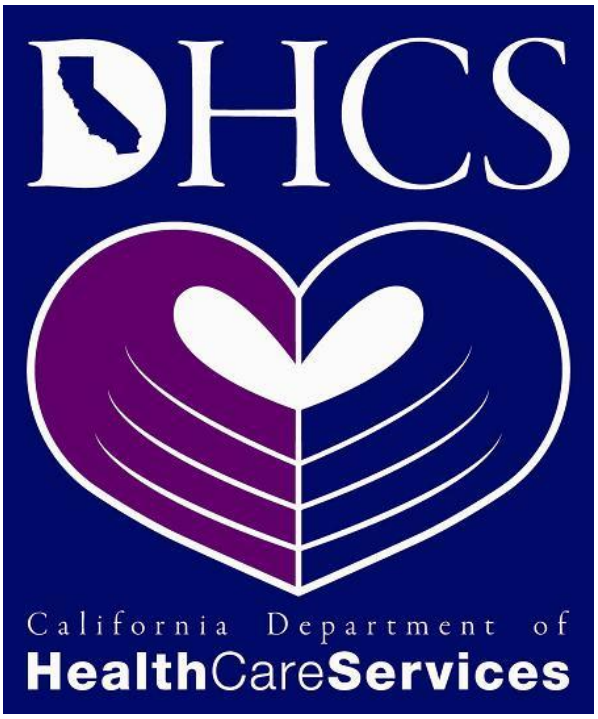
CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION (11-W-00103/9)



Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Fifteen (07/01/2019 – 06/30/2020)
Third Quarter Reporting Period: 01/01/2020 – 03/31/2020

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 18: Post Award Forum

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

In DY15-Q3, DHCS hosted a SAC meeting on February 12, 2020. DHCS discussed the budget, coverage expansion to undocumented young adults, and financing Medi-Cal Healthier California for All (Currently known as CalAIM).

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/021220-SAC-Agenda.pdf
The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/021220-SAC-Meeting-Minutes.pdf

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on January 13, 2020, February 10, 2020, and March 9, 2020, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following were some of the topics that were discussed: Whole Person Care Program Updates, Health Homes Program Updates, Draft interim Evaluation Reports, Budget Neutrality, COHS 16% Threshold, and the Global Payment Program extension.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

All CCS Demonstration members in San Mateo County were transitioned into Health Plan San Mateo's (HPSM's) managed care plan effective July 1, 2018. In addition to HPSM, DHCS contracted with Rady Children's Hospital of San Diego (RCHSD), an ACO beginning July 1, 2018.

Enrollment Information:

The monthly enrollment for RCHSD CCS Demonstration Project (DP) is reflected in Table 1 below. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Table 1: Monthly Enrollment for RCHSD CCS Demonstration Project (DP)

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-July	0	$2,733.54	$0.00
18-Aug	44	$2,733.54	$120,275.76
18-Sep	128	$2,733.54	$349,893.12
18-Oct	151	$2,733.54	$412,764.54
18-Nov	210	$2,733.54	$574,043.40
18-Dec	321	$2,733.54	$877,466.34
19-Jan	357	$2,733.54	$975,873.78
19-Feb	357	$2,733.54	$975,873.78
19-Mar	369	$2,733.54	$1,008,676.26
19-Apr	365	$2,733.54	$997,742.10
19-May	367	$2,733.54	$1,003,209.18
19-Jun	368	$2,733.54	$1,005,942.72
19-Jul	363	$2,733.54	$992,275.02
19-Aug	354	$2,733.54	$967,673.16
19-Sep	350	$2,733.54	$956,739
19-Oct	351	$2,733.54	$959,472.54
19-Nov	351	$2,733.54	$959,472.54
19-Dec	348	$2,733.54	$951,271.92
20-Jan	352	$2,733.54	$962,206.08
20-Feb	346	$2,733.54	$945,804.84
20-Mar	342	$2,733.54	$934,870.68
Total			$16,931,546.76

Table 2: RCHSD Monthly Enrollment and Quarterly Member Months

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Member Months
CCS	352	346	342	3	1,040

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

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

protocols, however DHCS received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design.

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

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. In April 2020, RCHSD submitted their CCS Quarterly Grievance Report for reporting period January – March 2020. During the reporting period, RCHSD did not receive any member grievances.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Regents of the University of California, San Francisco (UCSF) was selected as the evaluator for the California Children's Services (CCS) evaluation design. This evaluation is currently running from July 1, 2019, to June 30, 2021, and will be completed in two phases. Phase one will include Health Plan San Mateo (HPSM), and phase two will include Rady Children's Hospital of San Diego (RCHSD). In July 2019, UCSF began its contracting work on the evaluation and has since completed qualitative interviews with families of CCS pilot patients. UCSF had used the qualitative data obtained in the interviews to develop a telephone survey instrument for parents of CCS children in both Fee-for-Service and CCS pilot transition counties. UCSF has collected survey responses from parents/guardians and key informants. USCF will continue to conduct surveys through April 2020. UCSF is currently working on the CCS Pilots Interim Report which is due to Centers for Medicare & Medicaid Services on June 30, 2020.

The final evaluation design is available on this website:
http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

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

Program Requirements:

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

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

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

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

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and Fee-for-Service (FFS) members per county for Demonstration Year 15 (DY15), Quarter 2 (Q2), represents the period of October 2019 to December 2019. CBAS enrollment data is shown in the table 3, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.* Table 4 titled *CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

CBAS enrollment data are self-reported quarterly by the MCPs, which sometimes results in data lags. As such, DHCS will report CBAS MCP data for DY15-Q3 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same population.

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

Please note: DHCS anticipates there will be a reduction in enrollment and assessments, as well as overall CBAS participation, as a result of the COVID-19 public health emergency. Further information will be provided in subsequent reports to CMS.

Table 3: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS

	DY14-Q3		DY14-Q4		DY15-Q1		DY15-Q2	
	Jan - Mar 2019		Apr - Jun 2019		Jul – Sep 2019		Oct – Dec 2019	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	533	81%	528	80%	513	78%	497	75%
Butte	34	33%	36	35%	30	30%	32	31%
Contra Costa	217	67%	202	63%	219	59%	203	54%
Fresno	614	47%	638	46%	646	46%	650	47%
Humboldt	97	25%	**4	**1%	85	22%	102	26%
Imperial	309	51%	387	64%	389	65%	381	63%
Kern	73	22%	76	11%	65	10%	57	8%
Los Angeles	21,595	64%	21,978	63%	21,994	60%	21,999	60%
Merced	97	53%	90	49%	95	51%	98	53%
Monterey	113	61%	106	57%	119	64%	116	62%
Orange	2,475	55%	2,519	56%	2,595	58%	573	58%
Riverside	464	36%	508	39%	538	44%	573	37%
Sacramento	442	43%	500	48%	503	49%	484	47%
San Bernardino	709	95%	768	103%	773	77%	777	78%
San Diego	2,100	56%	2,647	70%	2,630	70%	2,597	69%
San Francisco	660	42%	688	44%	679	43%	672	43%
San Mateo	66	29%	78	34%	66	29%	67	29%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	644	45%	626	47%	617	47%	581	44%
Santa Cruz	104	68%	101	66%	102	67%	99	65%
Shasta	*	*	*	*	*	*	*	*
Ventura	906	63%	910	63%	931	65%	918	64%
**Yolo	287	76%	279	74%	275	72%	279	74%
Marin, Napa,	81	16%	84	17%	85	17%	81	16%

Solano								
Total	**32,625**	**59%**	**33,765**	**60%**	**34,016**	**58%**	**33,883**	**58%**
FFS and MCP Enrollment Data 12/2019								

Note: Information is not available for DY15-Q3 due to a delay in the availability of data.
**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***The DY14-Q4 Humboldt County drop in capacity utilization was due to a one-time data collection error that has been corrected for DY15-Q1 and ongoing reporting.*

The data provided in Table 3 shows that while enrollment has slightly decreased between DY15-Q1 & DY15-Q2, it has remained consistent with nearly 34,000 CBAS participants. Additionally, the data reflects ample capacity for participant enrollment into most CBAS Centers. Statewide, license capacity utilization has remained at 58% with no change from the prior quarter.

In Riverside County, there was a more than 5 percent decrease of license capacity utilization compared to the previous quarter. A new CBAS center opened in Riverside County, which caused the overall license capacity to increase and accounts for the decrease in license capacity utilization.

CBAS Assessments for MCPs and FFS Participants

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

Table 4, titled *CBAS Assessments Data for MCPs and FFS* reflects the number of new assessments reported by the MCPs. The FFS data for new assessments listed in this table is reported by DHCS.

Table 4: *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
DY14-Q4 (04/01-06/30/2019)	2,343	2,296 (98%)	47 (2%)	4	1 (25%)	3 (75%)
DY15-Q1 (07/01-09/30/2019)	2,449	2,401 (98%)	48 (2%)	6	6 (100%)	0 (0%)
DY15-Q2 (10/01-	2,095	2,031 (97%)	64 (3%)	3	3 (100%)	0 (0%)

12/31/2020)						
DY15-Q3 (01/01-03/31/2020)	*	*	*	5	5 (100%)	0 (0%)
5% Negative change between last Quarter		*	*		No	No

*Note: *MCP assessment information is not reported for DY15-Q3 due to a delay in the availability of the data.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. As indicated in the table above, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. According to the table, for DY15-Q2, there were (2,095) assessments completed by the MCPs, of which (2,031) were determined to be eligible and (64) were determined to be ineligible. Assessment data for MCPs for DY15 Q3 will be reported in the next quarterly report due to a delay in the availability of the data. For DY15 Q3, the table identifies that five participants were assessed for CBAS benefits under FFS, with all five determined eligible.

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

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

Table 5 titled *CDA – CBAS Provider Self-Reported Data* identifies the number of counties with CBAS Centers, total license capacity, and the average daily attendance (ADA) for DY15-Q3. The ADA at the 260 operating CBAS Centers is approximately 23,382 participants, which corresponds to 68 percent Statewide Average Daily Attendance (ADA) per center. A slight decrease in statewide ADA was seen compared to the previous quarter. Additionally, four new CBAS Centers opened and three closed during DY15-Q3 that resulted in an overall slight decrease in total statewide license capacity at 34,633. Centers have varying capacity based on their size/location, so the opening/closure of one center may impact the license capacity of another center.

Note this data is as of the beginning of March 2020, and the COVID-19 public health emergency will impact this data in subsequent quarters.

Table 5: 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	260
Non-Profit Centers	53
For-Profit Centers	207
ADA @ 260 Centers	23,382
Total Licensed Capacity	34,633
Statewide ADA per Center	68%
	CDA - MSSR Data 03/2020

Outreach/Innovative Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans and other interested stakeholders via the *CBAS Updates* newsletter, CBAS All Center Letters (ACL), California Association for Adult Day Services (CAADS) conference presentations, and ongoing MCP and CBAS Quality Advisory Committee calls.

In the past quarter, CDA distributed two newsletters and six ACLs which included updates on the following topics: (1) Provider reimbursement related to California's 2019 Budget Act, (2) CBAS center operations during the COVID-19 outbreak, and (3) upcoming education and training opportunities.

CDA convenes triannual calls/outreach with all MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update them on CBAS activities and data including policy directives, and (3) request feedback on any CBAS provider issues requiring CDA assistance. DHCS and CDA convened calls with MCPs and CBAS providers in March 2020 due to the public health emergency

CDA also convenes triannual calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. A call was held on January 8, 2020, during which current implementation efforts and status related to person-centered care and multi-disciplinary best practices were discussed.

DHCS and CDA continue to work and communicate with CBAS providers and MCPs on an ongoing basis to provide clarification regarding CBAS benefits, CBAS operations,

and policy issues. This includes conducting triannual calls with MCPs, distributing All Center Letters and CBAS Updates newsletter for program and policy updates, and responding to ongoing written and telephone inquiries.

The primary operational and policy development issues during this quarter were the following: (1) CURES Act implementation and impact on CBAS centers and their staff/subcontractors, (2) provider reimbursement related to the California 2019 Budget Act – Proposition 56, (3) CBAS center compliance with the federal Home and Community-Based Settings requirements, and (4) response to the COVID-19 pandemic.

CURES Act

DHCS and CDA are collaborating to ensure that CBAS providers are informed about the State's implementation of the CURES Act and the MCPs' responsibilities specific to screening and enrollment, credentialing, and re-credentialing of their provider networks which will impact CBAS centers and their staff/subcontractors.

Proposition 56 – Supplemental Funds

The California State Budget for 2019-2020, signed by the Governor on June 27, 2019, included $13.7 million from the California Healthcare, Research, and Prevention Tax Act of 2016 (Proposition 56) funding for supplemental payments to CBAS providers through December 31, 2021. DHCS and CDA worked collaboratively to develop the structure for the supplemental payments.

Home and Community-Based (HCB) Settings and Person-Centered Planning Requirements

CDA, in collaboration with DHCS, continues to implement the activities and commitments to CMS for compliance of CBAS centers with the federal Home and Community-Based (HCB) settings requirements by March 17, 2022, and thereafter. CDA determines CBAS center for compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS's directive in the CBAS sections of the 1115 Waiver (STC 48c), CDA developed the *CBAS HCB Settings Transition Plan* which is an attachment to California's *Statewide Transition Plan (STP)*. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions of the STP and CBAS Transition Plan before it will grant final approval. DHCS has not yet determined the submission date of the STP to CMS for final approval. DHCS and CDA continue to participate in ongoing CMS technical assistance calls and webinar training for States.

COVID-19 Pandemic and Public Health Emergency

Due to the COVID-19 pandemic, the federal Health and Human Services Secretary issued a public health emergency declaration on January 31, 2020, the President issued a March 13,

2020 national emergency declaration, and California Governor Newsom issued Executive Order N-33-20, a stay-at-home order to protect the health and well-being of all Californians and slow the spread of COVID-19. As a result of the Governor's stay-at-home order, CBAS centers were not able to provide services in a congregate setting beginning the second half of March 2020.

In response, DHCS and CDA developed a new CBAS service delivery model, known as Temporary Alternative Services (TAS).

Under this model, CBAS centers provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants.

Services provided under CBAS TAS are person-centered; based on the assessed health needs and conditions identified in the participants' current Individual Plans of Care (IPC); identified through subsequent assessments; and noted in the health record. In addition to the in person, telephonic, and telehealth services that may be provided, all CBAS TAS providers are required to do the following:

1. Maintain phone and email access for participant and family support, to be staffed a minimum of 6 hours daily, during provider-defined hours of services, Monday through Friday. The provider-defined hours are to be specified in the CBAS Center's plan of operation.
2. Provide a minimum of one service to the participant or their caregiver for each authorized day billed. This service could include a telehealth (e.g., telephone, live video conferencing) contact, written communication via text or email, a service provided on behalf of the participant[2], or an in-person "door-step" brief well check conducted when the provider is delivering food, medicine, activity packets, etc.
3. Conduct a COVID-19 wellness check and risk assessment for COVID-19 at least once a week, with greater frequency as needed.
4. Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.
5. Respond to needs and outcomes through targeted interventions and evaluate outcomes.
6. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.
7. Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed.

[2] Services provided on behalf of the participant include care coordination such as those listed under Items 4, 5, 6, and 7

To authorize this CBAS TAS model, DHCS requested flexibility under a section 1135 waiver on March 19, 2020, and a section 1115 waiver on April 3, 2020. These requests are pending CMS approval. For CBAS, DHCS requested:

- Flexibility to allow following services to be provided at a beneficiary's home:
- Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
- Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
- Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
- Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.

Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

Consumer & Provider Issues:

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 CBASinfo@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs are generally related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaints gathered by CDA were mainly about the administration of plan providers and beneficiaries' services. Complaint data received by MCPs and CDA from CBAS participants and providers are also summarized in Table 6 entitled "*Data on CBAS Complaints"* and Figure 7 entitled "*Data on CBAS Managed Care Plan Complaints*."

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY15-Q3, as illustrated in the table, titled *Data on CBAS Complaints*. Table 7, titled *Data on CBAS Managed Care Plan Complaints* shows that MCPs received two beneficiary complaints and two provider complaints in DY15-Q2. As

indicated in the prior report, total complaints, as reported by MCPs, decreased during the last quarter. MCP complaint information for DY15-Q3 will be presented in the next quarterly report due to a delay in the availability of data.

Table 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY14-Q4 (Apr 1– Jun 30)	0	0	0
DY15-Q1 (Jul 1 – Sep 30)	0	0	0
DY15-Q2 (Oct 1 – Dec 31)	0	0	0
DY15-Q3 (Jan 1 – Mar 31)	0	0	0
CDA Data - Complaints 03/2020			

Table 7: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY14-Q3 (Jan 1 - Mar 31)	8	0	8
DY14-Q4 (Apr 1 - Jun 30)	12	0	12
DY15-Q1 (Jul 1 - Sep 30)	8	0	8
DY15-Q2 (Oct 1 - Dec 31)	2	2	4
Plan data - Phone Center Complaints 12/2019			

*Note: *MCP complaint information is not available for DY15-Q2 due to a delay in the availability of the data.*

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

Grievance and appeals data is provided to DHCS by the MCPs. According to Table 8, titled *Data on CBAS Managed Care Plan Grievances*, seven grievances were filed with the MCPs for DY15-Q2; three grievances were related to “CBAS Providers,” and the

remaining four grievances were related to “Other CBAS grievances.” MCP grievance information for DY15 Q3 will be presented in the next quarterly report due to a delay in the availability of data.

Table 8: 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
DY14-Q3 (Jan 1 - Mar 31)	3	0	2	3	8
DY14-Q4 (Apr 1 - Jun 30)	2	0	0	8	10
DY15-Q1 (Jul 1 - Sep 30)	4	1	0	2	7
DY15-Q2 (Oct 1 – Dec 31)	3	0	0	4	7
Plan data - Grievances 12/2019					

Note: MCP grievance information is not available for DY15-Q3 due to a delay in the availability of the data.

According to Table 9, titled *Data on CBAS Managed Care Plan Appeals,* four appeals were filed with the MCPs during DY15-Q2; all four appeals were related to denials or limited services. MCP appeals information for DY15 Q3 will be presented in the next quarterly report due to a delay in the availability of data.

The State Fair Hearings/Appeals continue to be facilitated by the California Department of Social Services (CDSS) with the Administrative Law Judges hearing all cases filed. Fair Hearings/Appeals data is reported to DHCS by CDSS. For DY15-Q3 (January 2020 to March 2020), there was one request for a fair hearing in Los Angeles County due to a delay/denial of CBAS services. This request for a fair hearing was granted.

Table 9: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY14 – Q3 (Jan 1 – Mar 31)	0	0	0	0	0
DY14 – Q4 (Apr 1 – Jun 30)	3	0	0	3	6
DY15 – Q1 (Jul 1 – Sep 30)	2	0	0	1	3
DY15-Q2 (Oct 1 – Dec 31)	4	0	0	0	4
		Plan data - Grievances 12/2019			

Note: MCP appeals information is not available for DY15-Q2 due to a delay in the availability of the data.

Financial/Budget Neutrality Development/Issues:

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

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

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Quality Assurance/Monitoring Activity:

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. CDA continues to convene quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy.

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 10, titled *CBAS Centers*

Licensed Capacity, indicates the number of each county's total licensed capacity since DY14-Q4. Overall utilization of licensed capacity by CBAS participants for DY15 Q3 will be presented in the next quarterly report due to a delay in the availability of data. Quality Assurance/Monitoring Activity reflects data through October2019 to December 2019.

Table 10: CBAS Centers Licensed Capacity

County	DY14-Q4 Apr-Jun 2019	DY15-Q1 Jul-Sep 2019	DY15-Q2 Oct-Dec 2019	DY15-Q3 Jan-Mar 2020	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	390	**390**	0%	*
Butte	60	60	60	**60**	0%	*
Contra Costa	190	220	220	**220**	0%	*
Fresno	822	822	822	**822**	0%	*
Humboldt	229	229	229	**229**	0%	*
Imperial	355	355	355	**355**	0%	*
Kern	400	400	400	**400**	0%	*
Los Angeles	20,578	21,492	21,522	**21,412**	-0.5%	*
Merced	109	109	109	**109**	0%	*
Monterey	110	110	110	**110**	0%	*
Orange	2,638	2,638	2,638	**2,438**	-7.6%	*
Riverside	760	720	920	**920**	0%	*
Sacramento	609	609	609	**569**	-6.6%	*
San Bernardino	440	590	590	**590**	0%	*
San Diego	2,233	2,233	2,233	**2,383**	+6.7%	*
San Francisco	926	926	926	**926**	0%	*
San Mateo	135	135	135	**135**	0%	*
Santa Barbara	100	100	100	**100**	0%	**
Santa Clara	780	780	780	**780**	0%	*
Santa Cruz	90	90	90	**90**	0%	*
Shasta	85	85	85	**85**	0%	**
Ventura	851	851	851	**851**	0%	*
Yolo	224	224	224	**224**	0%	*
Marin, Napa, Solano	295	295	295	**295**	0%	*
SUM	33,409	34,463	34,693	**34,493**	-0.6%	*
CDA Licensed Capacity as of 12/2019						

**Capacity used information is not available for DY15-Q3 due to a delay in the availability of the data. Capacity used information for DY15-Q2, the latest quarter for which data are available, can be found in Figure 3 Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS.*
***Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*

The average licensed capacity used by CBAS participants is at 58 percent statewide as of December 31, 2019. Overall, most of the CBAS Centers have not operated at full capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties.TC 52(e) (v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance. As demonstrated in the table titled *CBAS Centers Licensed Capacity*, two counties experienced a negative change in total capacity. Both Orange and Sacramento Counties experienced decreases of more than five percent in total provider capacity per County. One center closed in Sacramento County and one center closed in Orange County, which would explain the decrease in total capacity for those counties. In contrast, the opening of a new center in San Diego County lead to the increase in total license capacity for that county.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS*, and *CBAS Centers Licensed Capacity* CBAS licensed capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. There were three CBAS Center closures statewide during the DY15-Q3 reporting period, however, four new CBAS Centers opened, so overall impact of center closures were minimal.

Unbundled Services (STC 48.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers

since April 2012 when CBAS became operational. Table 11, titled *CBAS Center History*, shows the history of openings and closings of the centers. According to the Table below, for DY15-Q3 (January 2020 to March 2020), CDA currently has 260 CBAS Center providers operating in California. In DY15-Q3, three centers closed, and four centers opened. Table 11 below shows there was not a negative change of more than five percent from the prior quarter so no analysis is needed to addresses such variances.

Note this data is as of the beginning of March 2020, and the COVID-19 public health emergency will impact this data in subsequent quarters.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
March 2020	257	0	3	3	260
February 2020	257	1	1	0	257
January 2020	259	2	0	-2	257
December 2019	259	0	0	0	259
November 2019	259	0	0	0	259
October 2019	259	1	1	0	259
September 2019	256	0	3	3	259
August 2019	253	0	3	3	256
July 2019	252	0	1	1	253
June 2019	253	1	0	-1	252
May 2019	253	0	0	0	253
April 2019	251	0	2	2	253
March 2019	251	0	0	0	251

Evaluation:

Nothing to report.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through DTI, DHCS aims to:

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

Medi-Cal beneficiaries are enrolled in one of the two dental delivery systems: Fee-for-Service (FFS) and Dental Managed Care (DMC). DMC plans are only in Sacramento and Los Angeles counties. The Geographic Managed Care (GMC) plans are mandatory in Sacramento. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, DMC, and those providing dental services at SNCs can participate in all domains of the DTI; with the exception of Domain 3, DMC providers are not included in this domain.

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

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

Overview of Domains

Domain 1 – Increase Preventive Services for Ages 20 and under[3]

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

Domain 2 – Caries Risk Assessment (CRA) and Disease Management[4]

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

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

Domain 3 – Continuity of Care[5]

This domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing ongoing relationships between a beneficiary and a dental provider in selected counties. Incentive payments are issued to dental service office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods.

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

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[3] DTI Domain 1
[4] DTI Domain 2
[5] DTI Domain 3

Domain 4 – Local Dental Pilot Projects (LDPPs) [6]

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

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

Enrollment Information

Table 12: Statewide Beneficiaries Ages 1-20 with Three Months Continuous Enrollment and Preventive Dental Service Utilization[7]

Measure Period	01/2019-12/2019	02/2019-01/2020	03/2019-02/2020	04/2019-03/2020
Denominator[8]	5,351,854	5,359,611	5,340,355	5,336,210
Numerator[9]	2,550,186	2,524,319	2,457,529	N/A[10]
Preventive Dental Service Utilization	47.65%	47.10%	46.02%	N/A[8]

[6] DTI Domain 4
[7] Data Source: DHCS Data Warehouse MIS/DSS Dental Dashboard March 2020. Utilization does not include one-year full run-out allowed for claim submission.
[8] Denominator: Three months continuous enrollment - Number of beneficiaries ages one (1) through twenty (20) enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.
[9] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (Current Dental Terminology (CDT) codes D1000-D1999 or 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.
[10] Utilization for the third month of each quarter is not available due to claim submission time lag.

Table 13: State Fiscal Year 2019-2020 Statewide Active Service Offices, Rendering Providers, and SNCs[11]

Delivery System and Plan[12] Delivery	Provider Type	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
FFS	Service Offices	5,909	5,919	5,921	5,888	5,895	5,889
FFS	Rendering	11,077	11,149	11,207	11,242	11,325	11,353
GMC	Service Offices	125	135	136	138	141	144
GMC	Rendering	264	273	285	286	297	301
PHP	Service Offices	916	916	915	916	917	914
PHP	Rendering	1,539	1,581	1,546	1,569	1,589	1,618
Both FFS and DMC	Safety Net Clinics	566	567	491	462	530	N/A[13]

Outreach/Innovative Activities

DTI Small Workgroup

This workgroup meets on a bi-monthly basis, the third Wednesday of the month. During this quarter, this workgroup had two meetings scheduled: January 16, 2020 and March 19, 2020. Due to lack of agenda items, emails were sent to stakeholders in lieu of both meetings which included updates on incentive payments, provider participation, and LDPP visits. The next DTI Small Workgroup meeting will be on May 21, 2020.

Domain 2 Subgroup

The purpose of this subgroup is to report on the domain's current activities, discuss ways to encourage providers who are eligible, to participate in the domain, and to provide an open forum for questions and answers specific to this domain. The group meets quarterly as needed. The subgroup did not meet this quarter.

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[11] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008A, PS-O-008B and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of SNCs is based on encounter data from the DHCS data warehouse as of January 2020. Only SNCs that submitted at least one dental encounter within a year were included.
[12] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.
[13] Count of SNCs for the third month of each quarter is not available due to claim submission time lag.

DTI Clinic Subgroup

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

Domain 3 Subgroup

The purpose of this subgroup is to report on the domain's current activities and discuss ways to increase participation from providers who are eligible to participate in the domain. This subgroup is no longer active due to the lack of agenda items specific to Domain 3. Any topics brought to DHCS' attention are included in the DTI Small Workgroup meetings.

DTI Data Subgroup

The purpose of the DTI data subgroup is to provide an opportunity for stakeholders and DHCS to discuss various components of the DTI annual report and for opportunities to examine new correlations and data. The subgroup did not meet this quarter because DHCS did not receive feedback from stakeholders regarding the DTI PY 3 Annual Report.

Domain 4 Subgroup

DHCS continues the bi-monthly teleconferences with all LDPPs as an opportunity to educate, provide technical assistance, offer support, and address concerns. Additional teleconferences are conducted as needed. During this reporting period, there was a teleconference held on February 20, 2020.

DTI Webpage

This quarter's webpage posting included the Final DTI Interim Evaluation Report, along with the Centers for Medicare & Medicaid Services (CMS) Approval Letter. DHCS submitted DTI PY 3 Annual Report to CMS in late December 2019, which was published on the DTI Webpage on February 6, 2020. Lastly, the DTI Domain 1 Fact Sheet was updated to reflect the CDT 2019 code updates.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY15-Q3. In this quarter,

there were one hundred eighty-one (181) inquiries in the DTI inbox for domains 1, 2 and 3. Most inquiries during this reporting period included, but were not limited to, the following categories: county expansion, encounter data submissions, opt-in form submissions, payment status and calculations, check reissuances resource documents, and Domain 2 billing and opt-in questions.

Number of DTI Inbox Inquiries by Domain:

Domain	Inquiries
1	105
2	64
3	12
Total	**181**

Separately, the LDPP inbox for Domain 4 received one hundred ninety-nine (199) inquiries this quarter, with questions related to budget revisions, asset tagging, site visits, and reimbursement.

Outreach Plans

The dental Administrative Services Organization (ASO) shares DTI information with providers during outreach events, specifically about domains 1-3. DHCS presented information on the DTI at the following venues during this reporting period:

- February 4, 2020: Child Health and Disability Prevention Statewide Oral Health Committee
- February 27, 2020: Medi-Cal Dental Statewide Stakeholder Meeting (Agenda)

Operational/Policy Developments/Issues

Domain 1

Domain 1 providers are paid semiannually at the end of January and July. Table 14 represents incentives payments as of January 2020 for FFS, DMC and SNC providers during the DY15-Q3 reporting period. During this time, a total of $1,436,829.00 and $51,996,507.75 was paid to services rendered in PY 3 and PY 4 respectively. The next payment in July 2020 is on schedule.

Table 14: Incentive Payments as of January 2020

Provider Type	PY 3	PY 4
FFS	$96,903.75	$49,165,165.50
DMC	$11,407.50	$1,485,361.50
SNC	$1,328,517.75	$1,345,980.75
Total Paid	**$1,436,829.00**	**$51,996,507.75**

Domain 2

FFS providers are paid on a weekly basis; whereas, SNC and DMC providers are paid on a monthly basis. Table 15 represents incentive payments as of March 2020 for FFS, SNC, and DMC providers during the DY15-Q3 reporting period. During this time, a total of $21,830,469.04 in incentive claims were paid to 2,854 providers who have opted into the domain.

Table 15: Incentive Claims as of March 2020

County	FFS	DMC	SNC
Contra Costa	$ 322,171.25	$ -	$ -
Fresno	$ 1,169,102.00	$ 252.00	$ -
Glenn	$ 504.00	$ -	$ -
Humboldt	$ -	$ -	$ -
Imperial	$ 12,002.00	$ -	$ -
Inyo	$ -	$ -	$ 6,426.00
Kern	$ 1,455,042.02	$ -	$ -
Kings	$ 3,780.00	$ -	$ -
Lassen	$ -	$ -	$ -
Los Angeles	$ 6,678,700.98	$ 61,838.00	$ 173,485.00
Madera	$ 190,905.00	$ -	$ -
Mendocino	$ -	$ -	$ 882.00
Merced	$ 215,520.85	$ -	$ -
Monterey	$ 860,374.35	$ -	$ -
Orange	$ 1,576,783.00	$ 126.00	$ 4,252.00
Plumas	$ -	$ -	$ -
Riverside	$ 1,442,130.00	$ -	$ -
Sacramento	$ 171,477.50	$ 730,720.00	$ -
San Bernardino	$ 1,189,953.00	$ -	$ -
San Diego	$ 1,722,457.68	$ -	$ 236,378.00
San Joaquin	$ 436,523.05	$ -	$ -
Santa Barbara	$ 383,824.50	$ -	$ -
Santa Clara	$ 408,660.50	$ -	$ -
Sierra	$ -	$ -	$ -

Sonoma	$ 12,845.75	$ -	$ 115,032.00
Stanislaus	$ 713,701.65	$ -	$ -
Tulare	$ 634,620.10	$ -	$ -
Ventura	$ 736,846.86	$ -	$ 163,152.00
Yuba	$ -	$ -	$ -
Total	$ 20,337,926.04	$ 792,936.00	$ 699,607.00

Table 16 represents incentive claims paid for FFS, SNC, and DMC providers from the beginning of the Domain 2 program in February 2017 until the end of DY15-Q3 reporting period, March 2020. The total incentive claims paid for this period was $79,282,413.19.

Table 16: Incentive claims from February 2017 until March 2020

County	FFS	DMC	SNC
Contra Costa	$ 818,414.25	$ -	$ -
Fresno	$ 3,824,798.20	$ 252.00	$ 17,528.00
Glenn	$ 8,781.00	$ -	$ -
Humboldt	$ 70.00	$ -	$ 126.00
Imperial	$ 64,656.00	$ -	$ -
Inyo	$ -	$ -	$ 42,840.00
Kern	$ 5,153,610.14	$ -	$ -
Kings	$ 29,200.50	$ -	$ -
Lassen	$ -	$ -	$ -
Los Angeles	$ 21,898,248.18	$ 217,915.00	$ 1,139,257.00
Madera	$ 572,664.00	$ -	$ -
Mendocino	$ -	$ -	$ 504,276.00
Merced	$ 518,747.10	$ -	$ -
Monterey	$ 2,593,468.45	$ -	$ -
Orange	$ 5,031,004.00	$ 126.00	$ 241,326.00
Plumas	$ -	$ -	$ -
Riverside	$ 3,981,686.75	$ -	$ -
Sacramento	$ 1,597,961.40	$ 3,716,790.00	$ -
San Bernardino	$ 3,846,283.00	$ 126.00	$ -
San Diego	$ 5,840,918.28	$ -	$ 479,797.00
San Joaquin	$ 1,463,449.05	$ 126.00	$ 18,322.00
Santa Barbara	$ 1,487,822.00	$ -	$ -
Santa Clara	$ 1,505,107.38	$ -	$ -
Sierra	$ -	$ -	$ -
Sonoma	$ 222,293.75	$ -	$ 794,052.00
Stanislaus	$ 2,151,729.65	$ -	$ -
Tulare	$ 6,461,967.29	$ -	$ -
Ventura	$ 2,629,941.82	$ -	$ 406,732.00
Yuba	$ -	$ -	$ -
Total	$ 71,702,822.19	$ 3,935,335.00	$ 3,644,256.00

Domain 3

There were no payments issued during this quarter as Domain 3 annual payments are made annually in June; thus, the next payment will be issued in June 2020. The Domain 3 payment for this year will be reported in the 1115 Waiver DY 15 Annual Report.

Outreach Efforts

Domain 2

In this quarter, the ASO's outreach team visited ten (10) of the twenty-nine (29) counties (Yuba, Fresno, Orange, Stanislaus, Tulare, Los Angeles, Madera, San Joaquin, Ventura, and Merced). The ASO continues to outreach to interested providers during their regular course of business. In this quarter, Domain 2 enrollment increased by one hundred eighty-one (181) providers, bringing the total from 2,673 to 2,854.

Domain 3

In this quarter, the ASO's outreach team visited thirteen (13) of the thirty-six (36) pilot counties (Alameda, Fresno, Madera, Merced, Orange, Placer, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Ventura). Outreach efforts included offering benefits information available to Medi-Cal beneficiaries, Medi-Cal dental training for dental office staff, and resource information. An additional six SNCs elected to opt-in for participation during this quarter, bringing the total from one hundred nine (109) to one hundred fifteen (115).

Domain 4

The LDPPs have utilized the email inbox to submit invoices electronically on a quarterly basis and this inbox is also used to communicate any necessary follow-up requests for back up documentation from the LDPPs. During this quarter $6,472,798 was paid in total for invoices.

In this reporting period, DHCS staff completed one LDPP site visit to the Alameda County pilot on January 21, 2020 to observe the administrative and clinical initiatives as outlined in the LDPP's executed contract.

Consumer Issues

The State of California enacted a shelter in place mandate. Dental services were told to postpone all non-emergency services. This has caused a cascading effect on dental utilization, and various ongoing dental policies, which include DTI and its various domains.

Financial/Budget Neutrality Development/Issues:

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

Quality Assurance/Monitoring Activities:

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

Evaluation:

During DY15-Q3, Mathematica, the DTI independent evaluator, finalized the DTI Interim Evaluation Report and other tasks associated with the final evaluation. Mathematica also participated in bi-weekly conference calls with DHCS and monthly conference calls with LDPPs.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

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

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

Enrollment Information:

Table 17: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY14-Q4	38,803	17,816	55,840
DY15-Q1	41,213	19,164	59,576
DY15-Q2	37,480	16,597	53,398
DY15-Q3	25,393	10,752	35,852

Member Months:

To permit full recognition of “in-process” eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded. The term “eligible member months” refers to the number of months in which persons are eligible to receive services.

For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2

eligible member months to the total, for a total of 4 eligible member months.

Table 18

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	28610	28578	28684	DY14-Q4	38,803
	30858	30528	30466	DY15-Q1	41,213
	28981	27726	26521	DY15-Q2	37,480
	21126	18960	6169	DY14-Q3	25,393
Non-ACA	13929	14119	14440	DY14-Q4	17,816
	15549	15263	15359	DY15-Q1	19,164
	13898	13481	13079	DY15-Q2	16,597
	9511	7559	1941	DY15-Q3	10,752

Outreach/Innovative Activities:

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

Table 19: Counties where DMC-ODS documentation occurred

County	Training Dates	Training Attendees
Tulare	February 11-12, 2020	9

Additional DMC-ODS activities are listed below:

On Thursday, March 19, 2020, Governor Newsom ordered all individuals living in the State of California to stay home or at their place of residence, except as needed to maintain continuity of essential services and operations. In light of these circumstances, DHCS initiated multiple federal requests, waivers, and provisions to assist counties with continuing to provide needed services in a way that minimizes COVID-19 exposure and transmission. DHCS established guidance through the DHCS COVID-19 Response webpage, information notices, and weekly conference calls with stakeholders to review COVID-19 related materials and frequently asked questions.

All activities related to DMC-ODS technical assistance and ongoing development are listed as follows:

- January 6, 2020 – Behavioral Health SAC Meeting
- January 15, 2020 – All County Behavioral Health Call

- January 22, 2020 – CalAIM Stakeholder Workgroup: Enhanced Care Management
- January 23, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- January 29, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- January 30, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- January 31, 2020 – CalAIM Stakeholder Workgroup: Full Integration Plan
- February 4, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- February 6, 2020 – CCJBH Council Meeting
- February 10, 2020 – SMHS & DMC-ODS call with CMS
- February 12, 2020 – DHCS Behavioral Health Stakeholder Advisory Committee
- February 19, 2020 – All County Behavioral Health Call
- February 26, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- February 27, 2020 – CalAIM Stakeholder Workgroup: Behavioral Health
- March 5, 2020 – Behavioral Health Targeted Stakeholder Engagement Meeting
- March 11-13, 2020 – California Quality Improvement Coordinators Meeting
- March 18, 2020 – All County Behavioral Health Call
- March 20, 2020 – COVID-19 All State Call
- March 24, 2020 – 1135 Waiver Implementation Meeting
- March 25, 2020 – Multi-Agency COVID Coordination Meeting
- March 26, 2020 – COVID-19 All County Weekly Call

Operational/Policy Developments/Issues:

In response to the COVID-19 national public health emergency, DHCS submitted requests for section 1135 waiver flexibilities to CMS on March 16, March 19, and April 10, 2020. The waivers requested flexibilities regarding billing requirements; conditions for payment; state fair hearing requests and appeal deadlines; eligibility flexibilities; and administrative activities such as modification of the timeframe for submission of annual network certification to CMS; external quality review activities including site visits and consumer focus groups; and modification of the timeframe for submitting the technical reports to CMS and posting them.

DHCS received approval on March 23, 2020, through the end of the public emergency, for the modification of the timeframe for managed care entities to resolve appeals under 42 CFR 438.408(f)(1) and before an enrollee may request a State Fair Hearing, no less than one day in accordance with the requirements specified; this allows managed care enrollees to proceed almost immediately to a State Fair Hearing, without having a managed care plan resolve the appeal first, by permitting the state to modify the timeline for managed care plans resolving appeals to one day allowing impacted appeals to satisfy the exhaustion requirements. Enrollees are also allowed an additional 120 days to request a fair hearing with the initial 120 day deadline for an enrollee occurred during the period of the 1135 waiver. Other behavioral health related requests are still pending CMS approval.

DHCS released guidance to DMC-ODS counties to assist them in safely providing

medically necessary services in a timely fashion for beneficiaries. DHCS released Behavioral Health Information Notice 20-009, which notified counties of flexibilities to requirements including the following:

- Starting March 1, 2020, through the duration of the emergency, the initial clinical diagnostic assessment, determination of medical necessity, and the level of care can 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 Medi-Cal 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.

- Currently, 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 in DMC-ODS counties.

- Services provided via telehealth are currently optional for counties in the DMC-ODS waiver. DMC-ODS counties that have not previously authorized services via telehealth in their program should allow providers to bill for services via telehealth during the period of heightened COVID-19 concern; DHCS approval is not required.

- No additional billing code is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.

- External quality reviews of DMC-ODS counties are currently being conducted remotely by desk reviews. No on-site focus groups or facility inspections were conducted as part of CalEQRO's review starting the last week of March 2020.

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

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

Financial/Budget Neutrality Developments/Issues:

Table 20: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY14-Q4					
ACA	2,466,482	$73,136,547.72	$62,910,830.15	$5,896,743.48	$4,328,974.09
Non ACA	1,311,682	$26,903,843.49	$13,602,293.00	$3,185,287.12	$10,116,263.37
DY15-Q1					
ACA	4,685,008	$154,032,527.24	$137,241,031.23	$11,232,658.21	$5,558,837.80
Non ACA	1,473,919	$31,494,890.58	$15,898,550.00	$3,979,403.46	$11,616,937.12
DY15-Q2					
ACA	4,205,520	$145,324,209.33	$129,833,697.76	$10,459,748.11	$5,030,763.46
Non ACA	1,269,994	$27,662,096.33	$13,806,135.28	$3,674,330.90	$10,181,630.15
DY15-Q3					
ACA	2,171,592	$81,779,365.72	$70,861,079.89	$7,919,614.09	$2,998,671.74
Non ACA	566,219	$13,603,229.85	$6,787,371.06	$2,070,132.13	$4,475,726.66

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

Consumer Issues:

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

:

Table 21: Grievances

Grievance	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals
Alameda	2	-	-	-	-	3	5
Contra Costa	-	3	-	1	1	-	5
El Dorado	-	-	-	-	-	-	0
Fresno	3	-	1	-	-	1	5
Imperial	-	-	-	-	-	-	0
Kern	1	5	-	-	1	-	7
Los Angeles	6	-	1	3	-	7	17
Marin	-	-	-	-	2	1	3
Merced	-	-	-	-	-	1	1
Monterey	-	-	-	-	-	-	0
Napa	-	-	-	-	-	-	0
Nevada	-	-	-	-	-	*	*
Orange	1	-	1	3	1	2	8
Placer	1	-	1	-	8	-	10
Riverside	-	2	-	-	-	-	2
Sacramento	-	-	-	-	2	-	2
San Benito	-	-	-	-	-	-	0
San Bernardino	-	6	-	-	-	-	6
San Diego	-	14	2	3	-	3	22
San Francisco	-	-	-	-	-	3	3
San Joaquin	-	-	-	-	-	-	0
San Luis Obispo	1	4	-	-	-	-	5
San Mateo	-	2	-	-	-	2	4
Santa Barbara	-	2	1	3	3	1	10
Santa Clara	-	-	4	-	-	1	5
Santa Cruz	-	4	1	-	1	2	8
Stanislaus	-	3	-	-	-	1	4
Tulare	-	-	-	-	-	-	0
Ventura	-	-	-	-	-	-	0
Yolo	-	-	2	-	3	-	5

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

Table 22: Resolutions

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Transition of Care (TOC) requests	TOC Approved	TOC Denied
Alameda	5	1	-	1	-	-	-
Contra Costa	2	-	-	-	-	-	-
El Dorado	1	-	-	-	-	-	-
Fresno	2	1	-	-	-	-	-
Imperial	-	-	-	-	-	-	-
Kern	5	-	-	-	-	-	-
Los Angeles	11	6	3	3	-	-	-
Marin	2	-	-	-	-	-	-
Merced	1	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	*	-	-	-	-	-	-
Orange	-	2	-	1	-	-	-
Placer	10	-	-	-	-	-	-
Riverside	-	-	-	-	-	-	-
Sacramento	1	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	5	-	-	-	-	-	-
San Diego	34	5	6	4	-	-	-
San Francisco	3	-	-	-	-	-	-
San Joaquin	-	-	-	-	-	-	-
San Luis Obispo	4	2	-	2	-	-	-
San Mateo	4	-	-	-	-	-	-
Santa Barbara	1	-	-	-	-	-	-
Santa Clara	3	-	-	-	-	-	-
Santa Cruz	9	6	2	4	-	-	-
Stanislaus	5	1	1	-	1	1	-
Tulare	-	-	-	-	-	-	-
Ventura	1	-	-	-	-	-	-
Yolo	5	-	-	-	-	-	-

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers*

are suppressed to protect the privacy and security of participants.

Quality Assurance/Monitoring Activities:

DHCS completed compliance monitoring reviews for the following counties:

County	Date
Solano	January 13, 2020
Monterey	January 28, 2020
Sacramento	January 28, 2020
Tehama	January 28, 2020
Placer	February 3, 2020
Colusa	February 13, 2020
Del Norte	February 13, 2020
Glenn	February 21, 2020
San Diego	February 24, 2020
Riverside	February 25, 2020
San Bernardino	March 4, 2020
Fresno	March 9, 2020
Marin	March 9, 2020
San Francisco	March 13, 2020
Kern	March 19, 2020
Stanislaus	March 19, 2020

Evaluation:

During this reporting period (January - March 2020), UCLA conducted the following activities:

UCLA provided DMC-ODS evaluation services and technical assistance to DHCS for activities completed July 1, 2019, to December 31, 2019, via the Bi-Annual Progress Report completed January 2020 and submitted to DHCS on January 31, 2020.

UCLA-ISAP preliminarily developed a fast and free initial placement screener tool to assist personnel answering counties' 24/7 toll free lines. Under the current scope of work, UCLA-ISAP, on behalf of DHCS, has been beta testing and refining the tool, which is called the Brief Questionnaire for Initial Placement (BQuIP). The BQuIP Mid-Year Report was completed January 2020 and submitted to DHCS on February 6, 2020.

Administrative Data Analysis

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

Treatment Perceptions Survey (TPS)

- The Treatment Perceptions Survey (TPS) is used to measure client satisfaction under the DMC-ODS waiver. As part of the waiver evaluation, counties are required to have their network of providers administer the TPS. Statewide results for the 2019 survey period were prepared on February 27, 2020. Additional TPS information is available here: http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

County Administrator Survey

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

  UCLA disseminated the county administrator survey on February 28, 2020. As of March 31, 2020, 53% of surveys have been returned. Data collection remains open to allow administrators additional time to complete the survey, given the challenges of responding to COVID-19.

Provider Survey

- UCLA is conducting surveys of providers in each waiver county throughout the state. Provider surveys are conducted at the care delivery unit level, referring to a treatment modality (e.g., inpatient, outpatient, methadone maintenance) at a specific site. Clinical directors are asked questions related to access (e.g., treatment capacity), quality (e.g., ASAM criteria, electronic health records) and coordination of care (e.g., partnerships with other treatment and recovery support providers, levels of integration with physical and mental health scare systems) in their treatment programs. During this period, UCLA continues to survey providers after they have implemented services once “live” under the waiver. As of the end of this reporting period, 136 surveys have been completed.

Beneficiary Access Line Secret Shopper

- UCLA conducts secret shopper calls to evaluate access to counties’ beneficiary access lines. The purpose of these calls is to verify that the requirement of

having a phone number available to beneficiaries is being met by counties that have started providing DMC-ODS services. Initiation of these secret shopper calls occurs soon after the county's contract with DHCS is executed. As of the end of this reporting period, 259 calls were made to DMC-ODS counties' beneficiary access lines. Each county receives feedback on its beneficiary access line in the form of a written report.

Qualitative Interviews with Stakeholders

- UCLA conducts key informant interviews with county administrators and SUD provider program administrators from counties participating in the DMC-ODS waiver to develop case studies on topics of particular interest to DHCS. Interviews were conducted in June and July 2019 with county administrators and the analyses included in the Year 4 Evaluation report. These interviews were meant to gather data on successful strategies implemented by counties under the waiver.

Additional Technical Assistance (TA) provided to State and Counties

- During this reporting period, UCLA provided ongoing TA to DMC-ODS counties on the data collection and submission processes for ASAM level of care data.
- UCLA also provided TA related to TPS data to Santa Barbara, Orange County, Alameda, Ventura, San Diego, Placer, and Kern.
- On January 17, 2020, UCLA presented evaluation data from the ODS waiver at the DHCS/EQRO/UCLA quarterly meeting.

FINANCIAL/BUDGET NEUTRALITY PROGRESS: DSHP

Designated State Health Program

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

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

Table 23: DY15-Q2 Federal Fund Payments for DSHP-eligible services

Payment	FFP		CPE	Service Period	Total Claim
Designated State Health Program (DSHP)					
(Qtr. 1 July - Sept)	$0		$0		$0
(Qtr. 2 Oct - Dec)	$0		$0		$0
(Qtr. 3 Jan – Mar)	$0		$0		$0
Total	**$0**		**$0**		**$0**

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

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (GPP) assists public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCSs in their key role of providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Under the GPP, participating 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 total amount of funds available for the GPP is a combination of a portion of the state's Disproportionate Share Hospital (DSH) Program's allotment that would otherwise be allocated to the PHCSs, and the amount associated with the Safety Net Care Pool under the Bridge to Reform demonstration.

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

Nothing to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 24: DY15-Q2 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 2, Final DSH GPP (July - June)	$2,187,256.50	$2,187,256.50	DY 12	$4,374,513.00
PY 5 IQ2 (October - December)	$367,989,408.50	$367,989,408.50	DY 15	$735,978,817.00
Total	$370,176,665.00	$370,176,665.00		$740,353,330.00

DY 15 Q2 reporting includes GPP payments made on January 9, 2020. The payments made during this time period were for Program Year (PY) 2, Final DSH (April 1, 2019 – June 30, 2019), and PY 5, IQ2 (October 1, 2020 – December 31, 2020).

For PY 2, Final DSH GPP, the PHCSs received $2,187,256.50 in federal fund payments and $2,187,256.50 in IGT for GPP.

For PY 5, IQ2, the PHCSs received $367,989,408.50 in federal fund payments and $367,989,408.50 in IGT for GPP.

The PY 5 Q2 payment removes the effect of the federal DSH reduction because on December 20, 2019, the President signed House Resolution 1865, which delayed the implementation of the DSH reduction for FFY 2020 until May 23, 2020. Due to this delay, the PY 5 Q2 payment removed the effect of the federal DSH reduction by paying the PY 5 Q2 amount in full, and paying additional monies that were previously withheld from the PY 5 Q1 payment.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

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

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

The PRIME Program aims to:

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

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

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

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

Projects in Domain 3 – Resource Utilization Efficiency will reduce unwarranted variation

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

In DY15-Q3, DHCS provided the opportunity for any newly interested entity participants to join any of the six ongoing PRIMEd topic-specific learning collaborative (TLC) groups for calendar year 2020. Of these six TLC groups, four met during DY15-Q3, with the session topics identified below.

- Behavioral Health:
    - Session on January 13, 2020, covered behavioral health integration into primary care led by Dr. Jagruti Shukla from the Los Angeles County hospital system.
    - Session on February 10, 2020, gave new and old behavioral health TLC members the opportunity to introduce themselves and discuss their role in their behavioral and mental health department, including current quality improvement progress and the challenges they face.
    - Session on March 9, 2020, featured Ms. Shannon Dickerson and Ms. Amanda Dold from Contra Costa Regional Health System. They spoke on their efforts to integrate primary care and behavioral health into Contra Costa's hospital system.
- Care Transitions:
    - Session on February 20, 2020, welcomed new and continuing members and discussed ideas for TLC meeting topics this year. The TLC plans to discuss topics including acute-ambulatory transitions, HCAHPS, and best practices for sustaining improvements over time.
- Health Disparities: No sessions occurred during DY15-Q3.
- Health Homes for Foster Children: No sessions occurred during DY15-Q3.
- Maternal and Infant Health:
    - Session on February 19, 2020, welcomed new and continuing members and discussed the proposed meeting schedule for the year. Participants will discuss topics including Nulliparous, Term, Singleton, Vertex (NTSV) cesarean births, exclusive breastfeeding, and strategies for improving prenatal and postpartum care during the years. The TLC also plans to

hold a joint session with the Behavioral Health TLC on the cross-cutting topic of substance use and pregnancy.

- Tobacco Cessation:
    - Session in March 24, 2020, focused on what members would like to get out to TLC participation. Members expressed interest in discussing Electronic Medical Record (EMR) workflows/referrals, vaping, networking, and cessation resources. The group also discussed the importance of addressing tobacco during the COVID-19 pandemic.

Operational/Policy Developments/Issues:

The COVID-19 pandemic response heavily affected administration of the PRIME program during DY15-Q3. Two TLC sessions were either cancelled or rescheduled, and other learning collaborative planning activities were delayed. Additionally, many entities inquired about how to request a reporting extension for the DY15 Mid-Year report. On March 26, 2020, DHCS distributed an email communication to all PRIME entities addressing entities' concerns for how PRIME would move forward in light of the public health emergency. In that email, DHCS provided guidance on how to request a DY15 Mid-Year reporting extension, and committed to sharing information on how it will handle potentially negative effects on meeting metric targets whenever that information becomes available. At that time, the situation was rapidly evolving and there were too many unknowns to provide definitive answers to many entity questions.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 25: DPH and DMPH Payments

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$96,999,522.24	$96,999,522.07	DY 12/13/14	$193,999,044.31
(Qtr. 2 Oct - Dec)	$308,898,350.68	$308,923,350.54	DY 13/14	$617,821,701.22
(Qtr. 3 Jan - Mar)	$47,066,720.83	$47,066,720.82	DY 14	$94,133,441.64
Total	**$452,964,593.75**	**$452,989,593.43**		**$905,954,187.17**

In DY15 Q2, 2 DPHs and 3 DMPHs received payments.

This quarter, Designated Public Hospitals and District/Municipal Public Hospitals received **$47,066,720.83** in federal fund payments for PRIME-eligible achievements.

Quality Assurance/Monitoring Activities:

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

Evaluations:

DHCS submitted the final version of the Interim PRIME Evaluation to CMS on January 22, 2020. On February 6, 2020, Heather Ross from CMS notified DHCS via email that CMS approved the submitted report, and DHCS received an official CMS approval letter on March 8, 2020. The approved PRIME Interim Evaluation is posted on the DHCS PRIME website and available at the following link.

Throughout DY15-Q3, DHCS continued to work with the external program evaluator to identify what Medi-Cal claims and encounter data is necessary for the Summative PRIME Evaluation.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 10.8 million Medi-Cal beneficiaries in all 58 counties. DHCS provides six types of managed care models:

1. Two-Plan, which operates in 14 counties.
2. County Organized Health System (COHS), which operates in 22 counties.
3. Geographic Managed Care (GMC), which operates in two counties.
4. Regional, which operates in 18 counties.
5. Imperial, which operates in one county, Imperial.
6. San Benito, which operates in one county, San Benito.

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

Enrollment Information:

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

Table 26: TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
January 2020 – March 2020

County	Total Member Months
Alameda	53,100
Contra Costa	33,218
Fresno	46,744
Kern	38,294
Kings	5,273
Los Angeles	351,452
Madera	4,594
Riverside	70,180
Sacramento	69,154
San Bernardino	76,117
San Diego	76,475
San Francisco	26,227
San Joaquin	31,535
Santa Clara	42,611
Stanislaus	22,585
Tulare	21,024
Total	**968,583**

Table 27: TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
January 2020 – March 2020

County	Total Member Months
Alameda	47,059
Contra Costa	22,069
Fresno	28,622
Kern	21,103
Kings	2,986
Los Angeles	665,549
Madera	3,006
Marin	12,603
Mendocino	11,373
Merced	32,468
Monterey	31,670
Napa	9,967
Orange	222,307
Riverside	76,590
Sacramento	47,479
San Bernardino	74,401
San Diego	125,440
San Francisco	31,970
San Joaquin	19,946
San Luis Obispo	16,452
San Mateo	26,964
Santa Barbara	30,863
Santa Clara	80,861
Santa Cruz	20,989
Solano	39,901
Sonoma	34,109
Stanislaus	12,332
Tulare	13,582
Ventura	58,053
Yolo	17,082
Total	**1,837,796**

Table 28: TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
January 2020 – March 2020

County	Total Member Months
Alpine	26
Amador	699
Butte	11,371
Calaveras	1,104
Colusa	531
El Dorado	3,345
Glenn	1,080
Imperial	7,272
Inyo	305
Mariposa	475
Mono	109
Nevada	2,040
Placer	6,687
Plumas	647
San Benito	221
Sierra	78
Sutter	3,980
Tehama	3,458
Tuolumne	1,667
Yuba	4,113
Total	**49,208**

Table 29: TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
January 2020 – March 2020

County	Total Member Months
Del Norte	5,306
Humboldt	17,312
Lake	12,757
Lassen	2,878
Modoc	1,404
Shasta	26,290
Siskiyou	7,349
Trinity	1,754
Total	75,050

WHOLE PERSON CARE

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

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

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

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

Eighteen LEs began implementing and enrolling 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 began implementation on July 1, 2017.

In total, there are 25 LEs operating a WPC pilot.

- Ten LEs are from the initial eighteen LEs. These LEs continue to implement their originally approved pilots that began implementation and enrollment on January 1, 2017.
- Eight LEs are also part of the initial eighteen LEs. These eight reapplied during the second round and were approved to expand their existing pilots. These eight LEs continue to implement their originally approved pilots that began implementation and enrollment on January 1, 2017 as well as new aspects that were approved during the second round that began implementation and enrollment on July 1, 2017.
- Seven new LEs applied and were approved in the second round and began implementation and enrollment on July 1, 2017.

Enrollment Information:

The data reported below in Table 30 reflects the most current unique new beneficiary enrollment counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Enrollment data is updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly enrollment counts reflect the cumulative number of unique new beneficiaries enrolled in Quarter Two (Q2) of Demonstration Year (DY) 15. The total-to-date column reflects the cumulative number of unique new beneficiaries enrolled from beginning of the program, DY 12 (January 2017), to the most current data available, DY 15 - Q2 (October - December 2019). Due to a delay in availability of data, DY 15 - Q3 data will be reported in the next report. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (QEU) reports. The DY 15 - Q2 data reported is point-in-time as of March 25, 2020.

Table 30: Enrollment Counts

Lead Entity	DY 15 - Q2 (Oct.-Dec. 2019) Unduplicated	Jan. 2017 - Dec. 2019 Total-to-Date (Unduplicated)
Alameda	516	11,197
Contra Costa	2,446	41,602
Kern	187	1,533
Kings*	82	562
LA	4,349	50,670
Marin*	137	1,568
Mendocino*	78	384
Monterey	79	438
Napa	45	504
Orange	620	11,005
Placer	24	420
Riverside	580	6,039
Sacramento*	170	1,730
San Bernardino	75	1,047
San Diego	101	614
San Francisco	916	17,343
San Joaquin	188	1,565
San Mateo	69	3,550
Santa Clara	457	5,120
Santa Cruz*	47	509

Lead Entity	DY 15 - Q2 (Oct.-Dec. 2019) Unduplicated	Jan. 2017 - Dec. 2019 Total-to-Date (Unduplicated)
Small County Whole Person Care Collaborative (SCWPCC*)	9	127
Shasta	32	364
Solano	21	206
Sonoma*	344	1,932
Ventura	33	1,202
Total**	**11,605**	**161,231**

**Indicates one of seven LEs that implemented on July 1, 2017.*
*** Due to a delay in the availability of data, DY 15 - Q3 data will be reported in the next quarterly report.*

Member Months:

The data reported below in Table 31 reflects the most current member month counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months are updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly and cumulative total-to-date member months are reflected in the table below. The cumulative total-to-date column reflects the cumulative number of member months from the beginning of the program, DY 12 (January 2017), to the most current data available, DY 15 - Q2 (October – December 2019). Due to a delay in availability of data, DY 15 - Q3 data will be reported in the next report. Member months are extracted from the LE's self-reported QEU reports. The DY 15 - Q2 data reported is point-in-time as of March 25, 2020.

Table 31: Current Member Month Counts

Lead Entity	DY 15 - Q2 (Oct.-Dec. 2019)	Jan 2017 - Dec. 2019 Cumulative Total-to-Date
Alameda	27,182	160,789
Contra Costa	39,919	439,020
Kern	4,294	15,810
Kings*	581	3,127
LA	50,572	374,742
Marin*	4,315	16,400
Mendocino*	507	3,724

Lead Entity	DY 15 - Q2 (Oct.-Dec. 2019)	Jan 2017 - Dec. 2019 Cumulative Total-to-Date
Monterey	678	3,413
Napa	776	4,828
Orange	13,727	108,843
Placer	440	3,792
Riverside	15,751	57,998
Sacramento*	2,274	14,481
San Bernardino	1,571	13,327
San Diego	1,168	5,012
San Francisco	28,129	264,219
San Joaquin	3,169	15,595
San Mateo	6,361	76,123
Santa Clara	11,366	81,091
Santa Cruz*	1,219	9,329
SCWPCC*	199	1,030
Shasta	229	2,124
Solano	181	2,517
Sonoma*	2,885	8,966
Ventura	1,716	18,443
Total	**219,209**	**1,704,743**

**Indicates one of seven LEs that implemented on July 1, 2017.*
***Due to a delay in the availability of data, DY 15 - Q3 data will be reported in the next quarterly report.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

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

On January 8, DHCS held a teleconference with LEs focused on administrative topics

and TA, allowing the LEs to ask questions about DHCS' guidance and various contract issues such as reporting, reporting templates, deadlines, and expectations. The call included the following topics: budget adjustments, rollovers, and the QEU reports.

The LC advisory board met on January 16 and February 20 to discuss how the LC can support the LEs as they transition to the enhanced care management (ECM) benefit and In-Lieu-of Services (ILOS) under the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Advisory board members have emphasized their interest in joint TA opportunities with Medi-Cal managed care health plans (MCPs) and other stakeholders to prepare for the transition. In response to this feedback, the LC has combined its efforts with CalAIM TA activities, focusing on combined, in-person meetings referred to as CalAIM regional meetings. However, the CalAIM regional meetings originally proposed for April and May 2020 have been postponed due to the COVID-19 public health emergency (PHE).

The LC has drafted a "Promising Practices" summary paper that crosswalks the ECM benefits and ILOS proposed under CalAIM. The LC will submit the summary paper to DHCS for approval, once the LC has completed their review.

COVID-19 Public Health Emergency:

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

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

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

As shown below in Table 32, no WPC payments were made during the third quarter, in accordance with the WPC payment schedule. Although the payment schedule indicates that PY 4 annual invoices are due on April 1, 2020, with payments scheduled for May

2020, DHCS extended the due date for PY 4 annual invoice submittals to May 1, 2020, due to the COVID-19 PHE; payments will be scheduled for May and June 2020.

Table 32: WPC Payments for DY 15 for all 25 LEs

DY 15 Payment	Federal Financial Participation	Intergovernmental Transfer	Service Period	Total Funds Payment
Qtr 1 (July 1 – Sept 30)	$0	$0	DY 15 (PY* 4)	$0
Qtr 2 (Oct 1 – Dec 31)	$119,071,064.41	$119,071,064.41	DY 15 (PY* 4)	$238,142,128.82
Qtr 3 (Jan 1 – Mar 31)	$0	$0	DY 15 (PY* 4)	$0
Total	**$119,071,064.41**	**$119,071,064.41**		**$238,142,128.82**

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

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- Fourth quarter PY 4 QEU report; and
- PY 5 budget rollover request.

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

Evaluation

The WPC evaluation report, required pursuant to Special Terms and Conditions 127 of the California Medi-Cal 2020 Demonstration Waiver, will assess whether: 1) the LEs successfully implemented their planned strategies and improved care delivery; 2) these 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 the Centers for Medicare and Medicaid Services (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 2021, will provide the complete assessment of care and outcome

improvements, including an assessment of the impact of the various packages of interventions on specific target populations. The final report will also include an assessment of reduction of avoidable utilization of emergency and inpatient services, and associated costs, challenges and best practices, and assessments of sustainability.

During the third quarter, DHCS' independent evaluator, the University of California, Los Angeles (UCLA):

- Tested modifications to the difference-in-difference model used in the interim evaluation report to improve analysis for the final report. The difference-in-difference model examines the change in trends from pre-WPC to post-WPC and between the treatment group and control group. As compared to the previous analysis, which examined change in the average metric rate in the pre-WPC and post-WPC periods, this analysis will improve the ability to assess whether WPC changed the trajectory of key outcome metrics.
- Developed refined service categories to better understand services provided to WPC beneficiaries. These new categories were incorporated into the LE survey, along with the recent list of per-member-per-month and Fee-For-Service categories from the QEU reports, in order to get more up-to-date data for the WPC final evaluation report.
- Advanced the development of a "report card" template, which will compare WPC pilots based on outcome metrics by target populations, alongside key descriptive elements and metrics, including beneficiary demographics, care coordination elements, implementation measures, and service availability. Key elements of the report card will come from the updated infrastructure, implementation, and service details in the LE survey, as well as enrollment and population descriptive elements. The new model will rank and target population outcome metrics.
- Advanced the development of a shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final report.
- Finalized a draft of the LE survey instrument. Key content areas include data sharing infrastructure; perceived impact on better health, better care, and cost savings; and plans for sustainability of critical WPC components. The survey instrument was tested with a select sample of LEs and feedback was incorporated.
- Analyzed data software codes for challenges, successes, and lessons learned in relation to: 1) identifying, engaging, and enrolling beneficiaries; 2) care coordination; 3) data sharing; 4) outcomes and sustainability; and 5) biggest barriers to implementation as discussed by LEs in PY 4 mid-year narrative reports.
- Finalized an Americans with Disabilities Act-compliant version of the interim report and posted on the UCLA Center for Health Policy Research website.
- Presented interim evaluation findings at the CalAIM ECM/ILOS workgroup on January 22, 2020.
- Drafted and submitted an enrollment and demographics report to DHCS in February 2020.

- Collected updated information on participating partner organizations and level of involvement by LEs.
- Created a narrative report update to highlight key findings over time and for PY 4 mid-year. This report was submitted to DHCS in March 2020.
- Completed a draft of the partner survey instrument.
- Developed a scoping document detailing the intent to conduct surveys and select follow-up interviews with frontline staff responsible for WPC care coordination activities. This data collection will be separate from, but complementary to, existing WPC evaluation activities.