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

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October 21, 2021

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U.S. Department of Health & Human Services
90 Seventh Street, Suite 5-300
San Francisco, CA 94103

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

Dear Ms. Young:

Enclosed is the Annual 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 annual progress report submission to the Centers for Medicare and Medicaid Services for Demonstration Year (DY) Sixteen, which covers the reporting period from July 1, 2020, through June 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 16 Annual Progress Report
Attachment QQ - Out-of-State Former Foster Youth 2019 Data
DY 16 DMC-ODS Expenditures

cc: See Next Page

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

Section 1115 Waiver Annual Report

Demonstration Reporting Period:
Demonstration Year: Sixteen (July 1, 2020 – June 30, 2021)

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INTRODUCTION:

The Department of Health Care Services (DHCS) submits the Annual Report for Demonstration Year (DY) 16 to the Centers for Medicare & Medicaid Services (CMS), in accordance with Item 28 of the Special Terms and Conditions (STCs) in California's Section 1115 Waiver Medi-Cal 2020 Demonstration (11-W-00193/9). This report addresses the following areas of operations for the various Demonstration programs during DY 16:

- Accomplishments
- Program Highlights
- Qualitative and Quantitative Findings
- Policy and Administrative Issues or Challenges
- Progress on the Evaluation and Findings

DHCS submitted an application to renew the State's Section 1115 Waiver Demonstration to CMS on March 27, 2015 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 STCs. 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 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 (CCI), and Community-Based Adult Services (CBAS)

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

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

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

The 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 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). The bill, 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. The final development of DHCS' health care delivery system was delayed by the impact of the COVID-19 pandemic, and the one-year extension allows 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.

TIME PERIODS:

Demonstration Year

The periods for each demonstration year of the Waiver consisted of 12 months, except for DY 11, which was six months respectively. The DY timeframes are indicated below:

- 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

Annual Report

This report covers the period from July 1, 2020 through June 30, 2021.

GENERAL REPORTING REQUIREMENTS

Item 8 of the STCs – Amendment Process

Global Payment Program and Program of All-Inclusive Care for the Elderly Amendment

DHCS submitted an amendment to the STCs of the California Medi-Cal 2020 demonstration waiver, in February 2020, which allows DHCS to operate an additional six-month GPP program year (PY) for the service period of July 1, 2020, to December 31, 2020 (PY 6A). This amendment also allows Medicaid beneficiaries in Orange County at their election to be disenrolled from CalOptima, a county-organized health system (COHS), to be enrolled in the Program of All-Inclusive Care for the Elderly (PACE), if eligible. This amendment was approved by CMS on August 3, 2020. DHCS sent CMS California's official acceptance letter on September 25, 2020.

Item 18 of the STCs – Post Award Forum

The purpose of the Stakeholder Advisory Committee (SAC) is to provide DHCS with valuable input from the stakeholder community on ongoing implementation efforts for the 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 DY 16, DHCS hosted four SAC meetings to provide waiver implementation updates and address stakeholder questions and comments. SAC convened on the following dates:

- April 29, 2021
- February 11, 2021
- October 28, 2020
- July 16, 2020

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

Item 25 of the STCs – Contractor Reviews

Seniors and Persons with Disabilities (SPDs)

Under the authority of the Section 1115 Medicaid Demonstration Waiver titled "California Bridge to Reform Demonstration," California transitioned the SPD population from the Medi-Cal Fee-For-Service (FFS) delivery system into the managed care delivery system. This transition occurred between June 2011 and May 2012. In order to evaluate the success of California's Bridge to Reform Waiver, the Medi-Cal 2020 (Medi-Cal 2020) Demonstration Waiver requires the state to provide evaluations on several waiver programs, including the SPD program. The SPD program evaluation must include:

- An evaluation of the impact of the program on member experience as well as the impact of the state's administration of the program overall using measures that describe three specific content areas: access to care, quality of care, and costs of coverage.
- A focused evaluation on the specific health care needs of SPDs, including specific needs associated with multiple complex conditions.

DHCS has contracted with the Regents of the University of California on behalf of its Los Angeles campus (UCLA) to conduct the SPD program evaluation.[1] UCLA began its contracting work on July 1, 2018. The interim SPD evaluation report was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 18, 2019. The final SPD evaluation report is due to CMS by December 31, 2021 at the completion of the Medi-Cal 2020 Waiver.

Item 26 of the STCs – Monthly Calls

CMS and DHCS schedule monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. During DY 16, the conference calls were held on the following dates:

- July 13, 2020
- August 10, 2020
- September 14, 2020
- October 19, 2020

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

- November 09, 2020
- January 15, 2021
- February 08, 2021
- March 08, 2021
- April 08, 2021
- May 13, 2021
- June 12, 2021

The main discussion topics included: Whole Person Care program updates; Health Homes program updates; Budget Neutrality Workbook updates; PRIME updates; DTI/DSHP updates; Medi-Cal Rx Attachment N updates; 1115 Waiver Extension and 1115 Waiver Renewal requests; and COVID-19 Flexibilities.

Item 27 of the STCs – Demonstration Quarterly Reports

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 16, DHCS submitted three quarterly reports to CMS electronically on the following dates:

- Quarter 1 (July 1, 2020 – September 30, 2020): Submitted November 24, 2020
- Quarter 2 (October 1, 2020 – December 31, 2020): Submitted February 26, 2021
- Quarter 3 (January 1, 2021 – March 31, 2021) – Submitted May 27, 2021

Per CMS' guidance, the fourth quarterly reporting information have been folded into the annual reports beginning in DY-15.

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

Each year, the Department of Health Care Services (DHCS) selects a set of performance measures, known as the Managed Care Accountability Set (MCAS) to assess the quality of care Medi-Cal managed care health plans (MCPs) provide. For Measurement Year (MY) 2019 / Reporting Year (RY) 2020, DHCS selected a set of quality measures from the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets. For applicable measures, DHCS continues to utilize benchmarks from the National Committee for Quality Assurance Quality (NCQA) Compass, for setting the Minimum Performance Level (MPL) for MCP performance. As of MY 2019 / RY 2020, DHCS increased the MPL from the 25th to the 50th percentile. DHCS contracts require MCPs to reach the MPL as a minimum, meaning they must perform at least as well as the bottom 50 percent of all Medicaid programs nationwide on each MCAS measure for which DHCS has identified a benchmark exists. The High-Performance Level (HPL) remains at the 90th percentile.

During DY 15, data for the relative RY 2020 included data from January 1, 2019 – December 31, 2019. The MCPs' MCAS included the measure on rates for *Children and Adolescents' Access to Primary Care Practitioners (CAP)*. The measure is distributed by the following age groups:

- 12 - 24 months (CAP-1224);
- 25 months - 6 years (CAP-256);
- 7 - 11 years (CAP-711); and
- 12 -19 years (CAP-1219).

As noted in last year's annual report, because the NCQA, the measure steward for the CAP measure, retired this CAP measure in 2019, DHCS chose not to hold MCPs to the MPL for this measure during RY 2020 and will not be including this measure in future annual waiver reports. DHCS continues to have the MCPs report on numerous indicators of children's access to health care services including Child and Adolescent Well Care Visits, Well Child Care Visits in the First 30 Months of Life, Childhood Immunizations and Adolescent Immunizations.

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

The 2022 DHCS Comprehensive Quality Strategy will provide a summary of the extensive work being done to assess and improve the quality and equity of health care covered by DHCS, as well as its vision for the future of quality and health equity in Medi-Cal. This upcoming report will serve as an update to the previously published 2018 Medi-Cal Managed Care Quality Strategy Report, which was limited to managed care programs. The revised Comprehensive Quality Strategy will serve as a broader quality strategy to encompass all DHCS quality activities, while meeting the requirements of the Code of Federal Regulations (CFR) at 42 CRF 438.340, as amended, under the managed care rule. The revised strategy will:

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

Incorporated into the Quality Improvement section are details about DHCS's California Advancing and Innovating Medi-Cal (CalAIM) five-year policy framework which encompasses broader delivery system, program and payment reform across the Medi-Cal program. While conceived with extensive stakeholder engagement prior to the COVID-19 PHE, CalAIM's goals are even more relevant as we emerge from the

pandemic. They have been strengthened with additional historic investments in the Governor's 2021-2022 budget and the Home and Community Based Services spending plan. While not required as a part of the Comprehensive Quality Strategy, these transformational initiatives will support DHCS's efforts to drive quality outcomes and reduce health disparities, and are interwoven with our quality strategy. DHCS expects to submit our 2022 Comprehensive Quality Strategy to CMS in early 2022.

Item 31 of the STCs – External Quality Review

Medi-Cal Managed Care

Every year, DHCS releases an External Quality Review (EQR) technical report to CMS and the public. These reports are compliant with federal regulations (Title 42 Code of Federal Regulations (CFR) Part 438, Subpart E). The EQR technical report is usually released by the last day of April each year, but in 2020, due to COVID-19 impacts, DHCS obtained an extension from CMS to release the 2018-19 EQR technical report in July. This report is available on DHCS' Medi-Cal Managed Care – Quality Improvement & Performance Measurement webpage.[2]

Item 33 of the STCs – Certified Public Expenditures (CPE)

Nothing to report.

Item 34 of the STCs – Designated State Health Programs

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

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the Safety Net Care Pool. To implement this limitation, 13.95 percent of total certified public expenditures for services to uninsured individuals will be treated as expended for non-emergency care to non-qualified aliens.
The STCs allow the State to claim Federal Financial Participation (FFP) using the certified public expenditures of approved DSHP. The annual FFP limit the State may

[2] DHCS Website, External Quality Review Technical Reports, 2016-2020, http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEQRTR.aspx.

claim for DSHP during each demonstration year is $75 million for a five-year total of $350 million.

Figure 1

Payment	CPE	FFP	Service Period	Total Claim
(Qtr. 1 July - Sept)	$0	$0		$0
(Qtr. 2 Oct-Dec)	$0	$0		$0
(Qtr. 3 Jan-Mar)	$0	$0		$0
(Qtr. 4 Apr - Jun)	$0	$0		$0
Total	$0	$0		$0

In DY 15 Q1-Q4, the Department claimed $0 FFP for DSHP-eligible services. DSHP claiming was placed on hold in DY 14 Q2 due to the fact that DSHP claiming exceeded the non-federal share of amounts expended by the state for the DTI program. DHCS will resume DSHP claiming in state fiscal year 2020-21.

Item 37 of the STCs – Managed Care Expansions

Nothing to report.

Item 38 of the STCs – Encounter Data Validation Study for New Health Plans

DHCS annually performs an Encounter Data Validation (EDV) study with its contracted External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG). During each study, DHCS pulls encounter data from its Management Information System/Decision Support System (MMIS/DSS) and provides it to the EQRO. The EQRO then examines, through review of medical records, the completeness and accuracy of the professional encounter data submitted to DHCS by MCPs.

In February 2020, DHCS published the DY 14 EDV Study, titled *SFY 2018-19 Encounter Data Validation Study Report*.[3] In the report, HSAG provided recommendations to DHCS to improve encounter data quality.

[3] DHCS Website, SFY 2018-19 Encounter Data Validation Study Report, 2019, https://www.dhcs.ca.gov/Documents/2018-19-Encounter-Data-Validation-Study-Report.pdf

In early 2020, HSAG began work on the DY 15 EDV Study, however, in March 2020, DHCS stopped all work, including medical record procurement efforts, for the DY 15 EDV Study in order to minimize non-critical burdens on MCPs and their network providers during the COVID-19 PHE. Prior to stopping the project, HSAG had completed the study plan; data collection and sampling; and a portion of medical record procurements. Due to the continuation of the PHE into 2021, DHCS extended the cancellation of EDV Study activities into DY 16. DHCS will be resuming EDV activities in November 2021 for DY 17 and medical records procurement will begin in early 2022.

Item 39 of the STCs – Submission of Encounter Data

In May 2017, CMS approved DHCS to move into production for data transmission to the Transformed Medicaid Statistical Information System (T-MSIS), which replaced the Medicaid Statistical Information System. During DY 15, DHCS continued to work with CMS to identify and resolve concerns with its production encounter data transmissions through T-MSIS.

Item 41 of the STCs – Contracts

Nothing to report.

Item 43 of the STCs – Network Adequacy

DHCS performs extensive ongoing and scheduled monitoring activities as well as network certification and network readiness reviews when expansion occurs or when there is a significant change. DHCS annually submits network certification reports on the status of MCP network adequacy to CMS.

MCPs must obtain written approval from DHCS prior to making significant changes in their networks that would impact the availability or location of covered services or before they begin enrollment of new populations. MCPs are also required to submit provider data to DHCS on a monthly basis so that DHCS and MCPs can actively work together to resolve any network adequacy issues as they arise.

DHCS conducts comprehensive ongoing reviews of MCP networks and sends data analysis and inquiries to MCPs for responses and necessary resolutions. DHCS then evaluates MCP responses to identify any deficiencies or outliers to address during the next review of MCP networks. Network adequacy indicators, include, but are not limited to:

- Primary Care Provider (PCP) Capacity (PCPs accepting new members);
- PCP-to-member ratios;
- Physician-to-member ratios;

- Termination of contracts;
- PCP time and distance standards;
- Specialist time and distance standards;
- Mental health time and distance standards;
- Hospital time and distance standards;
- OB/GYN time and distance standards;
- Pharmacy time and distance standards;
- Timely access to PCPs, specialists, mental health providers, and ancillary providers;
- MCP alternative access standards (AAS);
- Out-of- network requests/approvals/denials;
- State Fair Hearings; and
- Independent Medical Reviews.

Beginning in DY 14, MCPs are required to submit comprehensive data to DHCS on an annual basis that reflects the MCP's entire contracted provider network for each service area. DHCS evaluates the data to confirm that each MCP's network is sufficient to meet the anticipated needs of its members with adequate availability and accessibility of services including an appropriate range of providers.

Item 44 of the STCs – Network Requirement

In DY 13, DHCS implemented new network adequacy standards, in addition to the existing network requirements. These standards consider elements specified in 42 CFR Sections 438.68, 438.206, and 438.207, Welfare and Institutions Code Section 14197, the Knox-Keene Health Care Service Plan Act of 1975, and the MCP contract. DHCS initially released its Network Adequacy Standards pursuant to the Medicaid Managed Care Final Rule on July 19, 2017; however, they were subsequently revised to account for changes pursuant to state law.[4]

In DY 13, DHCS issued All Plan Letter (APL) 18-005, *Network Certification Requirements*, to provide guidance to MCPs regarding annual network certification, other network reporting requirements, associated network adequacy standards, and AAS requirements. Then, in DY 14, DHCS released APL 19-002, *Network Certification Requirements*, which superseded APL 18-005. APL 19-002 clarified MCP responsibilities regarding 274 file submissions; DHCS' authority to determine significant changes to a network; the process for submitting AAS requests; DHCS' provider validation process; the use of telehealth; and out-of-network monitoring and oversight. In DY 15, DHCS released APL 20-003*, Network Certification Requirements*, which superseded APL 19-002, to include provisions related to AAS required under

[4] DHCS Website, Network Adequacy Standards, 2018, https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacyStandards.aspx

Assembly Bill (AB) 1642 (Wood, Chapter 465, Statutes of 2019).[5] [6] The APL also clarifies the enforcement of time and distance standards and the DHCS validation process.

In DY 14, DHCS published two reports pertaining to the annual network certification on the DHCS website. The first report, titled *Approved Alternative Access Standards Report,* contains all MCP AAS requests that were approved by DHCS during the annual network certification of MCPs. The second report, titled *2018 Annual Network Certification: AB 205 Medi-Cal Managed Care Health Plan Corrective Action Plan Report*, identifies all MCPs that were subject to a Corrective Action Plan (CAP) due to non-compliance with network adequacy standards, as well as each MCP's response to the CAP.

In DY 15, DHCS published two reports pertaining to the annual network certification on the DHCS website. The first report, titled *Approved Alternative Access Standards Report,* contains all MCP AAS requests that were approved by DHCS during the annual network certification of MCPs.[7] The second report, titled July *2019 Annual Network Certification: Medi-Cal Managed Care Health Plan Corrective Action Plan Report*, identifies all MCPs that were subject to a Corrective Action Plan (CAP) due to non-compliance with network adequacy standards, as well as each MCP's response to the CAP.[8]

On June 28, 2019, DHCS submitted the report titled *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report* to CMS in accordance with 42 CFR 438.207(d). The report confirmed that MCPs contracting with DHCS are compliant with the network certification requirements set forth in 42 CFR Sections 438.206, 438.207, and 438.68.[9]

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

To guide the MCPs through the annual network certification process DHCS made updates to the statewide provider network adequacy standards in APL 20-003,

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[5] DHCS Website, APLs, including APL 20-003, 2020, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003.pdf.
[6] California Legislative Information, AB 1642, 2019, http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1642.
[7] DHCS Website, *Approved Alternative Access Report*, 2019, https://www.dhcs.ca.gov/formsandpubs/Documents/AB_205_AAS_Report_2019.pdf.
[8] DHCS Website, July *2019 Annual Network Certification: Medi-Cal Managed Care Health Plan Corrective Action Plan Report, 2019,* https://www.dhcs.ca.gov/formsandpubs/Documents/2019-July-Corrective-Action-Plan-Findings.pdf.
[9] DHCS Website, *July 2019 Medi-Cal Managed Care Health Plans Annual Network Certification Assurance of Compliance Report, 2019,* https://www.dhcs.ca.gov/formsandpubs/Documents/2019-July-Annual-Network-Certification-Report-Final.pdf.

Network Certification Requirements.[10] Due to the PHE in DY 15, DHCS requested an extension from CMS to submit documentation of assurances in DY 16 and received approval to submit on January 1, 2021.

DHCS continues to work with the MCPs to improve and automate the submission process. However, any changes to the submission process will not detract from the requirements placed on DHCS to report documentation to CMS that demonstrates each MCP is compliant with the following requirements:

- Offers an appropriate range of preventative, primary care, specialty services, and Long Term Services and Supports (LTSS) that is adequate for the anticipated number of members for the service area in compliance with 42 CFR, Sections 438.68 (network adequacy standards) and 438.206 (c)(1) (availability of services);

- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area; and

- Submits the documentation at the time it enters into a contract with DHCS, on an annual basis, and at any time there has been a significant change in the MCP's operations that would affect the adequacy of capacity and services.

Item 58 of the STCs – 2016 CCS Pilot Update

As of June 2020, DHCS is working with CMS to finalize the CCS protocols. The report will meet the STCs' requirements and includes:

- Brief description of the pilot program
- Description of Health Plan San Mateo (HPSM) as a MCP
- HPSM DP status update
- Description of Rady Children's Hospital of San Diego (RCHSD) as an Accountable Care Organization (ACO)
- RCHSD DP status update
- Number of children enrolled and cost of care

Items 69-73 of the STCs – Access Assessment

California's Section 1115(a) Medicaid Waiver Demonstration STCs required DHCS to contract with its EQRO, HSAG, to conduct a one-time assessment to care.

[10] DHCS Website, APL 20-003, 2020, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-003.pdf.

This assessment evaluated primary, core specialty, and facility access to care during 2017-18 for Medi-Cal managed care members based on requirements in the Knox-Keene Health Care Service Plan Act of 1975 and existing MCP contracts.
HSAG began working with DHCS in October 2016 to develop the overall access assessment evaluation design. An advisory committee was formed to provide input on the assessment structure. The advisory committee included representatives from consumer advocacy organizations, providers, provider associations, MCPs, health plan associations, and legislative staff. With participation from the advisory committee, DHCS submitted a draft evaluation design to CMS for review in April 2017. The evaluation design included:

- Network Capacity;
- Geographic Distribution;
- Appointment Availability;
- Service Utilization; and
- Grievances and Appeals.

HSAG hosted a final access assessment advisory committee meeting in June 2019 to review the results and provide guidance to the committee for submitting its feedback to HSAG. DHCS and HSAG then presented an initial draft of the California 2017-18 Access Assessment Report for public comment.[11]

Summary of results:

- No critical access issues were identified that would require immediate attention; and
- Although some MCPs did not meet all standards, no single MCP consistently performed poorly.

The following activity completed this project:

- HSAG presented DHCS with a final report which DHCS submitted to CMS October 8, 2019. CMS confirmed receipt of the report October 10, 2019.

Items 211-216 of the STCs – Evaluation of the Demonstration

Detailed information about the CCS, DTI, GPP, SPD, PRIME, and WPC evaluations are available in their respective program updates provided below. Copies of the program evaluation designs are available on the DHCS website at:

http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.

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

PROGRAM UPDATES:

CALIFORNIA CHILDREN'S SERVICES

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 Medi-Cal 2020 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 189,312 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 ACO
- Medi-Cal MCP (existing)

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

Accomplishments:

Figure 2: Pilot Accomplishments

Date	Pilot Accomplishment Items
September 19, 2016	The draft CCS evaluation design was originally submitted to CMS on September 19, 2016. The draft CCS evaluation is located at: https://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx
November 2017	DHCS received preliminary approval of the evaluation design from CMS on November 3, 2017, and received the formal approval package for the CCS evaluation design on November 17, 2017. The approval documents as well as the final design are available on this website: http://www.dhcs.ca.gov/provgovpart/Pages/Medi-Cal2020Evaluations.aspx.
Date	**HPSM Pilot Accomplishment Items**
October 2017 – November 2017	Submitted and received CMS approval of contract amendment A02.
October 2017 - Present	Preparing contract amendment A03 for signature.
June 2018	Transitioned CCS beneficiaries from demonstration pilot plan to managed care plan.
Date	**RCHSD Pilot Accomplishment Items**
July 1, 2018	RCHSD was implemented as a full risk plan. RCHSD began enrolling members into their plan.

Program Highlights:

RCHSD CCS Demonstration Pilot

RCHSD – San Diego pilot demonstration was implemented on July 1, 2018. Under their contract with DHCS, RCHSD took full-risk as Medi-Cal managed care health plan for beneficiaries in San Diego County that had one the following five CCS eligible medical diagnoses: cystic fibrosis, sickle cell, diabetes types I and II, acute lymphoblastic leukemia, or hemophilia. On December 31, 2021, the RCHSD Pilot will be sunsetting and a full discussion of the program and transition will be included in the final Waiver report.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

Enrollment

The monthly enrollment for RCHSD CCS DP is reflected in Figure 3 below. Eligibility data is extracted from the Children's Medical Services Network (CMS Net) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to RCHSD. RCHSD is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Figure 3: Monthly Enrollment for RCHSD CCS DP

Month	RCHSD Enrollment Numbers	Difference Prior Month
July 2019	363	-3
August 2019	356	-7
September 2019	351	-5
October 2019	350	-1
November 2019	351	+1
December 2019	349	-2
January 2020	352	+3
February 2020	349	-3
March 2020	346	-3
April 2020	349	+3
May 2020	352	+3
June 2020	372	+20
July 2020	372	+0
August 2020	373	+1
September 2020	374	+1
October 2020	375	+1
November 2020	371	-4
December 2020	372	+1
January 2021	371	-1
February 2021	373	+2
March 2021	383	+10
April 2021	381	-2
May 2021	382	+1
June 2021	384	+2

Policy/Administrative Issues and Challenges:

Nothing to report.

Progress on the Evaluation and Findings:

Researchers at the University of California, San Francisco (UCSF) is leading the CCS evaluation that is currently running from July 1, 2019, to December 31, 2022. The evaluation will be completed in two phases: Phase one includes HPSM, and phase two includes RCHSD. To date, UCSF has completed interviews with key informant and families of CCS pilot patients; surveyed parents of CCS children in both Fee-for-Service and CCS pilot transition counties; and analyzed claims/encounter data and eligibility records. UCSF has provided its preliminary findings in the CCS Pilots Interim Report submitted to Centers for Medicare & Medicaid Services on August 31, 2020 as required. DHCS is in the process of reviewing UCSF's Interim Report and the finalized version be posted on the website for public viewing by December 2021.

COMMUNITY-BASED ADULT SERVICES

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

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

CBAS is a CMS-approved benefit through December 31, 2021, under California's 1115(a) "Medi-Cal 2020" waiver approved by CMS on December 30, 2015.

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. The federal public comment period was July 16, 2021to 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 and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the Medi-Cal 2020; and 4) exhibit ongoing compliance with the requirements listed above.

Initial eligibility for the CBAS benefit is traditionally through a face-to-face assessment

by a Managed Care Plan (MCP) registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the plan possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every 12 months for individuals determined by the MCP to be clinically appropriate. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment.
Note: Due to the COVID-19 public health emergency (PHE), a face-to-face assessment is not required at this time. On October 9, 2020, CMS granted approval of DHCS' disaster 1115 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.[12] From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service benefit. On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model (available in 14 counties) Geographic Managed Care plans (available in two counties) and the final COHS County (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

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

[12] 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.

Coordinated Care Initiative county and is enrolled in managed care, the Medi-Cal MCP will be responsible for facilitating the appropriate services on the members' behalf.

Program Highlights:

Response to COVID-19 PHE

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), Alliance for Leadership and Education (ALE), CBAS providers, and 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 during the COVID-19 PHE 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). CDA continues to provide policy guidance and training to CBAS providers on the implementation of CBAS TAS based on public health guidance. More information about CBAS TAS is provided in subsequent sections of this report.

Beginning in April 2021, based on the decrease of COVID-19 cases and deaths statewide, and the numbers of vaccinations administered to eligible individuals including ADHC/CBAS participants and staff, CDA in collaboration with DHCS began planning for the phased lifting of restrictions on in-center services and the transitioning of CBAS participants to full congregate services.

However, public health conditions with the COVID-19 pandemic have since changed. Vaccination levels failed to reach anticipated numbers, and infections and hospitalizations have been increasing around the state with the spread of the Delta variant. In response, CDPH issued new public health orders which include mandated testing and vaccination requirements for all ADHC/CBAS center staff, with exemptions for staff documenting religious objections and qualified medical reasons. Staff who refuse vaccination or submit allowed exemptions require testing for COVID-19, at a minimum, on a weekly basis.

Due to the current conditions and ongoing risks to providers, participants, families, and caregivers, CDA in collaboration with DHCS determined it appropriate to postpone requiring the transition of participants to in-center services at this time. However, CBAS providers may continue to transition willing participants to in-center services to the extent providers determine that it is safe and feasible based on conditions in their individual communities and centers, and in accordance with the state's public health guidance.

Ongoing Program Activities

In addition, as a result of stakeholder processes during 2015 and 2016, CDA and DHCS in collaboration with CBAS providers, managed care plans and other interested stakeholders developed and continue to utilize the following documents: (1) New CBAS Individual Plan of Care (IPC); (2) CBAS Quality Assurance and Improvement Strategy: A Five-Year Plan (dated October 2016); and (3) Revised CBAS Home and Community-Based (HCB) Settings Transition Plan (dated May 2021).

These documents were developed in response to the following directives by CMS in the CBAS provisions of the 1115 Demonstration Waiver: (1) STC 48(c) and STC 49(c) requiring all CBAS settings to comply with the federal Home and Community-Based (HCB) Settings requirements (42 CFR 441.301(4)) and Person-Centered Planning requirements (42 CFR 441.301(c)(1)(2)(3)); and (2) STC 53 requiring the State to develop a quality strategy to assure the health and safety of Medi-Cal beneficiaries receiving CBAS. The following is an update on CBAS program activities during DY 16 related to each of these documents:

IPC

No update. New IPC was implemented June 1, 2019.

CBAS Quality Assurance and Improvement Strategy

The CBAS Quality Assurance and Improvement Strategy (dated October 2016) is a five-year plan to assure CBAS participant health and safety by addressing the following: (1) the quality and implementation of the CBAS beneficiary's person-centered IPC, (2) provider adherence to state and licensure and certification requirements, (3) quality metrics for person-centered care/continuity of care, (4) clinical and program outcome measures/indicators, (5) CBAS center staff training on best practices and quality improvement, and (6) improved use of existing enforcement provisions for CBAS centers that do not meet licensing or certification standards. The *CBAS Quality and Improvement Strategy* is designed to assure federal partners, beneficiaries and the public that CBAS providers meet program standards while they continue to develop new approaches to improving service delivery.

The *CBAS Quality and Improvement Strategy* will be a continuous quality improvement effort. This will be reflected in ongoing evaluation and possible revision of goals and objectives in partnership with a CBAS Quality Advisory Committee comprised of CBAS providers, managed care plans, and advocates. The short-, medium-, and long-term objectives identified in Goals I and II, some of which have been revised, guided CBAS program activities for DY 16. For example, during DY 16, CDA achieved the following quality objectives:(1) promoted education/training

opportunities on person-centered care, addressing social isolation and loneliness, and other issues impacting CBAS participants and their caregivers during the pandemic; (2) identified consumer guides that could be used by caregivers to help them identify long term services and supports including adult day health care programs/CBAS centers which would meet the needs of their family member in a person-centered way; (3) identified data elements and published state-wide, county-wide, and center-specific CBAS participant characteristics on the CDA website reflecting CBAS participants' complexity and acuity; and, (4) convened triannual calls with MCPs that contract with CBAS providers to promote communication, provide updates on CBAS activities and policy directives, and request feedback on CBAS provider issues requiring CDA assistance.

Since the CBAS Quality Strategy (October 2016) was a five-year plan, CDA will continue quality assurance activities to comply with the CBAS 1115 Waiver Special Terms and Conditions (STC) - CBAS Quality Assurance and Improvement Strategy and discuss next steps with the Quality Advisory Committee, at the Quality Advisory Committee Meeting on September 23, 2021. This discussion will include continued work on the long-term objectives that have not yet been completed, identifying the objectives which require ongoing evaluation and monitoring, and determining additional objectives that will promote and support the quality of CBAS services.

CBAS Home and Community-Based (HCB) Settings Transition Plan Update

All CBAS centers must comply with the federal HCB settings and person-centered planning requirements by March 17, 2023, and thereafter, or risk losing their CBAS Medi-Cal certification. The State submitted *California's Statewide Transition Plan (STP)* to the CMS on November 23, 2016, which included as an attachment the *Revised Draft CBAS HCB Settings Transition Plan* (dated November 23, 2016). CMS requested additional information from the State, which resulted in DHCS submitting revised STPs including revised CBAS Transition Plans on September 1, 2017, and January 11, 2018. 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 to 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.

Qualitative and Quantitative Findings:

Enrollment and Assessment Information

Per STC 52(a), the CBAS Enrollment data for both MCP and FFS members per county for DY 16 represents the period of July 2020 to June 2021 as shown in the table entitled "*Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS."* The table entitled "*CBAS Centers Licensed Capacity"* provides the CBAS capacity available per county, which is also incorporated into the table. Per the data presented, enrollment for CBAS has been consistent in DY 16 for Q1-Q4.

The CBAS enrollment data as described in the table below is self-reported quarterly by the MCPs. Some MCPs report enrollment data based on the geographical areas they cover which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties and they share the same data through July 2020 to June 2021.

Figure 4: Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS

See next page.

Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS								
	DY16-Q1		DY16-Q2		DY16-Q3		DY16-Q4	
	Jul - Sept 2020		Oct - Dec 2020		Jan - Mar 2021		Apr - Jun 2021	
County	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	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	0	0%	2	1%	21	12%	13	8%
Santa Clara	523	40%	551	42%	618	47%	628	48%
Santa Cruz	88	58%	88	58%	0	0%	79	52%
Shasta	47	33%	1	1%	39	27%	44	31%
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

The data provided in the previous table shows a steady increase in enrollment throughout DY 16 with the ongoing PHE. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Several counties experienced increased capacity utilization from Q2 to Q3, including Merced, Monterey, Sacramento, and Santa Clara. Similarly, Fresno and San Diego experienced greater than 5% increases from Q3 to Q4. San Mateo County has a significant increase of capacity 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 percent decrease of license capacity 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 there were counties that maintained consistent enrollments that did not see fluctuations greater than five percent. These counties include Alameda, Butte, Contra Costa, Kern, Orange, San Francisco, San Joaquin, San Mateo, Santa Clara, Ventura, Yolo, and the combined counties of Marin, Napa, and Solano.

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, San Joaquin, San Mateo, Santa Clara, Ventura, Yolo, and the combined counties of Marin, Napa, and Solano.

Overall, there is a 2% increase statewide as many counties continue to reflect a slight increase in unduplicated participants. Unduplicated participants remained fairly consistent throughout DY 16.

CBAS Assessments for MCPs and FFS Participants

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

Figure 5 below lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the table is reported by DHCS.

Figure 5: 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-Q1 (07/01-09/30/2020)	1,948	1845 (94.7%)	103 (5.3%)	0	0 (0%)	0 (0%)
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%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous table, for DY 16, 10,459 assessments were completed by the MCPs, of which 10,176 were determined to be eligible, and 283 were determined to be ineligible. For DHCS, it was reported that 14 participants were assessed for CBAS benefits under FFS and of these, all 14 were determined to be eligible. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases 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. The table entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY 16. As of DY 16, the number of counties with CBAS Centers and the ADA of each center are listed below in Figure 6. On average, the ADA at the 269 operating CBAS Centers is approximately 32,756 participants, which corresponds to 86.4 percent of total capacity. Provider-reported data identified in the table below, reflects data through June 2021.

Figure 6: 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	48
For-Profit Centers	221
ADA @ 269 Centers	32,756
Total Licensed Capacity	37,913
Statewide ADA per Center	86.4%

CDA - MSSR
Data 06/2021

Outreach/Innovative Activities: Stakeholder Process

CDA provides ongoing CBAS program updates and outreach to CBAS providers, managed care plans, CAADS, ALE, and other interested stakeholders via the *CBAS Updates* newsletter, CBAS All Center Letters (ACL), CBAS webinars, CAADS conferences, and ongoing MCP and CBAS Quality Advisory Committee calls, and responds to ongoing written and telephone inquiries.

During DY 16 CDA distributed five newsletters, issued 10 All Center Letters (ACLs), provided a CBAS program update and training session at the virtual CAADS November 2020 conference, and provided four CBAS Updates webinar trainings. 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 public health emergency (PHE), (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) Education and training opportunities to promote quality of care and to comply with CBAS program requirements, and (4) Notification of the public comment period for the STP and CBAS Transition Plan for compliance with the federal Home and Community-Based Settings Requirements.

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 wellbeing of CBAS participants, their families and CBAS staff.

CDA convenes triannual calls/outreach with MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update MCPs on CBAS activities and data collection, including policy directives, and the number, location, and approval status of new center applications, and (3) request feedback from MCPs on any CBAS provider issues requiring CDA assistance.

CDA 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 as described previously

CBAS Beneficiary/Provider Call Center Complaints (FFS / MCP) (STC 52.e.iv)

DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the Press, and members of the Legislature on various aspects of the CBAS program. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBAS@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in Figure 7 entitled "*Data on CBAS Complaints"* and Figure 8 entitled "*Data on CBAS Managed Care Plan Complaints*." According to the table below, no complaints were submitted to CDA for DY 16.

Figure 7: Data on CBAS Complaints

Data on CBAS Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY16-Q1 (Jul 1 - Sep 30)	0	0	0
DY16-Q2 (Oct 1 – Dec 31)	0	0	0
DY16-Q3 (Jan 1 - Mar 31)	0	0	0

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q4 (Apr 1 - Jun 30)	0	0	0

CDA Data - Complaints 06/2021

For complaints received by MCPs, the table below illustrates there were 20 beneficiary complaints and two provider complaints submitted for DY 16. The data reflects that for DY 16, complaints increased and remained consistent for both beneficiaries and providers. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 8: Data on CBAS Managed Care Plan Complaints

Data on CBAS Managed Care Plan Complaints			
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY16-Q1 (Jul 1 - Sep 30)	0	0	0
DY16-Q2 (Oct 1 - Dec 31)	0	0	0
DY16-Q3 (Jan 1 - Mar 31)	11	1	12
DY16-Q4 (Apr 1 - Jun 30)	9	1	10

Plan data - Phone Center Complaints 06/2021

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Figure 9 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 28 grievances were filed with MCPs during DY 16. Thirteen of the grievances were solely regarding CBAS providers. Two grievances were related to contractor assessment or reassessment. No grievances were related to excessive travel time to access CBAS services. Thirteen grievances were designated as "other". Overall, total grievances have decreased from the prior DY 15: 15 to 28. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Figure 9: Data on CBAS Managed Care Plan Grievances

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

Plan data - Grievances 06/2020

Figure 10: Data on CBAS Managed Care Plan Appeals

Data on CBAS Managed Care Plan Appeals					
Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CBAS	Other CBAS Appeals	Total Appeals
DY16 – 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

Plan data - Grievances 06/2020

During DY 16, Figure 10 entitled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 12 CBAS appeals filed with the MCPs. The table illustrates that nine of the appeals were related to "denial of services or limited services", one was categorized as "denial to see requested provider" and two were categorized as "other CBAS appeals".
The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 16, there were no requests for hearings related to CBAS services.

Quality Assurance/Monitoring Activity

The CBAS Quality Assurance and Improvement Strategy, developed through a year- long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Figure 11 entitled "*CBAS Centers Licensed Capacity*" indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The table below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 16. Quality Assurance/Monitoring Activity reflects data through July 2020 to June 2021.

Figure 11: CBAS Centers Licensed Capacity

County		CBAS Centers Licensed Capacity					
	DY16-Q1 Jul-Sep 2020	DY16-Q2 Oct-Dec 2020	Percent Change Between Last Two Quarters	DY16-Q3 Jan-Mar 2021	DY16-Q4 Apr-Jun 2021	Percent Change Between Last Two Quarters	Capacity Used
Alameda	370	370	0.0%	370	**370**	0.0%	72%
Butte	60	60	0.0%	60	**60**	0.0%	31%
Contra Costa	220	220	0.0%	220	**220**	0.0%	42%
Fresno	1062	1132	+6.6%	1132	**1,132**	0.0%	47%
Humboldt	349	349	0.0%	349	**349**	0.0%	14%
Imperial	355	355	0.0%	355	**355**	0.0%	47%
Kern	400	400	0.0%	610	**610**	0.0%	16%
Los Angeles	22,770	23,140	+1.6%	23,636	**24,211**	+2.4%	59%
Merced	124	124	0.0%	124	**124**	0.0%	57%
Monterey	110	110	0.0%	110	**110**	0.0%	54%
Orange	2,438	2,438	0.0%	2,678	**2,678**	0.0%	55%

County		CBAS Centers Licensed Capacity					
	DY16-Q1 Jul-Sep 2020	DY16-Q2 Oct-Dec 2020	Percent Change Between Last Two Quarters	DY16-Q3 Jan-Mar 2021	DY16-Q4 Apr-Jun 2021	Percent Change Between Last Two Quarters	Capacity Used
Riverside	935	935	0.0%	935	**935**	0.0%	34%
Sacramento	680	680	0.0%	680	**680**	0.0%	44%
San Bernardino	590	590	0.0%	590	**590**	0.0%	67%
San Diego	2,278	2,383	+4.6%	2,383	**1,903**	-20.0%	81%
San Francisco	926	926	0.0%	926	**926**	0.0%	57%
San Joaquin	140	140	0.0%	140	**140**	0.0%	24%
San Mateo	135	135	0.0%	135	**60**	-55.5%	62%
Santa Barbara	100	100	0.0%	100	**100**	0.0%	*
Santa Clara	780	780	0.0%	780	**780**	0.0%	48%
Santa Cruz	90	90	0.0%	90	**90**	0.0%	52%
Shasta	85	85	0.0%	85	**85**	0.0%	*
Ventura	851	851	0.0%	851	**886**	+4.1%	62%
Yolo	224	224	0.0%	224	**224**	0.0%	20%
Marin, Napa, Solano	295	295	0.0%	295	**295**	0.0%	14%
SUM	35,361	36,367	+2.8%	37,858	**37,913**	+.15%	56%
	CDA Licensed Capacity as of 06/2020						

The previous table reflects that the average licensed capacity used by CBAS participants is 56% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of Alameda and San Diego. Alameda is at 72% capacity and San Diego is at 81% capacity. This allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percent 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 percent 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 DY 15, total licensed capacity has slightly and steadily increased statewide.

Access Monitoring (STC 52.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the first table for CBAS, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers.

Unbundled Services (STC 48.b.iii.)

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 16, CDA had 269 CBAS Center providers operating in California. According to Figure 12 entitled "*CBAS Center History*," 7 CBAS Centers closed and 18 new centers were opened in DY 16.

Figure 12: CBAS Center History

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

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
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
July 2020	258	2	1	-1	257
June 2020	258	1	1	0	258

The previous table shows there was no negative change of more than five percent in DY 16, from June 2020 to June 2021, so no analysis is needed to address such variances.

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 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.

Policy/Administrative Issues and Challenges:

As previously identified in the Program Highlights section, DHCS and CDA implemented CBAS TAS beginning in March 2020, in response to the COVID-19 PHE. DHCS, through a disaster 1115 amendment, requested temporary flexibility for its 1115 waiver, to implement CBAS TAS. On June 9, 2021, CMS notified DHCS that it "is approving California's May 26, 2021, request to extend the approval period of certain previously approved Emergency Preparedness and Response Attachment K authorities, which are part of California's section 1115(a) demonstration titled, "Medi-Cal 2020" (Project No. 11-W-00193/9) to respond to the COVID-19 PHE. The authorities that CMS approved in the Attachment K are effective from March 13, 2021, through six months after the PHE ends and will apply to all locations served by the demonstration for anyone impacted by COVID-19 who receive home and community-based services through the demonstration."

DHCS and CDA continue to work with CBAS providers and MCPs to provide ongoing clarification regarding CBAS benefits, CBAS operations, and policy issues. The following were the primary policy and administrative issues and challenges during DY 16 impacting state oversight agencies and CBAS providers: (1) Providing CBAS TAS and allowable in-center services while monitoring the local and statewide public health conditions and adhering to all public health risk mitigation requirements to ensure the safe delivery of CBAS services to participants, (2) Educating, motivating and monitoring CBAS participants who are unwilling or hesitant to be vaccinated, (3) Complying with CDPH public health orders which include determining and documenting the vaccination status of staff, requiring the vaccination of staff unless they submit an exemption for religious beliefs or for qualified medical reasons, testing of staff at minimum weekly who are unvaccinated or incompletely vaccinated including staff with vaccination exemptions, and keeping required documentation.

Progress on the Evaluation and Findings:

Not applicable.

COORDINATED CARE INITIATIVE

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), including beneficiaries who are dually-eligible for Medicare and Medicaid (Duals). The CCI's aim is to achieve substantial savings by rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013), SB 75 (Chapter 18, Statutes of 2015), and SB 97 (Chapter 52, Statutes of 2017).

The three major components of the CCI are:

1. A Duals Demonstration Project (Cal MediConnect) that combines the full continuum of acute, primary, institutional services, and mild to moderate mental health care, as well as home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system comprised of Medicare-Medicaid Plans (MMPs). Originally this was a three-year demonstration that has been extended to the end of 2022;
2. Mandatory Medi-Cal managed care enrollment for Duals ; and
3. The inclusion of Long Term Services and Supports (LTSS), with the exception of In-Home Supportive Services (IHSS), which has transitioned back to counties, as a Medi-Cal managed care benefit for SPDs and other beneficiaries who are eligible for Medi-Cal only, and for beneficiaries who are Duals but are not enrolled in Cal MediConnect.

The seven CCI counties are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Four counties implemented CCI in April 2014 (San Bernardino, San Diego, San Mateo, and Riverside). Los Angeles County launched CCI in July 2014. Santa Clara County began in January 2015 and Orange County implemented in July 2015.

Accomplishments:

Figure 13: CCI Pilot Accomplishments

Date	Pilot Accomplishments
Implementation of Streamlined Enrollment	
2018 - present	Since DHCS implemented streamlined enrollment in August 2016, MMPs have been able to submit enrollment changes to DHCS on behalf of their members. This provides a simpler method for members to enroll in Cal MediConnect and has continued through

	DY 15 to contribute to a modest increase in enrollment for all MMPs.
Monthly Conference Calls	
2018 - present	DHCS and CMS continue to support MMPs in simplifying enrollment for all services, including Managed Long Term Services and Supports (MLTSS) by holding bi-monthly conference calls.
Bi-Weekly Conference Calls	
2018 - present	DHCS and CMS assist MMPs in resolving any enrollment or plan issues by holding bi-weekly conference calls.
Duals Plan Letters (DPLs) Released	
No DPLs were released during DY 16.	

Program Highlights:

In January 2019, DHCS requested stakeholder feedback on cost-neutral initiatives and activities to help improve Cal MediConnect. In total, DHCS received 23 sets of comments, representing 43 organizations and individuals. Stakeholders highlighted efforts to ensure members have appropriate access to durable medical equipment (DME). As a result, DHCS in collaboration with Aurrera Health Group focused on this feedback by creating a DHCS and MMP workgroup to review the challenges around accessing DME and to establish feasible solutions to identified barriers. The workgroup's efforts have been paused due to the COVID-19 Public Health Emergency (PHE).

Qualitative and Quantitative Findings:

Enrollment

As of December 1, 2020, approximately 114,977 members were enrolled in MMPs across the seven participating CCI counties. Detailed enrollment information for each CCI county can be found below in Figure 14.

Figure 14: Enrollment Information for Each CCI County

County	Number of Members Enrolled
Los Angeles	32,254
Orange	14,979
Riverside	16,961
San Bernardino	16,288

County	Number of Members Enrolled
San Diego	14,191
Santa Clara	11,640
San Mateo	8,664

DHCS updates the Cal MediConnect dashboard on a quarterly basis to include updated enrollment numbers and tables on key aspects of the Cal MediConnect program that assist MMPs in improving their performance and quality standards.[13]

Cal MediConnect Ombudsman Call Volume

From July 1, 2019, to June 30, 2020, the Cal MediConnect Ombudsman received approximately 4,465 calls from members. Below is a breakdown of the Cal MediConnect Ombudsman call data by each county's corresponding Ombudsman service provider:

- Legal Aid Society of San Diego (San Diego): 719
- Neighborhood Legal Services (Los Angeles): 1,370
- Inland Counties Legal Services (San Bernardino and Riverside): 334
- Bay Area Legal Aid: 422
- Community Legal Aid of SoCal: 213
- Legal Aid Society of San Mateo: 27
- Other Health Consumer Alliance programs: 1,237
- Abandoned calls: 143
- Totals Calls: 4,465

Continuity of Care Data

DHCS began to collect continuity of care data for MLTSS on a quarterly basis beginning the first quarter of 2015. From Quarter 3 of 2020 to Quarter 2 of 2021, there was a total of 405 continuity of care requests. Overall, 93.6% of the requests were approved, 5.7% were denied, and 0.7% were in process. The continuity of care requests were denied due to reasons such as providers refusing to work with managed care, no relationship found between the enrollee and provider, and other reasons such as availability of a network provider.

Policy and Administrative Difficulties in the Operation of this DY:

Cal MediConnect continued to encounter the following difficulties that have continued since it began and during DY 16:

[13] DHCS Website, *Cal MediConnect Performance Dashboard*, June 2021, https://www.dhcs.ca.gov/Documents/MCQMD/CMCDashboard6-21.pdf.

- The “unable to reach” reporting metric reached an all-time high for several MMPs;
- The resistance from providers to participate in the Cal MediConnect program; and
- The resistance from providers to participate in the Cal MediConnect program.

MMPs have encountered a high level of “unable to reach” percentages for members within Cal MediConnect due to several external factors. There are many possible reasons for this, such as members moving, phones being disconnected, and members not responding to attempted contacts. MMPs have attempted multiple workarounds to reach their members for Health Risk Assessment and Individual Care Plan completion. However, negative reporting metrics remain high, and efforts have not been as successful as the MMPs had hoped. To respond, CMS and DHCS partnered with MMPs to first understand the extent of this issue and second, to conduct short-term focused quality improvement efforts, which resulted in CMS and DHCS putting several of the MMPs on Performance Improvement Projects to address the “unable to reach” percentage rates.

Some providers continue to misunderstand Cal MediConnect and discourage enrollment in the program. This resistance has created difficulties maintaining enrollment in a few counties; however, most counties have been able to create positive relationships that assist members in accessing services in a collaborative manner.

Progress on the Evaluation and Findings:

Research Triangle Institute International

CMS contracted with the Research Triangle Institute International (RTI) to monitor the implementation of demonstrations, including Cal MediConnect, under the federal Medicare-Medicaid Financial Alignment Initiative and to evaluate their impact on member experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and state-specific evaluations. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide.

The goals of the evaluation are to monitor demonstration implementation, the impact of the demonstration on member experience, unintended consequences, and the impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g. people with mental health and/or substance use disorders, LTSS recipients, etc.). To achieve these goals, RTI collects qualitative and quantitative data from DHCS each quarter; analyzes Medicare and Medi-Cal enrollment and claims data; conducts site visits; conducts member focus groups and key informant interviews; and incorporates relevant findings from any member surveys conducted by other entities.

MMPs are required to conduct a Medicare Advantage – Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on an annual basis, which

is designed to measure important aspects of an individual's health care experience, including the accessibility to and quality of services. MMPs are also required to include supplemental questions as part of their annual survey in order to assist with RTI's independent evaluation. In January 2018, RTI added supplemental questions to the 2017 CAHPS survey and released the additional questions to the MMPs ahead of time to allow them to prepare appropriately. RTI assesses their questions as necessary to ensure they are gathering pertinent information to the demonstration. The first annual evaluation report provided by RTI, titled *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report,* was released on November 29, 2018.[14] The second annual evaluation report is not available at this time but will be provided in a future update.

The SCAN Foundation

The SCAN Foundation (TSF) funded two evaluations of Cal MediConnect: a Rapid Cycle Polling Project and a longer-term University of California Evaluation of Cal MediConnect, as described below. While TSF funded these evaluations, DHCS has been working collaboratively with TSF and stakeholders to develop and update the content of both evaluations.

TSF contracted with Field Research Corporation (FRC) to conduct a Rapid Cycle Polling Project, which is a series of rapid cycle polls to quantify the impact of Cal MediConnect on California's Duals population in as close to real time as possible. FRC completed four waves of the project, and the University of California San Francisco completed the fifth and sixth waves. The study compared the levels of confidence and satisfaction of Cal MediConnect enrollees with Duals who are eligible for Cal MediConnect but are not participating, or live in a non-CCI county within California.

The results of the sixth wave, released in October 2018, found that Cal MediConnect members' confidence in navigating their healthcare increased. This increase shows a large majority of members express confidence that they know how to manage their health conditions (82%), how to get questions about their health needs answered (84%), and who to call if they have a health need or question (89%). In alignment with the first finding, a large majority of Cal MediConnect members expressed satisfaction and confidence with their health care services, similar to the results in previous waves. Of particular note, between 10% and 16% of Cal MediConnect members reported that they encountered problems with their health service. Cal MediConnect members are also reporting longer relationships with their personal doctor. This is a key indicator of the care continuum that is especially important when transitioning to managed care. In 2014, an evaluation team was formed comprised of researchers from the University of San Francisco Institute for Health and Aging and the University of California, Berkeley School of Public Health. The evaluation team engaged stakeholder input and built upon the national evaluation conducted in 2014, by the University of California San Francisco Community Living

[14] CMS Website, *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*, November 2018, https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf.

Policy and the University of California Berkeley Health Research for Action Center to develop, pilot test, and finalize data collection instruments, with approval from California's Committee for the Protection of Human Subjects. The following evaluations, which often include data from previous years, were conducted for DY 14. These are outlined below.

In September 2018, TSF released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging to assess Cal MediConnect members' experiences with care, including access, quality, and coordination over time.[15] A total of 2,100 Duals completed the first telephone survey in 2016. Of those, 1,291 members completed a second survey in both 2016 and 2017. Key findings include:

- Very few people (less than 0.5%) changed MMPs or disenrolled from Cal MediConnect after one year in the program;
- Cal MediConnect satisfaction overall was very high (94%) with members reporting they were "very" or "somewhat" satisfied with their benefits. Satisfaction with benefits was highest among Cal MediConnect members compared to those who opted out or those in non-CCI counties;
- In both 2016 and 2017, one in five Cal MediConnect members reported delays or problems in getting care or services. Of those, 61% reported the problems were unresolved;
- Primary care visits decreased among Cal MediConnect members between 2016 and 2017, from 3.5 visits down to 2.9 average visits in a six-month period;
- Two-thirds of Cal MediConnect members used specialty care;
- Over 70% of Cal MediConnect members reported the ability to go to their hospital of choice all the time, and almost 90% of those hospitalized reported being ready to go home when discharged;
- One in five Cal MediConnect members used behavioral health services, and a majority of those took medication for mental health conditions;
- Cal MediConnect enrollees took an average of six prescription medications. About two-thirds reported having paid out of pocket for prescriptions; this is lower than the out-of-pocket expenses reported by those who opted-out, of whom three-quarters reporting paying out of pocket;
- Less than one-third of Cal MediConnect members reported having a care coordinator;
- Over three-quarters of Cal MediConnect members said their PCP seemed informed and up-to-date about their care from specialists; and about 54% said their providers usually or always share information with each other;
- Compared to opt-outs, more Cal MediConnect members reported getting a ride from their health plan to medical appointments;
- Half of non-English speaking Cal MediConnect members reported they could "never" get a medical interpreter when they needed one;

[15] Scan Foundation Website, *Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey,* September 2018, https://www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf

- Among Cal MediConnect members, those who need LTSS had lower satisfaction overall, and were almost four times more likely to rate their overall quality of care as fair or poor; and
- Approximately 37% of Cal MediConnect members who needed help with routine needs (e.g., household chores, doing necessary business, shopping, and getting around outside the home) reported they needed more help, or got no help at all with those activities.

In May 2019, TSF released a partnered evaluation from the University of California, San Francisco Community Living Policy Center and the Institute for Health and Aging that described the findings of the 2018 wave of the Cal MediConnect Rapid Cycle Polling Project, a tracking survey that included over 2,900 interviews with older adults and people with disabilities who were Duals.[16] Cal MediConnect MMPs integrate all Medicare and Medi-Cal benefits, including LTSS, in seven California counties. Since 2015, almost 10,000 Cal MediConnect members were surveyed about their experiences with the program.

Members were asked about their confidence and satisfaction with health care, and any problems they had encountered. Previous analyses report member experiences over the four year survey, including changes over time and comparisons with the non-CCI groups. In this analysis, researchers analyzed data from Cal MediConnect members and compared by several characteristics including: county, race, language, and disability (need for LTSS).

[16] The Scan Foundation Website, *Findings from the Cal MediConnect Rapid Cycle Polling Project,* 2019, https://www.thescanfoundation.org/initiatives/advancing-integrated-care/evaluating-cal-mediconnect/.

DENTAL TRANSFORMATION INITIATIVE

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

Through DTI, DHCS aims to:

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

Medi-Cal beneficiaries are enrolled in one of the two dental delivery systems: Fee-for-Service (FFS) and Dental Managed Care (DMC). DMC plans are only in Sacramento and Los Angeles counties. The Geographic Managed Care (GMC) plans are mandatory in Sacramento. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, 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.

The Medi-Cal 2020 Section 1115 Demonstration Waiver (Medi-Cal 2020 Waiver) was originally approved by CMS on December 30, 2015, and would be effective through December 31, 2020. Following the end of the waiver period, DHCS intended to implement the California Advancing and Innovating Medi-Cal (CalAIM), a multi-year initiative to support DTI goals. However, with the delay in implementation of CalAIM due to the 2019-Novel Coronavirus (COVID-19) public health emergency (PHE), DHCS submitted a one-year extension of the Medi-Cal 2020 Waiver to CMS on September 16, 2020, which CMS on December 29, 2020, with an additional demonstration year for PY 6 ending on December 31, 2021. The extension included DTI Domains 1, 2, and 3.

For reference, below are DTI's program years (PYs) with the corresponding 1115 Demonstration Waiver Years (DY) including the Medi-Cal 2020 12-month extension:

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	DTI PYs
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)

Overview of Domains

- *Domain 1 – Increase Preventive Services for Ages 20 and under*[17]

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

- *Domain 2 – Caries Risk Assessment (CRA) and Disease Management*[18]

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*[19]

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

[17] DTI Domain 1
[18] DTI Domain 2
[19] DTI Domain 3

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 – Local Dental Pilot Projects (LDPPs)* [20]

Since Domain 4 was not included in the one-year extension of the Medi-Cal 2020 Waiver, operations for these efforts concluded on December 31, 2020. The LDPPs have submitted all their final reports and invoices relative to PY 5. Final payments have all been processed as of June 2021. While active, the LDPPs supported the aforementioned Domains through thirteen (13) innovative pilot programs to test alternative methods to increase preventive services, reduce early childhood caries, and establish and maintain continuity of care. The LDPPs were required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

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

Program Highlights:

The impacts of the COVID-19 PHE continued in DY 16 where a majority of counties continued with the stay-at-home order and social distancing. However, dental offices statewide resumed operations for routine dental procedures following the California Department of Public Health guidelines on safe office practices. DHCS also worked diligently with the Administrative Services Organization (ASO) contractor through outreach activities to educate both beneficiaries and providers to increase preventive and other oral health services during DY 16.

Domain 1

- DHCS issued incentive payments to providers in July 2020 which included, the second PY 4 (calendar year (CY) 2019) payment and in January 2021 for the first PY 5 (CY 2020) and final PY 4 (CY 2019) payments.

Domain 2

- As of June 2021, 3,336 providers have opted-in Domain 2, which is a 15 percent increase when compared to DY 15.

[20] DTI Domain 4

Domain 3

- DHCS issued incentive payments to providers in July 2021, which included the second and final payment of PY 44 (CY 2019) and the first payment for PY 5 (CY 2020).

Domain 4

- DHCS did not include Domain 4 in the 12 month extension request. As of December 31, 2020, all 13 LDPPs concluded their operations.
- Based on the quarterly invoices LDPPs submitted, DHCS issued a total of $108.5 million payments to LDPPs for all PYs as of June 2021.

Preventive Dental Services Utilization

Figure 15 summarizes the preventive dental service utilization during DY 16 for children ages one through twenty statewide. Dental utilization in DY 16 was impacted by the COVID-19 PHE and are lower than previous DY 15; however, utilization is showing a positive trend since March 2021. Note that the utilization is preliminary and is expected to change as DHCS receives more claims for 2020 and 2021 dates of services.

Figure 15: Statewide Three Months Continuously Enrolled Medi-Cal Members Age 1-20 and the Preventive Dental Services Utilization[21]

Measure End Month	Measure Period	Numerator[22]	Denominator[23]	Utilization
Jul 2020	08/2019-07/2020	2,230,681	5,344,666	41.74%
Aug 2020	09/2019-08/2020	2,166,909	5,330,764	40.65%
Sep 2020	10/2019-09/2020	2,113,732	5,280,885	40.03%
Oct 2020	11/2019-10/2020	2,067,576	5,232,095	39.52%
Nov 2020	12/2019-11/2020	2,038,740	5,172,848	39.41%
Dec 2020	01/2020-12/2020	2,039,443	5,264,624	38.74%
Jan 2021	02/2020-01/2021	1,991,159	5,248,423	37.94%
Feb 2021	03/2020-02/2021	1,966,185	5,257,885	37.39%

[21] Data Source – DHCS Data Warehouse MIS/DS Dental Dashboard August 2021 update. Utilization does not include one-year full run-out allowed for claim submission.
[22] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (CDT codes D1000-D1999 or Current Procedural Terminology (CPT) code 99188 with safety net clinics' (SNCs) dental encounter with International Classification of Diseases (ICD)-10 diagnosis codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) during the measure year.
[23] Denominator: Number of beneficiaries ages one (1) through twenty (20) enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.

Measure End Month	Measure Period	Numerator[22]	Denominator[23]	Utilization
Mar 2021	04/2020-03/2021	2,010,050	5,284,631	38.04%
Apr 2021	05/2020-04/2021	2,116,834	5,298,314	39.95%
May 2021	06/2020-05/2021	2,189,846	5,314,126	41.21%
Jun 2021	07/2020-06/2021	2,174,787	5,327,480	40.82%

Provider Enrollment

By the end of DY 15, the numbers of active FFS service offices increased from 5,997 to 6,006 and rendering providers increased from 11,556 to 12,068 constituting an increase of 9 offices and 512 rendering providers respectively. The numbers of active DMC (Geographic Managed Care (GMC) and Prepaid Health Plans (PHP)) service offices increased from 1,066 to 1,077 and rendering providers increased from 1,729 to 1,807 constituting an increase of 11 offices and 78 rendering providers respectively. These numbers are per enrollment data and not based upon activity in rendering and billing for services. The numbers of SNCs who provided at least one dental service in the recent one year increased from 589 to 557. Figure 16 lists monthly provider counts across all delivery systems.

Figure 16: Statewide Enrolled Dental Offices, Rendering Providers, and Safety Net Clinics[24]

Measure Month	FFS Offices	FFS Rendering	GMC Offices	GMC Rendering	PHP Offices	PHP Rendering	Safety Net Clinics
Jul 2020	5,997	11,556	154	269	912	1,460	589
Aug 2020	5,972	11,576	154	269	909	1,466	588
Sep 2020	5,984	11,645	150	270	908	1,450	591
Oct 2020	5,994	11,721	154	277	908	1,433	589
Nov 2020	5,930	11,808	158	275	910	1,423	592
Dec 2020	5,954	11,848	156	282	907	1,423	598
Jan 2021	5,951	11,875	161	335	896	1,415	594
Feb 2021	5,965	11,920	154	287	888	1,409	588

[24] Enrolled service offices and rendering providers are sourced from FFS Contractor Delta Dental's report PS-O-008M, PS-O-008N and DMC Plan deliverables of each month. This table does not indicate whether a provider provided services during the reporting month. Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net and LIBERTY. The count of Safety Net Clinics is based on encounter data from the DHCS Data Warehouse MIS/DSS as of August 2021. Only Safety Net Clinics who submitted at least one dental encounter within one year were included.

Measure Month	FFS Offices	FFS Rendering	GMC Offices	GMC Rendering	PHP Offices	PHP Rendering	Safety Net Clinics
Mar 2021	5,965	11,969	156	296	898	1,436	559
Apr 2021	5,984	11,999	162	353	908	1,449	560
May 2021	5,994	12,014	157	290	900	1,447	557
Jun 2021	6,006	12,068	161	349	916	1,458	557

Outreach/Innovative Activities:

Outreach Plans

To increase the public awareness of DTI, DHCS presented the goals, incentive payments methodologies, implementation efforts, and outcomes in numerous events and meetings statewide. Figure 17 is a list of events and meetings where DHCS shared information on DTI during DY 16.

Figure 17: DTI Outreach Presentations

Date	DTI Outreach Presentations
August 4, 2020	Child Health and Disability Prevention Statewide Oral Health Subcommittee
August 6, 2020	Medi-Cal Dental Advisory Committee Meeting (agenda)
August 27, 2020	Medi-Cal Dental Statewide Stakeholder Meeting (agenda)
October 1, 2020	Medi-Cal Dental Advisory Committee Meeting (agenda)
November 5, 2020	Medi-Cal Dental Los Angeles Stakeholder Meeting (agenda)
December 3, 2020	Medi-Cal Dental Advisory Committee Meeting (agenda)
December 9, 2020	2020 National Medicaid | Medicare | CHIP Oral Health Symposium (agenda)
February 2, 2021	Child Health and Disability Prevention Oral Health Subcommittee Meeting
February 4, 2021	Medi-Cal Dental Advisory Committee (agenda)
February 18, 2021	Statewide Dental Stakeholder Meeting (agenda)
April 1, 2021	Medi-Cal Dental Advisory Committee (agenda)
May 20, 2021	Medi-Cal Dental Los Angeles Stakeholder Meeting (agenda)

DTI Small Workgroup

The objective of this meeting is to share updates on all DTI Domains and gather feedback from provider representatives, dental plans, county representatives, consumer advocates, legislative staff, and other interested parties. This workgroup

meets on a bi-monthly basis, the third Wednesday of the month. When there are no agenda items for discussion, email updates are sent, which include information on incentive payments, provider participation, LDPP visits, DTI program extension and a change in frequency of the meeting from bi-monthly to quarterly. The following were the scheduled meetings during DY 16:

- July 16, 2020– email sent in lieu of meeting.
- September 17, 2020 - email sent in lieu of meeting.
- November 19, 2020 -email sent in lieu of meeting
- March 18, 2021 – email sent in lieu of meeting.
- June 17, 2021 – email sent in lieu of meeting.

Domain 2 Subgroup

The purpose of this quarterly subgroup was to report on the domain's current activities, discuss ways to encourage providers to participate in the domain, and to provide an open forum for questions and answers specific to this domain. However, in DY 16, DHCS has not held any of these meetings due to no agenda items being identified by any of the meeting participants. Originally, the DTI Domain 2 subgroup meeting series was created to discuss and brainstorm methods of improving provider participation, and that purpose has since been fulfilled. Consequently, DHCS issued an email notification on September 9, 2020, to notify participants that this meeting series was canceled, and future updates for Domain 2 would be included in the DTI Small Workgroup meeting series.

DTI Clinic Subgroup

The clinic subgroup is still active and meets on an as needed basis. The subgroup did not meet during DY 16 as there were no changes to operations or policies prompting a need for the group to meet.

DTI Data Subgroup

The purpose of the DTI data subgroup is to provide an opportunity for stakeholders and DHCS to discuss various components of the DTI annual report and for opportunities to examine new correlations and data. The subgroup did not meet during DY 16 as DHCS did not receive any feedback on the DTI PY 4 Annual Report or requests to discuss DTI data.

Domain 4 Subgroup

DHCS held the bi-monthly teleconference with the LDPPs on October 15, 2020 as an opportunity to educate, provide technical assistance, offer support and address concerns. In lieu of the Domain 4 teleconference in December, DHCS sent an email update on December 17, 2020. As noted above, as of December 31, 2020, all 13 LDPPs have concluded operations

and DHCS continued offering technical assistance to LDPPs regarding closeout guidelines to ensure that all deliverables were received and final payments were made.

DTI Webpage

During DY 16, webpage posting included the following:

- Domain 1 and 3 encounter data submission deadlines for paper and electronic claims.
- Domain 2 Provider Opt-In Attestation Form was revised to reflect the updated email address for Delta Dental of California's Medi-Cal Dental Program Provider Enrollment Department.
- Domain 3 SNC opt-in and claims submission deadline dates were updated.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY 16. Figure 18 is the list of inquiries received during each quarter of this DY with a total of five hundred seventy-seven (577) inquiries in the DTI inbox for Domains 1, 2, and 3. Most inquiries during this reporting period included, but were not limited to, the following categories: DTI program extension encounter data submissions, opt-in form submissions, payment status and calculations, check reissuances, resource documents, procedure codes and Domain 2 billing and opt-in questions.

Figure 18: Number of DTI Inbox Inquiries by Domain

Domain	Q1 Inquiries	Q2 Inquiries	Q3 Inquiries	Q4 Inquiries
1	180	12	67	24
2	54	25	26	91
3	42	16	17	23
Total	**276**	**53**	**110**	**138**

Separately, the LDPP inbox for Domain 4 received a total of four hundred forty (440) inquiries during DY 16, with questions related to quarterly reports, closeout activities, invoice submission and reimbursement status.

Operational/Policy Developments/Issues:

Domain 1

- Domain 1 providers are paid semi-annually at the end of January and July. The following payments were issued during DY 16:
    - The second payment for PY 4 totaling $3,845,519.25 was issued in July 2020. The payment details by each county and delivery system are available in the DY 16-Q1 Progress Report.
    - The first payment for PY 55 and the final PY 4 payment totaling $33,550,530.50

was issued in February 2021. The payment details by each county and delivery system are available in the DY 16-Q3 Progress Report.
    - The next payment in July 2021 is on schedule.

Domain 2

- FFS providers are paid weekly, whereas SNC and DMC providers are paid on a monthly basis. Figure 19 represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY 16, which totals $45,451,140.83 (for all Domain 2 benefits including CRA, Silver Diamine Fluoride and preventive services) paid to 3,336 providers who opted-in to Domain 2. Figure 20 represents incentive claims paid for FFS, SNC, and DMC providers from the beginning of the Domain 2 program until the end of DY 16, which equals $194,286,835.24.

Figure 19: Domain 2 Payments by County and Delivery System Paid in DY 16[25]

County	FFS	DMC	SNC
Contra Costa	$695,041		$0
Fresno	$2,024,531	$0	$0
Glenn	$504	$0	$0
Humboldt	$0	$0	$0
Imperial	$31,422	$0	$0
Inyo	$0	$0	$5,418
Kern	$2,429,340	$0	$1,260
Kings	$7,590	$0	$0
Lassen	$0	$0	$0
Los Angeles	$14,882,278	$56,194	$97,204
Madera	$280,986	$0	$0
Mendocino	$0	$0	$26,591
Merced	$499,287	$0	$0
Monterey	$1,655,773	$0	$0
Orange	$4,053,043	$0	$00
Plumas	$0	$0	$0
Riverside	$3,550,340	$0	$0
Sacramento	$423,711	$408,485	$0
San Bernardino	$3,210,763	$0	$10,974
San Diego	$3,696,231	$126	$90,779
San Joaquin	$1,110,070	$0	$0
Santa Barbara	$758,620	$0	$0
Santa Clara	$944,418	$0	$0
Sierra	$0	$0	$0
Sonoma	$81,604	$0	$212,776
Stanislaus	$1,501,711	$0	$0
Tulare	$1,159,100	$0	$0

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

County	FFS	DMC	SNC
Ventura	$1,446,471	$0	$98,500
Yuba	$0	$0	$0
Total	**$44,442,834**	**$464,805**	**$543,502**

Figure 20: Domain 2 Payments by County and Delivery System between February 2017 and June 2021 (End of DY 16)[26]

County	FFS	DMC	SNC
Contra Costa	$2,539,476	$0	$0
Fresno	$8,985,427	$252	$17,528
Glenn	$11,223	$0	$0
Humboldt	$70.00	$0	$126
Imperial	$138,787	$0	$0
Inyo	$0	$0	$48,636
Kern	$10,689,591	$126	$2,016
Kings	$52,154	$0	$0
Lassen	$0	$0	$0
Los Angeles	$59,666,399	$530,150	$2,214,968
Madera	$1,377,340	$0	$0
Mendocino	$0	$0	$781,330
Merced	$1,740,338	$0	$0
Monterey	$6,590,859	$0	$0
Orange	$15,151,333	$252	$714,024
Plumas	$0	$0	$0
Riverside	$10,838,409	$126	$48,895
Sacramento	$2,659,275	$6,066,622	$0
San Bernardino	$11,177,637	$252	$36,979
San Diego	$15,242,499	$126	$1,335,215
San Joaquin	$4,246,225	$504	$18,322
Santa Barbara	$3,490,318	$0	$0
Santa Clara	$3,789,042	$0	$28,875
Sierra	$0	$0	$0
Sonoma	$428,812	$0	$994,030
Stanislaus	$5,978,068	$126	$0
Tulare	$9,589,459	$0	$0
Ventura	$6,190,781	$252	$873,585
Yuba	$0	$0	$0
Total	**$180,573,518**	**$6,598,788**	**$7,114,529**

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

Domain 3

- The total number of SNCs participating in Domain 3 increased by 3 in DY 16, bringing the total to 123.
- Incentive payments for Domain 3 are issued to providers once a year. In July 2021, DHCS issued the fifth payment, which included the second and final payment of PY 4 and the first payment for PY 5. Figure 21 lists the second and final payment issued to counties for PY 4 and Figure 22 lists the first payment issued to counties for PY 5.

Figure 21: Domain 3 Payments by Delivery System and County for PY 4[27]

County	FFS	SNC	Total
Alameda	$620	$83,150	$83,770
Contra Costa	$700	$0	$700
Fresno	$990	$0	$990
Kern	$920	$0	$920
Madera	$100	$0	$100
Merced	$200	$0	$200
Modoc	$0	$14,990	$14,990
Monterey	$400	$0	$400
Orange	$6,400	$1,700	$8,100
Placer	$1,100	$0	$1,100
Riverside	$5,040	$0	$5,040
San Bernardino	$2,700	$0	$2,700
San Diego	$1,200	$17,900	$19,100
San Francisco	$400	$0	$400
San Joaquin	$200	$0	$200
San Luis Obispo	$110	$0	$110
San Mateo	$100	$200	$300
Santa Barbara	$400	$0	$400
Santa Clara	$3,900	$85,300	$89,200
Solano	$400	$0	$400
Sonoma	$10	$155,870	$155,880
Stanislaus	$480	$0	$480
Tehama	$0	$81,300	$81,300
Tulare	$500	$0	$500
Ventura	$100	$0	$100
Total	**$21,935**	**$440,410**	**$467,380**

[27] List of counties that received either a FFS payment, SNC payment or both. Counties that did not receive a payment are not listed.

Figure 22: Domain 3 Payments by Delivery System and County for PY 5[28]

County	FFS	SNC	Total
Alameda	$2,123,650	$273,130	$2,396,780
Butte	$191,010	$0	$191,010
Contra Costa	$1,213,800	$0	$1,213,800
El Dorado	$252,430	$0	$252,430
Fresno	$4,567,270	$0	$4,567,270
Imperial	$217,510	$0	$217,510
Kern	$5,063,300	$0	$5,063,300
Madera	$730,930	$0	$730,930
Marin	$8,040	$0	$8,040
Merced	$844,850	$0	$844,850
Modoc	$2,530	$0	$2,530
Monterey	$2,418,000	$0	$2,418,000
Napa	$155,460	$0	$155,460
Nevada	$7,270	$8,700	$15,970
Orange	$9,738,520	$147,570	$9,886,090
Placer	$576,210	$23,940	$600,150
Riverside	$7,590,550	$0	$7,590,550
San Bernardino	$8,108,190	$6,500	$8,114,690
San Diego	$6,427,740	$404,900	$6,832,640
San Francisco	$1,285,440	$0	$1,285,440
San Joaquin	$2,495,990	$0	$2,495,990
San Luis Obispo	$584,010	$0	$584,010
San Mateo	$966,060	$1,810	$967,870
Santa Barbara	$1,663,000	$0	$1,663,000
Santa Clara	$2,846,670	$0	$2,846,670
Santa Cruz	$347,340340	$441,670	$789,010
Shasta	$347,340	$0	$140,660
Solano	$140,660	$20,820	$1,001,910
Sonoma	$981,090	$305,770	$509,390
Stanislaus	$203,620	$108,870	$2,671,990
Sutter	$2,563,120	$0	$1,494,180
Tehama	$1,494,180	$64,640	$65,340
Tulare	$700	$0	$2,197,200
Ventura	$2,197,200	$194,600	$3,186,540
Yolo	$2,991,940	$32,080	$101,520
Total	$69,440	**$2,035,000**	**$73,102,720**

[28] Data Source: ASO DTI Reports as of June 2021.

Domain 4

For DY 16, paid amounts for each LDPP are shown in Figure 23. DHCS paid a total of $42,514,660.

Figure 23: Domain 4 Payments by LDPP[29]

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

For all DYs, paid amounts for each LDPP are shown in Figure 24. DHCS paid a total of $108,546,404.

Figure 24: Domain 4 Payments by LDPP[30]

LDPPs	Total Paid
Alameda County	$16,252,324
California Rural Indian Health Board, Inc.	$1,911,233
California State University, Los Angeles	$15,218,815
First 5 San Joaquin	$4,487,937
First 5 Riverside	$8,422,689
Fresno County	$8,231,086
Humboldt County	$3,515,891
Orange County	$15,495,453
Sacramento County	$9,315,478
San Luis Obispo County	$1,643,747

[29] Data Source: ASO Invoices as of June 2021.
[30] Data Source: ASO Invoices as of June 2021.

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

Outreach Efforts

During DY 16, the ASO outreach team modified their approach by substituting routine, in person visits with emails and phone calls to participating providers in Domains 1, 2 and 3 because of the COVID-19 PHE. The outreach efforts included sharing benefits information available to Medi-Cal beneficiaries, Medi-Cal dental training for dental office staff, resource information, COVID-19 PHE updates, provider bulletins regarding Personal Protective Equipment (PPE) and safety protocols, DTI extension and updates, Proposition 56 supplemental payments, and Proposition 56 loan repayment program (CalHealthCares).

Domain 2

The ASO continued to outreach to interested providers during their regular course of business. In DY 16, 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 dental offices in relation to the benefits available to Medi-Cal dental providers who participate in DTI Domain 2. In the last quarter of DY 16, Domain 2 participation increased by 75 providers, bringing the total from 3,261 to 3,336.

Domain 3

In DY 16, the ASO's outreach team visited/contacted 32 of the 36 pilot counties. Domain 3 outreach activities from the first three quarters of DY 16 are listed in the DY 16 Quarterly Progress Reports. During the last quarter of DY 16, the ASO's outreach team visited/contacted twenty-nine (29) of the thirty-six (36) pilot counties - Alameda, Butte, Contra Costa, Fresno, Imperial, Kern, Madera, Marin, Merced, Monterey, Napa, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo. The ASO outreach team offered a vast range of assistance and while networking with enrolled providers, they presented and discussed information about Prop 56 supplemental payments and dental student loan forgiveness as well as DTI. They also helped with renewing their enrollment paperwork.

Visits to the Medi-Cal dental providers that are already enrolled in the program provide an opportunity to establish positive support, communication, and furthers efforts to encourage offices to accept new patients as a result of the additional coverage and performance incentives available to them.

Domain 4

In DY 16, the LDPPs have utilized the email inbox to submit invoices electronically on a quarterly basis as well as communicate individual program concerns, share best practices, request assistance, and inform their liaison of changes to their programs.

Consumer Issues:

There were no consumer issues reported during DY 16.

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 reporting period.

Evaluation:

During DY 16, Mathematica, the DTI independent evaluator, continued to complete tasks associated with the final evaluation of the DTI Program. 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 October 31, 2022.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides an evidence-based benefit design that covers the full continuum of substance use disorder (SUD) care. It requires providers to meet industry standards of care, has a strategy to coordinate and integrate across systems of care, creates utilization controls to improve care and efficient use of resources, reports specific quality measures, and ensures there are the necessary program integrity safeguards and a benefit management strategy. The DMC-ODS allows counties to selectively contract with providers in a managed care environment to deliver a full array of services consistent with the American Society of Addiction Medicine (ASAM) Treatment Criteria, including recovery supports and services. CMS requires all residential providers participating in the DMC-ODS to meet the ASAM requirements and obtain a DHCS issued 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.

Program Highlights:

Please refer to previous quarterly reports for additional activities and details.

Qualitative Findings:

Outreach/Innovative Activities

- Annual DMC-ODS compliance training: On June 9, 2021, DHCS conducted Annual DMC-ODS compliance training. The focus of the training was addressing current compliance trends and technical assistance on frequently missed compliance requirements.

- First-year monthly follow-up with Regional Model counties: DHCS continued to hold monthly technical assistance call with seven regional model counties and PHC to support their DMC-ODS implementation.

- DHCS continued with a monthly call with each county participating in DMC-ODS

to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including a status update on Corrective Action Plans.

- DHCS continued with monthly all county call to address various behavioral health policy issues, including DMC-ODS guidance.

Please refer to previous quarterly reports for additional activities that occurred during DY 16. Recent activities including DMC-ODS guidance are listed below:

- April-June – Weekly DMC-ODS Meetings with DHCS & Aurrera Health Group, Consultant
- April 6, 2021 – External Stakeholder Engagement Meeting, DMC-ODS Documentation Reform
- April 7, 2021 – BHC – DMC-ODS Review Budget Meeting
- April 12, 2021 - CA SMHS and DMC-ODS monthly monitoring call
- April 21, 2021 – DMC-ODS STCs Stakeholder Feedback Review
- April 23, 2021 – DMC-ODS STCs Stakeholder Feedback Review
- April 29, 2021 – Behavioral Health Stakeholder Advisory Committee Meeting
- May 6, 2021 – DMC-ODS Prospective County TA Webinar
- May 10, 2021– CA SMHS and DMC-ODS monthly monitoring call
- May 12, 2021 – DMC-ODS EQRO Contract and Leadership Meeting
- May 13, 2021 – CA 1115 Monthly Monitoring Call
- May 25, 2021 – DMC-ODS Collaborative Model TA Webinar
- June 3, 2021 – DMC-ODS EQRO Contract: County Report Process
- June 3, 2021 – DMC-ODS Prospective County TA Webinar: Collaborative Model
- June 8, 2021 – DMC-ODS EQRO Contract Extension FY 21/22 - Budget
- June 8, 2021 – 1115 Review Meeting
- June 14, 2021 – CA SMHS and DMC-ODS monthly monitoring call
- June 14, 2021 – CA 1115 Monthly Monitoring Call (Zoom)

<u>Quality Assurance/Monitoring Activities</u>

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

DHCS analyzed recent compliance data and developed annual compliance training for DMC-ODS counties on June 9, 2021. The training focused on the compliance trends, compliance review and corrective action plan process, frequently missed compliance requirements, and overview of CalAIM changes that will affect the DMC-ODS program.

DHCS formed a special project team to support the first year of implementation of the regional model. 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 phasing out of the project in the next two quarters as the regional model counties transition to the regular ongoing monitoring and technical assistance process.

In response to the COVID-19 pandemic affecting counties during DY 15, many counties requested postponements for their scheduled monitoring reviews. Postponements from DY 15, Q4 delayed the completion of the FY 2019-20 review year to September 2020.

The altered schedule delayed the start of the FY 2020-21 review year to October 2020, from the originally scheduled date of July 2020. Subsequently, the first reviews for the FY 2020-21 review year during DY 16 began in January 2021.

Additional requests from counties for postponements of monitoring reviews due to the continued impacts of COVID-19 and natural disasters occurring during DY 16 required the rescheduling of reviews for the FY 2020-21 review year to as late as October 2021.

DHCS conducted compliance monitoring reviews for the following Counties listed in Figure 25 during DY 16:

Figure 25: Compliance Monitoring Reviews

County	Review Date
Alpine	July 2020
Inyo	July 2020
Lake	July 2020
Lassen	July 2020
Madera	July 2020
Nevada	July 2020
Orange	July 2020
San Joaquin	July 2020
Shasta	July 2020
Sutter/Yuba	July 2020
Mendocino	August 2020

County	Review Date
Santa Cruz	August 2020
Ventura	August 2020
Yolo	August 2020
Los Angeles	September 2020
Santa Barbara	September 2020
Santa Clara	September 2020
Sierra	September 2020
Amador	January 2021
Colusa	February 2021
Fresno	February 2021
Glenn	February 2021
Placer	February 2021
San Diego	February 2021
Butte	March 2021
San Francisco	March 2021
San Mateo	March 2021
Contra Costa	April 2021
Marin	April 2021
Napa	April 2021
Stanislaus	April 2021
Imperial	May 2021
Lassen	May 2021
Mariposa	May 2021
Modoc	May 2021
San Benito	May 2021

County	Review Date
Siskiyou	May 2021
Alpine	June 2021
Mono	June 2021
San Luis Obispo	June 2021
Santa Clara	June 2021
Shasta	June 2021
Solano	June 2021

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 4 of FY 2020-21, and the annual data for FY 2020-21 is as follows.

From Quarter 3 to Quarter 4, there were significant increases in grievances submitted from Los Angeles, San Diego, San Joaquin, and Santa Cruz counties. Each of these counties were contacted to ascertain the reason for the increase to grievances filed. Los Angeles County attributed the increase to one provider who has submitted grievances to contest several member authorization denials. San Diego County attributed the increase to one program and they are currently investigating those grievances. San Joaquin County attributed the increase of grievances to complaints about food in a residential program being used beyond the date of expiration as well as reports of staff being rude, not helpful or approachable. The County/Provider Operations and Monitoring Branch are working closely with these counties to address issues that are raised.

Santa Cruz County reported that the fluctuation in appeals per quarter is due to their contracted MAT program's operational procedure of issuing Termination NOABDs in groups or batches, which causes fluctuations in appeal activity throughout the year. The County's Quality Improvement department has provided technical assistance to the contracted MAT Clinic's Supervisor regarding the need for consistent issuance of Termination NOABDs and directed them to update their procedures by August 31, 2021. DHCS will continue to monitor the County to ensure the County brings the provider into compliance with NOABD requirements.

Although San Diego County reported an increase of grievances submitted from Quarter 3 to Quarter 4 there was a decrease from 174 reported in FY 2019-20 to 85 in FY 2020-21. The Regional Model, implemented DMC-ODS services on July 1, 2020, includes Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. The reported numbers for these counties are combined on the Regional Model line in each chart below.

Figure 26: Grievance Data FY 2020-21 Quarter 4

FY 2020-21 Quarter 4 (April 2021 – June 2021) Grievance							
County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
Alameda	-	-	2	-	-	1	**3**
Contra Costa	1	-	-	-	-	-	**1**
El Dorado	-	-	1	-	-	-	**1**
Fresno	-	-	-	-	-	-	**0**
Imperial	-	-	-	-	-	-	**0**
Kern	-	3	-	1	-	-	**4**
Los Angeles	-	-	53	-	-	-	**53**
Marin	-	-	5	-	-	-	**5**
Merced	-	1	-	-	-	1	**2**
Monterey	-	-	-	-	-	-	**0**
Napa	-	-	-	-	-	-	**0**
Nevada	-	-	-	1	-	-	**1**
Orange	2	5	1	1	-	1	**10**
Placer	1	3	3	-	1	-	**8**
Riverside	1	11	-	-	-	-	**12**
Sacramento	-	2	-	-	1	1	**4**
San Benito	-	1	-	-	-	-	**1**

County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
San Bernardino	1	8	-	-	-	-	**9**
San Diego	1	21	4	4	-	8	**38**
San Francisco	-	-	1	-	-	-	**1**
San Joaquin	-	5	-	-	-	15	**20**
San Luis Obispo	-	3	-	-	-	-	**3**
San Mateo	-	2	-	-	-	-	**2**
Santa Barbara	1	2	5	2	3	-	**13**
Santa Clara	-	-	-	-	-	1	**1**
Santa Cruz	-	2	-	1	1	1	**5**
Stanislaus	-	1	-	-	-	-	**1**
Tulare	-	-	-	-	-	-	**0**
Ventura	-	1	-	-	-	-	**1**
Yolo	-	-	-	-	-	3	**3**
Regional Model	5	1	-	-	5	4	**15**

Figure 27: Resolution and Transition of Care FY 2020-21 Quarter 4

FY 2020-21 Quarter 4 (April 2021 – June 2021) Resolution and Transition of Care Data							
	Resolution				Transition of Care (TOC)		
County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
Alameda	3	-	-	-	-	-	-
Contra Costa	-	-	-	-	-	-	-
El Dorado	1	-	-	-	-	-	-
Fresno	-	-	-	-	-	-	-
Imperial	-	-	-	-	-	-	-
Kern	4	-	-	-	-	-	-
Los Angeles	8	33	16	17	-	-	-
Marin	-	-	-	-	-	-	-
Merced	2	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	-	-	-	-	-	-	-
Orange	7	-	-	-	-	-	-
Placer	8	-	-	-	-	-	-
Riverside	12	-	-	-	-	-	-
Sacramento	5	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	7	-	-	-	-	-	-
San Diego	23	4	2	2	-	-	-
San Francisco	1	-	-	-	-	-	-
San Joaquin	10	-	-	-	-	-	-

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
San Luis Obispo	1	-	-	-	-	-	-
San Mateo	-	-	-	-	-	-	-
Santa Barbara	8	-	-	-	-	-	-
Santa Clara	2	-	-	-	-	-	-
Santa Cruz	7	3	-	3	-	-	-
Stanislaus	1	-	-	-	-	-	-
Tulare	-	-	-	-	-	-	-
Ventura	-	-	-	-	-	-	-
Yolo	3	-	-	-	-	-	-
Regional Model	13	2	1	1	-	-	-

The following figures show annual grievance and appeal data for FY 2020-21.

Figure 28: Grievance Data FY 2020-21

FY 2020-21 Grievances							
County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
Alameda	-	-	3	-	1	1	**5**
Contra Costa	2	-	-	-	1	5	**8**
El Dorado	-	-	1	1	-	1	**3**
Fresno	1	3	-	-	-	-	**4**
Imperial	-	-	-	-	1	1	**2**
Kern	4	24	7	1	1	-	**37**
Los Angeles	2	1	63	2	2	9	**79**

County	Access to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	**Totals**
Marin	-	3	5	1	1	-	**10**
Merced	-	4	-	-	-	2	**6**
Monterey	-	-	-	-	-	-	**0**
Napa	-	-	-	-	-	-	**0**
Nevada	-	6	-	5	-	2	**13**
Orange	13	12	1	2	1	1	**30**
Placer	1	4	8	5	7	-	**25**
Riverside	8	28	-	-	4	3	**43**
Sacramento	-	3	1	-	2	3	**9**
San Benito	-	3	-	-	-	-	**3**
San Bernardino	2	17	-	-	-	-	**19**
San Diego	6	51	5	9	-	14	**85**
San Francisco	-	-	2	-	1	1	**4**
San Joaquin	-	7	-	1	-	17	**25**
San Luis Obispo	-	4	-	1	1	5	**11**
San Mateo	-	6	2	1	2	1	**12**
Santa Barbara	2	7	8	7	9	3	**36**
Santa Clara	1	-	2	-	-	2	**5**
Santa Cruz	1	5	-	1	2	11	**20**
Stanislaus	-	8	-	-	-	8	**16**
Tulare	-	-	-	-	-	-	**0**
Ventura	-	1	-	-	-	-	**1**
Yolo	1	6	2	-	-	4	**13**
Regional Model	6	1	2	-	24	4	**37**

Figure 29: Resolution and Transition of Care FY 2020-21

FY 2020-21 Resolution and Transition of Care Data							
	Resolution				Transition of Care (TOC)		
County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
Alameda	4	2	1	1	-	-	-
Contra Costa	7	-	-	-	-	-	-
El Dorado	3	1	-	1	-	-	-
Fresno	2	-	-	-	-	-	-
Imperial	2	-	-	-	-	-	-
Kern	31	-	-	-	-	-	-
Los Angeles	28	117	56	73	-	-	-
Marin	5	-	-	-	-	-	-
Merced	6	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	6	-	-	-	-	-	-
Orange	27	5	3	2	-	-	-
Placer	25	-	-	-	-	-	-
Riverside	40	1	-	-	-	-	-
Sacramento	5	-	-	-	-	-	-
San Benito	2	-	-	-	-	-	-
San Bernardino	9	-	-	-	-	-	-
San Diego	66	8	6	2	-	-	-
San Francisco	5	1	1	-	-	-	-

County	Grievances	Appeal	Appeal in favor of Plan	Appeal in favor of Beneficiary	Requests	Approved	Denied
San Joaquin	15	-	-	-	-	-	-
San Luis Obispo	2	1	-	3	-	-	-
San Mateo	10	-	-	-	-	-	-
Santa Barbara	15	1	-	-	-	-	-
Santa Clara	7	-	-	-	1	-	-
Santa Cruz	22	24	9	15	-	-	-
Stanislaus	16	1	1	-	1	-	1
Tulare	-	1	-	1	-	-	-
Ventura	-	1	-	1	-	-	-
Yolo	12	-	-	-	-	-	-
Regional Model	33	2	1	1	-	-	-

Quantitative Findings:

Nothing to report.

Enrollment Information

Prior quarters have been updated based on new claims data. For State Fiscal Year (SFY) 2020-21, DY16-Q3 and DY16-Q4, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Figure 30: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total*
DY16-Q1	41,362	16,332	57,144
DY16-Q2	41,591	15,780	56,780
DY16-Q3	43,342	14,505	57,235
DY16-Q4	40,381	12,385	52,346

* *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:

Figure 31: DY 15 Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	32,820	33,352	33,317	DY16-Q1	41,362
	34,137	32,911	33,153	DY16-Q2	41,591
	33,389	33,429	32,696	DY16-Q3	43,342
	31,098	30,802	31,132	DY16-Q4	40,381
Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
Non-ACA	16,937	17,139	17,201	DY16-Q1	16,332
	17,425	16,935	17,112	DY16-Q2	15,780
	16,772	15,860	15,797	DY16-Q3	14,505
	14,560	14,669	14,753	DY16-Q4	12,385

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 reported numbers when data is pulled prior to the claiming deadline. Accurate enrollment numbers are updated and provided in subsequent quarterly report cycles.

Financial/Budget Neutrality Developments/Issues:

Figure 32: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY16-Q1					
ACA	2,773,463	$104,891,371.40	$87,439,081.39	$10,418,496.55	$7,033,793.46
Non ACA	1,207,550	$32,949,646.64	$17,615,629.62	$4,429,172.77	$10,904,844.25
DY16-Q2					
ACA	2,790,875	$108,694,626.47	$91,060,397.03	$10,819,162.13	$6,815,067.31

Non ACA	1,168,074	$33,228,612.42	$18,694,933.03	$4,629,376.97	$9,904,302.42
DY16-Q3					
ACA	2,785,159	$107,008,859.83	$89,766,846.37	$10,226,431.16	$7,015,582.30
Non ACA	954,464	$29,563,797.61	$16,629,861.89	$4,336,019.78	$8,597,915.94
DY16-Q4					
ACA	2,517,242	$101,198,340.39	$85,047,974.99	$10,019,858.61	$6,130,506.79
Non ACA	804,541	$26,090,011.65	$14,704,997.18	$4,393,275.56	$6,991,738.91

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.

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

Progress on the Evaluation and Findings:

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. The following summarizes evaluation activities for DY16-Q1 through DY16-Q4:

ODS Annual Activity Summary Report FY 2020-2021

Over the course of this fiscal period (July 2020 – June 2021), UCLA continued to collect quantitative and qualitative data based on the approved 1115 waiver DMC-ODS Evaluation Plan. Data sources included the following:

- **Administrative Data** were prepared and analyzed. Sources included: CalOMS-Tx, Short Doyle Medi-Cal claims, Managed Care/Fee for Service, and ASAM Level of Care Referral data.

- **Stakeholder surveys** were conducted using five sets of administrator surveys.

- **Treatment Perception Surveys (TPS)** were administered to all California clients in publicly funded SUD treatment from November 9-13, 2020. Due to COVID-19 restrictions, online and automated phone surveys were added. A TPS 2020 Summary Report can be found online here: https://drive.google.com/file/d/10ixkEHnQ2xQeeziZ5erCTXxjDFaCT1T4/view?usp=sharing

- **Qualitative interviews** included patient interviews to uncover barriers and facilitators in the transition from residential to outpatient treatment, county experiences with waiver implementation, and lessons learned from California's only regional model.

- **Beneficiary access line secret shopper calls** were conducted following the roll out of the Partnership regional model to verify the line's availability to beneficiaries while rating wait times and staff friendliness.

Results from the analyses of these data sources as well as recommendations based on the findings have been published in UCLA's 2020 DMC-ODS Evaluation Report, which can be found at: https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf.

This report documented the following:

- The positive impact of the waiver on access, quality, and coordination of care.
- The impact of COVID-19 on SUD treatment and the promising emergence of telehealth.
- Feedback from current DMC-ODS stakeholders.
- What current non-waiver counties would need in order to join the DMC-ODS program.
- Challenges presented by stimulants and homelessness.

In addition to the data analyses and reporting described above, UCLA also provided technical assistance to various stakeholders. Highlights of these efforts include the development of free tools for SUD screening and assessment. These include:

Brief Questionnaire for Initial Placement (BQuIP): UCLA worked with DHCS to launch BQuIP, a fast and free web-based tool designed to automatically generate recommendations for initial placement for individuals seeking treatment for substance use disorders. BQuIP can be found here: https://www.uclaisap.org/bquiptool/index.html.

Paper-based ASAM Criteria Assessment Tool: UCLA worked closely with an expert group from the American Society of Addiction Medicine (ASAM) and an internal group of addiction experts at UCLA ISAP to develop a free paper-based ASAM Criteria assessment tool. The draft is pending approval from the ASAM Criteria Strategy Committee, and UCLA is working with Siskiyou County to pilot test the form. When complete, the form will be freely available to any user.

Enclosures/Attachments:
The attachment titled *DY 16 DMC-ODS Expenditures* 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 DY 16.

GLOBAL PAYMENT PROGRAM

The Global Payment Program (GPP) assists public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCS 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 PHCS receive GPP payments that are calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforces structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. Care being received in appropriate settings is valued relatively higher than care provided in inappropriate care settings for the type of illness.

The total amount of funds available for the GPP is a combination of a portion of the state's Disproportionate Share Hospital (DSH) Program's allotment that would otherwise be allocated to the PHCS, and the amount associated with the Safety Net Care Pool under the Bridge to Reform demonstration.

Accomplishments:

The Department of Health Care Services (DHCS) successfully utilized the GPP Encounter Data Collection SharePoint Extranet site as a method of data transmission. Each PHCS submitted encounter level data on their uninsured services using excel templates provided in accordance with the Standard Terms and Conditions, Attachments EE and FF. DHCS extended the deadline to submit the GPP encounter level data reports to alleviate hospital workload resulting from the COVID crisis. The original due date was March 31, 2020. The encounter level data documents for Program Year (PY) 5 were submitted to DHCS on March 31, 2021.

Program Highlights:

On August 3, 2020, DHCS received CMS approval to amend and extend the GPP program. The amendment allows DHCS to operate an additional six-month GPP program year for the service period of July 1, 2020, to December 31, 2020.

Two Demonstration Year (DY) 16 final reports were due to DHCS from all participating GPP PHCS on March 31, 2021. Those reports were the PY 5 final year-end summary aggregate report, and the PY 5 encounter level data report. DHCS received all reports on time, conducted thorough evaluations of the reports, and completed the final reconciliation and redistribution process. PHCS were notified of the final reconciliation and redistribution process payment amounts and Intergovernmental Transfer (IGT) amounts on June 14, 2021.

Qualitative Findings:

Nothing to report.

Quantitative Findings:

The SFY 2018-19 PY 4 Final Reconciliation occurred at the beginning of DY 16 and DHCS recouped $19,823,677.00 in total funds from PHCS. The recoupment was a result of two PHCS that submitted final year-end reports with revisions to the interim report. The table below shows the PHCS requiring recoupment and their associated PY 4 Interim and Final reporting differences in the percent of GPP threshold met.

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

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

In SFY 2019-20 PY 5, DHCS recouped $9,367,751.00 in total funds from Ventura County Medical Center (VCMC). The recoupment was due to overpayment to VCMC. In PY 5, IQ 1 – 3 (July 1, 2019 – March 30, 2020), VCMC was paid 75% of its total annual budget. On August 15, 2020, VCMC submitted an interim year-end summary aggregate report. The threshold points earned for VCMC was 70% of GPP thresholds. The 70% is less than 75% of its total annual budget. Therefore, DHCS adjusted the payments previously made to VCMC for GPP PY 5 and recouped the difference in the amount of $9,367,751.00 from VCMC.

The payments table on the next page shows the GPP payments made to the PHCS in the order that they were paid during DY 16.

Figure 33: Payments Table

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 4 (July – June) Overpayment collection	($9,911,838.50)	($9,911,838.50)	DY 14	($19,823,677.00)
PY 4 Final Rec. (July – June)	$59,119,552.50	$59,119,552.50	DY 14	$118,239,105.00
PY 5, IQ4 (July-March) Overpayment collection	($4,683,875.50)	($4,683,875.50)	DY 15	($9,367,751.00)
PY 5, IQ4 (April – June)	$203,395,684.86	$158,518,345.14	DY 15	$361,914,030.00
PY 6A, IQ1 (July – September)	$250,438,727.00	$195,181,783.00	DY 16	$445,620,510.00
PY 6A, IQ2 (October – December)	$144,554,360.73	$112,659,804.27	DY 16	$257,214,165.00
PY 6A, IQ2B (October – December)	$101,770,870.40	$79,316,087.60	DY 16	$181,086,958.00
PY 6B, IQ 1 (January – March)	$251,197,595.22	$195,773,214.78	DY 16	$446,970,810.00
Total	**$995,881,076.71**	**$785,973,073.29**		**$1,781,854,150.00**

Policy/Administrative Issues and Challenges:

Nothing to report.

OUT-OF-STATE FORMER FOSTER CARE YOUTH

On August 18, 2017, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow the Department of Health Care Services (DHCS) to continue providing Medicaid coverage for former foster care youth under age 26, consistent with federal requirements for coverage of this population. Given the waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category.

The evaluation design (Attachment QQ) was approved on December 22, 2017, using the most current data from 2015. CMS agreed that the OOS FFY population was statistically insignificant for comparison in the evaluation design. Any statistical comparisons in Attachment QQ were to be between the FFY population and the Medi-Cal population age 18 to 25, inclusive. The waiver amendment authorized Medi-Cal 2020 to include OOS FFY starting on November 1, 2017. The DY 16 report and Attachment QQ uses the most current data for FFY from 2019.

DHCS submitted the Interim Evaluation Report for the OOS FFY Program to CMS on June 23, 2020. The State of California also submitted a request to CMS on September 16, 2020 for a 12-month extension of Medi-Cal 2020 to extend Medi-Cal 2020 to December 31, 2021. On December 29, 2020, CMS approved a temporary extension of Medi-Cal 2020 to December 31, 2021. CMS and the State will continue working on approval of a longer term extension of the demonstration.

Under the temporary extension, an annual report for Medi-Cal 2020 for Demonstration Year (DY) 16 for the OOS FFY is due to CMS by October 28, 2021.

Accomplishments:

California was the first state to have its 1115 Waiver approved by CMS to provide Medi-Cal eligibility to FFY who were in foster care in a state other than California and currently residing in California. Under the FFY Program, the OOS FFY under age 26 who qualify consistent with the federal requirements receive full scope benefits in Medi-Cal until they turn 26. These youths do not have to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

California continues to increase the number of FFY who are enrolled in the FFY Medi-Cal Program. Since 2016, California has added over 6,500 FFY to the FFY Program under the HEDIS requirements of being enrolled for eleven out of twelve months in a year. Almost 3,000 additional FFY have utilized Ambulatory Care Visits demonstrating the progress in meeting the DHCS goal of improving health outcomes for FFY. FFY utilizations of Emergency Department Visits have also increased since 2016 by

approximately 2,200 FFY. The remaining utilization measures in the FFY Waiver continue to show increases in FFY use.

Program Highlights:

By 2019, California has increased total enrollment of FFY in Medi-Cal to 18,153, and of those, 81 are OOS FFY. These FFY meet the HEDIS requirements of being enrolled in Medi-Cal for eleven out of twelve months at any time in 2019. FFY continue to actively utilize the full scope Medi-Cal benefits available to them whether it is behavioral health visits, emergency department visits, inpatient stays or specific courses of treatment. Attachment QQ is based upon HEDIS requirements and provides the FFY data based upon the number of FFY who remained enrolled in 2019 for eleven of the twelve months.

Qualitative Findings:

California continues to:

- use the current single-streamlined application that is used for all Insurance Affordability Programs within the state, including Medi-Cal, as applicable for OOS FFY;
- hold regular meetings with the counties to resolve issues that arise for the FFY;
- collaborate with our county partners in the development of a flag in the Medi-Cal Eligibility Data System (MEDS) to allow counties to track FFY eligibility in one system location, accessible to all counties, to simplify tracking youths for eligibility purposes as they change residence from one county to another;
- work closely with the California Department of Social Services to ensure the foster care youths are being transitioned seamlessly into the FFY Program without a break in Medi-Cal coverage, and;
- regularly meet with stakeholders for feedback on any concerns or issues.

Quantitative Findings:

According to the 2019 Enrollment, Utilization, and Health Outcomes evaluation (DY 16 Attachment QQ), the FFY population continues to show greater use of Emergency Department (ED) visits, behavioral health visits and inpatient stays when compared to the 18-25 year old Medi-Cal population. Quality measures for Chlamydia Screening in Women (CHL) and Cervical Cancer Screening (CCS) also continue to be accessed more by the FFY group than the 18-25 year old Medi-Cal population.

When comparing the FFY Medi-Cal utilization from 2018 to 2019, the number of FFY who were actively enrolled for 11 months grew from 17,387 to 18,153. There was also an increase of utilization of ambulatory care visits, behavioral health visits, emergency

department visits and inpatient stays. The OOS FFY population experienced an increase in 11 months enrollment in Medi-Cal from 66 to 81 and showed an increase of utilization.

Comparison of quality measures for FFY from 2018 to 2019 show an increased utilization of all quality measures other than Initiation and Engagement of Alcohol and Other Drug Treatment (IET). The OOS FFY utilization of quality measures is insufficient to allow for disclosure due Data De-Identification Guidelines.

Policy/Administrative Issues and Challenges:

FFY are a group of individuals who move often, and are accustomed to having their health care needs taken care of by the foster care system and/or caretakers. A youth new to California will have limited knowledge on where to access health care resources. They may also be unaware that California offers Medi-Cal for the former foster youth from ages 18 to 25 inclusive, until they are in need of services. Engagement with FFY stakeholders to convey information on access to services is conducted monthly.

Many FFY are also eligible for other programs that offer cash aid in addition to Medi-Cal. When these youths lose their eligibility for the cash aid programs, they are not always placed back into the FFY program, potentially creating a gap in their Medi-Cal coverage. California currently lacks the administrative ability to track OOS FFY entering or exiting the state or transitioning to other programs. To remedy this, DHCS is developing a system alert for counties to flag these cases, in an effort to ultimately prevent any gaps in Medi-Cal coverage. Due to the complexity of the project, the alert will be completed in stages. Completion of all stages is anticipated by 2022.
On October 24, 2018, Congress passed H.R. 6, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

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

To remedy the potential gap in coverage for the OOS FFY, California included the OOS FFY in its request for an amendment and five-year renewal of the CalAIM Section 1115 Demonstration. The request was submitted on June 30, 2021 with a requested effective date of January 1, 2022. Since OOS FFY were included in the new CalAIM Section

1115 Demonstration request, their Medi-Cal eligibility will be maintained for the next five years under the CalAIM Demonstration.

Under H.R. 6, Section 1001 of the SUPPORT Act “At-Risk Youth Medicaid Protection”, eligibility for medical assistance for eligible juveniles may not be terminated because the juvenile is incarcerated. The initial definition of eligible juveniles included FFY as described in Section 1902 of the Social Security Act (SSA) subsection of (a)(10)(A)(i)(IX). OOS FFY were excluded in this initial definition and therefore were not eligible for the coverage under Section 1001 of the SUPPORT Act.

CMS published additional guidance on January 19, 2021 that redefined ““eligible juvenile” to include beneficiaries eligible under the state plan and/or under a section 1115 demonstration project for whom expenditures are regarded as expenditures under the state plan, including individuals under age 26 who were enrolled in both Medicaid and in foster care under the responsibility of another state upon attaining age 18 or higher applicable age.” Under the revised definition of “eligible juvenile” OOS FFY are eligible for coverage under Section 1001 of the SUPPORT Act.

Progress on the Evaluation and Findings:

Please see Attachment QQ – FFY Out-of-State Foster Care 2019 Data.

PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL

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

The PRIME Program aims to:

- Advance improvements in the quality, experience, and value of care that Designated Public Hospitals (DPH)/District/Municipal Public Hospitals (DMPH) provide

- Align projects and goals of PRIME with other elements of Medi-Cal 2020, avoiding duplication of resources and double payment for program work

- Develop health care systems that offer increased value for payers and patients

- Emphasize advances in primary care, cross-system integration, and data analytics

- Move participating PRIME entities toward a value-based payment structure when receiving payments for managed care beneficiaries

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

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

The projects in Domain 2 – Targeted High-Risk or High-Cost Populations – focus on specific populations that would benefit most significantly from care integration and coordination: populations in need of perinatal care, individuals in need of post-acute

care or complex care planning, foster children, individuals who are reintegrating into society post-incarceration, individuals with chronic non-malignant pain, and those with advanced illness.

Projects in Domain 3 – Resource Utilization Efficiency – reduce unwarranted variation in the use of evidence-based diagnostics and treatments (antibiotics, blood or blood products, and high cost imaging studies and pharmaceutical therapies) by targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects also eliminate the use of ineffective or harmful targeted clinical services.

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

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

Accomplishments:

- DHCS hosted its final annual PRIME Learning Collaborative meeting on October 26-28, 2020 for all participating PRIME entities using a virtual conference format due to the COVID-19 Public Health Emergency (PHE).
- Entities submitted their DY 15 Year-End (YE) final reports and following DHCS review and approval of these reports, all remaining PRIME payment payments were approved in November 2020 and issued to hospitals.
- DHCS submitted the PRIME Preliminary Summative Evaluation to CMS on December 17, 2020 and obtained CMS approval on the PRIME Preliminary Summative Evaluation in February 8, 2021.
- During DY 16, DHCS and the PRIME external evaluator, University of California Los Angeles, Center for Health Policy Research (UCLA), worked extensively on the Summative PRIME Evaluation. The draft PRIME Summative Evaluation was submitted August 19, 2021 and is currently with CMS for review and feedback

Policy/Administrative Issues and Challenges:

On July 27, 2020, CMS approved DHCS's proposal to modify the methodology for the distribution of incentive payments under the PRIME program to participating PRIME entities for DY 15 YE payments and DY 15 supplemental payments. The modifications are authorized by CMS' approval of revisions to the Medi-Cal 2020 Special Terms &

Conditions (STCs), Attachment II – Program Funding and Mechanics Protocol. DHCS issued PRIME Policy Letter 20-003 notifying entities of these modifications on August 24, 2020.

Program Highlights:

PRIMEd Annual Conference 2020

DHCS hosted the 2020 PRIMEd Annual Conference, a virtual event starting on Monday, October 26, 2020 through Wednesday, October 28, 2020, which consisted of three half-day sessions.

On Monday, October 26, topics explored the COVID-19 pandemic and how it influenced PRIME hospitals. The keynote speaker was Dr. Donald Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, who spoke on how health systems could focus on effectively navigating through COVID-19 challenges. The other presentation topics for this half-day were on Addressing COVID-19-Related Health and Health Care Disparities, and Trauma-Informed Practices to Address Stress Related to COVID-19.

On Tuesday, October 27, the topic focused on developments in telehealth policies and expansion efforts during the pandemic. The session ended with presentations by PRIME entities about their hospital-level initiatives and changes.

The final day of the conference, Wednesday, October 28, focused on PRIME programmatic updates, with a presentation by PRIME's external evaluator, UCLA on the interim evaluation results, practical tips for sustaining quality improvement efforts, and next steps for mechanics of the new Quality Incentive Pool (QIP) Program.

Additional Learning Collaborative Activities

DHCS continued to host PRIME Topic-Specific Learning Collaboratives (TLCs) from July 2020 through December 2020. These TLCs originally began in Q4 of DY 13. These TLCs created opportunities for PRIME entities to exchange ideas, engage in peer-to-peer learning and disseminate best practices in a collaborative effort to improve care delivery and meet project goals.

During July 2020 through December 2020, PRIME TLC meetings were held on the following topics:

- Health Homes for Foster Children
    - August 2020, the TLC featured a joint webinar with the Care Transition TLC group. The National Alliance to Advance Adolescent Health

presented to the TLC on pediatric to adult transitions and the Got Transition program.
    - September 2020, the TLC featured Dr. Bimla Schwarz, Professor of Internal Medicine at UC Davis Health, Maternal and Family Health Medical Officer, who works in the field of Maternal Child Adolescent Health, presented to the TLC on adolescent health issues resulting from tobacco use in the home.

- Reducing Health Disparities
    - July 2020, Dr. Seema Jain, MD, Chief of the Disease Investigations Section for the Infectious Diseases Branch and COVID-19 Response Science Branch Director at the California Department of Public Health, shared current California COVID-19 data stratified by age and race/ethnicity showing disproportionate impact on certain populations.
    - August 2020, after seeing the COVID-19 data from Dr. Jain's presentation, the workgroup discussed COVID-19 and Health Disparity Data among PRIME entities i.e. collecting and tracking data and what insights or conclusions emanate from this data.

- Care Transitions
    - August 2020, the TLC featured a joint webinar with the Health Homes for Foster Children TLC group. The National Alliance to Advance Adolescent Health presented to the TLC on pediatric to adult transitions and the Got Transition program.

- Maternal and Infant Health
    - August 2020, Dr. Bimla Schwarz, Professor of Internal Medicine at UC Davis Health, Maternal and Family Health Medical Officer, who works in the field of Maternal Child Adolescent Health, presented to the TLC on tobacco use and treatments for perinatal health.
    - December 2020, the Maternal and Infant Health TLC engaged in a discussion about interest in maternal and infant health-related shared learning opportunities in 2021.

- Tobacco Cessation (facilitated by the CA Quits Team)
    - July 2020, Dr. Ulfat Shaikh, Professor of Pediatrics, Director of Healthcare Quality and Quality Improvement Officer at UC Davis Health, presented on clinical champions in quality improvement Health Systems Promoting Cessation Services.
    - August 2020, TLC participants discussed who they partner with to address tobacco, why those partnerships and collaborations are important, and how COVID-19 may have affected their work with the partners.

- September 2020, Rebecca Hsieh, CA Quits Communication & Education Coordinator presented on Educational Materials Design Considerations and shared key concepts and resources when creating materials.
- October 2020, TLC participants discussed disparities among priority populations and effective use of tailored resources to connect with the priority populations.
- November 2020, Dr. Bimla Schwarz, Professor of Internal Medicine and CA Quits faculty advisor at UC Davis Health presented on Managing Tobacco for Maternal Health.
- December 2020, TLC participants presented 2020 highlights and goals moving forward. CA Quits reinforced their support and resources available to the health systems.

- Behavioral Health
  - July 2020, the TLC featured Dr. Amy Walters, PhD a clinical health psychologist and the Director of Behavioral Health Services for St. Luke's Humphreys Diabetes Center in Boise, Idaho. Dr. Walters presented on the impact of psycho-social factors on diabetes management and the importance of support for behavior change goals then led an open discussion with the group.
  - August 2020, the TLC featured a presentation by Dr. Stuart A. Buttlaire, PhD, MBA board member of the California Hospital Association Behavioral Health Board and who had been recently selected to serve on the American Hospital Associations Regional Policy Board for the Western Section. Dr. Buttlaire is a regional leader in the development of Best Practices at Kaiser Permanente and presented on the effect of COVID-19 on youth wellness, mental health care delivery, and related topics.
  - September 2020, the TLC featured a presentation by Dr. Aimee Moulin, MD Associate Professor at UC Davis appointed dually to the Department of Emergency Medicine and Psychiatry. Dr. Moulin is the Behavioral Health Director for the Emergency Department at UC Davis. Dr. Moulin presented on the California Bridge Project and how the COVID-19 PHE has affected treatment for opioid use disorder.
  - December 2020, the TLC featured an open discussion amongst the group to provide TLC members the opportunity to share best practices, tools, and challenges in behavioral health care during the COVID-19 PHE.

Qualitative Findings:

In accordance with DHCS' monitoring responsibilities, DY 15 Final YE Reports were due to DHCS from all participating PRIME entities on September 30, 2020. DHCS conducted its administrative reviews of all reports, and approved them for payment, appropriate to the demonstrated achievement values. Eight DMPHs were approved for

reporting extensions while 43 entities submitted their reports by the original reporting deadline. All 8 DMPHs met their extended deadline. Final DY 15 YE payments were approved in November 2020.

Quantitative Findings:

Figure 34

Payment	FFP	IGT	Service Period	Total Funds Payment
(Qtr. 1 July - Sept)	$147,262,246.65	$129,659,024.55	DY 13/14/15	$276,921,271.20
(Qtr. 2 Oct – Dec)	$368,716,274.76	$287,627,274.58	DY 14/15	$656,343,549.34
(Qtr. 3 Jan – Mar)	$5,928,111.92	$4,620,129.93	DY 15	$10,548,241.85
(Qtr. 4 Apr – Jun)	$88,675,339.55	$69,129,599.19	DY 14/15	$157,804,938.74
Total	$610,581,972.88	$491,036,028.25		$1,101,618,001.13

In DY 16 Q1-Q4, 17 DPHs and 34 DMPHs received payments. In DY16 Q4, 17 DPHs and 27 DMPHs received their DY 15 Supplemental payments and one DPMH received a DY 14 Annual Adjustment payment. During this quarter, DPHs and DMPHs received $88,675,339.53 in federal financial participation (FFP) for PRIME-eligible achievements instead of $78,813,469.35. The difference of **$9,772,870.18**, which is 6.2 percent in FFP above the normal rate of FFP, is due to the transactions qualifying for increased FMAP of 56.2 percent under the Families First Coronavirus Response Act.

Progress on the Evaluation and Findings:

PRIME Evaluation – Preliminary Summative

The PRIME Preliminary Summative Evaluation Report was submitted to CMS on December 17, 2020 and CMS approved the report in February 8, 2021. UCLA analyzed survey data examining the potential role of synergies between PRIME projects with organizational goals and other initiatives, hospital perspectives of the progress in implementation of PRIME project goals and activities, the level of effort and difficulty in implementation, facilitators of success, and sustainability of PRIME activities. Additionally, the report assessed all available years of hospital-reported metrics. Data

sources included hospital surveys (completed April 2020) which reflected active projects in DY 15. Survey data analysis limitations include those associated with self-reported data, such as potential biases in survey responses. The timing of the survey mostly excluded disruptions caused by the COVID-19 pandemic. UCLA also analyzed PRIME hospital-reported data from DY 11 through DY 14 (July 2017 through June 2019). UCLA analyzed the final reports for each DY to assess the change in performance levels. Limitations of this data analysis include inability to infer causal relationships from observational data and unknown or underlying variations in metric calculation by hospitals. The findings for all PRIME evaluation reports are summarized on the following page.

PRIME Evaluation – Final Summative

The draft Final Summative Evaluation Report was developed in DY 16, with the final draft submission to CMS on August 19, 2021. Data sources included patient discharge data from California's Office of Statewide Healthcare Planning and Development through December 2019, as the data is annual and 2020 was not available yet. The evaluation also used DHCS Medi-Cal enrollment, claims, and encounter data that was available through June 30, 2020. Limitations with using this data included claims run-out and lag, as well as any changes or delays caused by the pandemic. Qualitative data included survey and key-informant data from prior data collection, as well as a new survey about the impact of COVID in the last 6 months of PRIME. Additionally, hospital-reported DY 15 YE data was included in the report; however, DY 15 YE was not included in metric trend analysis due to the COVID-19 PHE.

Findings

An intensive assessment of PRIME hospitals' efforts in developing the infrastructure and care processes, as well as system-wide and project specific implementation of PRIME, was conducted and described in the Interim Evaluation released in August 2019. Collectively, the findings indicate substantial improvements in the fundamental infrastructure needed to implement PRIME projects both system-wide and for specific projects with advances in administrative capacity and increased Electronic Health Record (EHR) functionality. Hospitals reported that they utilized significant effort to implement the recommended core components (outlined in STC Attachment Q) and a systematic approach to project implementation to achieve the desired outcomes. Hospitals frequently overcame challenges in collecting standardized data by implementing innovative solutions and workarounds.

An additional assessment of progress in PRIME project activities by the end of the program was described in detail in the Preliminary Summative Evaluation Report completed in August 2020. Hospitals were surveyed by UCLA and they rated the extent to which they achieved the goals of PRIME projects in which they participated. Hospitals

reported a high level of effort for all projects, but DMPH Critical Access Hospitals most frequently reported a high level of difficulty across most projects. Hospitals perceived that the highest impact of PRIME was on the quality of care followed by patient health outcomes and cost containment.

The Final Summative Evaluation Report assessed and demonstrated success in achieving all five of PRIME's overarching goals; (1) Increase provision of patient-center, data-driven, team-based care, (2) Improve provision of point of care services, complex care management, population health management, and culturally competent care, (3) Improve population health and patient experience in Medi-Cal, (4) Integrate physical and behavioral health and coordinate care for vulnerable populations and (5) Transition public hospitals to value-based care. This report was submitted to CMS on August 19, 2021 and is currently under review by CMS.

SENIORS AND PERSONS WITH DISABILITIES

The “mandatory SPD population” consists of Medi-Cal only members with certain aid codes who reside in all counties operating under the Two-Plan and Geographic Managed Care (GMC) models of managed care. The “existing SPD population” consists of members with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Duals 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 members 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 members 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.

Figure 35: DY 16 Total Member Months for Mandatory SPDs by County

County	DY16-Q1 (July – Sept.)	DY16-Q2 (Oct. – Dec.)	DY16-Q3 (Jan. – March)	DY16-Q4 (April – June)	DY 16 Total Member Months
Alameda	80,970	80,828	80,494	80,077	322,369
Contra Costa	50,364	49,834	49,717	49,674	199,589
Fresno	71,603	71,390	70,637	69,838	283,468
Kern	58,371	58,156	57,847	57,508	231,882
Kings	8,255	8,259	8,218	8,113	32,845
Los Angeles	535,219	534,053	531,987	528,862	2,130,121
Madera	7,114	7,054	6,970	6,937	28,075
Riverside	108,847	108,913	108,822	108,311	434,893
Sacramento	105,218	104,548	103,981	103,136	416,883
San Bernardino	117,385	117,151	116,240	115,184	465,960
San Diego	117,904	117,926	117,335	116,300	469,465
San Francisco	39,330	38,977	38,670	38,213	155,190
San Joaquin	48,058	47,802	47,537	47,014	190,411
Santa Clara	65,212	65,435	65,611	65,530	261,788
Stanislaus	33,786	33,456	33,061	32,551	132,854
Tulare	32,863	32,699	32,545	32,321	130,428
Total	1,480,499	1,476,481	1,469,672	1,459,569	5,886,221

Figure 36: DY 16 Total Member Months for Existing SPDs by County

County	DY16-Q1 (July – Sept.)	DY16-Q2 (Oct. – Dec.)	DY16-Q3 (Jan. – March)	DY16-Q4 (April – June)	DY 16 Total Member Months
Alameda	75,495	77,396	78,415	79,337	310,643
Contra Costa	35,924	36,729	37,510	38,246	148,409
Fresno	45,586	46,230	46,631	46,840	185,287
Kern	33,838	34,512	34,968	35,519	138,837
Kings	4,819	4,859	4,901	4,926	19,505
Los Angeles	1,043,147	1,055,246	1,068,807	1,071,496	4,238,696
Madera	4,782	4,871	4,988	5,070	19,711
Marin	19,642	19,761	19,851	19,831	79,085
Mendocino	17,495	17,599	17,825	17,777	70,696
Merced	50,419	50,987	51,624	51,702	204,732
Monterey	49,368	49,980	50,784	50,844	200,976
Napa	15,447	15,553	15,810	15,609	62,419
Orange	345,037	350,186	354,531	355,075	1,404,829
Riverside	119,112	120,021	121,387	121,437	481,957
Sacramento	74,945	76,023	76,571	77,131	304,670
San Bernardino	115,268	116,438	118,085	118,233	468,024
San Diego	197,475	199,807	203,221	203,898	804,401
San Francisco	50,703	51,627	52,288	52,886	207,504
San Joaquin	31,796	32,256	32,576	33,118	129,746
San Luis Obispo	25,529	25,809	26,285	26,384	104,007
San Mateo	41,940	42,335	42,894	42,481	169,650
Santa Barbara	48,146	48,842	49,640	49,766	196,394
Santa Clara	124,158	124,380	124,845	124,471	497,854
Santa Cruz	32,541	32,749	32,963	32,780	131,033
Solano	62,082	62,656	63,258	63,352	251,348
Sonoma	52,225	52,554	52,964	52,977	210,720
Stanislaus	19,595	19,819	19,957	20,071	79,442
Tulare	21,820	22,011	22,163	22,252	88,246
Ventura	90,794	91,903	92,963	93,166	368,826
Yolo	26,545	26,843	27,410	27,580	108,378
Total	**2,875,673**	**2,909,982**	**2,946,115**	**2,954,255**	**11,686,025**

Figure 37: DY 15 Total Member Months for SPDs in Rural Non-COHS Counties

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Alpine	38	39	41	42	160
Amador	1,100	1,095	1,079	1,053	4,327
Butte	16,718	16,462	16,241	15,981	65,402
Calaveras	1,616	1,644	1,651	1,622	6,533
Colusa	828	823	829	831	3,311
El Dorado	5,142	5,143	5,134	5,145	20,564
Glenn	1,628	1,623	1,618	1,601	6,470
Imperial	11,001	10,998	10,898	10,812	43,709
Inyo	491	483	474	464	1,912
Mariposa	726	694	691	688	2,799
Mono	164	163	161	161	649
Nevada	3,148	3,131	3,079	3,041	12,399
Placer	10,502	10,570	10,644	10,628	42,344
Plumas	1,007	991	954	955	3,907
San Benito	392	385	361	364	1,502
Sierra	104	102	94	86	386
Sutter	6,093	6,122	6,030	6,006	24,251
Tehama	5,312	5,246	5,218	5,181	20,957
Tuolumne	2,521	2,520	2,477	2,428	9,946
Yuba	6,421	6,432	6,323	6,256	25,432
Total	**74,952**	**74,666**	**73,997**	**73,345**	**296,960**

Figure 38: DY 15 Total Member Months for SPDs in Rural COHS Counties

County	DY15-Q1 (July – Sept.)	DY15-Q2 (Oct. – Dec.)	DY15-Q3 (Jan. – March)	DY15-Q4 (April – June)	DY 15 Total Member Months
Del Norte	8,091	8,220	8,311	8,246	32,868
Humboldt	26,426	26,660	27,006	26,836	106,928
Lake	19,798	19,905	20,006	19,936	79,645
Lassen	4,344	4,422	4,493	4,507	17,766
Modoc	2,249	2,283	2,316	2,306	9,154
Shasta	40,466	40,561	40,890	40,634	162,551
Siskiyou	11,368	11,462	11,666	11,587	46,083
Trinity	2,825	2,838	2,873	2,884	11,420
Total	**115,567**	**116,351**	**117,561**	**116,936**	**466,415**

WHOLE PERSON CARE

The Whole Person Care (WPC) pilot is a five-year program authorized under the Medi-Cal 2020 Waiver. In December 2020, 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 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 expand access to supportive housing options for these high-risk populations.

An organization eligible to serve as the lead entity (LE) develops and locally operates 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 these entities.

WPC pilot payments support infrastructure to integrate services among local entities that serve the target population; provide services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing components; and other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Eighteen LEs began implementing and enrolling WPC members 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 received and approved fifteen WPC pilot applications the second round. In December 2020, DHCS notified the LEs that CMS had approved a temporary extension of the Medi-Cal 2020 Waiver to December 31, 2021. Two of the 25 LEs had opted out of the extension and discontinued operations as of January 1, 2021. DHCS approved the close out of their programs effective December 31, 2020.

The WPC evaluation report, required pursuant to Standard Terms and Conditions (STC) 127 of the Medi-Cal 2020 Waiver will assess: 1) if the LEs successfully implemented their planned strategies and improved care delivery, 2) whether these

strategies resulted in better care and better health, and 3) whether better care and health resulted in lower costs through reductions in avoidable utilization.

The midpoint report, which was submitted to CMS in December 2019, included an assessment of the population demographics, intervention descriptions, care and outcome improvements, and implementation challenges, though only preliminary outcome data was available. The Final Evaluation Report, due to CMS in 2021, will provide the complete assessment of care and outcome improvements, including an assessment of the impact of the various packages of interventions for specific target populations. The Final Evaluation Report will also include assessment of reductions in avoidable utilization and associated costs, challenges and best practices, and assessments of sustainability.

Accomplishments:

Figure 39: Pilot Accomplishments

Date	Pilot Accomplishments
STC 117 & 130 WPC Payments	
June 2021	All twenty-five LEs received WPC payments totaling $889,345,719.72 in DY 16.
	DY 12-16 total-to-date payments of $2,891,454,488.11 represent payments made through June 30, 2021 and 80% of the $3.6 billion allocated for WPC over the 6 years of the program until December 31, 2020. Four LEs submitted their program year (PY) 5 Annual invoices late due to lack of program staff and data discrepancies; therefore their payments were made in July and August 2021. The July and August 2021 payments of approximately $23 million will be counted in the DY 17 report. There are two scheduled payments remaining, 2021 PY 6 mid-year and 2021 PY 6 annual. Payments are anticipated to be released October 2021, for mid-year PY 6 activities.
STC 118 Housing and Supportive Services	
June 2021	All LEs are providing a range of housing services including individual housing and tenancy sustaining services and individual housing transition services. These housing services include tenant screening, housing assessments and individualized housing support plans, work with property owners, identification of community resources, and training tenants to maintain housing once it is established. As of June 2020, LEs reported 50% (96,436) of WPC members were homeless.
STC 119 Lead and Participating Entities	
June 2020	Participating entities have increased from 350 to more than 558 for the 25 LEs since program implementation began in 2017.
STC 123 Learning Collaborative	
July 2020-June 2021	The Learning Collaborative (LC) supports the WPC LEs with the following goals:

	• Enhance the permanent capacity of providers to effectively care for high-risk, high-utilizing populations targeted by the WPC LEs; • Inform state oversight and policy making relevant to the WPC pilot, their target populations, and related delivery system reforms; and • Grow and sustain a peer network among LEs to encourage the continued spread of best practices. The LC structure includes a variety of learning activities, such as webinars, technical assistance (TA) calls, and access to a resource portal as a means to address the topics and questions from LEs. The LC has consistently hosted monthly Advisory Board meetings, unless there were no agenda items for a specific month. The focus of these meetings has been on LE's response to the COVID-19 PHE and, more recently in 2021, on the implementation of California Advancing and Innovating Medi-Cal (CalAIM). The LC has combined efforts with DHCS on CalAIM TA activities and began to host bi-weekly meetings for LEs.
December 2020	Due to the COVID-19 PHE, there was not an in-person convening in DY 16. The LC hosted a virtual WPC Appreciation Event on December 9th, 2020. The event acknowledged the hard work of the WPC Pilots, especially throughout 2020 in response to the PHE and the uncertainties of PY 6. In addition, the LEs recognized their staff and presented "Unsung Hero" awards. Presentations from Riverside, Santa Cruz, San Diego, and San Francisco were featured regarding the successes of their program. There were a total of 148 attendees.
STC 125 Progress Reports	
September 2020	Twenty-five LEs submitted the PY 5 mid-year report for 2020.
April 2021	Twenty-five LEs submitted the PY 5 annual report for 2020.
STC 126 Universal and Variant Metrics	
September 2020	Twenty-five LEs submitted their baseline PY 5 mid-year variant and universal metric reports.
April 2021	Twenty-five LEs submitted their PY 5 annual variant and universal metric reports.
STC 127 Mid-Point and Final Evaluations	
September 2019	University of California Los Angeles (UCLA) submitted the draft WPC interim evaluation to DHCS on September 30, 2019. The WPC interim evaluation report was submitted to CMS on December 18, 2019.

Program Highlights:

In December 2020, two of the twenty-five LEs opted out of operating the additional PY due to service provider contractual limitations, inconsistent staffing retention, and limited availability to secure matching funds for the local match portion of the Intergovernmental Transfer payment. With DHCS' approval, Small County Collaborative Whole Person

Care (SCCWPC) and Solano County discontinued their pilot programs as of January 1, 2021, and have successfully transitioned all of their beneficiaries to other modes of care.

On March 17th, DHCS began restructuring the bi-weekly TA calls to focus on CalAIM Enhanced Care Management (ECM) and Community Supports transition and implementation process. The LC began to host the bi-weekly ECM and Community Supports TA calls in partnership with DHCS and Manatt, DHCS' CalAIM implementation consultant.

During DY 16, DHCS held a total of nine TA teleconferences with LEs. The teleconferences focused on administrative topics and provided the opportunity for LEs to ask questions about DHCS' guidance and various operational issues such as deliverable reporting, timelines, budget adjustments, COVID-19 impacts and flexibilities, CalAIM ECM/Community Supports implementation, ECM/Community Supports client transition mapping, and overall DHCS expectations.

During DY 16 Quarter 4, all LEs submitted the following reports:

- PY 5 Quarter 4 (Q4) quarterly enrollment and utilization (QEU) report;
- Revised PY 5 Quarters 1 (Q1), 2 (Q2), 3 (Q3) and Q4 QEU report (optional);
- PY 5 Annual Narrative, Invoice, and Plan Do Study Act;
- PY 5 Annual Variant and Universal Metrics report;
- PY 5 first quarter Enrollment & Utilization; and
- PY 6 Budget Request;
- PY 6 Q1 Enrollment & Utilization;
- WPC eligible service transition into ECM/Community Supports report; and
- Round 1 of WPC enrollee data mapping transition into ECM/Community Supports report.

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

In preparation for the sunset of the WPC Pilot Program, DHCS is working closely with LEs to ensure eligible WPC beneficiaries will be transitioned into CalAIM ECM and Community Supports services. DHCS utilizes the Data Mapping reports to provide a list of WPC beneficiaries who will transition to services provided by MCPs on January 1, 2022. DHCS will continue to update the Data Mapping reports in DY 17 as updated WPC enrollment is captured.

By way of background, after two rounds of applications, the WPC program consists of 25 LEs with 18 legacy LEs that implemented on January 1, 2017 and 7 LEs (counties of Kings, Marin, Mendocino, Santa Cruz, and Sonoma, the City of Sacramento, and the SCWPCC, which includes San Benito and Mariposa Counties) that implemented on July 1, 2017. Eight of the legacy LEs (Los Angeles, Monterey, Napa, Orange, San Francisco, San Joaquin, Santa Clara, and Ventura) continued their original programs and were approved to expand their programs with additional or expanded target populations, services, and administrative/delivery infrastructure to support the expansions in the second round. By June 30, 2021, WPC touched more than 232,245 unique lives with more than 3,242,601 member months.

Qualitative and Quantitative Findings:

DHCS uses the mid-year and annual narrative reports, quarterly enrollment and utilization reports, and invoices to monitor and evaluate the programs and to verify invoices for payment.

Enrollment Information

The data reported below in Figure 40 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 during Q1 to Q4 of DY 16. The total-to-date column reflects the cumulative number of unique new beneficiaries enrolled from the beginning of the program, DY 12 (January 2017), to the end of the reporting period for DY 16 – Q4 (April – June 2020). The DY 16 Q1 – Q4 data is point-in-time as of September 10, 2021.

Figure 40: Quarterly Enrollment Counts

Lead Entity	DY 16 Q1 (July – Sept. 2020)	DY 16 Q2 (Oct. – Dec 2020)	DY 16 Q3 (Jan. – Mar. 2021)	DY16 Q4 (April – June 2021)	Jan. 2017 – June 2021
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	160	130	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

Lead Entity	DY 16 Q1 (July – Sept. 2020)	DY 16 Q2 (Oct. – Dec 2020)	DY 16 Q3 (Jan. – Mar. 2021)	DY16 Q4 (April – June 2021)	Jan. 2017 – June 2021
Mendocino*	23	14	10	17	455
Monterey	58	28	87	32	806
Napa	18	20	27	44	678
Orange	457	277	275	392	13,475
Placer	5	6	8	11	494
Riverside	565	349	405	393	8,652
Sacramento*	128	58	85	N/A	2,294
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**	**9,684**	**9,712**	**232,245**

**Indicates one of the 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 LEs no longer submit quarterly enrollment reports after December 31, 2020.*

The data provided in the figure above shows the count of unduplicated members has steadily increased since implementation began in 2017. The program began with 11,286 unduplicated members by March of 2017 and has increased to 232,245 unduplicated members as of June 30, 2021. The data reflects continued outreach and engagement to increase enrollment as disenrollment occurs on a monthly basis. Enrollment data that indicates "N/A" reflects pending QEU files as LEs continue to revise their data to address discrepancies.

Member Months

The data reported below in Figure 41 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 member month counts reflect the number of member months from Q1 to Q4 of DY 16. 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 end of the reporting period for DY 16 – Q4 (April – June 2021). Member months are extracted from the LE's self-reported QEU reports. The DY 16 – Q4 data is point-in-time as of September 10, 2021.

Figure 41: Member Months Counts

Lead Entity	DY 16 Q1 (July – Sept. 2020)	DY 16 Q2 (Oct- Dec. 2020)	DY 16 Q3 (Jan – Mar. 2021)	DY 16 Q4 (Apr.- June 2021)	DY 16 Q1 (July – Sept. 2020)
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	6,675	7,114	50,641
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	729	566	7,427
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	N/A	29,172
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

Lead Entity	DY 16 Q1 (July – Sept. 2020)	DY 16 Q2 (Oct- Dec. 2020)	DY 16 Q3 (Jan – Mar. 2021)	DY 16 Q4 (Apr.- June 2021)	DY 16 Q1 (July – Sept. 2020)
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**	**268,308**	**271,922**	**3,242,601**

**Indicates one of seven new 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 LEs no longer submit quarterly enrollment reports after December 31, 2020.*

The data provided in the figure above shows the count of member months has dramatically increased since implementation began in 2017 as the unduplicated members and enrollment increased. The program began with 28,974 member months by March of 2017, and has increased to 3,242,601 member months as of June 30, 2020. It is important to note that the number of member months plays a significant role in the utilization of services. Member month data that indicates "N/A" reflects pending QEU files as LEs continue to revise their data to address discrepancies.

Payments

As shown below in Figure 42, DHCS released WPC payments for DY 16 to all 25 LEs, in accordance with the WPC payment schedule. WPC received $511,074,750.79 in Federal Financial Participation (FFP) and $419,025,358.95 in Intergovernmental Transfers (IGT), for a total of $930,100,109.76 in payments to the LEs.

DY 16 Q4, twenty-one LEs received WPC payments totaling $420,597,286.32 and the remaining 4 LEs received WPC payments of approximately $23 million in the first quarter of DY 17.

Figure 42: WPC Payments for DY 12 to DY 15 for all 25 Les

DY 12 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 3 (Jan. 1 – Mar 31)	$216,787,499.88	$216,787,499.88	DY 12 (PY 1)	$433,574,999.75
Qtr. 4 (Apr. 1 – June 30)	$22,206.521.50	$22,206.521.50	DY 12 (PY 1)	$44,413,043.00
DY 13 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$9,730,650.50	$9,730,650.50	DY 13 (PY 1)	$19,461,301.00
Qtr. 2 (Oct. 1 – Dec. 31)	$63,309,652.68	$63,309,652.68	DY 13 (PY 2)	$126,619,305.36
Qtr. 3 (Jan. 1 – Mar 31)	$0	$0	DY 13 (PY 2)	$0
Qtr. 4 (Apr. 1 – June 30)	$116,574,244.78	$116,574,244.78	DY 13 (PY 2)	$233,148,489.56
DY 14 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$0	$0	DY 14 (PY 3)	$0
Qtr. 2 (Oct. 1 – Dec. 31)	$101,981,216.28	$101,981,216.28	DY 14 (PY 3)	$203,962,432.56
Qtr. 3 (Jan. 1 – Mar. 31)	$0	$0	DY 14 (PY 3)	$0
Qtr. 4 (Apr. 1 – June 30)	$169,064,564.15	$169,064,564.15	DY 14 (PY 3)	$338,129,128.30
DY 15 Payment	**FFP**	**IGT**	**Service Period**	**Total Funds Payment**
Qtr. 1 (Jul. 1 – Sept. 30)	$0	$0	DY 15 (PY4)	$0
Qtr. 2 (Oct. 1 – Dec. 31)	$119,071,064.41	$119,071,064.41	DY 15 (PY4)	$238,142,128.82
Qtr. 3 (Jan. 1 – Mar. 31)	$0	$0	DY 15 (PY4)	$0
Qtr. 4 (Apr. 1 – June 30)	$161,951,775.00	$161,951,775.00	DY 15 (PY4)	$323,903,550.00*
Total	**$980,677,189.18**	**$980,677,189.18**		**$1,961,354,378.35**

** Due to the COVID19 PHE, LEs were allowed a one month extension to submit their PY4 Annual invoice; therefore, the majority of the originally planned payments in June 2020 were made in July 2020. The July 2020 payments of approximately $193 million will be counted in the DY 16 report.*

Figure 43: WPC Payments for DY 16 for all 25 Les

DY 16 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr. 1 (Jul. 1 – Sept. 30)	$96,573,902.01	$96,573,902.01	DY 16 (PY 5)	$193,147,804.02*
Qtr. 2 (Oct. 1 – Dec. 31)	$177,791,520.89	$138,563,498.50	DY 16 (PY 5)	$316,355,019.41
Qtr. 3 (Jan. 1 – Mar. 31)			DY 16 (PY 5)	$0
Qtr. 4 (Apr. 1 – June 30)	$236,709,327.89	$183,887,958.44	DY 16 (PY 5)	$420,597,286.32**
Total	**$511,074,750.79**	**$419,025,358.95**		**$930,100,109.76**

** Due to the COVID19 PHE, LEs were allowed a one month extension to submit their PY4 Annual invoice; therefore, the majority of the originally planned payments in June 2020 were made in July 2020. The July 2020 payments of approximately $193 million will be counted in the DY 16 report.*

***Twenty-one LEs were paid during DY16 Q4 for PY5 Annual. Four LEs submitted their PY5 Annual invoices late due to data discrepancies; therefore their payments are made in July and August 2021. The July and August 2021 payments of approximately $23 million will be counted in the DY 17 report.*

Operational/Policy Developments/Issues:

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

During the Q3 and Q4 of DY 15, DHCS completed approval of both the optional budget adjustment and rollover requests from LEs. The budget adjustment process allowed adjustments to future PY budgets while the rollover process allowed an LE to move unspent budgeted funds from the previous PY to the current PY. The budget adjustment and rollover enable the LEs to overcome operational challenges and barriers. Furthermore, these processes allow LEs the flexibility to more fully maximize funding

integral to the success of the WPC and support the activities aligned with WPC goals and objectives, including the expansion of services and enrollment, sustainability efforts in preparation for the CalAIM, and COVID-19 PHE response.

DHCS, along with the WPC LC, communicated with the LEs through phone calls, video conferencing and emails to understand the issues that are of most interest and concern to guide DHCS' TA and LC content. The LC structure includes a variety of learning activities, such as webinars, teleconferences, and access to a resource portal as a means to address the topics and questions from LEs.

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

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

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

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

The LC has developed a year-long TA plan to support the LE's transition to CalAIM. This plan was developed in coordination with other DHCS efforts to support the LEs and will include a number of activities including state-wide webinars on topics of interest, development of FAQs, and other opportunities for pilots to learn from each other as they navigate the transition. In March 2021, the LC began to host the bi-weekly ECM and Community Supports TA calls in partnership with DHCS and Manatt.

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; therefore, they are more susceptible and unable to isolate themselves from exposure. WPC services are vital to ensure clients are able to receive care coordination and housing support, during this PHE.

DHCS continued to support LEs and their response to the COVID-19 PHE. DHCS provided guidance to LEs to ensure the safety of their clients as well as, to continue to provide WPC services as safely as possible. DHCS has allowed LEs to adjust their PY 5 budget to add needed infrastructure such as hygiene pods, personal protective supplies, and telehealth equipment, and refocus on previously approved activities that support COVID-19 identified needs, to ensure the health and safety of both clients and staff. Many LEs have continued to include COVID-19 related services and support into their PY 6 budget.

Progress on the Evaluation and Findings:

Due to the CMS' extension of the WPC Pilot Program for an additional year, the Final Evaluation Report will now be due in December 2022.

During DY 16, DHCS' independent evaluator, UCLA:

- Completed qualitative data analysis software coding to include challenges, successes, and lessons learned related to: (1) identifying, engaging, and enrolling clients; (2) care coordination; (3) data sharing; (4) outcomes and sustainability; and (5) biggest barriers to implementation as discussed by LEs in PY 4 mid-year narrative reports. Preliminary analysis was completed.
-
- Tested modifications to the difference-in-difference model used in the interim evaluation report to improve analysis for the final report. The difference-in-difference model examines the change in trends from pre-WPC to post-WPC and between the treatment group and control group. As compared to the previous analysis, which examined change in the average metric rate in the pre-WPC and post-WPC periods, this analysis will improve the ability to assess whether WPC changed the trajectory of key outcome metrics.

- Merged data on refined service categories with the Quarterly Enrollment and Utilization Reports (QUER) utilization data to better understand the distribution of

service types within and across LEs. UCLA will update this analysis with new QUER data as available. Analysis will be included in the final report.

- Finalized the “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 beneficiary health status, demographics, and health care utilization. The data can be used by MCPs and other organizations that are developing population health management programs for high-need, high-risk Medi-Cal beneficiaries under CalAIM.

- 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.

- Documented the potential implications of COVID-19 on the evaluation and identify ways to address data collection and quality concerns, in line with CMS guidance.

- Explored options for presenting preliminary analysis, including descriptions of COVID-19 impacts on WPC implementation, enrollment and healthcare utilization, in an upcoming policy brief publication.

- The final report will utilize the findings from the policy brief as context that will assist is explaining trends in utilization based metrics during the COVID-19 pandemic.

- Administered a 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.

- Began semi-structured interviews with program level management to follow up with the LE survey described above, as well as with frontline staff and supervisors. Data will be presented in the final report.

- Furthered refined the 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. This literature review informed the care coordination framework used in the WPC care coordination case studies and policy brief.

- Reviewed and summarized COVID-19 budget alternative narratives. The data will help better display how Pilots adapted and changed as a result of the COVID-19 pandemic.

- Compiled annual invoice data for presentation in the final report.

- Developed an outline and preliminary methods for the upcoming COVID-19 impact policy brief.

- Incorporated the PY 4 and PY 5 Pilot-reported metrics with the previously reported Pilot-reported metric in order to update that analysis. These data will be presented in the final report.

Enrollment Informantion:

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non ACA	Total
DY16-Q1	41,362	16,332	57144
DY16-Q2	41,591	15,780	56780
DY16-Q3	43,342	14,505	57235
DY16-Q4	40,381	12,385	52346

Member Months:

Population	Month 1	Month 2	Month 3	Quarter
ACA	32820	33352	33317	1920 1st Qtr
	34137	32911	33153	1920 2nd Qtr
	33389	33429	32696	1920 3rd Qtr
	31098	30802	31132	1920 4th Qtr
Non ACA	16937	17139	17201	1920 1st Qtr
	17425	16935	17112	1920 2nd Qtr
	16772	15860	15797	1920 3rd Qtr
	14560	14669	14753	1920 4th Qtr

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

Quarter	Population	Units of Service	Approved Amount	FFP Amount
DY16-Q1	ACA	2773463	$104,891,371.40	$87,439,081.39
	Non ACA	1207550	$32,949,646.64	$17,615,629.62
DY16-Q2	ACA	2790875	$108,694,626.47	$91,060,397.03
	Non ACA	1168074	$33,228,612.42	$18,694,933.03
DY16-Q3	ACA	2785159	$107,008,859.83	$89,766,846.37
	Non ACA	954464	$29,563,797.61	$16,629,861.89
DY16-Q4	ACA	2517242	$101,198,340.39	$85,047,974.99
	Non ACA	804541	$26,090,011.65	$14,704,997.18

Current Enrollees (to date)
41,362
41,591
43,342
40,381
16,332
15,780
14,505
12,385

SGF Amount	County Amount
$10,418,496.55	$7,033,793.46
$4,429,172.77	$10,904,844.25
$10,819,162.13	$6,815,067.31
$4,629,376.97	$9,904,302.42
$10,226,431.16	$7,015,582.30
$4,336,019.78	$8,597,915.94
$10,019,858.61	$6,130,506.79
$4,393,275.56	$6,991,738.91

ACA Expenditures by Level of Care for DY16-Q1				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	62	$2,898.50	$2,608.34	$0.00
1.0 Outpatient	378,756	$16,145,983.15	$12,936,301.72	$1,359,442.23
3.1 Residential	131,666	$23,827,398.53	$20,233,564.82	$3,391,760.12
3.3 Residential	1,298	$329,348.47	$296,113.24	$33,235.23
3.5 Residential	106,410	$22,318,749.86	$19,075,827.96	$3,160,423.66
Additional MAT	16,841	$430,721.85	$362,754.38	$0.00
Case Management	186,646	$6,543,868.63	$5,457,461.94	$6,277.90
Intensive Outpatient	31,874	$970,777.01	$783,615.64	$173,674.51
MAT Dosing	44,911	$1,184,094.50	$943,450.51	$0.00
Methadone	1,290,223	$18,714,508.05	$15,345,595.79	$1,518,707.48
Narcotic Treatment	539,390	$9,196,629.27	$7,556,303.09	$765,951.20
Physician Consultation	231	$19,130.45	$15,798.99	$974.39
Recovery Support Services	30,306	$1,132,251.60	$908,740.36	$0.00
Residential Withdrawal Management	14,849	$4,075,011.53	$3,520,944.61	$8,049.83

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	$4,768.50	$4,291.14	$0.00
1.0 Outpatient	378,623	$16,404,246.08	$13,187,680.03	$1,419,465.83
3.1 Residential	146,658	$25,630,478.14	$21,825,827.80	$3,584,500.75
3.3 Residential	1,353	$328,827.04	$293,354.13	$35,472.91
3.5 Residential	113,598	$23,356,895.88	$20,050,478.49	$3,247,638.91
Additional MAT	11,650	$430,380.16	$363,056.78	$0.00
Case Management	187,672	$6,762,799.29	$5,643,728.06	$11,601.43
Intensive Outpatient	36,734	$1,065,906.22	$866,791.71	$185,007.38
MAT Dosing	47,777	$1,258,890.45	$1,013,643.72	$0.00
Methadone	1,286,548	$18,376,993.87	$15,230,060.15	$1,504,104.55
Narcotic Treatment	531,650	$9,629,626.11	$7,952,498.29	$821,764.86
Physician Consultation	180	$9,668.10	$8,318.58	$316.20
Recovery Support Services	33,375	$1,328,172.78	$1,076,005.22	$1,659.22
Residential Withdrawal Management	14,955	$4,106,973.85	$3,544,662.93	$7,630.09

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	$3,085.50	$2,776.62	$0.00
1.0 Outpatient	397,325	$17,467,548.91	$14,067,977.58	$1,492,440.46
2.5 Partial Hospitalization	50	$17,900.00	$15,626.00	$0.00
3.1 Residential	131,593	$23,431,096.16	$20,117,702.79	$3,163,006.58
3.3 Residential	1,058	$260,455.12	$234,302.14	$26,152.98
3.5 Residential	101,655	$21,226,707.69	$18,224,936.89	$2,961,768.95
Additional MAT	14,669	$466,230.81	$394,929.55	$0.00
Case Management	217,362	$8,095,650.94	$6,781,063.57	$12,542.94
Intensive Outpatient	67,421	$1,981,674.90	$1,643,112.30	$320,579.06
MAT Dosing	45,039	$1,175,513.82	$947,837.31	$0.00

Methadone	1,228,344	$17,995,375.13	$14,909,806.15	$1,482,185.70
Narcotic Treatment	507,932	$8,978,513.52	$7,408,068.32	$756,888.84
Physician Consultation	147	$5,509.54	$4,326.32	$36.95
Recovery Support Services	57,038	$1,577,534.19	$1,289,051.69	$2,878.96
Residential Withdrawal Management	15,460	$4,326,063.60	$3,725,329.14	$7,949.74

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	$6,872.25	$5,141.49	$0.00
1.0 Outpatient	322,815	$13,476,338.39	$10,856,693.72	$1,143,402.85
2.5 Partial Hospitalization	28	$10,024.00	$6,238.60	$0.00
3.1 Residential	136,908	$24,790,423.42	$21,290,559.02	$3,357,557.75
3.3 Residential	552	$128,861.36	$111,971.02	$16,890.34
3.5 Residential	106,565	$22,518,031.10	$19,304,362.81	$3,156,374.84
Additional MAT	15,902	$409,673.39	$341,994.46	$0.00
Case Management	201,907	$7,177,479.09	$6,019,067.99	$11,544.99
Intensive Outpatient	71,694	$2,210,986.01	$1,839,517.24	$355,342.74
MAT Dosing	40,726	$1,013,601.96	$804,908.43	$0.00
Methadone	1,090,591	$15,994,017.08	$13,226,172.19	$1,327,039.10
Narcotic Treatment	442,057	$7,533,360.98	$6,234,502.41	$635,351.51
Physician Consultation	201	$27,105.18	$20,479.86	$2,739.14
Recovery Support Services	71,688	$1,347,838.14	$1,077,769.20	$2,745.00
Residential Withdrawal Management	15,461	$4,553,728.04	$3,908,596.55	$10,870.35

County Amount
$290.16
$1,850,239.20
$202,073.59
$0.00
$82,498.24
$67,967.47
$1,080,128.79
$13,486.86
$240,643.99
$1,850,204.78
$874,374.98
$2,357.07
$223,511.24
$546,017.09

County Amount
$477.36
$1,797,100.22
$220,149.59
$0.00
$58,778.48
$67,323.38
$1,107,469.80
$14,107.13
$245,246.73
$1,642,829.17
$855,362.96
$1,033.32
$250,508.34
$554,680.83

County Amount
$308.88
$1,907,130.87
$2,274.00
$150,386.79
$0.00
$40,001.85
$71,301.26
$1,302,044.43
$17,983.54
$227,676.51

$1,603,383.28
$813,556.36
$1,146.27
$285,603.54
$592,784.72

County Amount
$1,730.76
$1,476,241.82
$3,785.40
$142,306.65
$0.00
$57,293.45
$67,678.93
$1,146,866.11
$16,126.03
$208,693.53
$1,440,805.79
$663,507.06
$3,886.18
$267,323.94
$634,261.14

0

Non-ACA Expenditures by Level of Care for DY16-Q1				
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**
1-Withdrawal Management	31	$1,449.25	$724.47	$0.00
1.0 Outpatient	129,538	$5,488,026.76	$3,044,034.86	$46,116.58
3.1 Residential	22,317	$4,214,829.93	$2,238,276.32	$1,764,207.18
3.3 Residential	721	$177,650.84	$95,489.97	$82,160.87
3.5 Residential	24,193	$5,152,871.05	$2,747,241.70	$2,329,294.21
Additional MAT	5,189	$160,144.54	$87,612.93	$0.00
Case Management	51,397	$1,862,676.03	$1,008,957.96	$3,161.05
Intensive Outpatient	9,793	$233,026.49	$124,624.82	$96,076.38
MAT Dosing	10,311	$287,409.64	$152,010.92	$0.00
Methadone	682,580	$9,740,504.00	$5,137,968.82	$49,087.86
Narcotic Treatment	255,742	$4,255,965.80	$2,240,519.28	$52,728.88
Physician Consultation	88	$5,535.23	$2,856.43	$321.25
Recovery Support Services	12,589	$473,380.63	$255,894.42	$0.00
Residential Withdrawal Management	3,061	$896,176.45	$479,416.72	$6,018.51

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	120,723	$5,254,175.65	$2,956,427.74	$51,287.55
3.1 Residential	25,131	$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	28,124	$5,951,497.42	$3,354,663.53	$2,514,713.31
Additional MAT	4,199	$152,224.43	$85,510.07	$0.00
Case Management	51,227	$1,811,158.72	$1,022,407.45	$3,172.48
Intensive Outpatient	11,012	$275,718.51	$153,923.51	$106,286.86
MAT Dosing	10,286	$293,437.23	$164,720.22	$0.00
Methadone	659,269	$9,301,661.44	$5,227,907.48	$21,750.31
Narcotic Treatment	241,497	$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	12,644	$501,948.21	$285,120.82	$401.27
Residential Withdrawal Management	3,097	$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	120,561	$5,404,082.72	$3,027,248.66	$64,480.05
2.5 Partial Hospitalization	19	$6,802.00	$3,822.80	$0.00
3.1 Residential	24,089	$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	23,354	$4,926,951.33	$2,773,462.11	$2,109,330.44
Additional MAT	4,359	$155,706.90	$87,507.20	$0.00
Case Management	57,373	$2,182,082.83	$1,232,047.32	$5,470.52
Intensive Outpatient	16,401	$541,957.09	$305,634.81	$210,811.23
MAT Dosing	8,219	$228,867.07	$128,623.39	$0.00
Methadone	489,838	$7,062,689.24	$3,969,890.60	$44,006.12

Narcotic Treatment	184,409	$3,216,579.22	$1,807,777.24	$59,612.08
Physician Consultation	44	$2,264.61	$1,272.70	$0.00
Recovery Support Services	22,576	$597,971.50	$340,219.82	$1,279.25
Residential Withdrawal Management	2,622	$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	97,308	$4,082,814.90	$2,314,836.86	$67,954.48
2.5 Partial Hospitalization	61	$21,838.00	$12,273.20	$0.00
3.1 Residential	21,411	$4,091,573.95	$2,306,433.10	$1,684,402.15
3.3 Residential	461	$114,469.99	$64,332.59	$50,137.40
3.5 Residential	24,285	$5,249,619.44	$2,956,022.06	$2,270,055.43
Additional MAT	3,013	$128,372.92	$72,244.56	$0.00
Case Management	46,567	$1,802,477.85	$1,016,675.37	$6,845.25
Intensive Outpatient	17,504	$558,800.57	$315,083.06	$223,460.95
MAT Dosing	6,284	$165,049.37	$92,985.88	$0.00
Methadone	401,481	$5,775,010.68	$3,245,868.73	$42,411.85
Narcotic Treatment	150,386	$2,541,280.95	$1,428,425.06	$42,080.28
Physician Consultation	52	$3,106.54	$1,745.84	$0.00
Recovery Support Services	32,516	$477,386.14	$271,023.90	$1,279.25
Residential Withdrawal Management	3,129	$1,074,330.10	$604,866.56	$4,648.52

County Amount
$724.78
$2,397,875.32
$212,346.43
$0.00
$76,335.14
$72,531.61
$850,557.02
$12,325.29
$135,398.72
$4,553,447.32
$1,962,717.64
$2,357.55
$217,486.21
$410,741.22

County Amount
$2,246,460.36
$142,377.62
$0.00
$82,120.58
$66,714.36
$785,578.79
$15,508.14
$128,717.01
$4,052,003.65
$1,757,489.97
$1,732.06
$216,426.12
$409,173.76

County Amount
$839.68
$2,312,354.01
$2,979.20
$99,651.74
$0.00
$44,158.78
$68,199.70
$944,564.99
$25,511.05
$100,243.68
$3,048,792.52

$1,349,189.90
$991.91
$256,472.43
$343,966.35

County Amount
$1,699.84
$1,700,023.56
$9,564.80
$100,738.70
$0.00
$23,541.95
$56,128.36
$778,957.23
$20,256.56
$72,063.49
$2,486,730.10
$1,070,775.61
$1,360.70
$205,082.99
$464,815.02

ATTACHMENT QQ
Former Foster Youth in California
2019 Enrollment, Utilization, and Health Outcomes

	Medi-Cal 18 to 25 years old		Former Foster Youth		Former Fo Out o
	n=	%	n=	%	n=
ENROLLMENT [1]					
Any Enrolled in 2019	1,750,175	**100%**	29,004	**100%**	244
12 Months Enrolled	1,163,028	**66%**	17,422	**60%**	71
UTILIZATION [2]					
11 Months Enrolled	1,229,466	**100%**	18,153	**100%**	81
Ambulatory Care Visit	709,024	**58%**	8,206	**45%**	44
Behavioral Health Visit	113,409	**9%**	2,543	**14%**	21
ED Visit	350,306	**28%**	7,066	**39%**	31
Inpatient Stay	18,153	**1%**	684	**4%**	NR[4]
QUALITY MEASURES [3]					
CHL	186,776	**64%**	2,782	**72%**	15
IET initiation	7,082	**29%**	304	**30%**	NR[4]
CCS[6]	64,930	**43%**	1,276	**40%**	NR[4]
AMM continuous	4,245	**24%**	59	**14%**	NR[4]
FUH 30 day	4,767	**72%**	181	**71%**	NR[4]
OHD	20	**1.48%**	NR[4]	**NR[4]**	NR[4]
MPM (ACE/ARB)	NR[4]	**NR[4]**	NR[4]	**NR[4]**	NR[4]
AMR	5,533	**55%**	39	**34%**	NR[4]

[1] Continuously enrolled (12 months), full scope with no share of cost; age 18-25 as of 31DEC2(defined using aid codes; FFY Out-of-State from self-attestation; data source: MIS/DSS on 16S Enterprise Data and Information Management (EDIM).

[2] If enrolled 11/12 months, Ambulatory Care as defined in 2020 HEDIS value set 'Outpatient Vi 'Well Care'; Behavioral Health Visit if outpatient CA Specialty Mental Health (src_cd 21 or 37) c with CPT code in 907xx or 908xx or BH FQHC visit; ED visit as defined in 2020 HEDIS value s Inpatient Stay as in 2020 HEDIS Plan All Cause Readmission (PCR) denominator'; data source SEP2020 EDIM

[3] Core Set Quality Measures will be reported to CMS Dec 2020 by EDIM. Numerators and scor for:
Chlamydia Screening in Women (**CHL**),
Initiation and Engagement of Alcohol and Other Drug Treatment (**IET**) - Initiation Phase,
Cervical Cancer Screening (**CCS**),
Antidepressant Medication Management (**AMM**) - Continuous Phase,
Follow-Up After Hospitalization for Mental Illness (**FUH**) - 30 day,
Use of Opioids at High Dosage (**OHD**),
Annual Monitoring for Patients on Persistent Medication (**MPM**) - ACE or ARB, and
Medication Ratio (**AMR**),

[4] Not Reportable **(NR)**: Data is suppressed in accordance with CA DHCS De-identification Guic https://www.dhcs.ca.gov/dataandstats/Documents/DHCS-DDG-V2.0-120116.pdf

[6]CCS numerator captures 24 and 25 year olds with a three year look back. Many young adults denominator have not been in Medi-Cal for three years, thus reducing these scores compared overall Medi-Cal population.

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%
100%
29%
100%
54%
26%
38%
NR[4]
68%
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