State of California—Health and Human Services Agency
Department of Health Care Services

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November 16, 2021

Ms. Cheryl Young
Medicaid and CHIP Operations Group, DPO-West
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
90 Seventh Street, Suite 5-300
San Francisco, CA 94103

QUARTERLY PROGRESS REPORT FOR THE REPORTING PERIOD OF JULY 1, 2021, THROUGH SEPTEMBER 30, 2021 OF CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION

Dear Ms. Young:

Enclosed is the Quarterly Progress Report as required by Section 28 of the Special Terms and Conditions of California's Section 1115 Waiver, titled *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the first quarterly progress report for Demonstration Year (DY) Seventeen, which covers the reporting period from July 1, 2021, through September 30, 2021.

If you or your staff have any questions or need additional information regarding this report, please contact Aaron Toyama, Senior Advisor for Health Care Programs, by phone at (916) 345-8715, or by email at Aaron.Toyama@dhcs.ca.gov.

Sincerely,

[redacted]

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

Enclosures: Medi-Cal 2020 DY 17-Q1 Progress Report
Medi-Cal 2020 DY 17-Q1 DMC-ODS Expenditures

cc: See Next Page

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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Seventeen (07/01/2021 – 12/31/2021)
First Quarter Reporting Period: 07/01/2021 – 09/30/2021

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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 DY17-Q1, DHCS hosted a SAC meeting on July 29, 2021. DHCS provided updates on: FY 2022 State Budget and Implications for DHCS; CalAIM Section 1115 Demonstration

and 1915(b) Waivers; progress on the CalAIM Program; Children and Youth Behavioral Health Initiative; Health Equity Roadmap; Medi-Cal Enrollment and Novel Coronavirus (COVID-19) Vaccination Disparities; Home and Community-Based Services (HCBS) Spending Plan; and Medi-Cal Managed Care Plans (MCP) Procurement.

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/072921-SAC-Agenda.pdf

The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/SAC-042921-meetingsummary.pdf

STCs Item 26: Monthly Calls

This quarter, waiver monitoring conference calls were canceled due to lack of agenda items from both CMS and DHCS. However, 1115 waiver items were discussed, as needed, in separately held meetings between CMS and DHCS with key subject matter experts in attendance.

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	376	$2427.02	$912,559.52
20-Nov	371	$2427.02	$900,424.42
20-Dec	373	$2427.02	$905,278.46
21-Jan	372	$2427.02	$902,851.44
21-Feb	374	$2427.02	$907,705.48
21-Mar	384	$2427.02	$931,975.68
21- Apr	381	$3377.87	$1,286,968.47
21-May	382	$3377.87	$1,290,346.34
21-Jun	384	$3377.87	$1,297,102.08
21-Jul	385	$3377.87	$1,300,479.95
21-Aug	385	$3377.87	$1,300,479.95
21-Sep	384	$3377.87	$1,297,102.08
Total			**$30,468,308.72**

Table 2: RCHSD Monthly Enrollment and Quarterly Member Months

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Member Months
CCS	385	385	384	1	1,154

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 received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design. As of June 2020, DHCS is working with CMS to finalize the CCS protocols.

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 had one of the following five CCS eligible medical diagnoses: cystic fibrosis, sickle cell, diabetes types I and II, acute lymphoblastic leukemia, or hemophilia.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. In October 2021, RCHSD submitted their CCS Quarterly Grievance Report for reporting period July – September 2021. During the reporting period, RCHSD reported no grievances.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

DHCS contracted with the Regents of the University of California, San Francisco (UCSF) to conduct an evaluation of the CCS pilot which will be completed in two phases. Phase one includes HPSM, and phase two includes RCHSD.

To date, UCSF has 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, of CCS pilot members. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to CMS on August 31, 2020 as required. DHCS is in the process of reviewing UCSF's Interim Report and the finalized version be posted on the website for public viewing by December 2021. DHCS extended UCSF's contract to provide an additional year of assessment based on the one-year extension by CMS. Subsequently, the contract will now expire on December 31, 2022, and the Final Evaluation Report will be due to CMS on December 31, 2022.

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 is 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 a 12-month extension, through December 31, 2021, on December 29, 2020.

On June 30, 2021, after an extensive stakeholder process and public comment period, DHCS submitted the CalAIM Section 1115 Demonstration waiver application to CMS requesting a five-year renewal and amendment, with an effective date of January 1, 2022 through December 31, 2027. The federal public comment period was July 16, 2021, to August 15, 2021.

Program Requirements

CBAS is an outpatient, facility-based program, licensed by the California Department of Public Health (CDPH) and certified by CDA to participate in the Medi-Cal 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/certification and Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020 waiver; and 4) maintain compliance with the requirements listed above.

Initial eligibility for the CBAS benefit is traditionally determined by a Medi-Cal Managed Care Plan through a face-to-face assessment which is conducted by a registered nurse with level-of-care experience and by 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 MCP possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through a reauthorization process or up to every 12 months for individuals determined by the MCP to be clinically appropriate. Reauthorization is the process by which CBAS providers reassess members to ensure their needs are being met with the services they are receiving. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment. Note: Due to the COVID-19 public health emergency (PHE), a face-to-face assessment is not required at this time. On October 9, 2020, CMS granted approval of DHCS' disaster 1115 amendment, which allows flexibilities pertaining to the delivery of CBAS Temporary Alternative Services (TAS) and permits CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (if proper safety precautions are implemented). These flexibilities are described in greater detail below.

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 benefit which were required to be covered by MCPs. 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" if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services refer to component parts of CBAS delivered outside of centers with a similar objective of supporting participants, allowing them to remain in the community. 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

[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.

Instrumental Activities of Daily Living.). If the participant is residing in a Coordinated Care Initiative county and is enrolled in managed care, the MCP will be responsible for facilitating the appropriate services on the members' behalf.

Beginning in March 2020, in response to the COVID-19 PHE, DHCS and CDA worked with stakeholders including the California Association for Adult Day Services (CAADS), CBAS providers, and the MCPs to develop and implement CBAS Temporary Alternative Services (TAS). CBAS TAS is a short-term, modified service delivery approach that grants CBAS providers time-limited flexibility 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 MCP and participants per county for DY17-Q1 represents the period of July to September 2021. 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 DY17-Q1 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties 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 CBA

See next page.

County	DY16-Q1 July - Sept 2020		DY16-Q2 Oct - Dec 2020		DY16-Q3 Jan - Mar 2021		DY16-Q4 Apr – Jun 2021	
	Unduplicated Participants (MCP & FFS)	Capacity Used ***	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	444	71%	443	71%	445	71%	451	72%
Butte	27	27%	32	31%	31	31%	31	31%
Contra Costa	175	47%	171	46%	165	44%	155	42%
Fresno	609	34%	719	38%	812	42%	903	47%
Humboldt	87	15%	86	15%	93	16%	84	14%
Imperial	323	54%	303	50%	288	48%	284	47%
Kern	72	11%	34	5%	212	21%	162	16%
Los Angeles	21,498	56%	22,335	57%	24,337	61%	24,169	59%
Merced	96	46%	105	50%	119	57%	120	57%
Monterey	111	60%	107	57%	132	71%	101	54%
Orange	2,399	58%	2,415	58%	2,469	54%	2,503	55%
Riverside	490	31%	502	32%	520	33%	534	34%
Sacramento	371	32%	409	36%	483	42%	512	44%
San Bernardino	624	62%	656	66%	667	67%	668	67%
San Diego	2,316	60%	2,466	61%	2,587	64%	2,619	81%
San Francisco	670	43%	741	47%	826	53%	901	57%
San Joaquin	40	17%	49	21%	48	20%	56	24%
San Mateo	74	32%	71	31%	73	32%	63	62%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	523	40%	551	42%	618	47%	628	48%
Santa Cruz	88	58%	88	58%	0	0%	79	52%
Shasta	*	*	*	*	*	*	*	*
Ventura	935	65%	931	65%	926	64%	924	62%
Yolo	267	70%	265	70%	255	67%	245	65%
Marin, Napa, Solano	70	14%	62	12%	63	13%	70	14%
Total	**32,339**	**53%**	**33,571**	**54%**	**36,315**	**57%**	**36,319**	**57%**
FFS and MCP Enrollment Data 06/2021								

***Note: Information is not available for DY17-Q1 due to a delay in the availability of data and will be presented in the next quarterly report.*

**** Capacity Used measures the amount of total individuals receiving CBAS Services at a given CBAS Center versus the maximum capacity available.*

The data provided in Table 3 shows that enrollment has steadily increased throughout DY 16 with the ongoing PHE. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Several counties reported their CBAS centers experienced increased utilization from Q2 to Q3, including Merced, Monterey, Sacramento, and Santa Clara. Similarly, Fresno and San Diego experienced greater than five percentage points increase from Q3 to Q4. San Mateo County showed a significant increase in utilization due to licensing capacity decreasing as a result of a center closing down. In Kern and Monterey Counties during Q4, there was a greater than five percentage point decrease of license utilization compared to the previous quarter. There were no new centers opening or closing during Q3 in either county, the significant fluctuation is likely a result of a decline in participation.

It is important to note that a majority of counties maintained consistent enrollments that did not see fluctuations greater than five percent. These counties include Alameda, Butte, Contra Costa, Los Angeles, Merced, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Joaquin. Since the onset of the COVID-19 pandemic, fluctuations in unduplicated participants and capacity used have varied more drastically compared to previous demonstration years. Unduplicated participants experienced a sharp decline in DY15 Q4 as this was the implementation point of the initial stay-at-home order. Conversely, implementation of the CBAS TAS model in DY16 Q1 facilitated remote services and resulted in a significant increase in unduplicated participants which continued through DY16 quarters two and three. Unduplicated participants have stabilized in DY16 Q4 which makes sense as in this period the state initiated policy guidance to CBAS Centers beginning the planning process for a phased return to in-center services to align with the end of the COVID-19 PHE and 1115 Attachment K flexibility period.

<u>CBAS Assessments for MCPs and FFS Participants</u>

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

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

Table 4: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY16-Q2 (10/01-12/31/2020)	3,022	2,957 (97.8%)	65 (2.2%)	0	0 (0%)	0 (0%)
DY16-Q3 (01/01-03/31/2021)	2,844	2,793 (98.2%)	51 (1.8%)	0	0 (0%)	0 (0%)
DY16-Q4 (04/01-06/30/2021)	2,645	2,581 (97.6%)	64 (2.4%)	0	0 (0%)	0 (0%)
DY17-Q1 (07/01-09/30/2021)	*	*	*	1	1 (100%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

*Note: *MCP assessment information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. For DHCS, DY17-Q1 it was reported that one participant was 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. Due to a delay in MCP reporting of assessment data for DY17-Q1, assessment analysis will be reported in the next quarterly report.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 5, titled *CDA – CBAS Provider Self-Reported Data,* identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY16-Q4. As of DY16-Q4, 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 269 operating CBAS Centers is approximately 32,756

participants, which corresponds to 86 percent of total capacity. Provider-reported data identified in the table below, reflects data from April to June 2021.

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	269
Non-Profit Centers	49
For-Profit Centers	220
ADA at 265 Centers	31,172
Total Licensed Capacity	37,858
Statewide ADA per Center	82.3%

CDA - MSSR Data – 06/2021

*Note: *CDA CBAS Provider Self-Reported information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Outreach/Innovative Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans (MCP), the California Association for Adult Day Services (CAADS), the Alliance for Education and Leadership (ALE), and other interested stakeholders via the *CBAS Updates* newsletter, CBAS All Center Letters (ACL), CBAS webinars, CAADS conferences, CAADS and ALE webinar presentations, and ongoing MCP and CBAS Quality Advisory Committee calls, and responds to ongoing written and telephone inquiries.

During DY17-Q1, CDA distributed two newsletters, issued three All Center Letters (ACLs), provided three CBAS Updates webinar trainings, and participated in three ALE webinars. These outreach activities focused on various topics including but not limited to the following: (1) CBAS program operations and public health guidance during the COVID-19 pandemic and PHE, (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) CBAS planning activities and policy guidance to support CBAS providers and participants for a safe transition to CBAS in-center congregate services according to public health guidance, (4) CBAS Plan of Correction (POC) guidance to ensure CBAS center compliance with CBAS program requirements, (5) Education and training opportunities to promote quality of care and to comply with CBAS program requirements, and (6) Notification of the public comment period for California's Statewide Transition Plan (STP) and the Draft CBAS Transition

Plan, and (7) status reports on the CalAIM Section 1115 Demonstration waiver application submitted to CMS on June 30, 2021.

CDA continues to collaborate weekly with CAADS, ALE, and CBAS providers in the development of policy guidance and the planning of webinars for CBAS providers to which MCPs and other interested stakeholders are invited. These webinars have focused on CBAS center best practices in the implementation of CBAS TAS requirements including the provision of therapeutic activities, COVID-19 Wellness Checks, public health practices to mitigate the risks of COVID-19 infection, and other issues that affect the health and well-being of CBAS participants, their families and CBAS staff.

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. During this quarter, CDA convened a call with MCPs on August 26, 2021.

CDA also convenes triannual calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS and ALE to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. During this quarter, CDA convened a call with the CBAS Quality Advisory Committee on September 23, 2021. Additional details about this meeting are provided in the Quality Assurance/Monitoring Activity section of this report.

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

CDA, in collaboration with DHCS, continues to implement the activities and commitments to CMS for compliance of CBAS centers with the federal Home and Community-Based (HCB) settings requirements by March 17, 2023, and thereafter 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 continues to work with partner agencies including CDA, the Department of Developmental Services (DDS), and the California Department of Social Services (DSS) and stakeholders to finalize the STP, which includes the CBAS Transition Plan, for submission to CMS for final approval. On May 20, 2021, DHCS submitted the STP for tribal review and comment. DHCS posted the STP for public comment on June 19, 2021, through July 19, 2021, with the intention of submitting the STP to CMS for final approval

thereafter. DHCS will be postponing the final submission of the STP to CMS to enable DDS, DSS, and CDA to include clarifying information on remediation processes and to complete all required assessment and validation activities. There will be a second public comment period once all of these activities are completed. California is tentatively planning to submit the final STP to CMS in January 2022. The State continues to implement the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA continues to evaluate each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Due to the COVID-19 pandemic and implementation of CBAS 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 (PHE)

Due to the COVID-19 pandemic, the federal Health and Human Services Secretary issued a PHE 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 services to be provided at a beneficiary's home.
- Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
- Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
- Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
- Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.

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

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

- Add TAS 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;

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

- Modify the person-centered plan development process to allow assessments to be conducted telephonically using self-reported information by participants and/or caregivers.

On June 9, 2021, CMS approved California's request to extend the duration of the previously approved Emergency Preparedness and Response Attachment K, which is an attachment to California's section 1115(a) demonstration titled, "Medi-Cal 2020" (Project No. 11-W-00193/9), to respond to the COVID-19. The Attachment K flexibilities are effective, and available to be applied by the state, from March 13, 2021 through six months after the PHE ends. These flexibilities apply in all locations served by the demonstration for anyone who receives home and community-based services through the demonstration.

In April 2021, vaccination levels in the state were increasing, COVID-19 infections were decreasing, and there was optimism about the state of the PHE. As such, on April 8, 2021, CDA released policy guidance outlining a phased transition to CBAS in-center services requiring CBAS centers, by October 31, 2021, to transition all participants to in-center services at least one day per week. However, CDA, in collaboration with state partners, since determine it was appropriate to postpone the return to in-center services. Vaccination levels failed to reach anticipated numbers and COVID-19 infections and hospitalizations increased statewide due to the spread of the Delta variant. Additionally, on July 26 and August 5, 2021, the California Department of Public Health (CDPH) issued new public health orders on July 26 and August 5, 2021 mandating vaccine verification for workers in specified health care facilities (including Adult Day Health Care/CBAS facilities), testing of workers not fully vaccinated, and requiring the vaccination of all health care workers (with allowed vaccination exemptions) by September 30, 2021.

CDA continues to require CBAS providers to staff their centers with the full CBAS multidisciplinary team, conduct participant evaluations and assessments to determine a participant's willingness and ability to return to in-center congregate services, and to develop Individual Plans of Care (IPCs) every six months (or more frequently if the participant's needs/conditions change) that are person-centered, address participants' needs via remote and/or in-center services, and support the transition to in-center services based on conditions in their individual communities and their centers while adhering to public health guidance and risk mitigation requirements.

CDA, in collaboration with DHCS, MCPs, and stakeholders, continues to plan for the transition back to in-center congregate services in preparation for the end of the PHE. In the meantime, CDA continues to monitor the provision of CBAS TAS and the appropriate delivery of services to CBAS participants.

CDA will continue to provide guidance and training to ensure that providers have the flexibility, time, and support needed to address participants' needs until the resumption of in-center congregate services and program requirements. CDA will make further changes to transition guidance as data indicates and in response to CMS guidance. CDA's goal, as

always, is to ensure the safe and orderly transition of participants to in-center congregate services.

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, as illustrated in Table 6, titled *Data on CBAS Complaints*. MCP & CDA complaint information for DY17-Q1 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
DY16-Q1 (Jul 1 - Sep 30, 2020)	0	0	0
DY16-Q2 (Oct 1 – Dec 31, 2020)	0	0	0

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q3 (Jan 1 - Mar 31, 2021)	0	0	0
DY16-Q4 (Apr 1 - Jun 30, 2021)	0	0	0

CDA Data – Complaints 06/2021

Note: CDA information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

Due to delays in MCP and CDA data collection and reporting, information for DY17-Q1 will be presented in the next quarterly report. DHCS has processes to work with MCPs to uncover and resolve sources of complaints identified when reported.

Table 7: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q1 (Jul 1 - Sep 30, 2020)	0	0	0
DY16-Q2 (Oct 1 - Dec 31, 2020)	0	0	0
DY16-Q3 (Jan 1 - Mar 31, 2021)	11	1	12
DY16-Q4 (April 1 - Jun 30, 2021)	9	1	10

Plan Data – Phone Center Complaints 06/2021

*Note: *MCP assessment information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

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 10 grievances were filed with MCPs during DY16-Q4. MCP grievance information for DY17-Q1 will be presented in the next quarterly report due to a delay in the availability of data. There were 6 grievances related to CBAS providers, and two categorized as "Other CBAS Grievances." CDA grievance information for DY17-Q1 will be presented in the next quarterly report due to a delay in the availability of data. DHCS continues to work with MCPs 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
DY16-Q1 (Jul 1 - Sep 30)	4	1	0	5	10
DY16-Q2 (Oct 1 - Dec 31)	1	0	0	2	3
DY16-Q3 (Jan 1 - Mar 31)	2	1	0	2	5
DY16-Q4 (Apr 1 - Jun 30)	6	0	0	4	10
MCP data - Grievances 06/2021					
Note: CDA assessment information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.					

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
DY16 – Q1 (Jul 1 – Sep 30)	2	0	0	0	2
DY16 – Q2 (Oct 1 – Dec 31)	3	0	0	1	4
DY16 – Q3 (Jan 1 – Mar 31)	1	0	0	0	1
DY16 – Q4 (Apr 1 – Jun 30)	3	1	0	1	5
		MCP data - Grievances 06/2021			

Note: MCP appeals information is not available for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

During DY16-Q4, Table 9 titled *Data on CBAS Managed Care Plan Appeals*, shows there were three CBAS appeals filed with the MCPs as they pertain to a denial or limited services, one was categorized as “denial to see requested provider” and one was categorized as “other CBAS appeals DY16-Q4. Due to a delay in MCP reporting of appeals data for DY17-Q1, analysis will be reported in the next quarterly report.

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 DY17-Q1, there were two request for hearings related to CBAS services which are pending.

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, and the CalAIM Section 1115 Demonstration waiver, if approved by CMS, 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.

During the September 23, 2021, meeting/call, the CBAS Quality Advisory Committee recommended continuation of the CBAS Quality Strategy Plan beyond October 2021, to (1) continue work on previously identified long-term objectives that have not yet been completed, (2) identify completed objectives which require ongoing evaluation and monitoring, and (3) identify new objectives that will promote and support the quality of CBAS services such as collecting more participant characteristic data to post on the CDA website, collecting more center characteristic information to help individuals/families and managed care plans find centers to meet beneficiaries' needs, identifying obsolete licensing and Medi-Cal regulations that have been replaced with new laws, training providers on end of life care best practices that support participants and families, and looking at quality objectives through the lens of equity, access and inclusion, and streamline the new center application process that can increase access to CBAS services.

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 DY16-Q1. Overall utilization of licensed capacity by CBAS participants for DY17-Q1 will be presented in the next quarterly report due to a delay in the availability of data.

Table 10: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity					
	DY16-Q1 Jul-Sep 2020	DY16-Q2 Oct-Dec 2020	DY16-Q3 Jan-Mar 2021	DY16-Q4 Apr-Jun 2021	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	**370**	0.0%	72%
Butte	60	60	60	**60**	0.0%	31%
Contra Costa	220	220	220	**220**	0.0%	42%

County	DY16-Q1 Jul-Sep 2020	DY16-Q2 Oct-Dec 2020	DY16-Q3 Jan-Mar 2021	DY16-Q4 Apr-Jun 2021	Percent Change Between Last Two Quarters	Capacity Used ***
Fresno	1062	1132	1132	**1,132**	0.0%	47%
Humboldt	349	349	349	**349**	0.0%	14%
Imperial	355	355	355	**355**	0.0%	47%
Kern	400	400	610	**610**	0.0%	16%
Los Angeles	22,770	23,140	23,636	**24,211**	+2.4%	59%
Merced	124	124	124	**124**	0.0%	57%
Monterey	110	110	110	**110**	0.0%	54%
Orange	2,438	2,438	2,678	**2,678**	0.0%	55%
Riverside	935	935	935	**935**	0.0%	34%
Sacramento	680	680	680	**680**	0.0%	44%
San Bernardino	590	590	590	**590**	0.0%	67%
San Diego	2,278	2,383	2,383	**1,903**	-20.0%	81%
San Francisco	926	926	926	**926**	0.0%	57%
San Joaquin	140	140	140	**140**	0.0%	24%
San Mateo	135	135	135	**60**	-55.5%	62%
Santa Barbara	100	100	100	**100**	0.0%	*
Santa Clara	780	780	780	**780**	0.0%	48%
Santa Cruz	90	90	90	**90**	0.0%	52%
Shasta	85	85	85	**85**	0.0%	*
Ventura	851	851	851	**886**	+4.1%	62%
Yolo	224	224	224	**224**	0.0%	20%
Marin, Napa, Solano	295	295	295	**295**	0.0%	14%
SUM	35,361	36,367	37,858	**37,913**	+.15%	56%

***Capacity used information is not available for DY17-Q1 due to the delay in the availability of the data. Capacity used information for DY16-Q4, the latest quarter for which data is available, can be found in Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS.*

**** Capacity Used measures the amount of total individuals receiving CBAS Services at a given CBAS Center versus the maximum capacity available.*

Table 10 reflects that the average licensed capacity used by CBAS participants is 56% statewide. Statewide, most counties' CBAS Centers have not operated at full or near-to-full capacity with the exception of CBAS Centers in Alameda and San

Diego counties. Alameda is at 72% capacity and San Diego is at 81% capacity. Table 10 demonstrates the general capacity CBAS Centers to enroll more managed care and FFS members.

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percentage point change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. San Diego County experienced a decrease of more than 5 percentage point in licensed capacity, due to two closures of CBAS Centers. San Mateo County experienced a decrease of more than 5 percent in licensed capacity, due to a closure of a CBAS Center.

No other significant increases or decreases were noted over the last quarter. Over DY16, total licensed capacity has slightly and steadily increased statewide.

Due to a delay in reporting of data for DY17-Q1, analysis will be reported in the next quarterly report.

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 DY17-Q1 is not reflective in those tables due to a lack of availability, but will be reflected in the next quarterly report.

Unbundled Services (STC 48.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, MCPs 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-Q4, CDA had 269 CBAS Center providers operating in California. According to Table 11, titled *CBAS Center*

History, three CBAS Centers closed and three new centers were opened in DY16-Q4. DY17-Q1 will be presented in the next quarterly report due to a delay in the availability of the data.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
June 2021	269	0	0	0	269
May 2021	269	1	1	0	269
April 2021	269	2	2	0	269
March 2021	268	0	1	1	269
February 2021	266	0	2	2	268
January 2021	265	1	2	1	266
December 2020	265	0	0	0	266
November 2020	263	0	2	2	265
October 2020	262	0	1	1	263
September 2020	258	0	4	4	262
August 2020	257	0	1	1	258

*Note: *CDA assessment information is not reported for DY17-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Table 11 shows there was no negative change of more than five percent in DY16-Q4, from April to June 2021, 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.

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) which CMS approved on December 29, 2020, DHCS' approved proposal included extension of Domains 1-3 of the DTI program with a new demonstration date for PY 6 ending on December 31, 2021.

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)

DTI PYs	1115 Waiver DYs
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)
5 (January 1 – December 31, 2020)	15 (January 1 - June 30, 2020) and 16 (July 1 – December 31, 2020)
6 (January 1 – December 31, 2021)*	16 (January 1 – June 30, 2021) and 17 (July 1 – December 31, 2021)

**Note: PY 6 is only for DTI Domains 1-3.*

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: Contra Costa, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lassen, Los Angeles, Madera, Mendocino, Merced, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Sierra, Sonoma, Stanislaus, Tulare, Ventura, and Yuba.

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

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

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]
Since Domain 4 was not included in the one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver, operations for these efforts concluded December 31, 2020. The LDPPs have submitted all their final reports and invoices relative to PY5. Final payments are in process. 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. 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.

Enrollment Information:

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

Measure Period	8/2020-7/2021	9/2020-8/2021	10/2020-9/2021
Denominator[8]	5,342,551	5,355,833	5,327,848

[6] DTI Domain 4
[7] Data Source: DHCS Data Warehouse Management Information System/Decision Support System (MIS/DSS) Dental Dashboard September 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.

Numerator[9]	2,267,028	2,233,520	N/A[10]
Preventive Dental Service Utilization	42.43%	41.70%	N/A[8]

Table 13: Statewide Enrolled Dental Offices, Rendering Providers, and SNCs[11]

Delivery System and Plan[12]	Provider Type	July 2021	August 2021	September 2021
FFS	Service Offices	5,966	5,967	5,936
FFS	Rendering	12,071	12,149	12,186
GMC	Service Offices	161	157	N/A[13]
GMC	Rendering	356	358	N/A[14]
PHP	Service Offices	910	911	N/A[11]
PHP	Rendering	1,455	1,469	N/A[12]
Both FFS and DMC	Safety Net Clinics	558	559	N/A[13]

Outreach/Innovative Activities:

DTI Small Workgroup

This workgroup meets on a quarterly basis, near the end of the calendar quarter. During this quarter, this workgroup had one meeting scheduled on September 16, 2021. Due to lack of agenda items and DTI ending on December 31, 2021, this meeting series was cancelled. An email was sent to stakeholders in lieu of the meeting, which included

[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 enrollment and not claims submission. Source: 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 September 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.
[13] Data unavailable.
[14] Data unavailable.
[11] Data unavailable.
[12] Data unavailable.
[13] The count of SNCs for the third month of each quarter is not available due to claim submission time lag.

updates on incentive payments, provider participation, and DTI program extension for Domains 1-3.

DTI Clinic and Data Subgroups

The clinic and data subgroups meet on an as-needed basis. The subgroups did not meet this quarter as there were no changes to operations, clinic-related policies, or concerns with DTI reports prompting a need for the group to meet.

DTI Webpage

There were no changes to the DTI webpage or the DTI Domain webpages during this quarter.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY17-Q1. In this quarter, there were ninety-seven (97) 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. Domain 3 inquiries increased due to the released payment in early July.

Table 14: Number of DTI Inbox Inquiries by Domain:

Domain	Inquiries
1	31
2	33
3	33
Total	**97**

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 DTI at several venues during this reporting period. Below is a list of venues where DTI information was disseminated:

- August 5, 2021: Medi-Cal Dental Advisory Committee (agenda)
- August 26, 2021: Medi-Cal Dental Statewide Stakeholder Meeting (agenda)

Operational/Policy Developments/Issues:

Domain 1

Domain 1 providers are paid semiannually at the end of January and July. The next payment in January 2022, which will be the final payment for PY 5 and the first payment for PY 6. Table A represents Domain 1 incentive claims paid for FFS, DMC, and SNC providers on August 2, 2021, which totals $2,022,561.

Table 15: Domain 1 Incentive Claims

County	FFS	DMC	SNC
Alameda	$4,823	$0	$223,964
Alpine	$0	$0	$0
Amador	$0	$0	$0
Butte	$228	$0	$0
Calaveras	$0	$0	$0
Colusa	$150	$0	$0
Contra Costa	$16,237	$0	$0
Del Norte	$0	$0	$0
El Dorado	$3,564	$0	$10,505
Fresno	$35,408	$0	$0
Glenn	$36	$0	$0
Humboldt	$57	$0	$13,139
Imperial	$317	$0	$0
Inyo	$0	$0	$0
Kern	$115,313	$0	$0
Kings	$29	$0	$0
Lake	$0	$0	$0
Lassen	$0	$0	$0
Los Angeles	$194,869	$107,075	$71,759
Madera	$4,119	$0	$0
Marin	$0	$0	$0
Mariposa	$0	$0	$0
Mendocino	$101	$0	$7,935
Merced	$10,115	$0	$29
Modoc	$492	$0	$0
Mono	$0	$0	$0
Monterey	$7,543	$0	$0
Napa	$383	$0	$0
Nevada	$213	$0	$3,648
Orange	$102,305	$0	$8,175
Placer	$3,225	$5,735	$0

County	FFS	DMC	SNC
Plumas	$0	$0	$0
Riverside	$58,561	$0	$0
Sacramento	$7,755	$427,109	$0
San Benito	$208	$0	$0
San Bernardino	$74,943	$0	$36
San Diego	$52,232	$0	$73,661
San Francisco	$7,577	$0	$28,259
San Joaquin	$7,374	$0	$0
San Luis Obispo	$1,473	$0	$0
San Mateo	$1,515	$0	$63
Santa Barbara	$33,932	$0	$0
Santa Clara	$18,907	$0	$0
Santa Cruz	$296	$0	$62,826
Shasta	$263	$0	$0
Sierra	$0	$0	$0
Siskiyou	$0	$0	$0
Solano	$2,928	$0	$0
Sonoma	$497	$0	$26,085
Stanislaus	$10,848	$0	$14
Sutter	$6,903	$0	$0
Tehama	$0	$0	$0
Trinity	$0	$0	$0
Tulare	$40,485	$0	$0
Tuolumne	$302	$0	$0
Ventura	$24,165	$1,526	$91,830
Yolo	$612	$7,869	$0
Yuba	$29	$0	$0
Total	**$851,323**	**$549,314**	**$621,925**

Domain 2

FFS providers are paid on a weekly basis while SNC and DMC providers are paid on a monthly basis. Table 16 represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY17-Q1, which totals $7,779,353. Domain 2 benefits including CRA, Silver Diamine Fluoride (SDF) and preventive services) were paid to 3,261 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 16: Domain 2 Incentive Claims

County	FFS	DMC	SNC
Contra Costa	$ 114,828	$0	$0
Fresno	$167,060	$0	$68,288
Glenn	$0	$0	$0
Humboldt	$0	$0	$0
Imperial	$(420)	$0	$0
Inyo	$0	$0	$3,654
Kern	$1,522,285	$0	$(630)
Kings	$(2,033)	$0	$0
Lassen	$0	$0	$0
Los Angeles	$1,269,081	$76,997	$ 298,528
Madera	$24,270	$0	$0
Mendocino	$0	$0	$98,234
Merced	$63,542	$0	$0
Monterey	$86,641	$0	$0
Orange	$92,716	$0	$0
Plumas	$0	$0	$0
Riverside	$1,924,762	$0	$12,860
Sacramento	$(96,441)	$468,142	$0
San Bernardino	$510,505	$0	$4,643
San Diego	$3,851	$0	$137,044
San Joaquin	$83,005	$0	$84,976
Santa Barbara	$100,327	$0	$0
Santa Clara	$22,030	$0	$0
Sierra	$0	$0	$0
Sonoma	$(6,177)	$0	$218,129
Stanislaus	$73,230	$0	$0
Tulare	$184,200	$0	$0
Ventura	$39,549	$252	$131,172
Yuba	$0	$252	$0
Total	**$6,176,812**	**$545,643**	**$1,056,898**

Table 17 represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program, February 2017, until the end of DY17-Q1 reporting period, September 2021. The total incentive claims paid for this period was $202,066,192.

Table 17: Domain 3 Incentive Claims

County	FFS	DMC	SNC
Contra Costa	$2,654,304	$0	$0
Fresno	$9,152,487	$252	$85,816
Glenn	$11,223	$0	$0
Humboldt	$70	$0	$126
Imperial	$138,368	$0	$0
Inyo	$0	$0	$52,290
Kern	$12,211,876	$126	$1,386
Kings	$50,122	$0	$0
Lassen	$0	$0	$0
Los Angeles	$60,935,480	$607,147	$ 2,513,496
Madera	$1,401,610	$0	$0
Mendocino	$0	$0	$879,564
Merced	$1,803,880	$0	$0
Monterey	$6,677,500	$0	$0
Orange	$15,244,049	$252	$714,024
Plumas	$0	$0	$0
Riverside	$12,763,171	$126	$61,755
Sacramento	$2,562,834	$ 6,534,764	$0
San Bernardino	$11,688,142	$252	$41,622
San Diego	$15,246,350	$126	$1,472,259
San Joaquin	$4,329,230	$504	$103,298
Santa Barbara	$3,590,645	$0	$0
Santa Clara	$3,811,073	$0	$28,875
Sierra	$0	$0	$0
Sonoma	$422,636	$0	$1,212,159
Stanislaus	$6,051,298	$126	$0
Tulare	$9,773,659	$0	$0
Ventura	$6,230,330	$504	$1,004,757
Yuba	$0	$252	$0
Total	**$186,750,334**	**$7,144,431**	**$8,171,427**

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 will be reported in the 1115 Waiver DY 17 Annual Report.

Outreach Efforts:

Although provider offices are open, there are still restrictions for in-person outreach. As a result of the COVID-19 PHE, the ASO outreach team modified their approach by substituting routine, in-person visits with emails, phone calls, and virtual meetings. Contact with participating dental providers is an opportunity to support them, encourage them to accept new patients, and share the dental benefits available to Medi-Cal members. Outreach efforts in this quarter included contacting 1,042 offices in 4 underserved counties and 34 non-underserved counties. The ASO outreach team provided COVID-19 PHE updates and offered their assistance and contact information. They also shared updated provider bulletins as most provider offices have re-opened their practices and many had questions regarding personal protective equipment (PPE) and safety protocols. 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, twenty-three (23) of the twenty-nine (29) counties - Contra Costa, Fresno, Kern, Kings, Lassen, Los Angeles, Madera, Mendocino, Merced, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Sonoma, Stanislaus, Tulare, and Ventura. During these telephone calls, the ASO's outreach team provided information to Medi-Cal Dental offices within these counties in relation to the benefits available to Medi-Cal Dental providers who participate in DTI Domain 2. The expected outcome of these telephone calls is that provider participation in Domain 2 will increase after Medi-Cal Dental providers are informed of the additional benefits available to them via participation in the DTI Domain 2 program. The ASO continued to outreach to interested providers during their regular course of business. In this quarter, Domain 2 participation increased by 147 providers, bringing the total from 3,114 to 3,261.

Domain 3

In this quarter, the ASO's outreach team contacted by telephone, thirty-one (31) of the thirty-six (36) pilot counties - Alameda, Butte, Contra Costa, El Dorado, Fresno, Kern, Madera, Marin, Merced, Monterey, Napa, Nevada, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Ventura, and Yolo. The outreach team contacted Medi-Cal Dental offices to offer information on the benefits available to the Medi-Cal members, Medi-Cal Dental participating providers as it relates to Dental Transformation Initiative (DTI), Prop 56 supplemental payments and the student loan repayment program, and the "Smile, CA" website. Additionally, representatives offered Medi-Cal Dental training for billing staff and provided outreach contact information.

Consumer Issues:

There were no consumer issues for this quarter.

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 DY17-Q1, Mathematica, the DTI independent evaluator, continued to complete tasks associated with the final evaluation of the DTI Program. Mathematica is working to complete key informant interviews with LDPP subcontractors among the 13 LDPPs to add more insight on D4 to the final evaluation report. Additionally, Mathematica will continue to participate in bi-weekly conference calls with DHCS and gather and analyze data for inclusion in the Final Evaluation Report. Given that DTI has been extended for one additional year (PY 6), Mathematica has been directed to include data from PY 6 in the final evaluation of the DTI Program. Accordingly, the due date by which Mathematica must submit the final evaluation to DHCS has been extended for one additional year, due November 30, 2022.

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 ASAM requirements and obtain a DHCS-issued Level of Care Designation, or the equivalent national ASAM designation (see ASAM Designation (ca.gov) for details). SUD residential treatment providers can obtain an ASAM certification in lieu of obtaining the DHCS Level of Care (LOC) designation; however, the certification(s)/designation(s) must correspond with the LOC(s) that are provided in their program. The DMC-ODS includes residential treatment services for all DMC beneficiaries in facilities with no bed limits.

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 the Partnership Health Plan of California (PHC) have implemented an alternative regional model.

Enrollment Information:

Table 18: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY16-Q2	41,601	15,782	56,792
DY16-Q3	43,375	14,512	57,274
DY16-Q4	40,687	12,500	52,747
DY17-Q1	20,054	5,573	25,602

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 19: Member Enrollment

See next page.

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	32384	32670	32495	DY16-Q2	41,601
	32953	33836	34684	DY16-Q3	43,375
	33819	30755	30155	DY16-Q4	40,687
	21452	7148	200	DY17-Q1	20,054
Non-ACA	12553	12807	12587	DY16-Q2	15,782
	11472	11107	11116	DY16-Q3	14,512
	10668	9410	9183	DY16-Q4	12,500
	23359	7656	196	DY17-Q1	5,573

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

Outreach/Innovative Activities:

- DHCS continued to hold a monthly call with each participating DMC-ODS County to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance; including status updates on Corrective Action Plans.

- DHCS continued to hold an all-county monthly call to address various behavioral health policy issues, and provide ongoing DMC-ODS program guidance.

Recent activities including DMC-ODS guidance are listed below:

- July 6, 2021 – Cal-AIM Timelines Meeting
- July 7, 2021 – Cal-AIM Weekly System Risks and Issues Meeting
- July 12, 2021 – CA 1115 Monthly Monitoring Call (Zoom)
- July 13, 2021 – CalAIM Bi-Weekly Systems & Data Status Meeting
- July 21, 2021 – All County Behavioral Health Call
- July 21, 2021 – Cal-AIM Weekly System Risks and Issues Meeting
- July 22, 2021 – Cal-AIM Leadership Meeting
- July 29, 2021 – Behavioral Health Stakeholder Advisory Committee Meeting
- August 3, 2021 – Cal-AIM 1115 Renewal Monthly Meeting
- August 5, 2021 – CalAIM Leadership Meeting
- August 17, 2021 – CA 1115 to 1915(b) waiver transfer DHCS- CMS 2nd call
- August 18, 2021 – All County Behavioral Health Call

- August 24, 2021 – CalAIM 1115 Renewal Bi-Weekly Meeting
- September 6, 2021 – CalAIM 1115 Renewal Bi-Weekly Meeting
- September 21, 2021 – CMS/DHCS CalAIM 1115 Renewal Weekly Meeting
- September 21, 2021 – CalAIM Leadership Meeting
- September 28, 2021 – Monthly Full CalAIM Team 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 to maintain 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

Due to the PHE, many counties continue to experience staffing challenges due to the demands of responding to the emergency. To adapt to these challenges, counties have expanded telehealth services, where feasible.

DHCS submitted the DMC-ODS program in the 1915 (b) Waiver on June 30, 2021, and plans to launch CalAIM, including updates to the DMC-ODS program on January 1, 2022. The waiver submission is linked below.

https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx

Financial/Budget Neutrality Developments/Issues:

Table 20: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY16-Q2					
ACA	28,85,020	$114,507,408.50	$95,867,967.37	$11,600,105.15	$7,039,335.98
Non ACA	1,191,781	$34,706,004.85	$19,528,668.55	$5,075,622.68	$10,101,713.62
DY16-Q3					
ACA	2,937,344	$115,022,819.81	$96,419,592.25	$11,391,330.11	$7,211,897.45
Non ACA	9,96,637	$31,692,263.86	$17,829,233.13	$5,044,918.39	$8,818,112.34
DY16-Q4					
ACA	2,766,877	$112,697,523.84	$94,606,039.73	$11,525,969.01	$6,565,515.10
Non ACA	862,583	$28,735,832.04	$16,195,810.32	$5,136,546.23	$7,403,475.49
DY17-Q1					
ACA	657,795	$36,440,860.74	$30,693,024.53	$3,955,489.29	$1,792,346.92
Non ACA	714,482	$38,510,364.64	$31,869,141.39	$4,437,868.82	$2,203,354.43

For the detail of ACA and Non-ACA expenditures by level of care, please refer to the attached Excel file, tabs 'ODS Totals ACA' and 'ODS Totals Non-ACA'. A delta in expenditures levels is attributable to the timing of the data run. Counties have up to six months to submit their DMC claims, which can lead to lower reported expenditures when data is pulled within six months of the date of service. Accurate financial data will be provided in subsequent quarterly report cycles.

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 for Quarter 1 of FY 2021-22 is as follows:

Table 21: Grievance Data DY 17-Q1

County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals	Appeals
Alameda	0	0	0	0	0	0	**0**	0
Contra Costa	0	0	0	0	0	2	**2**	0
El Dorado	0	2	0	0	0	2	**2**	0
Fresno	0	1	0	0	0	1	**2**	0
Humboldt*	1	0	0	0	0	0	**1**	0
Imperial	0	0	0	0	0	0	**0**	0
Kern	2	2	2	0	0	0	**6**	0
Lassen*	0	0	0	0	0	0	**0**	0
Los Angeles	3	1	74	1	1	3	**83**	43
Marin	0	0	0	0	0	0	**0**	0
Mendocino*	0	0	0	0	1	0	**1**	0
Merced	0	1	0	0	0	0	**1**	0
Modoc*	0	0	0	0	0	0	**0**	0
Monterey	0	0	0	0	0	0	**0**	0
Napa	0	0	0	0	0	0	**0**	0
Nevada	0	0	0	4	0	0	**4**	0
Orange	1	5	0	0	0	1	**7**	4
Placer	1	2	0	0	0	0	**3**	0
Riverside	2	12	0	0	0	0	**14**	0
Sacramento	0	2	0	0	0	1	**3**	0
San Benito	0	0	0	0	0	0	**0**	0
San Bernardino	4	3	0	0	0	2	**9**	0
San Diego	0	25	0	5	0	1	**31**	9
San Francisco	0	0	1	0	0	0	**1**	0
San Joaquin	0	4	3	0	6	0	**13**	0

County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals	Appeals
San Luis Obispo	0	0	0	0	0	2	**2**	1
San Mateo	0	1	0	0	0	0	**1**	0
Santa Barbara	1	2	7	4	0	0	**14**	0
Santa Clara	0	3	0	1	0	0	**4**	0
Santa Cruz	0	0	0	0	1	7	**8**	11
Shasta*	0	0	0	0	0	0	**0**	0
Siskiyou*	0	0	0	0	0	0	**0**	0
Solano*	0	0	0	0	0	0	**0**	0
Stanislaus	0	0	0	0	0	0	**0**	1
Tulare	0	0	0	0	0	0	**0**	0
Ventura	0	0	0	0	0	0	**0**	0
Yolo	-	1	1	-	-	-	**2**	-

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

Table 22: Resolution and Transition of Care DY17-Q1

	Resolution				Transition of Care		
Q3– January – March 2021	**Grievances**	**Appeal**	**Appeal in favor of Plan**	**Appeal in favor of Beneficiary**	**Requests**	**Approved**	**Denied**
Alameda	1	0	0	0	0	0	0
Contra Costa	2	0	0	0	0	0	0
El Dorado	1	1	0	1	0	0	0
Fresno	2	0	0	0	0	0	0
Humboldt*	3	0	0	0	0	0	0
Imperial	0	0	0	0	0	0	0
Kern	3	0	0	0	0	0	0
Lassen*	0	0	0	0	0	0	0
Los Angeles	61	23	9	14	0	0	0
Marin	5	0	0	0	0	0	0
Mendocino*	1	0	0	0	0	0	0
Merced	1	0	0	0	0	0	0
Modoc*	0	0	0	0	0	0	0
Monterey	0	0	0	0	0	0	0
Napa	0	0	0	0	0	0	0
Nevada	0	0	0	0	1	0	0
Orange	9	3	3	0	0	0	0
Placer	3	0	0	0	0	0	0
Riverside	14	0	0	0	0	0	0

	Resolution				Transition of Care		
Sacramento	0	0	0	0	0	0	0
San Benito	4	0	0	0	0	0	0
San Bernardino	4	0	0	0	0	0	0
San Diego	42	11	8	2	0	0	0
San Francisco	1	0	0	0	0	0	0
San Joaquin	9	0	0	0	0	0	0
San Luis Obispo	1	1	0	1	0	0	0
San Mateo	1	0	0	0	0	0	0
Santa Barbara	13	0	0	0	0	0	0
Santa Clara	3	0	1	2	0	0	0
Santa Cruz	8	17	9	8	0	0	0
Shasta*	2	0	0	0	0	0	0
Siskiyou*	0	0	0	0	0	0	0
Solano*	0	0	0	0	0	0	0
Stanislaus	1	1	0	1	0	0	0
Tulare	0	0	0	0	0	0	0
Ventura	1	0	0	0	0	0	0
Yolo	3	0	0	0	0	0	0

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

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:

DHCS continued monthly webinars with DMC-ODS counties to monitor Corrective Action Plan implementation status, address deficiencies found during annual reviews and provided technical assistance as needed.

DHCS continued with a special project team to provide extended support beyond the first year of implementation of the regional model due to ongoing needs. This project team is in addition to the regularly assigned liaison to each DMC-ODS county. The project team coordinated monthly technical assistance calls with seven regional model counties and the PHC to support their DMC-ODS implementation. The project team coordinated with DHCS internal divisions to ensure timely technical assistance for the regional model counties during their first year of implementation. DHCS is reducing frequency of the project meeting starting October 2021, and plans to phase out the project by the end of FY 2021-22 and transition to the regular ongoing monitoring and

technical assistance process.

The original scheduled date of July 2020 to conduct county reviews for FY 2020-21 was delayed to October 2020, which required the rescheduling of some reviews into DY17-Q1.

Further delays to county reviews for FY 2020-2021, were due to county requests for postponement of monitoring reviews. Reasons cited included impacts from COVID-19 and natural disasters which occurred during DY16. This moved the start of FY 2020-2021 county reviews to October 2021.

Table 23: Compliance Monitoring Reviews

County	Review Date
Kings	July 2021
Nevada	July 2021
Orange	July 2021
Sierra	July 2021
Sonoma	July 2021
Sutter/Yuba	July 2021
Tehama	July 2021
Tuolumne	July 2021
Alameda	August 2021
El Dorado	August 2021
Humboldt	August 2021
Inyo	August 2021
Los Angeles	August 2021
Mendocino	August 2021
Monterey	August 2021
Tulare	August 2021
Calaveras	September 2021
Del Norte	September 2021
Lake	September 2021
Merced	September 2021
San Joaquin	September 2021
Santa Cruz	September 2021
Ventura	September 2021
Yolo	September 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 common challenges have also been identified, and the evaluation team has sought to target these challenges by developing case studies and recommending training topics based on stakeholder input.

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 PHC regional model (seven 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 program.

Enclosures/Attachments:

The attachment listed below contains the Enrollment data, Member Month data, and Aggregate Expenditures data referenced in this report. Additionally, the attachment contains the ACA and Non ACA Expenditures parsed by level of care for DY16-Q2 through DY17-Q1.

Medi-Cal 2020 DY 17-Q1 DMC-ODS Expenditures.xlsx

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.

GPP is funded by using a portion of the state's Disproportionate Share Hospital (DSH) allotment that would otherwise be allocated to the PHCSs.

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 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 6B IQ2 and PY 5 Final Reconciliation payment calculations were included at the increased FMAP percentages.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 24: DY16-Q3 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 6A, Q2 (April – June)	$251,197,595.22	$195,773,214.78	DY 16	$446,970,810.00
PY 5 Final Rec. (July – June)	$44,604,923.34	$34,763,267.66	DY 15	$79,368,191.00
Total	**$295,802,518.56**	**$230,536,482.44**		**$526,339,001.00**

DY 17 Q1 reporting includes GPP payments made in July and August 2021. The payments made during this time period were for PY 6B, Interim Quarter (IQ) 2 (April 1, 2021 – June 30, 2021), and PY 5 Final Reconciliation (July 1, 2019 – June 30, 2020).

In PY 6B, IQ2, the PHCS's received $251,197,595.22 in federal funded payments and $195,773,214.78 in IGT funded payments for GPP.

In PY 5 Final Reconciliation, the PHCSs received $44,604,923.34 in federal funded payments and $34,763,267.66 in IGT funded payments for GPP.

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
- 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 11.76 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 25: Total Member Months for Mandatory SPDs by County
July 2021 - September 2021

County	Total Member Months
Alameda	79,643
Contra Costa	50,659
Fresno	69,722
Kern	57,409
Kings	8,152
Los Angeles	526,249
Madera	7,006
Riverside	107,273
Sacramento	102,477
San Bernardino	114,499
San Diego	115,433
San Francisco	37,490
San Joaquin	46,543
Santa Clara	65,453
Stanislaus	32,175
Tulare	32,279
Total	**1,452,462**

Table 26: Total Member Months for existing SPDs by County
July 2021 - September 2021

County	Total Member Months
Alameda	80,551
Contra Costa	40,611
Fresno	48,115
Kern	36,590
Kings	4,941
Los Angeles	1,081,874
Madera	5,181
Marin	19,866
Mendocino	17,798
Merced	51,838
Monterey	51,023
Napa	15,610
Orange	356,576
Riverside	122,156
Sacramento	77,755
San Bernardino	119,065
San Diego	204,654
San Francisco	53,746
San Joaquin	33,754
San Luis Obispo	26,355
San Mateo	42,605
Santa Barbara	50,048
Santa Clara	124,461
Santa Cruz	32,781
Solano	63,380
Sonoma	53,128
Stanislaus	20,193
Tulare	22,554
Ventura	93,742
Yolo	27,749
Total	**2,978,700**

Table 27: Total Member Months for SPDs in Rural Non-COHS Counties
July 2021 - September 2021

County	Total Member Months
Alpine	44
Amador	1,022
Butte	15,822
Calaveras	1,593
Colusa	830
El Dorado	5,099
Glenn	1,564
Imperial	10,828
Inyo	460
Mariposa	694
Mono	156
Nevada	3,023
Placer	10,688
Plumas	960
San Benito	380
Sierra	83
Sutter	5,951
Tehama	5,096
Tuolumne	2,368
Yuba	6,136
Total	**72,797**

Table 28: Total Member Months for SPDs in Rural COHS Counties
July 2021 - September 2021

County	Total Member Months
Del Norte	8,279
Humboldt	26,745
Lake	19,980
Lassen	4,587
Modoc	2,300
Shasta	40,196
Siskiyou	11,562
Trinity	2,888
Total	**116,537**

WHOLE PERSON CARE (WPC)

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

WPC 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.

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

- 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.

PY 6 also knows as the extension year from January 1, 2021, to December 31, 2021, consisted of 23 Les operating a WPC Pilot. Additionally:

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

Enrollment Information:

The data reported below in Table 29 reflects the most current unique new beneficiary enrollment counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Enrollment data is updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly enrollment counts reflect the cumulative number of unique new beneficiaries enrolled in Quarter One (Q1) to Quarter Four (Q4) of Demonstration Year (DY) 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 Q4 (April – June 2021). Due to a delay in the availability of data, DY 17 – Q1 data will be reported in the next quarterly report. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (QEU) reports. The data reported is point-in-time as of September 24, 2021.

Table 29: New Beneficiary Enrollment Counts

LE	DY 16-Q1 (July – Sept. 2020)	DY 16 Q2 (Oct. – Dec. 2020)	DY 16 Q3 (Jan. – March 2021)	DY 16 Q4 (April – June 2021)	Jan. 2017 – June. 2021 Cumulative Total to Date
Alameda	2,514	1,816	1,768	1,562	27,831
Contra Costa	2,508	2,220	2,142	2,386	56,506
Kern	156	190	164	126	2,487
Kings*	44	26	22	N/A	784
LA	2,763	2,643	3,296	3,069	70,817
Marin*	39	23	47	34	1,926
Mendocino*	23	14	10	17	455
Monterey	58	28	75	18	780
Napa	18	20	27	44	678
Orange	457	277	275	392	13,475
Placer	5	6	8	11	494

LE	DY 16-Q1 (July – Sept. 2020)	DY 16 Q2 (Oct. – Dec. 2020)	DY 16 Q3 (Jan. – March 2021)	DY 16 Q4 (April – June 2021)	Jan. 2017 – June. 2021 Cumulative Total to Date
Riverside	565	349	405	393	8,652
Sacramento*	128	58	85	49	2,343
San Bernardino	92	33	48	38	1,447
San Diego	38	0	19	34	929
San Francisco	612	658	630	675	21,897
San Joaquin	147	273	145	127	2,698
San Mateo	109	76	40	129	4,026
Santa Clara	384	278	268	283	7,176
Santa Cruz*	10	15	6	12	599
SCWPCC**	5	0	NR	NR	143
Shasta	39	27	31	18	544
Solano**	14	0	NR	NR	254
Sonoma*	507	270	124	285	3,914
Ventura	22	30	41	41	1,413
Total	**11,257**	**9,330**	**9,676**	**9,743**	**232,268**

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

***Indicates the LE has closed out their WPC Pilot Program as of December 31, 2020. Q3 and Q4 enrollment data indicate not reportable "NR" as the LEs no longer submit quarterly enrollment reports after December 31, 2020.*

Member Months:

The data reported below in Table 30 reflects the most current member month counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months are updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly and cumulative total-to-date member months are reflected in the table below. The cumulative total-to-date column reflects the cumulative number of member months from the beginning of the program, DY 12 (January 2017), to the most current data available, DY 16 – Q4 (April – June 2021). Due to a delay in the availability of data, DY 17 – Q1 data will be reported in the next quarterly report. Member months are extracted from the LE's self-reported QEU reports. The data reported is point-in-time as of September 24, 2021.

Table 30: Member Month Counts

LE	DY16-Q1 (July – Sept. 2020)	DY 16 Q2 (Oct. – Dec. 2020)	DY 16 Q3 (Jan. – March 2021)	DY 16 Q4 (April – June 2021)	Jan. 2017 – June 2021 Cumulative Total-to-Date
Alameda	56,719	61,710	65,555	69,240	496,608
Contra Costa	38,072	37,978	38,074	38,735	670,146
Kern	5,638	6,163	6,685	7,114	50,651
Kings*	661	532	190	N/A	5,623
LA	53,280	53,248	54,810	56,057	701,660
Marin*	5,115	4,984	5,257	4,986	46,509
Mendocino*	387	443	457	463	6,449
Monterey	720	713	637	488	7,257
Napa	756	708	687	739	9,281
Orange	8,232	7,613	5,219	5,029	152,682
Placer	372	304	306	314	5,903
Riverside	19,594	20,767	21,754	22,670	178,955
Sacramento*	2,898	2,796	2,741	2,516	31,688
San Bernardino	1,600	1,515	1,497	1,484	22,461
San Diego	1,335	979	713	723	11,404
San Francisco	30,717	30,751	31,141	31,175	452,145
San Joaquin	4,440	5,000	5,493	5,149	43,559
San Mateo	6,404	6,479	6,381	6,246	114,019
Santa Clara	9,443	9,453	10,458	10,259	139,978
Santa Cruz*	1,380	1,406	1,439	1,450	17,645
SCWPCC**	132	104	NR	NR	1,578
Shasta	240	195	215	199	3,464
Solano **	161	113	NR	NR	3,186
Sonoma*	5,224	6,557	7,000	7,851	44,182
Ventura	1,587	1,546	1,517	1,473	27,924
Total	**255,107**	**262,057**	**268,226**	**274,360**	**3,244,957**

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

***Indicates the LE has closed out their WPC Pilot Program as of December 31, 2020. Q3 and Q4 enrollment data indicate not reportable "NR" as the LEs no longer submit quarterly enrollment reports after December 31, 2020.*

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 webinars, 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 due to the COVID-19 Public Health Emergency (PHE).

The LC held bi-weekly virtual conference meetings with LEs focusing on the new Medi-Cal benefits and services under the state's California Advancing and Innovating Medi-Cal (CalAIM) initiative including the new Enhanced Care Management (ECM) benefit and Community Supports(ILOS) The LC and DHCS provided robust TA to the Les to support the sunset of the WPC Pilot Program, the close out process and expectations, WPC member transition into ECM and Community Supports (ILOS), and DHCS published ECM/Community Supports (ILOS) policies and guidance. Bi-weekly virtual meetings during the reporting period were held on July 21, August 4, August 18, September 1, and September 15.The following topics were discussed on calls:

- WPC close out process and expectations
- Member Transition Notice and Template
- ECM/Community Supports (ILOS) WPC-Health Homes Program Transition and Reporting
- Member Transition List Part 2
- WPC Data Transfer Survey
- ECM /Community Supports (ILOS) FAQs
- Draft billing and invoicing guidance
- Draft member information file guidance
- ECM/Community Supports (ILOS) enrollment for WPC enrollees and reassessment criteria

DHCS has fully executed 22 contract amendments and has one pending contract amendment for a total of23 LEs that have confirmed they will be operating Pilot Programs through the end of 2021, as CMS has approved of the temporary extension of the Medi-Cal 2020 Demonstration through December 31, 2021. DHCS worked with the Office of Legal Services to draft appropriate language for the WPC contract amendments. DHCS anticipates all contracts will be fully executed by the next quarterly report.

The LC Advisory Board met on July 6, August 3, and September 7 to discuss feedback on TA needs as related to ECM/Community Supports (ILOS). The Advisory Board urged the need for timely policy guidance and consistent messaging between WPC LEs and Medi-Cal managed care health plans (MCPs). DHCS engaged Manatt Health to ensure LEs and MCPs receive coordinated messaging.

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 payment for four LEs. The payments this quarter are to the four LEs that had submitted their PY 5 annual invoices past the original due date of April 1, 2021, due to data discrepancy issues. In total, 21 LEs had received their payment on time in the previous reporting quarter. The total amount paid in DY 17 - Q1 is $23,159,842.97. Payments were made through the Intergovernmental Transfer (IGT) process. The total $13,015,831.75 represented the Federal Financial Participation (FFP) share and $10,144,011.22 represented the local non-federal (IGT) share for the remaining PY 5 annual payment.

Table 31: WPC Payments in DY 17 – Q1

DY 17 Payment	FFP	IGT	Service Period	Total Funds Payment
Q1 (July 1 - Sept 30)	$13,015,831.75	$10,144,011.22	DY 16 (PY 5)*	$23,159,842.97
Total	**$511,074,750.79**	**$419,025,358.95**		**930,100,109.76**

**PY 5 is from January 1, 2020 to December 31, 2020.*

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- PY 6 Budget with Rollover Adjustments (Due July 30, 2021)
- Second quarter (April 2021 – June 2021) PY 6 QEU Report (Due July 30, 2021)
- PY 6 Midyear Reporting Deliverables (Due August 31, 2021)

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.

Evaluation:

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

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

Due to the COVID-19 PHE, DHCS' independent evaluator, the University of California, Los Angeles (UCLA) 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 first quarter of DY 17, UCLA:

- Merged data on refined service categories with the QEU reports utilization data to better understand the distribution of service types within and across LEs. UCLA will update this analysis with new QEU report data as available. Analysis will be included in the final report.
- Produced a finalized "report card" table Along with complementary text in a published policy brief. This publication served as a tool to understand WPC LEs implementation strategies and enrollee characteristics. The policy brief included data on enrollment strategies, care coordination approach, WPC services offered, partnership characteristics, enrollment, and enrollee health status, demographics, and health care utilization.
- Finalized preliminary shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final report.
- Continued conversations around anticipated COVID-19 impact on Medi-Cal claims data and subsequent UCLA analysis. UCLA started to document potential implications of COVID-19 on the evaluation and identify ways to address data collection and quality concerns, in line with CMS guidance.
- Administered final LE survey through Qualtrics in April and May, with follow-up in early June 2021. Key topics of the survey included WPC target populations, use of incentives, community engagement, decision-making processes, and WPC impact and transition to CalAIM.
- Begin semi-structured interviews with program level management to follow-up with the LE survey described above, as well as with frontline staff and supervisors. UCLA intends to interview each LE.
- Refined a draft manuscript describing a novel prediction model to identify individuals experiencing homelessness or at-risk-of-homelessness using administrative and publicly available data.
- Published a manuscript that summarized the findings from a systematic literature review of care coordination across multiple sectors of care in the journal *Population Health Management* in June 2021.
- Reviewed and summarized COVID-19 budget alternative narratives. UCLA is using this data to better understand how LEs adapted and changed as a result of the COVID-19 PHE.
- Compiled annual invoice data for presentation in the final report.
- Developed an outline and preliminary methods for the upcoming COVID-19 impact policy brief.
- Received Medi-Cal enrollment and claims data for PY 2 through PY 4 enrollees through 2020. UCLA is currently analyzing the data.
- Incorporated the PY 4 and PY 5 LE-reported metrics with the previously reported LE-reported metric in order to update that analysis. Data will be presented in the final report.

Enrollment Informantion:

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non ACA	Total
DY16-Q2	41601	15782	56792
DY16-Q3	43375	14512	57274
DY16-Q4	40687	12500	52747
DY17-Q1	20054	5573	25602

Member Months:

Population	Month 1	Month 2	Month 3	Quarter
ACA	32384	32670	32495	DY16-Q2
	32953	33836	34684	DY16-Q3
	33819	30755	30155	DY16-Q4
	21452	7148	200	DY17-Q1
Non ACA	12553	12807	12587	DY16-Q2
	11472	11107	11116	DY16-Q3
	10668	9410	9183	DY16-Q4
	23359	7656	196	DY17-Q1

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

Quarter	Population	Units of Service	Approved Amount	FFP Amount
DY16-Q2	ACA	2885020	$114,507,408.50	$95,867,967.37
	Non ACA	1191781	$34,706,004.85	$19,528,668.55
DY16-Q3	ACA	2937344	$115,022,819.81	$96,419,592.25
	Non ACA	996637	$31,692,263.86	$17,829,233.13
DY16-Q4	ACA	2766877	$112,697,523.84	$94,606,039.73
	Non ACA	862583	$28,735,832.04	$16,195,810.32
DY17-Q1	ACA	657795	$36,440,860.74	$30,693,024.53
	Non ACA	714482	$38,510,364.64	$31,869,141.39

Current Enrollees (to date)
41,601
43,375
40,687
20,054
15,782
14,512
12,500
5,573

SGF Amount	County Amount
$11,600,105.15	$7,039,335.98
$5,075,622.68	$10,101,713.62
$11,391,330.11	$7,211,897.45
$5,044,918.39	$8,818,112.34
$11,525,969.01	$6,565,515.10
$5,136,546.23	$7,403,475.49
$3,955,489.29	$1,792,346.92
$4,437,868.82	$2,203,354.43

ACA Expenditures by Level of Care for DY16-Q2				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	102	4768.5	4291.14	0
1.0 Outpatient	378983	16416432.96	13197595.23	1420373.13
3.1 Residential	146764	25650568.32	21841680.29	3588738.44
3.3 Residential	1363	331347.34	295622.43	35724.91
3.5 Residential	113634	23365053.04	20057819.85	3248454.71
Additional MAT	11650	430380.16	363056.78	0
Case Management	187783	6766859.27	5647304.97	11601.43
Intensive Outpatient	36734	1065906.22	866791.71	185007.38
MAT Dosing	47781	1259469.09	1014164.48	0
Methadone	1286554	18377077.45	15230130.68	1504111.5
Narcotic Treatment	531709	9630554.77	7953307.52	821849.82
Physician Consultation	180	9668.1	8318.58	316.2
Recovery Support Services	33421	1330556.03	1077930.49	1659.22
Residential Withdrawal Management	14985	4117114.15	3553789.23	7630.09

ACA Expenditures by Level of Care for DY16-Q3				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	66	3085.5	2776.62	0
1.0 Outpatient	398748	17531620.8	14117926.65	1502343.56
2.5 Partial Hospitalization	50	17900	15626	0
3.1 Residential	131847	23482656.34	20163963.22	3168306.33
3.3 Residential	1069	263227.45	236797.27	26430.18
3.5 Residential	101723	21242608.61	18234733.98	2967872.78
Additional MAT	14669	466230.81	394929.55	0
Case Management	217890	8118704.83	6800689.81	12542.94
Intensive Outpatient	67626	2001252.47	1659597.68	323671.25
MAT Dosing	45051	1176671.74	948879.39	0
Methadone	1228350	17995458.71	14909881.39	1482194.04
Narcotic Treatment	507987	8979379.22	7408847.45	756975.41
Physician Consultation	147	5509.54	4326.32	36.95
Recovery Support Services	57171	1578779.69	1290172.63	2878.96
Residential Withdrawal Management	15528	4348447.68	3744560.88	7949.74

ACA Expenditures by Level of Care for DY16-Q4				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	147	6872.25	5141.49	0
1.0 Outpatient	334422.0653	14147888.64	11396359.65	1200831.68
2.5 Partial Hospitalization	28	10024	6238.6	0
3.1 Residential	139265	25225720.27	21662927.59	3419253.76
3.3 Residential	581	136572.17	116304.49	20267.68
3.5 Residential	107012	22638674.53	19404579.6	3176801.48
Additional MAT	16167.5551	470327.64	393187.11	0
Case Management	204163.0759	7272152.09	6099179.77	11544.99
Intensive Outpatient	73910.0194	2400212.24	1995261.06	388204.68

MAT Dosing	41207	1042669.85	828886.51	0
Methadone	1097844	16095105.68	13311665.69	1335556.73
Narcotic Treatment	447729	7622685.11	6310601.21	643665.47
Physician Consultation	213.3779	28090.7	21194.31	2743.02
Recovery Support Services	73310.4817	1358637.51	1084803.54	2745
Residential Withdrawal Management	15666	4606728.88	3954196.36	10870.35

ACA Expenditures by Level of Care for DY17-Q1

Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount
1-Withdrawal Management	23	1075.25	967.61	0
1.0 Outpatient	73031.1718	3670157.66	2959473.19	305089.18
3.1 Residential	50134	9292976.82	7972519.84	1271665.53
3.3 Residential	222	52778.28	47501.34	5276.94
3.5 Residential	33336	6814080.21	5807385.93	999100.62
Additional MAT	4118.0024	90684.01	77575.46	0
Case Management	51938.6354	2126781.57	1776663.26	985.08
Intensive Outpatient	18153.3391	947118.53	795805.41	146995.52
MAT Dosing	4884	154705.99	124136.97	0
Methadone	181878	3137959.77	2598467.1	277837.78
Narcotic Treatment	73703	1258284.95	1053332.96	110091.36
Physician Consultation	81.0669	4714.69	3948.45	248.75
Recovery Support Services	16472.702	351361.96	272819.89	0
Residential Withdrawal Management	5343	1429680.48	1230821.36	4853.34

County Amount
477.36
1798464.6
220149.59
0
58778.48
67323.38
1107952.87
14107.13
245304.61
1642835.27
855397.43
1033.32
250966.32
555694.83

County Amount
308.88
1911350.59
2274
150386.79
0
40001.85
71301.26
1305472.08
17983.54
227792.35
1603383.28
813556.36
1146.27
285728.1
595937.06

County Amount
1730.76
1550697.31
3785.4
143538.92
0
57293.45
77140.53
1161427.33
16746.5

213783.34
1447883.26
668418.43
4153.37
271088.97
641662.17

County Amount
107.64
405595.29
48791.45
0
7593.66
13108.55
349133.23
4317.6
30569.02
261654.89
94860.63
517.49
78542.07
194005.78

Non-ACA Expenditures by Level of Care for DY16-Q2				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1.0 Outpatient	120775	$5,255,908.73	$2,957,401.75	$51,287.55
3.1 Residential	25131	$4,341,845.85	$2,442,665.75	$1,756,802.48
3.3 Residential	804	$193,395.43	$108,688.27	$84,707.16
3.5 Residential	28136	$5,954,258.06	$3,356,215.05	$2,515,814.52
Additional MAT	4199	$152,224.43	$85,510.07	$0.00
Case Management	51298	$1,813,725.98	$1,023,850.26	$3,172.48
Intensive Outpatient	11012	$275,718.51	$153,923.51	$106,286.86
MAT Dosing	10286	$293,437.23	$164,720.22	$0.00
Methadone	659272	$9,301,703.23	$5,227,930.97	$21,750.31
Narcotic Treatment	241497	$4,207,480.52	$2,363,472.07	$86,518.48
Physician Consultation	61	$5,012.34	$2,816.93	$463.35
Recovery Support Services	12692	$503,794.47	$286,158.42	$401.27
Residential Withdrawal Management	3097	$939,056.67	$526,609.19	$3,273.72

Non-ACA Expenditures by Level of Care for DY16-Q3				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	41	$1,916.75	$1,077.07	$0.00
1.0 Outpatient	120662	$5,408,486.24	$3,029,723.42	$64,480.05
2.5 Partial Hospitalization	19	$6,802.00	$3,822.80	$0.00
3.1 Residential	24089	$4,301,780.50	$2,425,788.66	$1,776,340.10
3.3 Residential	559	$139,449.36	$78,370.97	$61,078.39
3.5 Residential	23387	$4,934,781.24	$2,777,862.53	$2,112,759.93
Additional MAT	4363	$156,200.37	$87,784.53	$0.00
Case Management	57469	$2,185,669.15	$1,234,062.83	$5,470.52
Intensive Outpatient	16427	$544,082.75	$306,829.43	$211,742.27
MAT Dosing	8224	$229,590.37	$129,029.89	$0.00
Methadone	489841	$7,062,731.03	$3,969,914.09	$44,006.12
Narcotic Treatment	184424	$3,216,815.32	$1,807,909.93	$59,612.08
Physician Consultation	44	$2,264.61	$1,272.70	$0.00
Recovery Support Services	22991	$600,317.11	$341,538.06	$1,279.25
Residential Withdrawal Management	2622	$794,696.49	$447,118.54	$3,611.60

Non-ACA Expenditures by Level of Care for DY 16-Q4				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	83	$3,880.25	$2,180.41	$0.00
1.0 Outpatient	100623	$4,280,236.90	$2,426,953.31	$67,954.48
2.5 Partial Hospitalization	61	$21,838.00	$12,273.20	$0.00
3.1 Residential	21719	$4,149,475.50	$2,338,973.37	$1,709,763.43
3.3 Residential	461	$114,469.99	$64,332.59	$50,137.40
3.5 Residential	24433	$5,280,771.48	$2,973,529.74	$2,282,620.69
Additional MAT	3098	$146,229.71	$82,280.07	$0.00
Case Management	47164	$1,828,832.99	$1,031,528.03	$6,845.25
Intensive Outpatient	18034	$609,183.69	$343,484.40	$244,932.88
MAT Dosing	6567	$176,240.21	$99,298.19	$0.00

Methadone	403810	$5,807,454.72	$3,264,079.11	$42,411.85
Narcotic Treatment	152360	$2,572,351.71	$1,445,807.87	$42,080.28
Physician Consultation	52	$3,106.54	$1,745.84	$0.00
Recovery Support Services	33411	$485,512.54	$275,590.98	$1,279.25
Residential Withdrawal Management	3201	$1,087,211.72	$612,106.00	$4,648.52

Non-ACA Expenditures by Level of Care for DY 17-Q1

Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount
1-Withdrawal Management	65	$3,038.75	$1,707.55	$0.00
1.0 Outpatient	19465	$1,001,864.72	$566,348.79	$10,432.01
3.1 Residential	6655	$1,302,439.98	$733,399.55	$537,003.12
3.3 Residential	121	$28,766.54	$16,166.81	$12,599.73
3.5 Residential	6648	$1,349,490.94	$760,531.85	$576,206.27
Additional MAT	667	$25,878.01	$14,543.37	$0.00
Case Management	12038	$491,454.19	$277,257.09	$0.00
Intensive Outpatient	3551	$190,913.78	$101,947.98	$82,562.58
MAT Dosing	496	$16,383.98	$9,209.03	$0.00
Methadone	64343	$1,087,280.78	$611,051.76	$26,023.95
Narcotic Treatment	23909	$409,371.36	$230,203.22	$396.55
Physician Consultation	3	$228.00	$128.14	$0.00
Recovery Support Services	5953	$126,231.19	$72,040.64	$0.00
Residential Withdrawal Management	874	$239,125.17	$134,934.09	$1,522.10

County Amount
$2,247,219.43
$142,377.62
$0.00
$82,228.49
$66,714.36
$786,703.24
$15,508.14
$128,717.01
$4,052,021.95
$1,757,489.97
$1,732.06
$217,234.78
$409,173.76

County Amount
$839.68
$2,314,282.77
$2,979.20
$99,651.74
$0.00
$44,158.78
$68,415.84
$946,135.80
$25,511.05
$100,560.48
$3,048,810.82
$1,349,293.31
$991.91
$257,499.80
$343,966.35

County Amount
$1,699.84
$1,785,329.11
$9,564.80
$100,738.70
$0.00
$24,621.05
$63,949.64
$790,459.71
$20,766.41
$76,942.02

$2,500,963.76
$1,084,463.56
$1,360.70
$208,642.31
$470,457.20

County Amount
$1,331.20
$425,083.92
$32,037.31
$0.00
$12,752.82
$11,334.64
$214,197.10
$6,403.22
$7,174.95
$450,205.07
$178,771.59
$99.86
$54,190.55
$102,668.98