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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Sixteen (07/01/2020 – 12/31/2020)
First Quarter Reporting Period: 07/01/2020 – 09/30/2020

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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 DY16-Q1, DHCS hosted a SAC meeting on July 16, 2020. DHCS discussed the budget, COVID-19, Plans for the Medi-Cal 2020 1115 Waiver Extension, Medi-Cal Enrollment, and Long Term Care at Home.

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/071620SAC-agenda.pdf
The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/071620-SAC-Summary.pdf

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on July 13, 2020, August 10, 2020, and September 14, 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, Retainer Payments, CBAS Flexibilities, Share of Cost, Postpartum Coverage, CalAIM Updates, PRIME Updates, and Budget Neutrality.

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	209	$2,733.54	$571,309.86
18-Dec	324	$2,733.54	$885,666.96
19-Jan	363	$2,733.54	$992,275.02
19-Feb	368	$2,733.54	$1,005,942.72
19-Mar	372	$2,733.54	$1,016,876.88
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	$2427.02	$881,008.26
19-Aug	356	$2427.02	$864,019.12
19-Sep	351	$2427.02	$851,884.02
19-Oct	350	$2427.02	$849,457
19-Nov	351	$2427.02	$851,884.02
19-Dec	349	$2427.02	$847,029.98
20-Jan	352	$2427.02	$854,311.04
20-Feb	348	$2427.02	$844,602.96
20-Mar	346	$2427.02	$839,748.92
20-Apr	349	$2427.02	$847,029.98
20-May	352	$2427.02	$854,311.04
20-Jun	372	$2427.02	$902,851.44
20-Jul	373	$2427.02	$905,278.46
20-Aug	374	$2427.02	$907,705.48
20-Sep	375	$2427.02	$910,132.5
Total			$21,373,15.08

Table 2: RCHSD Monthly Enrollment and Quarterly Member Months

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Member Months
CCS	373	374	375	1	1,122

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 the Federal CMS on December 30, 2015. The Waiver contains STCs for the CCS Demonstration. STC 54 required DHCS to submit to CMS 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 (RCHSD) Demonstration Pilot

The RCHSD demonstration pilot was implemented in San Diego county 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 who 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 October 2020, RCHSD submitted their CCS Quarterly Grievance Report for reporting period July – September 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:

DHCS contracted with the Regents of the University of California, San Francisco (UCSF) to conduct an evaluation of the CCS pilot which will be completed in two phases. Phase one includes HPSM, and phase two includes RCHSD. To date, UCSF has completed interviews with key informants and families of CCS pilot patients; surveyed parents of CCS children in both Fee-for-Service and CCS pilot transition counties; and analyzed

claims/encounter data and eligibility records. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to Centers for Medicare & Medicaid Services on August 31, 2020 as required. DHCS is in the process of posting the interim report on the website for public viewing.

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 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 was scheduled to continue as a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver approved by CMS on December 30, 2015. With the delayed implementation of CalAIM due to the COVID-19 public health emergency (PHE), DHCS submitted a 12-month extension request to CMS for the 1115(a) "Medi-Cal 2020" waiver to extend the effective date through December 31, 2021.

Program Requirements

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

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

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

days for services requires a face-to-face assessment.

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

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

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and Fee-for-

[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.

Service (FFS) members per county for Demonstration Year 16 (DY16), Quarter 1 (Q1), represents the period of July 2020 to September 2020. CBAS enrollment data is shown in 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 DY16-Q1 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.

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

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

***Note: Information is not available for DY16-Q1 due to a delay in the availability of data and will be presented in the next quarterly report.*

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

The data provided in Table 3 shows that enrollment has decreased throughout DY 15, with a significant decline in Q4 due to the COVID-19 PHE. The data reflects ample capacity for participant enrollment into all CBAS Centers.

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

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 illustrated in the 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
DY15-Q2 (10/01-12/31/2019)	2,095	2,031 (97%)	64 (2%)	3	3 (100%)	0 (0%)
DY15-Q3 (01/01-03/31/2020)	1,713	1,676 (97.8%)	37 (2.2%)	5	5 (100%)	0 (0%)
DY15-Q4 (04/01-06/30/2020)	438	419 (95%)	19 (5%)	0	0 (0%)	0 (0%)

DY16-Q1 (07/01-09/30/2020)	*	* (*%)	* (*%)	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		*	*		No	No

*Note: *MCP assessment information is not reported for DY16-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. For DHCS, DY16-Q1 it was reported that zero participants were assessed for CBAS benefits under FFS. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

During the previous demonstration year, CBAS assessments in DY 15 Q4 declined due to the COVID-19 PHE, as CBAS providers temporarily halted in-center congregate services and transitioned to CBAS Temporary Alternative Services (TAS). During this transition providers were challenged with enrollment of new participants – some who were already in the process and were at varying levels of readiness to begin services and some who were brand new and for whom enrollment had yet to begin. All Center Letter (ACL) 20-11 was issued on May 13, 2020, providing requirements and guidance for provider assessment and enrollment of new participants, to document enrollment steps, and to allow for CDA monitoring of CBAS TAS for participants not previously served by traditional CBAS.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 5 titled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY16-Q1. As of DY16-Q1, the number of counties with CBAS Centers and the ADA of each center are listed below in Table 5. On average, the ADA at the 262 operating CBAS Centers is approximately 28,076 participants, which corresponds to 76 percent of total capacity. Provider-reported data identified in the table below, reflects data from July 2020 to September 2020.

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	262
Non-Profit Centers	50
For-Profit Centers	212
ADA @ 262 Centers	28,076
Total Licensed Capacity	36,367
Statewide ADA per Center	77.2%%
	CDA - MSSR Data 09/2020

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), CBAS webinars, California Association for Adult Day Services (CAADS) conference and webinar presentations, and ongoing MCP and CBAS Quality Advisory Committee calls.

In the past quarter, CDA distributed two newsletters and one ACL, provided a webinar training on September 24, 2020, and collaborated with CAADS on their weekly webinar trainings for CBAS providers and MCPs, which included updates on the following topics: (1) CBAS program operations during the COVID-19 outbreak, (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, 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.. CDA convened a call on August 26, 2020, to provide an update on CBAS TAS policy directives and an overview of findings during CDA's tele-surveys for the certification/recertification of CBAS centers. In addition, on September 1, 2020, CDA distributed a survey to MCPs to identify the experiences they were having in the CBAS TAS environment specific to their oversight role with CBAS providers such as authorization of services, billing, and contract compliance. CDA used MCP survey responses to inform training for CBAS providers to support their compliance with CBAS TAS requirements, to help them address the needs of CBAS participants/MCP members, and to promote quality care.

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. CDA canceled the scheduled call for September 9, 2020, due to competing priorities among all members of the advisory committee due to the COVID-19 pandemic. The next meeting is scheduled for January 20, 2021.

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 newsletters 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) response to the COVID-19 pandemic, (2) CBAS center compliance with the federal Home and Community-Based Settings requirements.

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, 2023, 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 webinar training for States

Due to the COVID-19 pandemic and implementation of CBAS Temporary Alternative Services (TAS) requirements, CDA is conducting telephonic certification/recertification surveys instead of onsite surveys which includes determining compliance with the federal Home and Community-Based (HCB) Settings requirements. All existing CBAS compliance determination processes for the HCB Settings requirements are continuing during the provision of CBAS TAS, including the completion and validation of CBAS Provider Self-Assessment (PSA) and CBAS Participant surveys via telephonic/virtual methods that comply with public health guidance.

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 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.

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

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.

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. 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 is 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.

On October 9, 2020, CMS sent a letter to DHCS approving the following CBAS program modifications effective from March 13, 2020, through March 12, 2021:

- Add Temporary Alternative Services to allow certified CBAS providers to provide limited individual in-center activities, as well as telephonic, telehealth and in-home services;
- Expand settings where CBAS may be provided;
- Modify the person-centered plan development process to allow assessments to be conducted telephonically using self-reported information by participants and/or caregivers.

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 titled "*Data on CBAS Complaints"* and Table 7 titled "*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 DY16-Q1, as illustrated in Table 6, titled *Data on CBAS Complaints*.

Table 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY15-Q2 (Oct 1 – Dec 31)	0	0	0
DY15-Q3 (Jan 1 - Mar 31)	0	0	0
DY15-Q4 (Apr 1 – Jun 30)	0	0	0
DY16-Q1 (Jul 1 - Sep 30)	0	0	0
CDA Data - Complaints 09/2020			

For complaints received by MCPs, the table below illustrates there were 11 beneficiary complaints and two provider complaints submitted for DY 15. MCP complaint information for DY16-Q1 will be presented in the next quarterly report due to a delay in the availability of data. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Table 7: Data on CBAS Managed Care Plan Complaints

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

Plan data - Phone Center Complaints 06/2020

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Table 8 titled, "*Data on CBAS Managed Care Plan Grievances*," a total of 15 grievances were filed with MCPs during DY 15. MCP grievance information for DY16-Q1 will be presented in the next quarterly report due to a delay in the availability of data. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

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
DY15-Q1 (Jul 1 - Sep 30)	4	1	0	2	7
DY15-Q2 (Oct 1 - Dec 31)	3	0	0	4	7
DY15-Q3 (Jan 1 - Mar 31)	0	0	0	1	1
DY15-Q4 (Apr 1 - Jun 30)	0	0	0	0	0
					Plan data - Grievances 06/2020

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
DY15 – Q1 (Jul 1 – Sep 30)	2	0	0	1	3
DY15 – Q2 (Oct 1 – Dec 31)	4	0	0	0	4
DY15 – Q3 (Jan 1 – Mar 31)	2	0	0	0	2
DY15 – Q4 (Apr 1 – Jun 30)	1	0	0	0	1
					Plan data - Grievances 06/2020

Note: MCP appeals information is not available for DY16-Q1 due to a delay in the availability of the data.

During DY 15, Table 9 titled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 10 CBAS appeals filed with the MCPs. MCP appeals information for DY16 Q1 will be presented in the next quarterly report due to a delay in the availability of data.
The California Department of Social Services (CDSS) continues to facilitate the State

Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 16 Q1, there was one request for hearings related to CBAS services from Los Angeles County. The hearing is still pending a decision.

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 DY15-Q2. Overall utilization of licensed capacity by CBAS participants for DY16 Q1 will be presented in the next quarterly report due to a delay in the availability of data.

Table 10: CBAS Centers Licensed Capacity

County	DY15-Q2 Oct-Dec 2019	DY15-Q3 Jan-Mar 2020	DY15-Q4 Apr-Jun 2020	DY16-Q1 Jul-Sep 2019	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	390	370	**370**	0.0%	**
Butte	60	60	60	**60**	0.0%	**
Contra Costa	220	220	220	**220**	0.0%	**
Fresno	822	822	1,062	**1062**	0.0%	**
Humboldt	229	229	349	**349**	0.0%	**
Imperial	355	355	355	**355**	0.0%	**
Kern	400	400	400	**400**	0.0%	**
Los Angeles	21,522	21,412	21,715	**22,770**	+4.7%	**
Merced	109	109	124	**124**	0.0%	**
Monterey	110	110	110	**110**	0.0%	**
Orange	2,638	2,438	2,438	**2,438**	0.0%	**
Riverside	920	920	935	**935**	0.0%	**
Sacramento	609	569	729	**680**	-6.7%	**
San Bernardino	590	590	590	**590**	0.0%	**
San Diego	2,233	2,383	2,278	**2,278**	0.0%	**
San Francisco	926	926	926	**926**	0.0%	**
San Joaquin	140	140	140	**140**	0.0%	**
San Mateo	135	135	135	**135**	0.0%	**
Santa Barbara	100	100	100	**100**	0.0%	*
Santa Clara	780	780	780	**780**	0.0%	**
Santa Cruz	90	90	90	**90**	0.0%	**
Shasta	85	85	85	**85**	0.0%	*
Ventura	851	851	851	**851**	0.0%	**
Yolo	224	224	224	**224**	0.0%	**
Marin, Napa, Solano	295	295	295	**295**	0.0%	**
Total	34,833	34,633	35,361	**36,367**	+2.8%	**

CDA Licensed Capacity as of 09/2020

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.*
***Capacity used information is not available for DY16-Q1 due to the delay in the availability of the data. Capacity used information for DY15-Q4, the latest quarter for which data is available, can be found in "Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS.*

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. Sacramento County experienced a decrease of more than 5 percent in licensed capacity, due to a closure of a CBAS Center that had a licensing capacity of 49.

During DY16 Q1, Los Angeles County experienced an increase in licensed capacity as 6 new CBAS centers have be opened to increase licensing capacity by 1,055.

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, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. Data for DY16-Q1 is not reflective in those tables due to a lack of availability, but will be reflected in the next quarterly report.

Unbundled Services (STC 48.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since

April 2012 when CBAS became operational. For DY16 Q1, CDA had 262 CBAS Center providers operating in California. According to Table 11 titled "*CBAS Center History*," 2 CBAS Centers closed and 6 new centers were opened in DY 16 Q1.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
September 2020	258	0	4	4	262
August 2020	257	0	1	1	258
July 2020	258	2	1	-1	257
June 2020	258	1	1	0	258
May 2020	257	0	1	1	258
April 2020	256	0	1	1	257
March 2020	257	4	3	-1	256
February 2020	257	1	1	0	257
January 2020	259	2	0	-2	257
December 2019	259	0	0	0	259
November 2019	259	0	0	0	259
October 2019	259	1	1	0	259
September 2020	258	0	4	4	262

Table 11 shows there was no negative change of more than five percent in DY 16 Q1, from July 2020 to September 2020, so no analysis is needed to address such variances.

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 County. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, and those providing services through SNCs, can participate in all Domains of the DTI. DMC providers are allowed to participate in other Domains with the exception of Domain 3.

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

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

5 (January 1 – December 31, 2020)	15 (July 1, 2019 - June 30, 2020) and 16 (July 1- December 31, 2020)

With the delay in implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative due to the COVID-19 public health emergency (PHE), DHCS submitted a one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver to the CMS on September 16, 2020. The proposal included extension of Domains 1-3 of the DTI program for an additional 12 months after December 31, 2020. DHCS did not include Domain 4 in the extension request because of the setbacks faced by Local Dental Pilot Projects (LDPP) from delayed contract execution with partners and/or subcontractors, staff turnover, and inability to meet their self-selected performance metrics during the first two years of operations.

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.

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

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.

Domain 4 –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

[5] DTI Domain 3
[6] DTI Domain 4

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

Measure Period	08/2019-07/2020	09/2019-08/2020	10/2019-09/2020
Denominator	5,294,826	5,278,105	5,101,823
Numerator	2,196,663	2,084,969	N/A
Preventive Dental Service Utilization	41.49%	39.50%	N/A8

Table 13: State Fiscal Year 2020-2021 Statewide Active Service Offices, Rendering Providers, and SNCs[8]

Delivery System and Plan[9]	Provider Type	July 2020	August 2020	September 2020
FFS	Service Offices	5,997	5,972	5,984
FFS	Rendering	11,556	11,576	11,645
GMC	Service Offices	154	154	150
GMC	Rendering	269	269	270
PHP	Service Offices	912	909	908
PHP	Rendering	1,460	1,466	1,450
Both FFS and DMC	Safety Net Clinics	589	588	N/A[10]

[7] Data Source: DHCS Data Warehouse Management Information System/Decision Support System (MIS/DSS) Dental Dashboard October 2020. Utilization does not include one-year full run-out allowed for claim submission.
[8] Active service offices and rendering providers are sourced from FFS Dental reports PS-O-008M, PS-O-008N 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 MIS/DSS as of October 2020. Only SNCs that submitted at least one dental encounter within a year were included.
[9] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.
[10] The count of SNCs for the third month of each quarter is not available due to claim submission time lag.

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 on July 16, 2020 and September 17, 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, LDPP visits, and the request to CMS to extend DTI via the Medi-Cal 2020 Waiver demonstration project. The next DTI Small Workgroup meeting will be on November 19, 2020.

Domain 2 Subgroup

The purpose of this quarterly subgroup was to report on the domain's current activities, discuss ways to encourage providers to participate in the domain, and to provide an open forum for questions and answers specific to this domain. However, for the past year, DHCS has not held any of these meetings due to no agenda items being identified by any of the meeting participants. Originally, the DTI Domain 2 subgroup meeting series was created to discuss and brainstorm methods of improving provider participation, and that purpose has since been fulfilled. Since the Domain 2 expansion, effective January 1, 2019, DHCS has seen an influx of participating providers in the Domain 2 program. Consequently, DHCS issued an email notification on September 9, 2020 to notify participants that this meeting series is canceled, and future updates for Domain 2 will be included in the DTI Small Workgroup meeting series.

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.

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.

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 August 20, 2020.

DTI Webpage

This quarter's webpage postings included Domains 1 and 3 encounter data submission deadlines for paper and electronic claims.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY16-Q1. In this quarter, there were two hundred and seventy-six (276) inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to, the following categories: DTI program extension, county expansion, encounter data submission, opt-in form submissions, payment status and calculations, check reissuances resource documents, procedure codes, and Domain 2 billing and opt-in questions.

Table 14: Number of DTI Inbox Inquiries by Domain:

Domain	Inquiries
1	180
2	54
3	42
Total	**276**

Separately, the LDPP inbox for Domain 4 received one hundred-eighty (180) inquiries this quarter, with questions related to budget revisions, quarterly reports, asset tagging, site visits, and reimbursement status.

Outreach Plans

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

- August 6, 2020: Medi-Cal Dental Advisory Committee Meeting (agenda)
- August 4, 2020: Child Health and Disability Prevention Statewide Oral Health Subcommittee
- August 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. During this quarter, DHCS issued the second payment for PY 4 in July 2020. Table 15 represents the second payment for PY 4 by county and delivery system. The next payment in January 2021 is on schedule.

Table 15: Incentive Payments as of January 2020

County	FFS	DMC	SNC
Alameda	$13,153.50	$0	$357,792.00
Butte	$1,353.00	$0	$0
Colusa	$64.50	$0	$0
Contra Costa	$20,037.75	$0	$125,641.50
El Dorado	$1,563.00	$0	$0
Fresno	$19,891.50	$0	$0
Humboldt	$106.50	$0	$38,535.00
Imperial	$452.25	$0	$0
Kern	$98,942.25	$0	$0
Lassen	$36.00	$0	$0
Los Angeles	$406,215.00	$389,439.75	$161,533.50
Madera	$5,441.25	$0	$0
Marin	$180.00	$0	$0
Mendocino	$36.00	$0	$0
Merced	$5,104.50	$0	$0
Modoc	$270.00	$0	$0
Monterey	$17,203.50	$0	$0
Napa	$271.50	$0	$0
Nevada	$28.50	$0	$20,460.00
Orange	$120,414.75	$64.50	$20,068.50
Placer	$7,635.00	$21,766.50	$20,136.00
Riverside	$84,969.75	$0	$0
Sacramento	$5,256.00	$850,976.25	$0
San Benito	$286.50	$0	$0
San Bernardino	$64,563.75	$0	$5,895.00
San Diego	$45,410.25	$0	$372,003.75
San Francisco	$9,672.75	$0	$0
San Joaquin	$9,573.00	$0	$0

San Luis Obispo	$1,788.00	$0	$0
San Mateo	$2,416.50	$0	$2,413.50
Santa Barbara	$18,384.75	$0	$0
Santa Clara	$29,481.75	$0	$0
Santa Cruz	$1,207.50	$0	$154,894.50
Shasta	$721.50	$0	$0
Solano	$7,611.00	$0	$50,611.50
Sonoma	$3,188.25	$0	$73,770.00
Stanislaus	$9,923.25	$0	$0
Sutter	$5,550.00	$0	$0
Tulare	$25,523.25	$0	$0
Tuolumne	$213.00	$0	$0
Ventura	$29,757.00	$252.00	$92,527.50
Yolo	$1,908.00	$ 6,151.50	$4,780.50
Total	**$1,075,806.00**	**$1,268,650.50**	**$1,501,062.75**

Domain 2

FFS providers are paid on a weekly basis and SNC and DMC providers are paid on a monthly basis. Table 16 represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY 16-Q1, which totals $20,012,740.25 (for all Domain 2 benefits including CRA, Silver Diamine Fluoride (SDF) and preventive services) paid to 3,033 providers who opted-in to Domain 2. The incentive claims paid reflect the increased frequency allowances for preventive services allowed under Domain 2, beyond the frequency for preventive services covered in the Manual of Criteria. In addition, the incentive claims paid also reflect the CRA and SDF treatments which are not otherwise covered in the Manual of Criteria.

Table 16: Incentive Claims as of March 2020

County	FFS	DMC	SNC
Contra Costa	$300,972.25	$0	$0
Fresno	$927,912.50	$0	$0
Glenn	$630.00	$0	$0
Humboldt	$0	$0	$0
Imperial	$13,260.00	$0	$0
Inyo	$0	$0	$0
Kern	$878,089.78	$0	$0
Kings	$5,277.00	$0	$0
Lassen	$0	$0	$0

County	FFS	DMC	SNC
Los Angeles	$6,697,492.29	$ 58,583.00	$ 74,572.00
Madera	$133,803.80	$0	$0
Mendocino	$0	$0	$ 74,614.00
Merced	$199,717.25	$0	$0
Monterey	$581,939.98	$0	$0
Orange	$1,640,307.00	$0	$120.00
Plumas	$0	$0	$0
Riverside	$1,303,922.10	$0	$0
Sacramento	$155,370.50	$446,564	$0
San Bernardino	$1,157,797.95	$0	$0
San Diego	$1,575,246.36	$0	$16,576.00
San Joaquin	$510,912.75	$0	$0
Santa Barbara	$234,617.80	$0	$0
Santa Clara	$418,510.50	$0	$0
Sierra	$0	$0	$0
Sonoma	$37,548.00	$0	$9,323.00
Stanislaus	$773,335.60	$0	$0
Tulare	$474,159.50	$0	$0
Ventura	$1,278,131.34	$0	$ 33,434.00
Yuba	$0	$0	$0
Total	**$19,298,954.25**	**$505,147.00**	**$208,639.00**

Table 17 represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program, February 2017, until the end of DY16-Q1 reporting period, September 2020. The total incentive claims paid for this period was $106,262,219.96.

Table 17: Incentive claims from February 2017 until March 2020

County	FFS	DMC	SNC
Contra Costa	$1,211,267.50	$0	$0
Fresno	$ 3,078,303.70	$0	$0
Glenn	$ 9,537.00	$0	$0
Humboldt	$70.00	$0	$126.00
Imperial	$ 78,924.00	$0	$0
Inyo	$0	$0	$43,218.00
Kern	$ 6,439,487.71	$0	$0
Kings	$ 35,649.50	$0	$0
Lassen	$0	$0	$0
Los Angeles	$ 31,324,477.87	$ 370,440.00	$ 1,944,346.00
Madera	$803,866.8	$0	$0
Mendocino	$0	$0	$ 606,981
Merced	$780,903.10	$0	$0

County	FFS	DMC	SNC
Monterey	$3,458,931.33	$0	$0
Orange	$ 7,411,070.00	$0	$ 691,126.00
Plumas	$0	$0	$0
Riverside	$5,800,428.61	$0	$0
Sacramento	$1,852,512.90	$4,838,325.00	$0
San Bernardino	$ 5,377,636.45	$126.00	$0
San Diego	$ 8,000,760.55	$0	$812,181.00
San Joaquin	$ 2,144,542.30	$0	$18,322.00
Santa Barbara	$ 1,874,811.05	$0	$0
Santa Clara	$1,994,110.88	$0	$0
Sierra	$0	$0	$0
Sonoma	$260,607.00	$0	$ 811,585.00
Stanislaus	$3,063,362.50	$0	$0
Tulare	$7,174,198.54	$0	$0
Ventura	$3,368,551.67	$252.00	$ 581,181.00
Yuba	$0	$0	$0
Total	**$95,544,010.96**	**$ 5,209,143.00**	**$5,509,066.00**

Domain 3

There were no payments issued during this quarter as Domain 3 annual payments are made annually in June. The Domain 3 payment for this year was reported in the previous report – 1115 Waiver DY 15 Annual Report, although the payment was issued at the beginning of this quarter.

Outreach Efforts

During this quarter, a majority of counties continued with the shelter-in-place for residents, businesses and non-essential personnel to slow the COVID-19 PHE. As a result, the ASO outreach team modified their approach by substituting routine, in person visits with emails and phone calls to participating providers in Domains 1, 2 and 3. During this quarter, outreach efforts included sharing benefits information available to Medi-Cal beneficiaries, Medi-Cal dental training for dental office staff, resource information, COVID-19 PHE updates, and provider bulletins regarding Personal Protective Equipment (PPE) and safety protocols.

Domain 2

In this quarter, the ASO's outreach team virtually visited twenty-five (25) of the twenty-nine (29) counties (Contra Costa, Fresno, Glenn, Imperial, Kern, Kings, Lassen, Los Angeles, Madera, Mendocino, Merced, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Clara, Sonoma,

Stanislaus, Tulare, Ventura and Yuba). The ASO continues to outreach to interested providers during their regular course of business. In this quarter, Domain 2 participation increased by 179 providers, bringing the total from 2,854 to 3,033.

Domain 3

In this quarter, the ASO's outreach team visited all but one of the 36 pilot counties (Del Norte). An additional five SNCs elected to opt-in for participation during this quarter, bringing the total from 115 to 120.

Domain 4

The LDPPs have utilized the email inbox to submit invoices electronically on a quarterly basis as well as communicate individual program concerns, share best practices, request assistance, and inform their liaison of changes to their programs.

During this quarter, LDPPs operations continue to be impacted by the COVID-19 PHE. Many of the LDPPs continue to struggle with community and school-based outreach. However, LDPPs were able to quickly shift strategies by utilizing teledentistry services, leveraging virtual platforms, performing educational outreach, as well as provide emergency services to patients in need.

Consumer Issues

The State of California enacted a shelter-in-place mandate on March 11, 2020 to the slow the spread of COVID-19. Dental offices were instructed by the American Dental Association to postpone all non-emergency services. This caused a cascading effect on dental utilization, and postponing various dental initiatives including CalAIM to focus on the COVID-19 PHE.

In May 2020, DHCS recommended Medi-Cal dental providers review the California Department of Public Health guidance for resuming deferred and preventive dental care amidst the COVID-19 PHE. As of September 2020, 89 percent of the FFS offices and 100 percent of the DMC offices have re-opened statewide for routine dental procedures.

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 DY16-Q1, Mathematica, the DTI independent evaluator, finalized the DTI Evaluation Quarterly Progress Report for Quarter 4 of Year Two: April – June 2020 and other tasks associated with the final evaluation. In addition, Mathematica finalized its interview questions for beneficiary interviews, as well as evaluation interviews with the LDPPs, which began this quarter. The remaining LDPP and beneficiary interviews are due to take place over the next quarter. Mathematica also participated in bi-weekly conference calls with DHCS and is continuing to work on gathering and analyzing data for inclusion in the Final Evaluation Report.

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

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

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

Enrollment Information:

Table 18: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY15-Q2	43,804	20,143	63,102
DY15-Q3	42,975	19,221	61,400
DY15-Q4	38,435	16,258	54,214
DY16-Q1	27,094	9,908	36,794

The decline in beneficiary enrollment from DY15-Q4 to DY16-Q1 is due to the data lag in the availability of data. Counties have up to six months to submit their DMC claims and the accurate enrollment numbers for DY16-Q1 will be provided in the next quarterly report.

Member Months:

Table 19: ACA v. Non-ACA Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	34012	32447	33028	D15-Q2	43,804
	32972	32976	32216	D15-Q3	42,975
	30407	29977	29260	D15-Q4	38,435
	22020	21662	11692	D16-Q1	27,094
Non-ACA	16959	16266	16644	D15-Q2	20,143
	16009	15087	14912	D15-Q3	19,221
	13535	13590	12870	D15-Q4	16,258
	8479	8066	3916	D16-Q1	9,908

Outreach/Innovative Activities:

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

County	Training Dates	Training Attendees
Ventura	July 21-22, 2020	38
Imperial	September 28-29, 2020	24

Recent activities including DMC-ODS guidance are listed below:

- July 2, 2020 – DMC-ODS Roundtable Meeting
- July 16, 2020 - DHCS Behavioral Health Stakeholder Advisory Committee
- July 22, 2020 – DMC-ODS Oversight Protocol Meeting
- August 17, 2020 - Council on Criminal Justice and Behavioral Health (CCJBH) Council Pre-Meeting
- August 19, 2020 – COVID-19 All County Weekly Call
- August 27, 2020 - CCJBH Council Meeting
- September 2, 2020 - DHCS/CDSS CalAIM Foster Youth Monthly Meeting
- September 9, 2020 – CalAIM BCP Meeting
- September 30, 2020 – CalAIM Planning Meeting

Operational/Policy Developments/Issues:

DHCS continued to focus on minimizing the spread of COVID-19 and ensuring ongoing access to care by distributing guidance to stakeholders in support of maintaining the continuity of statewide essential services and operations. 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

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

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
DY15-Q2					
ACA	2,850,397	$92,636,557.87	$79,588,381.96	$7,438,433.49	$5,609,742.42
Non ACA	1,598,282	$34,216,232.13	$17,078,492.43	$4,391,086.32	$12,746,653.38
DY15-Q3					
ACA	2,813,344	$92,340,438.25	$76,972,216.62	$9,506,134.96	$5,862,086.67
Non ACA	1,443,287	$31,743,883.96	$15,836,563.56	$4,128,641.26	$11,778,679.14
DY15-Q4					
ACA	2,695,937	$81,594,637.81	$68,014,681.39	$8,151,898.65	$5,428,057.77
Non ACA	1,289,684	$27,603,295.15	$13,774,119.03	$3,259,371.21	$10,569,804.91
DY16-Q1					
ACA	1,656,464	$60,751,999.26	$50,453,217.58	$6,218,450.95	$4,080,330.73
Non ACA	657,475	$16,898,202.71	$8,443,881.09	$2,531,577.16	$5,922,744.46

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

County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
Alameda	-	-	-	-	-	-	**0**
Contra Costa	-	-	-	-	-	1	**1**
El Dorado	-	-	-	1	-	1	**2**
Fresno	-	1	-	-	-	-	**1**
Imperial	-	-	-	-	1	1	**2**
Kern	1	3	1	-	-	-	**5**
Los Angeles	-	1	6	-	2	3	**12**
Marin	-	3	-	-	1	-	**4**
Merced	-	3	-	-	-	-	**3**
Monterey	-	-	-	-	-	-	**0**
Napa	-	-	-	-	-	-	**0**
Nevada	-	*	-	-	-	-	*****
Orange	8	1	-	1	-	-	**10**
Placer	-	-	1	5	1	-	**7**
Riverside	2	4	-	-	4	-	**10**
Sacramento	-	-	1	-	-	1	**2**
San Benito	-	-	-	-	-	-	*****
San Bernardino	-	6	-	-	-	-	**6**
San Diego	-	9	1	1	-	3	**14**
San Francisco	-	-	-	-	-	1	**1**
San Joaquin	-	-	-	1	-	2	**3**
San Luis Obispo	-	-	-	1	1	2	**4**
San Mateo	-	1	-	1	-	-	**2**
Santa Barbara	-	4	3	-	1	-	**8**
Santa Clara	-	-	1	-	-	1	**2**
Santa Cruz	-	1	-	-	-	3	**4**
Stanislaus	-	4	-	-	-	2	**6**
Tulare	-	-	-	-	-	-	**0**
Ventura	-	-	-	-	-	-	**0**
Yolo	1	5	-	-	-	-	**6**

**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

	Resolution				Transition of Care		
Counties	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
Alameda	-	-	-	-	-	-	-
Contra Costa	2	-	-	-	-	-	-
El Dorado	1	-	-	-	-	-	-
Fresno	1	-	-	-	-	-	-
Imperial	1	-	-	-	-	-	-
Kern	3	-	-	-	-	-	-
Los Angeles	6	22	12	10	-	-	-
Marin	3	-	-	-	-	-	-
Merced	3	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-
Orange	9	4	2	2	-	-	-
Placer	7	-	-	-	-	-	-
Riverside	9	-	-	-	-	-	-
Sacramento	-	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	2	-	-	-	-	-	-

- The Partnership Health Plan of California consists of seven counties which implemented an alternative DMC-ODS regional model on July 1, 2020; consumer issues for those counties will be available in the DY16-Q2 Progress Report.

DHCS conducted compliance monitoring reviews for the following Counties.

County	Date
Alpine	July 2020
Inyo	July 2020
Lake	July 2020
Lassen	July 2020
Madera	July 2020
Nevada	July 2020
Orange	July 2020
San Joaquin	July 2020

Shasta	July 2020
Sutter/Yuba	July 2020
Mendocino	August 2020
Santa Cruz	August 2020
Ventura	August 2020
Yolo	August 2020
Los Angeles	September 2020
Santa Barbara	September 2020
Santa Clara	September 2020
Sierra	September 2020

Evaluation:

DHCS is contracted with the University of California Los Angeles Integrated Substance Abuse Programs (UCLA) to conduct work defined under the California Organized Delivery System (ODS) Evaluation and Technical Assistance Interagency Agreement. Over a 2.5- year period, UCLA will provide evaluation services and technical assistance to DHCS on the current SUD treatment system with specific emphasis on the impact of policy changes on system performance, patient outcomes, access, and collaboration. Bi-annual reports are submitted to DHCS describing the progress of evaluation activities and summarizing technical assistance provided by UCLA within each specified time period, in order to meet requirements within both domains.

During DY16-Q1 (07/01/20-09/30/20) UCLA conducted the following activities:

Administrative Data Analysis

- The evaluation makes use of various data sources including the California Outcomes Measurement System, Treatment (CalOMS-Tx), Drug Medi-Cal Claims, Medi-Cal Managed Care Fee-For-Service (FFS) data, and client level-of-care data, as they become available to researchers.

  During this time period, UCLA worked with DHCS to obtain the most current datasets available. Of the requested datasets, UCLA has not received the 2018 Managed Care/FFS data. UCLA worked to explore the various datasets, conducting multiple analyses to address the research questions in the evaluation plan. UCLA meets quarterly with DHCS and BHC to discuss these data and preliminary findings. Findings will be reported in the end of year evaluation report, due in January 2021.

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. Additional TPS information is available here:

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

  During this time period, UCLA worked to prepare for the launch of the TPS data collection period scheduled for November 9-13, 2020. Due to COVID-19 pandemic and stay at home/social distancing requirements across the state, UCLA worked to transition the paper-based data collection forms to an online survey format as well as an interactive voice recognition (IVR) format for patients to access and complete the TPS questions remotely. UCLA has been developing the TPS online survey on Qualtrics platform for both adults and youth, in 13 languages. A telehealth question was added to the TPS for both adults and youth, in 13 languages to address impact of services delivered over phone and video-conference (telehealth). UCLA has also revised the TPS paper forms (52 different forms, including adult and youth, 1-page and large print versions, in 13 languages). UCLA reached out to the counties to update the list of TPS county contacts and to collect updated provider lists for purposes of generating customized survey links and provider codes for the phone/voice survey for each provider. UCLA posted updates to the TPS website with information, instructions, and FAQs for the upcoming data collection period. Finally, UCLA has also worked with DHCS to prepare the Information Notice required to disseminate the information and participation requirements for counties and providers.

County Administrator Survey

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

  During this time period, UCLA worked to analyze the survey data from the waivered county administrators. In addition, the state plan counties (not participating in the waiver) received a county administrator survey (similar to the waivered county survey, but adapted as needed). The data collection period occurred between 7/23 – 8/31, analysis began in September and is continuing to interpret results for the end of year evaluation report. In addition, development of

a county administrator survey for the Partnership region network, which recently went Live under the waiver in July 2020. Data collection period for this survey is planned for October/November. Finally, following approval from DHCS, UCLA began the development of a new online survey for CA county administrators assessing statewide the impact of COVID-19 on SUD treatment delivery, access issues, needs of the community, and utilization of Telehealth. Dissemination and data collection across the state began in July 2020. Analysis of these data will also be reported in the end of year evaluation report.

Provider Survey

- UCLA conducts 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 time period, analysis of the provider survey data collected among the waivered counties is underway. Findings will be reported in the end of year evaluation report.

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. Each county receives feedback on their county's beneficiary access line in the form of a written report.

  During this reporting period, UCLA initiated calls following the roll out of the Partnership regional network going live under the waiver (July 2020). UCLA conducted 12 secret shopper calls to the beneficiary access lines of partnership counties, which included 3 calls to the Beacon contractor number and 9 calls to county specific phone numbers. Analysis of these data will be reported in the end of year evaluation report.

Qualitative Interviews with Stakeholders

- UCLA conducts key informant interviews with county administrators and SUD provider programs administrators from counties participating in the DMC-ODS waiver to develop case studies on topics of particular interest to DHCS. These interviews were meant to gather data on successful strategies implemented by counties under the waiver.

  During this time period, UCLA conducted a phone interview with Sacramento County on 7/7/20 to learn about their experiences with perspectives on the implementation of the waiver as one of the counties that recently went live (7/1/19). In addition, UCLA expanded efforts to understand the processes (barriers and facilitators) from patient perspectives on transitions from residential to outpatient treatment. In September UCLA-ISAP met with MFI Recovery, VARP Inc. and Recovery Ranch Centers of Riverside County to plan interviews of a random sample of patients who are going to be discharged from residential treatment. Interviews were conducted with 5 men and 5 women from both VARP Inc. and MFI Recovery (9/8/2020-MFI Recovery, 9/14/2020-MFI Recovery, and 9/30/2020-VARP Inc. In the next reporting period, UCLA-ISAP will interview more clients from VARP Inc. and Recovery Ranch Centers. All interviews are transcribed and analyzed for themes by the UCLA-ISAP qualitative analyses group. Analysis of these data will be reported in the end of year evaluation report.

<u>Additional Technical Assistance (TA) provided to State and Counties</u>

- UCLA attends quarterly data meetings with DHCS and Behavioral Health Concepts (BHC) to discuss statewide data findings and methods. In this reporting period UCLA attended/presented on July 2, 2020. Next scheduled meeting is October 27, 2020.
- UCLA provided updated information on COVID's impact, telehealth, and other adaptations to COVID on July 10, 2020 in response to interest from DHCS.
- UCLA presented at the DHCS SUD annual conference (virtual) on August 25, 2020 presenting on Recovery Services under the DMC-ODS with Behavioral Health Concepts and county representatives from Napa and Santa Barbara.
- UCLA provided DHCS on Sept 3 and 9, 2020 with preliminary findings from the county administrator survey with regard to methamphetamine.

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:

The public health emergency was extended during this quarter from an end date of 7/23/2020 to 12/1/2020. Due to this change, PY 5 IQ4 payment calculations were included at the Family First Coronavirus Response Act (FFCRA) increased FMAP percentages. This update created a change in the overpayment totals that were recouped for PY 5 IQ4.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 23: DY16-Q1 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Public Health Care Systems				
GPP				
PY 4 (July – June) Overpayment collection	($9,911,838.50)	($9,911,838.50)	DY 14	($19,823,677.00)
PY 4 Final Rec. (July – June)	$59,119,552.50	$59,119,552.50	DY 14	$118,239,105.00
PY 5 IQ4 (Apr – June) Overpayment collection	($4,683,875.50)	($4,683,875.50)	DY 15	($9,367,751.00)
Total	$44,523,838.50	$44,523,838.50		$89,047,677.00

In the Program Year (PY) 4 Final Reconciliation round, the Department of Healthcare Services (DHCS) recouped $19,823,677.00 in total funds. The recoupment process is a result of two PHCSs that submitted final year-end reports with revisions to the interim report. The table below shows the PHCS PY 4 Interim and Final reporting differences.

Public Health Care System	Interim Report % of threshold met	Final Report % of threshold met
Santa Clara Valley Medical Center	95%	90%
Ventura County Medical Center	71%	63%

The two PHCSs received interim quarterly GPP payments based on their percent of threshold met as reported in the interim report. Their final report indicated a decrease in percent of threshold met. Therefore, the payments previously received by the PHCS exceeded the amounts earned as reported in the final report. DHCS adjusted the payments previously made to the PHCSs for GPP PY 4 and recouped the difference in the amount of $19,823,677.00. The final year-end report served as the basis for the final reconciliation of GPP payments and recoupments for GPP PY 4.

DY 16 Q1 reporting includes GPP payments made on August 10, 2020 and August 12, 2020. The payments made during this time period were for PY 4, Final Reconciliation (July 1, 2018 – June 30, 2019). The PHCSs received $59,119,552.50 in federal fund payments and $59,119,552.50 in Intergovernmental Transfer (IGT) for GPP.

On September 22, 2020, DHCS recouped $9,367,751.00 in total funds from Ventura County Medical Center (VCMC). The recoupment was due to overpayment to VCMC. In PY 5, IQ 1-3 (July 1, 2019 – March 31, 2020), VCMC was paid 75% of its total annual budget. On August 15, 2020, VCMC submitted an interim year-end summary aggregate report. The threshold points earned for VCMC were 7,078,031 GPP points, or 70% of

GPP thresholds. The 70% is less than 75% of its total annual budget. Therefore, DHCS adjusted the payments previously made to VCMC for GPP PY 5 and recouped the difference in the amount of $9,367,751.00 from VCMC.

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 as the PRIME program concluded in DY15.

Member Months:

Nothing to report as the PRIME program concluded in DY15.

Outreach/Innovative Activities:

Nothing to report as the PRIME program concluded in DY15.

Operational/Policy Developments/Issues:

Nothing to report as the PRIME program concluded in DY15.

Financial/Budget Neutrality Development/Issues:

Table 24: DPH and DMPH Payments

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$147,262,246.56	$129,659,024.63	DY 13/14/15	$276,921,271.19
Total	**$147,262,246.56**	**$129,659,024.63**		**$276,921,271.19**

In DY16 Q1, 17 DPHs and 34 DMPHs received payments.

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

Safety Net Financing Division (SNFD) issued payments at 50 percent FMAP while waiting for the qualifications clarification from the Centers for Medicare and Medicaid

Services. Once the qualifications were established, SNFD issued additional 6.2 percent FFP payments to comply with the requirements. These payments totaled $23,682,000.46 in FFP funds. This amount was added to the $147,262,246.56 FFP which was paid out for the current July-September quarter transactions. Altogether, Designated Public Hospitals and District/Municipal Public Hospitals received **$170,944,247.02** in federal fund payments for the PRIME-eligible achievements.

Consumer Issues:

Nothing to report as the PRIME program concluded in DY15.

Quality Assurance/Monitoring Activity:

Nothing to report as the PRIME program concluded in DY15.

Evaluations:

Nothing to report as the PRIME program concluded in DY15.

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 25: TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
July 2020 – September 2020

County	Total Member Months
Alameda	80,302
Contra Costa	50,073
Fresno	70,443
Kern	57,436
Kings	8,107
Los Angeles	531,514
Madera	6,973
Riverside	107,029
Sacramento	103,892
San Bernardino	115,505
San Diego	116,613
San Francisco	39,220
San Joaquin	47,697
Santa Clara	65,163
Stanislaus	33,424
Tulare	32,200
Total	**1,465,591**

Table 26: TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2020 – September 2020

County	Total Member Months
Alameda	74,350
Contra Costa	35,358
Fresno	45,067
Kern	33,330
Kings	4,756
Los Angeles	1,031,126
Madera	4,730
Marin	19,543
Mendocino	17,231
Merced	49,991
Monterey	48,863
Napa	15,314
Orange	342,207
Riverside	117,881
Sacramento	74,176
San Bernardino	113,965
San Diego	195,558
San Francisco	49,999
San Joaquin	31,487
San Luis Obispo	25,198
San Mateo	41,559
Santa Barbara	47,686
Santa Clara	122,697
Santa Cruz	32,244
Solano	61,291
Sonoma	51,827
Stanislaus	19,327
Tulare	21,514
Ventura	89,907
Yolo	26,308
Total	2,844,490

Table 27: TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
July 2020 – September 2020

County	Total Member Months
Alpine	37
Amador	1,097
Butte	16,424
Calaveras	1,597
Colusa	813
El Dorado	5,099
Glenn	1,604
Imperial	10,832
Inyo	467
Mariposa	703
Mono	158
Nevada	3,089
Placer	10,396
Plumas	994
San Benito	362
Sierra	101
Sutter	6,026
Tehama	5,200
Tuolumne	2,490
Yuba	6,339
Total	73,828

Table 28: TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
July 2020 – September 2020

County	Total Member Months
Del Norte	8,005
Humboldt	26,159
Lake	19,626
Lassen	4,282
Modoc	2,214
Shasta	40,051
Siskiyou	11,242
Trinity	2,793
Total	114,372

WHOLE PERSON CARE (WPC)

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 29 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 One (Q1) to Quarter Four (Q4) 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 – Q4 (April - June 2020). Due to a delay in the availability of data, DY 16 – Q1 data will be reported in the next quarterly report. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (QEU) reports. The data reported is point-in-time as of November 2, 2020.

Table 29: New Beneficiary Enrollment Counts

LE	DY15-Q1 (July - Sept. 2019)	DY15-Q2 (Oct. - Dec. 2019)	DY15-Q3 (Jan. - March 2020)	DY15-Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total to Date
Alameda	559	449	3,041	5,330	19,703
Contra Costa	3,059	2,446	3,193	2,455	47,250
Kern	250	187	173	159	1,860
Kings*	71	82	84	46	692
LA	5,251	4,088	5,113	2,551	58,672
Marin*	183	137	176	39	1,783
Mendocino*	18	78	3	4	391
Monterey	53	79	129	34	601
Napa	79	45	24	40	568
Orange	935	619	504	198	11,708
Placer	76	24	24	20	464
Riverside	728	580	666	235	6,940
Sacramento*	209	170	175	117	2,023
San Bernardino	89	74	68	122	1,236
San Diego	124	101	122	103	839
San Francisco	1,397	956	959	455	19,232
San Joaquin	178	188	303	139	2,006
San Mateo	110	69	72	53	3,675
Santa Clara	816	457	493	363	5,976
Santa Cruz*	14	47	24	23	556
SCWPCC*	22	9	3	8	138

LE	DY15-Q1 (July - Sept. 2019)	DY15-Q2 (Oct. - Dec. 2019)	DY15-Q3 (Jan. - March 2020)	DY15-Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total to Date
Shasta	35	32	33	32	429
Solano	11	21	22	12	240
Sonoma*	328	341	280	193	2,521
Ventura	43	33	46	31	1,279
Total	**14,638**	**11,312**	**15,730**	**12,762**	**190,782**

**Indicates one of seven LEs that implemented on July 1, 2017.*
*** Due to a delay in the availability of data, DY 16 - Q1 data will be reported in the next quarterly report.*

Member Months:

The data reported below in Table 30 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 - Q4 (April – June 2020). Due to a delay in the availability of data, DY 16 - Q1 data will be reported in the next quarterly report. Member months are extracted from the LE's self-reported QEU reports. The data reported is point-in-time as of November 2, 2020.

Table 30: Member Month Counts

LE	DY15-Q1 (July - Sept. 2019)	DY15-Q2 (Oct. - Dec 2019)	DY15-Q3 (Jan. - March 2020)	DY15-Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total-to-Date
Alameda	27,219	27,704	32,712	47,442	242,309
Contra Costa	40,669	39,919	39,807	38,460	517,287
Kern	3,650	4,276	4,173	5,132	25,068
Kings*	583	581	538	575	4,240
LA	51,131	50,587	55,202	55,731	488,405
Marin*	3,958	4,315	4,778	4,989	26,167
Mendocino*	317	507	553	422	4,699
Monterey	668	678	650	636	4,699
Napa	730	776	779	781	6,388
Orange	14,202	13,494	9,673	7,080	125,369

LE	DY15-Q1 (July - Sept. 2019)	DY15-Q2 (Oct. - Dec 2019)	DY15-Q3 (Jan. - March 2020)	DY15-Q4 (April - June 2020)	Jan. 2017 – June 2020 Cumulative Total-to-Date
Placer	427	440	402	413	4,607
Riverside	13,819	15,751	17,690	18,482	94,170
Sacramento*	2,543	2,657	2,833	2,803	20,737
San Bernardino	1,506	1,571	1,553	1,485	16,365
San Diego	1,055	1,168	1,265	1,385	7,662
San Francisco	28,491	29,539	30,615	30,290	327,693
San Joaquin	2,908	3,173	3,822	4,007	23,477
San Mateo	6,672	6,361	6,256	6,141	88,514
Santa Clara	10,697	11,366	10,078	9,602	100,771
Santa Cruz*	1,111	1,219	1,304	1,337	11,970
SCWPCC*	199	199	171	141	1,342
Shasta	227	229	254	237	2,615
Solano	253	181	220	175	2,912
Sonoma*	2,122	3,106	3,908	4,248	17,529
Ventura	1,753	1,712	1,702	1,660	21,801
Total	**216,910**	**221,509**	**230,938**	**243,654**	**2,186,796**

**Indicates one of seven LEs that implemented on July 1, 2017.*
***Due to a delay in the availability of data, DY 16 - Q1 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. All in-person meetings are currently on-hold due to restrictions on large gatherings caused by the COVID-19 PHE.

DHCS held monthly teleconferences with LEs focused on administrative topics and TA, allowing the LEs to ask questions about DHCS' guidance and various issues regarding reporting templates, deliverable deadlines, and expectations. The monthly teleconferences were held on July 1st, August 8th, and September 9th. The following topics were discussed on the calls: the Program Year (PY) 5 midyear invoice

template, the PY 5 Midyear narrative submission, the Q3 Enrollment and Utilization report, and the COVID-19 Budget Alternative process.

The LC advisory board met on August 20th and September 17th. Participants on the call discussed how the LC can support the pilots through the COVID-19 PHE and through a potential one year extension of the program, pending the Centers for Medicare and Medicaid Services (CMS) approval of California's 1115 waiver extension request. Advisory board members asked the LC to plan a two-hour virtual convening to share and acknowledge the pilots' accomplishments over the last four years. The advisory board discussed potential agenda items for this event, which included pilot highlights, certificates of appreciation for frontline WPC staff, and other acknowledgements of the program's success.

COVID-19 Public Health Emergency:

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

DHCS' efforts to support LEs and their response to the COVID-19 PHE include providing guidance to LEs to ensure the safety of their staff and enrollees, as well as offering opportunities for budget flexibilities to address the PHE. In August 2020, DHCS allowed optional budget flexibilities in a COVID-19 Budget Alternative to:

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

DHCS has approved seven COVID-19 Budget Alternatives in this quarter and expects to review an additional ten requests.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

As shown below in Table 31, during this quarter, DHCS released WPC payments for 18 of the 25 LEs. Although the WPC payment schedule indicated PY 4 annual invoices

were 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. The additional month that LEs had to submit invoices delayed the review period and payments were made in June and July 2020. WPC payments for seven LEs were made prior to June 30, 2020, while the remaining eighteen were made after July 1, 2020. Total amounts paid prior to June 30, 2020, were reported in the DY15 Annual Progress Report. The total amount paid after July 1, 2020, totaled $193,147,804.02. Payments were made through the Intergovernmental Transfer process. These payments represented the 50% Federal Financial Participation (FFP) and 50% local non-federal share for PY 4 annual, which includes the time period of July through December 2019.

Table 31: WPC Payments in DY 16 Q1

DY 16 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 1 (July 1 – Sept 30)	$96,573,902.01	$96,573,902.01	DY 15 (PY* 4)	$193,147,804.02
Total	**$96,573,902.01**	**$96,573,902.01**		**$193,147,804.02**

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

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- Second quarter April 2020 – June 2020 PY 5 QEU (Due 7/31/2020)
- COVID-19 Budget Alternative Request (Due 8/14/2020)
- PY 5 Midyear Narrative and Plan Do Study Act (Due 8/31/2020)

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) the strategies resulted in better care and better health; and 3) better care and health resulted in lower costs through reductions in utilization.

The midpoint report submitted to CMS in December 2019 included an assessment of

population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, although only preliminary outcome data was available. The final report, due to CMS in 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 first quarter of DY 16, DHCS' independent evaluator, the University of California, Los Angeles (UCLA):

- Continued to test modifications to the difference-in-difference (DD) model used in the interim report to improve analysis for the final report. The DD model examines the change in trend from the pre- to post-WPC between the treatment group and control group. As compared to the previous analysis, which examined change in the average metric rate in the pre- and post-period, this analysis will improve DHCS' ability to assess whether WPC changed the trajectory of key outcome metrics.
- Developed more refined service categories to better understand services provided to WPC enrollees. These new categories were incorporated into the LE Part II survey along with the recent list of per-member per-month and Fee-For-Service categories from the Enrollment and Utilization (E/U) reports, in order to get more up-to-date data for the final report. Survey data was cleaned and prepared for future analysis.
- Refined a "report card" template, which compares pilots based on outcome metrics by target populations, alongside key descriptive elements and metrics, including enrollee demographics, care coordination elements, implementation measures, and service availability. Data collected from the LE survey, as well as enrollment and population descriptions, have been identified as key elements in the report card. UCLA ran a preliminary model to rank pilots by target population on their outcome metrics.
- Continued the process of developing a shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final report.
- Began conversations around anticipated COVID-19 impacts on Medi-Cal claims data and subsequent UCLA analysis. UCLA began documenting potential implications of COVID-19 on the evaluation and identifying ways to address data collection and quality concerns, in line with CMS guidance.
- Completed data collection of the final LE survey in July 2020, which consisted of two parts. Key survey content areas included data sharing infrastructure, perceived pilot impact on better health, better care, and cost savings, and plans for sustainability of critical WPC components. UCLA also completed data collection for a survey to partners and frontline workers directly involved in WPC care coordination efforts. UCLA began data cleaning and conducted preliminary analysis of survey trends.
- In the NVivo software program, UCLA coded and analyzed challenges, successes, and lessons learned related to (1) identifying, engaging, and enrolling

clients, (2) care coordination, (3) data sharing, (4) outcomes and sustainability, and (5) biggest barriers to implementation as discussed by LEs in the PY 4 annual narrative reports. UCLA determined key themes across pilots and presented analysis in the Narrative Report Update, to highlight critical program findings. This report was submitted to DHCS in September 2020.

- Recreated the E/U Chart Pack by summarizing new enrollment and enrollee descriptive findings using data from PY 4 Q3 and Q4. This report was submitted to DHCS in September 2020.
- Developed a draft manuscript describing a novel prediction model to identify individuals experiencing homelessness or at-risk-of-homelessness using administrative and publicly available data. This methodology was implemented to identify Medi-Cal beneficiaries as controls for WPC enrollees experiencing homelessness.
- Initiated a draft manuscript that summarizes the findings from a systematic literature review of care coordination across multiple sectors of care. This literature review informed the care coordination framework used in the WPC care coordination case studies and policy brief.