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 – 06/30/2020)
Second Quarter Reporting Period: 10/01/2020 – 12/31/2020

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INTRODUCTION

On March 27, 2015, the California 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 (GPP) 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 Public Hospital Redesign And Incentives In Medi-Cal (PRIME)
- Dental Transformation Initiative (DTI) program
- Whole Person Care (WPC) 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)

On December 30, 2015, CMS approved California's section 1115(a) Demonstration (11-W-00193/9), entitled "California Medi-Cal 2020 Demonstration." The approval was authorized under the section 1115(a) of the Social Security Act.

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 June 30, 2021
- DY 17: July 1, 2021 through December 31, 2021

To build upon the state's previous Delivery System Reform Incentive Payment (DSRIP) program, the new redesigned pool, the 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 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 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 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.

On December 19, 2017, DHCS received CMS approval for a freedom of choice waiver that allows the state to provide Health Homes Program (HHP) services through the Medi-Cal managed care delivery system to members enrolled in managed care. FFS members who meet HHP eligibility criteria may choose to enroll in a Medi-Cal Managed Care Plan (MCP) to receive HHP services as well as other State Plan services that are provided through MCPs.

On August 3, 2020, DHCS received CMS approval to amend and extend the GPP program and expand the Program of All Inclusive Care for the Elderly (PACE) in Orange County. This amendment allows DHCS to operate an additional six-month GPP program year for the service period of July 1, 2020, to December 31, 2020 and allows Medi-Cal beneficiaries in Orange County (at their election) to be disenrolled from CalOptima, a county-organized health system (COHS), to be enrolled in PACE, if eligible.

On December 29, 2020, CMS approved a temporary extension for the Medi-Cal 2020 Demonstration, in order to allow the state and CMS to continue working on the approval of a longer term extension of the demonstration. The demonstration will now expire on December 31, 2021.

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-Q2, DHCS hosted a SAC meeting on October 28, 2020. DHCS provided updates

on Medi-Cal Enrollment, Managed Care Procurement Process/Timeline, CalAIM, COVID-19, and the 1115 Waiver Extension.

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/102820-SAC-Agenda.pdf
The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/102820-SAC-meetingsummary.pdf

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on October 19, November 9, and December 14, 2020, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following were some of the topics discussed: Updates for WPC, HHP, and PRIME, COVID-19 public health emergency (PHE) period, CalAIM 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	349	$2427.02	$847,029.98
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	$910,132.50
20-Oct	377	$2427.02	$914,986.54
20-Nov	372	$2427.02	$902,851.44
20-Dec	374	$2427.02	$907,705.48
Total			**$24,101,123.56**

Table 2: RCHSD Monthly Enrollment and Quarterly Member Months

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Member Months
CCS	377	372	374	2	1,123

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 January 2021, RCHSD submitted their CCS Quarterly Grievance Report for reporting period October – December 2020. During the reporting period, RCHSD reported one grievance. The one member grievance was related to transportation and the issue was resolved in the member's favor and for future similar issues.

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 provided its preliminary findings, inclusive of an analysis of claims/encounter data and eligibility records, as well as an analysis from interviews with key informants and families, in the CCS Pilots Interim Report submitted to CMS on August 31, 2020 as required. DHCS received comments and suggestions from CMS regarding the Interim Report and is working in conjunction with UCSF to provide a response and revise as necessary. The Final Evaluation Report is due to CMS on December 31, 2021.

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 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 PHE, DHCS received approval from CMS for the 12-month extension on December 29, 2020.

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 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-Service (FFS) members per county for DY16-Q2 represents the period of October to

[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.

December 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-Q2 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-Q2 Oct - Dec 2019		DY15-Q3 Jan -Mar 2020		DY15-Q4 Apr - Jun 2020		DY16-Q1 Jul-Sep 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	497	75%	487	74%	467	75%	444	71%
Butte	32	31%	30	30%	33	32%	27	27%
Contra Costa	203	54%	207	56%	223	57%	175	47%
Fresno	650	47%	634	46%	625	35%	609	34%
Humboldt	102	26%	101	26%	93	16%	87	15%
Imperial	381	63%	365	61%	335	56%	323	54%
Kern	57	8%	52	8%	74	11%	72	11%
Los Angeles	21,999	60%	21,610	60%	18,384	50%	21,498	56%
Merced	98	53%	98	53%	58	28%	96	46%
Monterey	116	62%	119	64%	116	62%	111	60%
Orange	2,611	58%	2,579	62%	2,360	57%	2,399	58%
Riverside	573	37%	576	37%	444	28%	490	31%
Alameda	497	75%	487	74%	467	75%	444	71%
Butte	32	31%	30	30%	33	32%	27	27%

County	DY15-Q2 Oct - Dec 2019		DY15-Q3 Jan -Mar 2020		DY15-Q4 Apr - Jun 2020		DY16-Q1 Jul-Sep 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
Contra Costa	203	54%	207	56%	223	57%	175	47%
Fresno	650	47%	634	46%	625	35%	609	34%
Humboldt	102	26%	101	26%	93	16%	87	15%
Imperial	381	63%	365	61%	335	56%	323	54%
Kern	57	8%	52	8%	74	11%	72	11%
Los Angeles	21,999	60%	21,610	60%	18,384	50%	21,498	56%
Merced	98	53%	98	53%	58	28%	96	46%
Monterey	116	62%	119	64%	116	62%	111	60%
Orange	2,611	58%	2,579	62%	2,360	57%	2,399	58%
Riverside	573	37%	576	37%	444	28%	490	31%
Sacramento	484	47%	443	46%	445	36%	371	32%
San Bernardino	777	78%	691	69%	586	59%	624	62%
San Diego	2,597	69%	2,362	59%	2,283	59%	2,316	60%
San Francisco	672	43%	723	46%	735	47%	670	43%
San Joaquin	38	16%	33	14%	35	15%	40	17%
San Mateo	67	29%	76	33%	80	35%	74	32%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	581	44%	582	44%	574	43%	523	40%
Santa Cruz	99	65%	101	66%	92	60%	88	58%
Shasta	*	*	*	*	*	*	*	*
Ventura	918	64%	901	63%	907	63%	935	65%
Yolo	279	74%	283	75%	273	72%	267	70%
Marin, Napa, Solano	81	16%	76	15%	61	12%	70	14%
Total	**33,963**	**58%**	**33,172**	**57%**	**29,309**	**49%**	**32,339**	**53%**
							FFS and MCP Enrollment Data 09/2020	

***Note: Information is not available for DY16-Q2 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.

A majority of the counties unduplicated participants stayed at the same approximate level for DY16-Q1. There is only one county with a greater than 5% decline, which is a negative 10% change for Contra Costa County. There were no new centers opening or closing during Q1 in this County, the significant fluctuation is likely a result of a decline in participation. Contra Costa county does not have large participant total, so slight fluctuations yield higher percentages than other counties.

Overall, there is a 4% increase statewide as many counties continue to reflect an increase in unduplicated participants. Merced County registered an 18% increase, a result of normal fluctuations in participation, however, due to the size of the county, it caused the percentage change to be significant. Los Angeles County had a 6% increase in capacity utilization, which is a result of an increase of participant fluctuation.

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 MPs and FFS						
Demonstration Year	**MCPs**			**FFS**		
	New Assessmts	**Eligible**	**Not Eligible**	**New Assessments**	**Eligible**	**Not Eligible**
DY15-Q2 (10/01-12/31/2019)	2,095	2,031 (97%)	64 (2%)	3	(100%)	0 (0%)
DY15-Q3 (01/01-03/31/2020)	1,713	1,676 (97.8%)	37 (2.2%)	5	(100%)	0 (0%)
DY15-Q4 (04/01-06/30/2020)	438	419 (95%)	19 (5%)	0	(0%)	0 (0%)

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY16-Q1 (07/01-09/30/2020)	*	* (*%)	* (*%)	0	0 (0%)	0 (0%)
DY16-Q2 (10/01-12/31/2020	1,948	1845 (94.7%)	103 (5.3%)	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		*	*		No	No

*Note: *MCP assessment information is not reported for DY16-Q2 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-Q2 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 DY15-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.

DY16-Q1 data for MCP assessments reflects an increase in requests for new assessments. This is a significant increase from the DY15-Q4 period and is reflective of the typical number of new assessments each quarter prior to the COVID-19 public health emergency.

<u>CBAS Provider-Reported Data (per CDA) (STC 52.b)</u>

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-Q2. As of DY16-Q2, 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 265 operating CBAS Centers is approximately 30,110 participants, which corresponds to 81 percent of total capacity. Provider-reported data identified in the table below, reflects data from October to December 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	265
Non-Profit Centers	49
For-Profit Centers	216
ADA @ 265 Centers	30,110
Total Licensed Capacity	36,912
Statewide ADA per Center	81.6%

CDA - MSSR
Data 12/2020

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 one newsletters and one ACL, which included updates on the following topics: (1) CBAS program operations during the COVID-19 outbreak and PHE, (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) upcoming education and training opportunities, (4) Federal Home and Community-Based (HCB) Settings Requirements, (5) COVID-19 and the flu, and (6) CBAS disaster plan requirements. CDA continued to collaborate with CAADS on their weekly webinar trainings for CBAS providers and MCPs.

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 December 9, 2020, to provide an update on CBAS TAS policy directives, CBAS quality assurance activities, status of new center applicants' pre-screening packages and applications, and an overview of findings from the survey CDA distributed to MCPs to identify their experiences 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 21, 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, and (3) CBAS center compliance with CBAS TAS required services, staffing and documentation, and with CBAS certification standards.

<u>Home and Community-Based (HCB) Settings and Person-Centered Planning Requirements</u>

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 on an ongoing basis. 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 and CDA are in the process of revising the STP and CBAS Transition Plan in preparation for 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.
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:

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

- 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-Q2, as illustrated in Table 6, titled *Data on CBAS Complaints*. MCP complaint information for DY16-Q2 will be presented in the next quarterly report due to a delay in the availability of data.

Table 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY15-Q3 (Jan 1 - Mar 31)	0	0	0
DY15-Q4 (Apr 1 – Jun 30)	0	0	0

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q1 (Jul 1 - Sep 30)	0	0	0
DY16-Q2 (Oct 1 – Dec 31)	0	0	0

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CDA Data Complaints 12/2020

For complaints received by MCPs, the table below illustrates there were no new complaints, either from beneficiaries or providers reported to the Call Centers about CBAS. MCP complaint information for DY16-Q2 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-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
DY16-Q1 (Jul 1 - Sept 30)	0	0	0

Plan data - Phone Center Complaints 09/2020

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 DY16-Q1. MCP grievance information for DY16-Q2 will be presented in the next quarterly report due to a delay in the availability of data. There were 4 grievances relating to CBAS providers, 1 Contractor Assessment or Reassessment, and 5 categorized as "other CBAS Grievances." 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-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
DY16-Q1 (Jul 1 – Sept 30)	4	1	0	5	10
					Plan data - Grievances 09/2020

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 – 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
DY16 – Q1 (Jul 1 – Sept 30)	2	0	0	0	2
					Plan data - Grievances 09/2020

Note: MCP appeals information is not available for DY16-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.

During DY16-Q1, Table 9 titled "*Data on CBAS Managed Care Plan Appeals*"; shows

there were 2 CBAS appeals filed with the MCPs as they pertain to a denial or limited services. There were no other category of appeals for DY16-Q1. MCP appeals information for DY16-Q2 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 DY16-Q2, there were no request for hearings related to CBAS services.

Financial/Budget Neutrality Development/Issues:

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

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

Quality Assurance/Monitoring 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. It is a five-year strategy plan. 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. Many of the initial quality goals and objectives have been achieved. CDA and the CBAS Quality Strategy Advisory Committee have established new quality goals and objectives to ensure ongoing quality improvement activities beyond October 2021.

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-Q2 will be presented in the next quarterly report due to a delay in the availability of data.

Table 10: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity					
	DY15-Q3 Jan-Mar 2020	DY15-Q4 Apr-Jun 2020	DY16-Q1 Jul-Sep 2019	DY16-Q2 Oct-Sept 2020	Percent Change Between Last Two Quarters	Capacity Used
Alameda	390	370	370	**370**	0.0%	**
Butte	60	60	60	**60**	0.0%	**
Contra Costa	220	220	220	**220**	0.0%	**
Fresno	822	1,062	1062	**1132**	+6.6%	**
Humboldt	229	349	349	**349**	0.0%	**
Imperial	355	355	355	**355**	0.0%	**
Kern	400	400	400	**400**	0.0%	**
Los Angeles	21,412	21,715	22,770	**23,140**	+1.6%	**
Merced	109	124	124	**124**	0.0%	**
Monterey	110	110	110	**110**	0.0%	**
Orange	2,438	2,438	2,438	**2,438**	0.0%	**
Riverside	920	935	935	**935**	0.0%	**
Sacramento	569	729	680	**680**	0.0%	**
San Bernardino	590	590	590	**590**	0.0%	**
San Diego	2,383	2,278	2,278	**2,383**	+4.6%	**
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%	**
SUM	**34,633**	**35,361**	**36,367**	**36,912**	+1.5%	**

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

***Capacity used information is not available for DY16-Q2 due to the delay in the availability of the data. Capacity used information for DY16-Q1, 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. No county experienced a decrease of more than 5 percent in licensed capacity during to DY16-Q2.

During DY16-Q2, Los Angeles and San Diego Counties experienced an increase in licensed capacity as three new CBAS centers opened to increase licensing capacity.

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-Q2 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-Q2, CDA had 265 CBAS Center providers operating in California. According to Table 11 titled "*CBAS Center History*," no CBAS Centers closed and three new centers were opened in DY16-Q2.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
December 2020	265	0	0	0	265
November 2020	263	0	2	2	265
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

Table 11 shows there was no negative change of more than five percent in DY16-Q2, from October to December 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, 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 – December 31, 2016)
2 (January 1 – December 31, 2017)	12 (January 1 – June 30, 2017) and 13 (July 1 - December 31, 2017)
3 (January 1 – December 31, 2018)	13 (January 1 – June 30, 2018) and 14 (July 1 – December 31, 2018)
4 (January 1 – December 31, 2019)	14 (January 1 – June 30, 2019) and 15 (July 1 – December 31, 2019)

DTI PYs	1115 Waiver DYs
5 (January 1 – December 31, 2020)	15 (January 1 - June 30, 2020) and 16 (July 1 – December 31, 2020)

*Note: PY 6 is only for DTI Domains 1-3 and contingent upon funding availability.

With the delay in implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative due to the 2019-Novel Coronavirus (COVID-19) public health emergency (PHE), DHCS submitted a one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) on September 16, 2020, which CMS approved on December 29, 2020, with a new demonstration date for PY 6 ending on December 31, 2021. DHCS' approved 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 various challenges experienced by Local Dental Pilot Projects (LDPP), which included delayed contract execution with partners and/or subcontractors, staff turnover, and inability to meet 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 one 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,

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

Merced, Monterey, Kern, Contra Costa, Santa Clara, Los Angeles, Stanislaus, Sonoma, Imperial, Madera, San Joaquin, Fresno, Orange, San Bernardino, Riverside, Ventura, Santa Barbara, and San Diego.

Domain 3 – Continuity of Care[5]
This Domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing ongoing relationships between a beneficiary and a dental provider in selected counties. Incentive payments are issued to dental service office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods.

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

Domain 4 –LDPPs [6]
As noted above, Domain 4 has concluded operations and the LDPPs are now in the administrative closeout phase relative to PY 5, which ended as of December 31, 2020. While active, the LDPPs supported 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 were required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

The approved lead entities for the LDPPs were 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.

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

Enrollment Information:

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

Measure Period	10/2019-09/2020	11/2019-10/2020	12/2019-11/2020	1/2020-12/2020
Denominator[8]	5,287,031	5,271,402	5,272,972	5,176,740
Numerator[9]	2,098,483	2,038,151	1,969,574	N/A[10]
Preventive Dental Service Utilization	39.69%	38.66%	37.35%	N/A[10]

Table 13: State Fiscal Year 2020-2021 Statewide Active Service Offices, Rendering Providers, and SNCs[11]

From October 2020 to November 2020, FFS dental office enrollment decreased by 64 primarily due to deactivations resulting from claim inactivity in the prior 12 months. Other reasons for the decrease were due to provider suspensions, lapse in licensure, voluntary withdrawal from the program, and failure to revalidate enrollment.

Delivery System and Plan[12]	Provider Type	September 2020	October 2020	November 2020	December 2020
FFS	Service Offices	5,984	5,994	5,930	5,954

[7] Data Source: DHCS Data Warehouse Management Information System/Decision Support System (MIS/DSS) Dental Dashboard January 2021. Utilization does not include one-year full run-out allowed for claim submission.
[8] Denominator: Three months continuous enrollment - Number of beneficiaries ages one (1) through twenty (20) enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.
[9] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (Current Dental Terminology (CDT) codes D1000-D1999 or CPT code 99188 with safety net clinics' (SNCs) dental encounter with International Classification of Diseases (ICD)-10 diagnosis codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) during the measure year.
[10] Utilization for the third month of each quarter is not available due to claim submission time lag.
[11] 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 January 2021. Only SNCs that submitted at least one dental encounter within a year were included.
[12] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.

Delivery System and Plan[12]	Provider Type	September 2020	October 2020	November 2020	December 2020
FFS	Rendering	11,645	11,721	11,808	11,848
GMC	Service Offices	150	154	158	156
GMC	Rendering	270	277	275	282
PHP	Service Offices	908	908	910	907
PHP	Rendering	1,450	1,433	1,423	1,423
Both FFS and DMC	Safety Net Clinics	591	589	592	N/A[13]

Outreach/Innovative Activities

DTI Small Workgroup

This workgroup meets on a bi-monthly basis, the third Wednesday of the month. During this quarter, this workgroup had one meeting scheduled on November 19, 2020. Due to lack of agenda items, an email was sent to stakeholders in lieu of the meeting, which included updates on incentive payments, provider participation, LDPP visits, DTI program extension, and a change in frequency of the meetings from bi-monthly to quarterly. The next DTI Small Workgroup meeting will be held on March 18, 2021.

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

In lieu of the Domain 4 teleconference with Local Dental Pilot Projects (LDPP) in December, DHCS sent an email update on December 17, 2020. As noted above, as of December 31, 2020, all 13 LDPPs have concluded operations and are now in the

[13] The count of SNCs for the third month of each quarter is not available due to claim submission time lag.

administrative closeout phase. DHCS will continue offering technical assistance to LDPPs regarding closeout guidelines to ensure that all deliverables are received and final payments are made.

DTI Webpage

There are no updates to the DTI webpage during this quarter.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY16-Q2. In this quarter, there were fifty-three (53) 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	12
2	25
3	16
Total	**53**

Separately, the LDPP inbox for Domain 4 received one hundred-seventy one (171) 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:

- October 1, 2020: Medi-Cal Dental Advisory Committee Meeting (agenda)
- November 5, 2020: Medi-Cal Dental Los Angeles Stakeholder Meeting (agenda)
- December 3, 2020: Medi-Cal Dental Advisory Committee Meeting (agenda)
- December 9, 2020: 2020 National Medicaid | Medicare | CHIP Oral Health Symposium (agenda)

Operational/Policy Developments/Issues

Domain 1

Domain 1 providers are paid semiannually at the end of January and July. The next payment in January 2021 is on schedule.

Domain 2

FFS providers are paid on a weekly basis and SNC and DMC providers are paid on a monthly basis. Table A represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY16-Q2, which totals $21,909,016.13 (for all Domain 2 benefits including CRA, Silver Diamine Fluoride (SDF) and preventive services) that are paid to 3,123 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 (MOC). In addition, the incentive claims paid also reflect the CRA and SDF treatments which are not otherwise covered in the MOC.

Table A

County	FFS	DMC	SNC
Contra Costa	$285,525.00	$0	$0
Fresno	$2,934,256.50	$252.00	$17,528.00
Glenn	$1,056.00	$0	$0
Humboldt	$0	$0	$0
Imperial	$ 11,334.50	$0	$0
Inyo	$0	$0	$0
Kern	$ 1,318,915.40	$126.00	$126.00
Kings	$ 4,126.50	$0	$0
Lassen	$0	$0	$0
Los Angeles	$ 6,062,284.71	$ 67,690.00	$ 111,240.00
Madera	$ 144,583.00	$0	$0
Mendocino	$0	$0	$ 147,758.00
Merced	$ 221,642.71	$0	$0
Monterey	$ 691,559.26	$0	$0
Orange	$ 1,621,927.50	$252.00	$2,751.00
Plumas	$0	$0	$0
Riverside	$ 1,329,109.60	$126.00	$16,342.00
Sacramento	$152,597.00	$ 472,010.00	$0
San Bernardino	$ 1,145,766.20	$126.00	$19,194.00
San Diego	$ 1,651,907.35	$0	$193,510.00

County	FFS	DMC	SNC
San Joaquin	$ 467,021.20	$504.00	$0
Santa Barbara	$ 398,332.37	$0	$0
Santa Clara	$ 358,641.00	$0	$28,875.00
Sierra	$0	$0	$0
Sonoma	$ 40,934.00	$0	$74,405.00
Stanislaus	$ 652,783.80	$126.00	$0
Tulare	$ 610,347.25	$0	$0
Ventura	$ 610,702.28	$0	$ 40,722.00
Yuba	$0	$0	$0
Total	**$ 20,715,353.13**	**$ 541,212**	**$652,451**

Table B represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program, February 2017, until the end of DY6-Q2 reporting period, December 2020. The total incentive claims paid for this period was $118,518,568.19.

Table B

County	FFS	DMC	SNC
Contra Costa	$1,496,792.50	$0	$0
Fresno	$ 6,012,560.20	$252.00	$17,528.00
Glenn	$10,593.00	$0	$0
Humboldt	$70.00	$0	$126.00
Imperial	$ 90,258.50	$0	$0
Inyo	$0	$0	$43,218.00
Kern	$ 7,758,403.11	$126.00	$126.00
Kings	$ 39,776.00	$0	$0
Lassen	$0	$0	$0
Los Angeles	$ 37,386,762.58	$ 438,130.00	$ 2,055,586.00
Madera	$ 948,449.80	$0	$0
Mendocino	$0	$0	$ 754,739.00
Merced	$ 1,002,545.81	$0	$0
Monterey	$ 4,150,490.59	$0	$0
Orange	$ 9,032,997.50	$252.00	$ 693,877.00
Plumas	$0	$0	$0
Riverside	$ 7,129,538.21	$126.00	$16,342.00
Sacramento	$ 2,005,109.90	$ 5,310,335.00	$0
San Bernardino	$ 6,523,402.65	$252.00	$19,194.00
San Diego	$ 9,652,667.90	$0	$1,005,691.00
San Joaquin	$ 2,611,563.50	$504.00	$18,322.00
Santa Barbara	$ 2,273,143.42	$0	$0
Santa Clara	$ 2,352,751.88	$0	$28,875.00

County	FFS	DMC	SNC
Sierra	$0	$0	$0
Sonoma	$ 301,541.00	$0	$ 885,990.00
Stanislaus	$ 3,716,146.30	$126.00	$0
Tulare	$ 7,784,545.79	$0	$0
Ventura	$ 3,979,253.95	$252.00	$ 621,903.00
Yuba	$0	$0	$0
Total	**$ 106,606,696.19**	**$ 5,750,355**	**$6,161,517**

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.

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. Although provider offices are opening, there are still restrictions preventing in-person outreach contact. As a result of the COVID-19 PHE, the ASO outreach team modified their approach with emails and phone calls. During this quarter, the ASO outreach team contacted Medi-Cal Dental offices to offer information about dental benefits available to Medi-Cal members, provider information about DTI, Proposition 56 supplemental payments, and student loan repayment program (CalHealthCares), and they offered Medi-Cal Dental training for dental office staff. The ASO outreach team will continue to follow-up with each provider.

Domain 2

In this quarter, the ASO's outreach team contacted by telephone, eighteen (18) of the twenty-nine (29) counties (Fresno, Glenn, Kern, Kings, Los Angeles, Madera, Merced, Orange, Plumas, Riverside, San Bernardino, San Diego, San Joaquin, Santa Clara, Sonoma, Stanislaus, Tulare, and Ventura). The ASO continued to outreach to interested providers during their regular course of business. In this quarter, Domain 2 participation increased by 81 providers, bringing the total from 3,033 to 3,114.

Domain 3

In this quarter, the ASO's outreach team contacted by telephone, twenty-five (25) of the thirty-six (36) pilot counties - Alameda, Butte, Fresno, Kern, Madera, Merced, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin,

San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, and Yolo.

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, although all LDPPs concluded operations as of December 31, 2020, they continue to be impacted by the COVID-19 PHE as they engage in final administrative closeout operations.

Consumer Issues

In May 2020, the State of California modified the initial shelter-in-place mandate to gradually resume non-emergency dental services. 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 December 2020, 98 percent of the FFS dental offices and 100 percent of the DMC offices have re-opened for routine dental procedures. However, the office closures during the initial stages of the COVID-19 PHE, followed by many Californians choosing to stay at home and practice social distancing, has impacted the dental utilization throughout 2020.

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-Q2, Mathematica, the DTI independent evaluator, continued to complete tasks associated with the final evaluation of the DTI Program. As such, Mathematica conducted evaluation interviews with representatives from each of the LDPPs to gain their insight on the successes and weaknesses of their various LDPPs. Additionally, Mathematica worked with the LDPP representatives to secure contact information for beneficiaries served by their projects, with the goal of completing ten (10) beneficiary

interviews per project. Throughout DY16-Q2, Mathematica also continued to participate in bi-weekly conference calls with DHCS and will continue to gather and analyze data for inclusion in the Final Evaluation Report.

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

The 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 17: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY15-Q3	43,290	19,336	61,823
DY15-Q4	39,287	16,583	55,362
DY16-Q1	51,304	14,454	51,309
DY16-Q2	38,727	10,377	38,729

Total may differ from the total of ACA and non ACA, because beneficiaries may move from one category to another during the course of a calendar year, meaning they will be represented in the data twice.

Member Months:

Table 18: ACA v. Non-ACA Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	33,120	33,150	32,452	D15-Q3	43,290
	30,888	30,594	31,140	D15-Q4	39,287
	41,119	38,673	35,571	D16-Q1	51,304

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
	33,209	25,983	7,743	D16-Q2	38,727
Non-ACA	16,069	15,144	14,995	D15-Q3	19,336
	13,913	13,865	13,687	D15-Q4	16,583
	11,926	11,113	10,028	D16-Q1	14,454
	8,905	6,584	1,559	D16-Q2	10,377

The decline in member months and expenditures are attributable to the timing of the data run. DY16-Q2 is 10/1/2020-12/31/2020. The data was run one month after the end of the quarter, so data is not yet complete. Counties have six months to submit their DMC claims, so we believe the numbers are lower because of the time of the data run (only one month after). The accurate enrollment numbers for DY16-Q2 will be provided in the next quarterly report.

Outreach/Innovative Activities:

DHCS did not conduct specialized trainings during DY16-Q2 due to the Public Health Emergency and holidays. Many SUD county staff were not working for various reasons related to COVID and/or county staff were redirected to temporarily assist with the public health needs at the local level. DHCS conducted regularly scheduled monthly technical assistance calls with counties and addressed concerns individually as requested.

Recent activities including DMC-ODS guidance are listed below:

- October-December – CalAIM Planning Meetings
- October-December – Monthly All County Behavioral Health Calls
- October-December – CalAIM Behavioral Health Project Meetings
- October 9, 2020 - CalAIM BCP Meeting
- October 26, 2020 – Target Stakeholder Engagement Meeting 1
- October 28, 2020 – Behavioral Health Stakeholder Advisory Committee Meeting
- November 12, 2020 - Target Stakeholder Engagement Meeting 2
- November 13, 2020 – DHCS/Aurrera DMC-ODS Renewal Meeting
- November 13, 2020 – CalAIM Internal Discussion
- November 16, 2020 - CalAIM BH Proposal-DHCS/MCP/MHP Collaboration
- November 18, 2020 – DMC-ODS Network Adequacy Meeting
- November 25, 2020 – Medical Necessity & DMC-ODS Waiver Meeting
- December 2, 2020 - DHCS/CDSS CalAIM Foster Youth Monthly Meeting
- December 11, 2020 – CalAIM Behavioral Health Workgroup
- December 14, 2020 – DMC-ODS Webinar
- December 17, 2020 - CalAIM System Sponsor/Internal Stakeholder 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 asked for Technical Assistance to re-design PIPs that were initially designed for treatment programs built around group therapies, such as Seeking Safety and some Intensive Outpatient Programs with housing links as step-downs from residential.

Financial/Budget Neutrality Developments/Issues:

Table 19: Aggregate Expenditures: ACA and Non-ACA

DY15-Q3					
Population	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
ACA	2,821,649	$92,930,075.43	$77,473,466.13	$9,556,393.56	$5,900,215.74
Non-ACA	1,446,288	$31,874,407.12	$15,907,730.03	$4,143,458.47	$11,823,218.62
DY15-Q4					
ACA	2,763,948	$84,409,551.51	$70,339,352.34	$8,440,020.87	$5,630,178.30
Non-ACA	1,330,021	$28,769,429.20	$14,428,214.47	$3,420,851.95	$10,920,362.78
DY16-Q1					
ACA	7,754,030	$282,344,420.81	$231,530,579.30	$28,809,638.55	$22,004,202.96
Non-ACA	1,044,210	$27,113,945.36	$14,141,247.71	$3,773,495.12	$9,199,202.53
DY16-Q2					
ACA	4,584,786	$174,721,850.19	$145,444,830.12	$17,562,283.49	$11,714,736.58
Non-ACA	533,488	$14,588,382.66	$8,167,975.89	$1,974,628.28	$4,445,778.49

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 20: 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	**2**
El Dorado	-	-	-	-	-	-	**0**
Fresno	1	1	-	-	-	-	**2**
Imperial	-	-	-	-	-	-	**0**
Kern	1	14	5	-	-	-	**20**
Los Angeles	1	-	4	2	-	3	**10**
Marin	-	-	-	1	-	-	**1**
Merced	-	-	-	-	-	-	**0**
Monterey	-	-	-	-	-	-	**0**
Napa	-	-	-	-	-	-	**0**
Nevada	-	**	-	-	-	**	**
Orange	1	3	-	-	-	-	**4**
Placer	-	-	3	-	3	-	**6**
Riverside	3	8	-	-	-	1	**12**
Sacramento	-	-	-	-	-	1	**1**
San Benito	-	**	-	-	-	-	**
San Bernardino	1	-	-	-	-	-	**1**
San Diego	5	9	-	1	-	-	**15**
San Francisco	-	-	-	-	-	-	**0**
San Joaquin	-	-	-	-	-	-	**0**
San Luis Obispo	-	-	-	-	-	1	**1**
San Mateo	-	1	1	-	2	1	**5**
Santa Barbara	1	1	-	-	-	1	**3**
Santa Clara	1	-	1	-	-	-	**2**
Santa Cruz	-	2	-	-	1	6	**9**
Stanislaus	-	-	-	-	-	-	**0**
Tulare	-	-	-	-	-	-	**0**
Ventura	-	-	-	-	-	-	**0**
Yolo	-	-	1	-	-	1	**2**
Regional Model*	1				3		**4**

Regional Model includes Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties

***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 21: Resolutions

	Resolution				Transition of Care		
Counties	**Grievances**	**Appeal**	**Appeal in favor of Plan**	**Appeal in favor of Beneficiary**	**Requests**	**Approved**	**enied**
Alameda	-	1	-	1	-	-	
Contra Costa	-	-	-	-	-	-	
El Dorado	1	-	-	-	-	-	-
Fresno	-	-	-	-	-	-	-
Imperial	1	-	-	-	-	-	-
Kern	16	-	-	-	-	-	
Los Angeles	8	19	12	12	-	-	-
Marin	2	-	-	-	-	-	-
Merced	-	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	**	-	-	-	-	-	-
Orange	4	1	1	-	-	-	
Placer	6	-	-	-	-	-	-
Riverside	9	-	-	-	-	-	-
Sacramento	-	-	-	-	-	-	-
San Benito	**	-	-	-	-	-	
San Bernardino	-	-	-	-	-	-	
San Diego	17	-	-	-	-	-	
San Francisco	-	-	-	-	-	-	-
San Joaquin	1	-	-	-	-	-	-
San Luis Obispo	-	-	-	1	-	-	
San Mateo	5	-	-	-	-	-	-
Santa Barbara	4	1	-	-	-	-	
Santa Clara	-	-	-	-	-	-	-

	Resolution				Transition of Care		
Santa Cruz	12	21	9	12	-	-	-
Stanislaus	3	1	1	-	-	-	-
Tulare	-	-	-	-	-	-	-
Ventura	-	-	-	-	-	-	
Yolo	2	-	-	-	-	-	-
Regional Model*	5						

**Regional Model includes Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties*

***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 figures reflect the number of grievances submitted and resolutions determined during the specific quarterly time period. Resolutions determined during this period may be the result of a grievance or appeal filed in a prior quarterly reporting period. So, the sum of grievances/appeals reported and the sum of the resolutions indicated may not always match.

Quality Assurance/Monitoring Activities:

In response to the COVID-19 pandemic and starting in March 2020, many counties requested postponements for their scheduled monitoring reviews. These postponements delayed completion of the FY 2019-20 review year to September 2020. The altered schedule also delayed the start of the FY 2020-21 review year to October 2020, from the originally scheduled date of July 2020. Subsequently, the first reviews for FY 2020-21 are scheduled with the counties starting in January 2021.

Evaluation:

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), under contract with DHCS, has been evaluating the DMC-ODS demonstration project since 2016 according to a CMS-approved evaluation plan. The evaluation has focused on measures of treatment access, quality, and coordination of care. Each year, as counties have joined DMC-ODS from 2017-2020, UCLA ISAP has collected statewide data through stakeholder surveys, key informant interviews, client treatment perceptions surveys, a unique ASAM screening and assessment database created for DMC-ODS, and secret shopper calls to beneficiary access lines. UCLA ISAP has also conducted analyses of administrative data received from DHCS (Medi-Cal claims, treatment episode data).

Overall, findings to date suggest DMC-ODS has had a positive impact on treatment access, quality, and coordination of care. Still, a number of challenges have also been

identified, and the evaluation team has sought to target these challenges by producing case studies on stakeholders overcoming common challenges, recommending training topics based on stakeholder input, and filling specific needs, e.g. by developing free screening and assessment tools.

Ongoing and future efforts will focus on tracking longer-term progress in the first 30 DMC-ODS counties and evaluating implementation for newer waiver participants including the Partnership regional model (7 counties) and the expansion of DMC-ODS to Indian health care providers. UCLA ISAP also plans to conduct cost analyses, continue making recommendations as new issues emerge, and potentially study the impact of any future changes to DMC-ODS that DHCS and CMS may agree upon.

GLOBAL PAYMENT PROGRAM (GPP)

The 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 Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the PHE. During DY16-Q2, the Secretary of Health and Human Services extended the COVID-19 PHE effective October 23, 2020. National public health emergencies are effective for 90 days unless extended or terminated. Due to this change, PY 5 Interim Quarter (IQ) 4 and PY 6A IQ1 payment calculations were included at the increased FMAP percentages. The implementation of the FFCRA PHCSs creates a lower Intergovernmental Transfer (IGT) requirement to claim federal funding. This lower IGT requirement is applied retroactively to PY5 IQ2 and IQ3, and is reflected in PY 5 IQ4.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 22: DY16-Q1 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 5 (July – March) Overpayment collection	($4,683,875.50)	($4,683,875.50)	DY 15	($9,367,751.00)
PY 5, IQ4 (April – June)	$203,395,684.86	$158,518,345.14	DY 15	$361,914,030.00
PY 6A IQ1 (July – September)	$250,438,727.00	$195,181,783.00	DY 16	$445,620,510.00
Total	**$44,523,838.50**	**$44,523,838.50**		**$89,047,677.00**

DY16-Q2 reporting includes GPP payments made in October 2020. The payments made during this time period were for PY 5, Interim Quarter (IQ) 4 (April 1, 2020 – June 30, 2020), and PY 6A, IQ1 (July 1, 2020 – September 30, 2020).

In PY 5, IQ4, the PHCSs received $203,395,684.86 in federal funded payments and $158,518,345.14 in IGT funded payments for GPP.

In PY 6, IQ1, the PHCSs received $250,438,727in federal funded payments and $195,181,783in IGT funded payments for GPP.

DHCS recouped $9,367,751 in total computable funds for PY 5. The recoupment was due to an overpayment to Ventura County Medical Center (VCMC). In PY 5, IQ1 – 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 was 6,767,489 GPP points, or 71.82% of GPP thresholds. The 71.82% is less than 75% of its total annual budget. DHCS adjusted the payments previously made to VCMC for GPP PY 5 and recouped the difference in the amount of $9,367,751 in total funds from VCMC.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

Between June 2011 and May 2012, DHCS transitioned its SPD population from the Medi-Cal fee-for-service (FFS) delivery system into the Medi-Cal managed care delivery system. The transition occurred in Two-Plan and Geographic Managed Care (GMC) plan model counties, 16 counties in total, located across California. Ongoing mandatory enrollment of SPDs into all models of managed care continues under DHCS' Medi-Cal 2020 Demonstration.

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 Model (Two-Plan), which operates in 14 counties.
2. County Organized Health System (COHS), which operates in 22 counties.
3. 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.

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 and GMC models of managed care. The "existing SPD population" consists of beneficiaries with certain aid codes who reside in all counties operating under the 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 24: Total Member Months for Mandatory SPDs by County
October – December 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 25: Total Member Months for Existing SPDs by County
October – December 2020

County	Total Member Months
Alameda	76,113
Contra Costa	36,182
Fresno	45,795
Kern	34,066
Kings	4,818
Los Angeles	1,037,439
Madera	4,827
Marin	19,678
Mendocino	17,429
Merced	50,594
Monterey	49,513
Napa	15,465
Orange	346,477
Riverside	119,248
Sacramento	75,439
San Bernardino	115,520
San Diego	197,636
San Francisco	50,922
San Joaquin	31,971
San Luis Obispo	25,558
San Mateo	41,921
Santa Barbara	48,319
Santa Clara	122,606
Santa Cruz	32,448
Solano	62,167
Sonoma	52,122
Stanislaus	19,618
Tulare	21,760
Ventura	90,886
Yolo	26,647
Total	**2,873,184**

Table 26: Total Member Months for SPDs in Rural Non-COHS Counties
October – December 2020

County	Total Member Months
Alpine	39
Amador	1,087
Butte	16,247
Calaveras	1,621
Colusa	816
El Dorado	5,118
Glenn	1,602
Imperial	10,826
Inyo	464
Mariposa	675
Mono	157
Nevada	3,067
Placer	10,449
Plumas	973
San Benito	365
Sierra	99
Sutter	6,073
Tehama	5,152
Tuolumne	2,494
Yuba	6,384
Total	**73,708**

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

County	Total Member Months
Del Norte	8,172
Humboldt	26,432
Lake	19,776
Lassen	4,369
Modoc	2,271
Shasta	40,173
Siskiyou	11,380
Trinity	2,820
Total	**115,393**

WHOLE PERSON CARE (WPC)

The 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.

CMS has conditionally approved a temporary extension of DHCS' Medi-Cal 2020 Demonstration, which is set to expire on December 31, 2021, contingent upon DHCS'

continued compliance with the STCs. This extension authorizes the WPC Pilot Program to operate for an additional year, known as PY 6, from January 1, 2021, to December 31, 2021.

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) of Demonstration Year (DY) 16. 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, DY16-Q1 (July - September 2020). Due to a delay in the availability of data, DY16-Q2 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 January 8, 2021.

Table 28: New Beneficiary Enrollment Counts

LE	DY16-Q1 (July - Sept. 2020)	Jan. 2017 – Sept. 2020 Cumulative Total to Date
Alameda	2,114	21,817
Contra Costa	2,508	49,758
Kern	112	1,972
Kings*	44	736
LA	2,883	61,555
Marin*	39	1,822
Mendocino*	23	414
Monterey	58	659
Napa	18	586
Orange	316	12,234
Placer	5	469
Riverside	565	7,505
Sacramento*	128	2,151
San Bernardino	92	1,328
San Diego	39	879
San Francisco	1,016	20,248
San Joaquin	190	2,196
San Mateo	109	3,784
Santa Clara	341	6,317
Santa Cruz*	10	566

LE	DY16-Q1 (July - Sept. 2020)	Jan. 2017 – Sept. 2020 Cumulative Total to Date
SCWPCC*	5	143
Shasta	39	468
Solano	14	254
Sonoma*	293	2,814
Ventura	22	1,301
Total	**10,983**	**201,976**

**Indicates one of seven LEs that implemented on July 1, 2017.*
*** Due to a delay in the availability of data, DY16-Q2 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, DY16-Q1 (July – September 2020). Due to a delay in the availability of data, DY16-Q2 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 January 8, 2021.

Table 29: Member Month Counts

LE	DY16-Q1 (July - Sept. 2020) **	Jan. 2017 – Sept. 2020 Cumulative Total-to-Date
Alameda	54,542	296,851
Contra Costa	38,072	555,359
Kern	5,596	30,664
Kings*	662	4,902
LA	55,668	544,073
Marin*	5,115	31,282
Mendocino*	387	5,086
Monterey	720	5,419
Napa	756	7,145
Orange	7,201	133,480
Placer	372	4,979
Riverside	19,594	113,764
Sacramento*	2,898	23,635
San Bernardino	1,600	17,965

LE	DY16-Q1 (July - Sept. 2020) **	Jan. 2017 – Sept. 2020 Cumulative Total-to-Date
San Diego	1,343	9,006
San Francisco	31,732	359,425
San Joaquin	4,562	28,039
San Mateo	6,404	94,918
Santa Clara	9,479	110,250
Santa Cruz*	1,380	13,350
SCWPCC*	132	1,474
Shasta	240	2,855
Solano	161	3,073
Sonoma*	4,468	21,997
Ventura	1,587	23,388
Total	**254,671**	**2,442,379**

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

***Due to a delay in the availability of data, DY 16-Q2 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 virtual conference meetings, phone calls, and emails to better 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 public health emergency (PHE).

DHCS held monthly virtual conference meetings with LEs focusing on on administrative topics and TA and allowing the LEs to ask questions about DHCS' guidance and issues with reporting templates, deliverable deadlines, and expectations. The monthly conference meetings were held on October 7th, November 10th, and December 2nd. The following topics were discussed on the calls:

- DHCS' request for a one year extension of the 1115 Demonstration Waiver
- Potential PY 6 allocations, adjustments, and close out process
- PY 5 midyear report status
- COVID-19 budget adjustment approval status
- PY 5 pay for outcomes metric flexibilities
- Virtual WPC appreciation event hosted by the LC
- PY 6 budget request template

The LC advisory board did not meet this quarter due to the holidays and the lack of agenda items. The advisory board will reconvene in 2021 and begin to focus on needs arising from the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

The LC hosted the WPC appreciation event on December 8th. The event acknowledged the hard work of the WPC pilots, especially throughout 2020 in response to the PHE and amidst the uncertainty of the 1115 Demonstration Waiver extension request. Pilots recognized their staff and presented "Unsung Hero" awards. LEs from Riverside, Santa Cruz, San Diego, and San Francisco presented successes of their respective programs. There were a total of 148 attendees.

The LC has drafted a summary of 21 WPC promising practices that crosswalk the enhanced care management benefit and in lieu of services proposed under CalAIM. The paper was approved by DHCS and shared with the WPC pilots this quarter.

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 approved seven COVID-19 budget alternatives in the previous quarter, and ten were approved this quarter. There are a total of 17 LEs that have modified their budgets to address the impacts of the COVID-19 PHE.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

As shown below in Table 31, during this quarter, DHCS released WPC payments for all25 LEs. The payment this quarter represents expenditures for PY 5 Midyear from January 1, 2020 to June 30, 2020. Payments totaling $316,355,019.41 were made through the Intergovernmental Transfer (IGT) process. These payments consisted of 50% Federal Financial Participation (FFP), a 6.2% Enhanced Federal Medical Assistance Percentage (which is included with FFP amounts presented in the table below), and a 43.8% local non-federal share. The total payment amount in DY 16 is $509,502,823.43.

Table 30: WPC Payments in DY 16

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 16 (PY 4*)	$193,147,804.02
Qtr 2 (Oct 1 – Dec 31)	$274,365,422.90	$138,563,498.50	DY 16 (PY 5)	$316,355,019.41
Total	**$274,365,422.90**	**$235,137,400.51**		**$509,502,823.43**

**Due to the COVID-19 PHE, DHCS extended the due date for PY 4 annual invoice submittals to May 1, 2020. The additional month LEs had to submit their invoices delayed the review period and payment processing. Seven LEs were paid prior to June 2020 and reported in the DY 15 Annual Progress Report. The remaining eighteen LEs were paid in June and July of 2020 and reported in the DY16-Q1 Progress Report.*

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- Third quarter July 2020 – September 2020 PY 5 QEU (Due 10/30/2020)
- PY 6 Budget Request (Due 12/18/2020)

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. DHCS also uses these reports to monitor and evaluate the WPC pilot programs and to verify invoices for payment purposes.

Prior to receiving approval from CMS regarding the 1115 Waiver Demonstration extension, DHCS had requested that LEs prepare potential PY 6 budgets. LEs were instructed to submit their proposed PY 6 budget on December 18th, to allow adequate time for DHCS review. The PY 6 budget includes the initial allocation amount and estimated rollover funds from potential unspent monies from PY 5. The initial allocation amount was determined by DHCS based on the percentage of total program

expenditures of each Pilot entity from PY 2 to PY 5 midyear.

Evaluation

The WPC evaluation report, required pursuant to STC127 of the Medi-Cal 2020 Demonstration Waiver, will assess whether: 1) the LEs successfully implemented their planned strategies and improved care delivery; 2) the strategies resulted in better care and better health; and 3) better care and health resulted in lower costs through reductions in utilization.

The midpoint report submitted to CMS in December 2019 included an assessment of population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, although only preliminary outcome data was available. The final report, due to CMS in 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.

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

During the second quarter of DY 16, 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.
- Continued to develop 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.
- Continued to refine 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.
- Continued 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.
- Continued to refine 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.
- Continued to refine 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.
- Received a supplemental grant from the Robert Wood Johnson Foundation to expand upon the WPC evaluation and better understand how organizations from different sectors have worked together to improve population health outcomes and health equity in the context of COVID-19.
- Reviewed and redacted PY 5 midyear narrative reports and began preliminary thematic coding. Key themes related to changes in implementation and outcomes as a result of the COVID-19 pandemic were identified.
- Compiled data from PY 5 midyear QEU reports.
- Reviewed and summarized COVID-19 budget alternative narratives
- Compiled annual invoice data for presentation in the final report.
- Submitted and received approval for the State Institutional Review Board continuing review amendment.