

Surveys also asked beneficiaries about their confidence and satisfaction with health care, and problems encountered. Previous analyses report beneficiary experiences over the 4-year survey, including changes over time and comparisons with the non-CCI groups. In this analysis, researchers analyzed data from CMC beneficiaries and compared by several member characteristics including county, race, language, and disability (need for long-term services and support).

[35] 2019 Findings from the Cal MediConnect Rapid Cycle Polling Project are available at https://www.thescanfoundation.org/initiatives/advancing-integrated-care/evaluating-cal-mediconnect/

SENIOR OR PERSONS WITH DISABILITIES (SPD)

SPD Enrollment (Data Component only):
The "mandatory SPD population" consists of Medi-Cal-only beneficiaries with certain aid codes who reside in all counties operating under the Two-Plan Model (Two-Plan) and Geographic Managed Care (GMC) models of managed care.

The "existing SPD population" consists of beneficiaries with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Dual Eligibles and other voluntary SPD populations with certain aid codes in all counties operating under the Two-Plan and GMC models of managed care.

The "SPDs in Rural Non-COHS Counties" consists of beneficiaries with certain aid codes who reside in all Non-COHS counties operating under the Regional, Imperial and San Benito models of managed care.

The "SPDs in Rural COHS Counties" consists of beneficiaries with certain aid codes who reside in all COHS counties that were included in the 2013 rural expansion of managed care. Due to aid code differences between COHS and non-COHS models, rural counties are presented separately.

Data for CY 2021 is pulled directly from the Enterprise Performance Monitoring (EPM), as of February 15, 2022. EPM is an internal business intelligence system which assists in pulling data for reporting purposes.

In the Existing SPDs by County table, there is a drop in enrollment from Q1 2017 to Q2 2017 for Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Both data pulls utilized the same parameters. The reason for this drop is unknown.

The SPD Evaluation Report notes that the SPD transition was successful and the SPD population were fully integrated into Managed Care, in accordance with Section 1115 demonstration Waiver.[36]

[36] The Section 1115 Demonstration Waiver can be found in the following: CalAIM Section 1115 Renewal Application 6.30.21

Figure 30: Total Member Months for Mandatory SPDs by County

County	Q1 2021 (Jan-Mar)	Q2 2021 (Apr-Jun)	Q3 2021 (Jul-Sep)	Q4 2021 (Oct-Dec)	2021 Total Member Months
Alameda	80,876	80,575	80,074	79,804	321,329
Contra Costa	49,907	49,921	50,730	50,959	201,517
Fresno	71,325	70,926	70,526	70,418	283,195
Kern	58,239	58,103	57,886	57,673	231,901
Kings	8,267	8,200	8,224	8,256	32,947
Los Angeles	532,850	530,724	528,333	524,934	2,116,841
Madera	7,027	7,024	7,081	7,035	28,167
Riverside	109,234	109,184	108,116	106,979	433,513
Sacramento	104,401	103,911	103,174	102,176	413,662
San Bernardino	117,191	116,504	115,716	114,804	464,215
San Diego	117,911	117,322	116,410	115,411	467,054
San Francisco	38,689	38,274	37,632	37,134	151,729
San Joaquin	47,667	47,229	46,753	46,346	187,995
Santa Clara	65,625	65,581	65,561	65,746	262,513
Stanislaus	33,202	32,816	32,502	31,988	130,508
Tulare	32,744	32,661	32,631	32,486	130,522
Total	**1,475,155**	**1,468,955**	**1,461,349**	**1,452,149**	**5,857,608**

Figure 31: Total Member Months for Existing SPDs by County

County	Q1 2021 (Jan-Mar)	Q2 2021 (Apr-Jun)	Q3 2021 (Jul-Sep)	Q4 2021 (Oct-Dec)	2021 Total Member Months
Alameda	78,936	80,164	81,338	82,041	322,479
Contra Costa	37,693	38,546	40,961	42,820	160,020
Fresno	47,044	47,496	48,558	50,079	193,177
Kern	35,136	35,758	36,822	37,828	145,544
Kings	4,927	4,967	4,974	5,045	19,913
Los Angeles	1,073,022	1,078,449	1,088,155	1,093,234	4,332,860
Madera	5,011	5,104	5,204	5,256	20,575
Marin	19,892	19,897	19,932	19,941	79,662
Mendocino	17,873	17,862	17,897	17,858	71,490
Merced	51,822	52,040	52,184	52,111	208,157
Monterey	50,955	51,080	51,280	51,241	204,556
Napa	15,861	15,691	15,680	15,639	62,871
Orange	355,383	356,607	358,052	359,056	1,429,098
Riverside	121,818	122,030	122,669	122,468	488,985
Sacramento	76,858	77,601	78,193	78,492	311,144
San Bernardino	118,513	118,904	119,702	119,975	477,094
San Diego	203,665	204,578	205,406	205,834	819,483
San Francisco	52,660	53,403	54,146	54,724	214,933
San Joaquin	32,771	33,409	33,993	34,381	134,554
San Luis Obispo	26,341	26,477	26,421	26,341	105,580
San Mateo	42,986	42,682	42,799	42,764	171,231
Santa Barbara	49,721	49,921	50,221	50,387	200,250
Santa Clara	125,297	125,176	125,101	124,966	500,540
Santa Cruz	33,016	32,900	32,912	32,802	131,630
Solano	63,401	63,597	63,666	63,540	254,204
Sonoma	53,063	53,158	53,327	53,170	212,718
Stanislaus	20,048	20,190	20,282	20,388	80,908
Tulare	22,262	22,397	22,662	22,906	90,227
Ventura	93,330	93,713	94,173	94,408	375,624
Yolo	27,508	27,718	27,845	27,948	111,019
Total	**2,956,813**	**2,971,515**	**2,994,555**	**3,007,643**	**11,930,526**

Figure 32: Total Member Months for SPDs in Rural Non-COHS Counties

County	Q1 2021 (Jan-Mar)	Q2 2021 (Apr-Jun)	Q3 2021 (Jul-Sep)	Q4 2021 (Oct-Dec)	2021 Total Member Months
Alpine	41	42	44	42	169
Amador	1,085	1,064	1,030	1,042	4,221
Butte	16,378	16,161	15,954	15,717	64,210
Calaveras	1,667	1,638	1,610	1,615	6,530
Colusa	838	848	844	844	3,374
El Dorado	5,171	5,184	5,148	5,174	20,677
Glenn	1,636	1,625	1,585	1,572	6,418
Imperial	10,976	10,930	10,899	10,941	43,746
Inyo	474	471	469	470	1,884
Mariposa	697	708	707	696	2,808
Mono	165	164	158	160	647
Nevada	3,096	3,075	3,042	3,005	12,218
Placer	10,668	10,680	10,718	10,692	42,758
Plumas	961	965	964	934	3,824
San Benito	357	364	385	387	1,493
Sierra	93	89	84	75	341
Sutter	6,046	6,045	6,011	5,960	24,062
Tehama	5,235	5,217	5,129	5,055	20,636
Tuolumne	2,503	2,470	2,394	2,372	9,739
Yuba	6,351	6,310	6,204	6,150	25,015
Total	**74,438**	**74,050**	**73,379**	**72,903**	**294,770**

Figure 33: Total Member Months for SPDs in Rural COHS Counties

County	Q1 2021 (Jan-Mar)	Q2 2021 (Apr-Jun)	Q3 2021 (Jul-Sep)	Q4 2021 (Oct-Dec)	2021 Total Member Months
Del Norte	8,353	8,289	8,316	8,259	33,217
Humboldt	27,116	26,999	26,850	26,559	107,524
Lake	20,059	20,032	20,079	19,945	80,115
Lassen	4,516	4,529	4,612	4,567	18,224
Modoc	2,320	2,307	2,306	2,296	9,229
Shasta	41,021	40,840	40,418	39,957	162,236
Siskiyou	11,727	11,660	11,630	11,576	46,593
Trinity	2,890	2,905	2,907	2,879	11,581
Total	**118,002**	**117,561**	**117,118**	**116,038**	**468,719**