State of California—Health and Human Services Agency

Department of Health Care Services

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May 27, 2021

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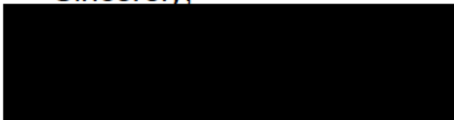
QUARTERLY PROGRESS REPORT FOR THE PERIOD JANUARY 1, 2021, THROUGH MARCH 31, 2021, OF CALIFORNIA'S MEDI-CAL 2020 DEMONSTRATION

Dear Ms. Young:

Enclosed is the Quarterly Progress Report as required by Special Terms and Conditions Paragraph 27 and Attachment I of California's Section 1115 Waiver, entitled *Medi-Cal 2020 Demonstration* (11-W-00193/9). This is the third quarterly progress report for Demonstration Year Sixteen, which covers the period from January 1, 2021, through March 31, 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,



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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:
Demonstration Year: Sixteen (07/01/2020 – 06/30/2021)
Third Quarter Reporting Period: 1/01/2021 – 3/31/2021

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INTRODUCTION

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

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

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

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

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

- DY 11: January 1, 2016 through June 30, 2016
- DY 12: July 1, 2016 through June 30, 2017
- DY 13: July 1, 2017 through June 30, 2018
- DY 14: July 1, 2018 through June 30, 2019
- DY 15: July 1, 2019 through June 30, 2020

- DY 16: July 1, 2020 through June 30, 2021
- DY 17: July 1, 2021 through December 31, 2021

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAIVER DELIVERABLES:

STCs Item 18: Post Award Forum

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

In DY16-Q3, DHCS hosted a SAC meeting on February 11, 2021. DHCS provided updates on State Budget Review and Implementation, including California Advancing and Innovating Medi-Cal (CalAIM); 1115 and 1915(b) Waivers; Racism and Equity; Telehealth Policies; Medi-Cal Enrollment and 2019-Novel Coronavirus (COVID-19) public health

emergency (PHE) Impacts; and Medi-Cal Managed Care Plans Procurement Updates.

The meeting agenda is available on the DHCS website:
https://www.dhcs.ca.gov/services/Documents/SAC-%20Agenda-021121.pdf

The meeting minutes are also available online:
https://www.dhcs.ca.gov/services/Documents/021121-SAC-Summary.pdf

STCs Item 26: Monthly Calls

This quarter, CMS and DHCS conducted waiver monitoring conference calls on January 15, February 8, and March 8, 2021, to discuss any significant actual or anticipated developments affecting the Medi-Cal 2020 Demonstration. The following were some of the topics discussed: Updates for WPC, HHP, and PRIME; COVID-19 PHE Period; CalAIM Updates; and Budget Neutrality.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

The two (2) health care delivery models include:

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

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

Enrollment Information:

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

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

Month	RCHSD Enrollment	Capitation Rate	Capitation Payment
18-July	0	$2,733.54	$0.00
18-Aug	44	$2,733.54	$120,275.76
18-Sep	128	$2,733.54	$349,893.12
18-Oct	151	$2,733.54	$412,764.54
18-Nov	209	$2,733.54	$571,309.86
18-Dec	324	$2,733.54	$885,666.96
19-Jan	363	$2,733.54	$992,275.02
19-Feb	368	$2,733.54	$1,005,942.72
19-Mar	372	$2,733.54	$1,016,876.88
19-Apr	365	$2,733.54	$997,742.10
19-May	367	$2,733.54	$1,003,209.18
19-Jun	368	$2,733.54	$1,005,942.72
19-Jul	363	$2427.02	$881,008.26
19-Aug	356	$2427.02	$864,019.12
19-Sep	351	$2427.02	$851,884.02
19-Oct	350	$2427.02	$849,457
19-Nov	351	$2427.02	$851,884.02
19-Dec	349	$2427.02	$847,029.98
20-Jan	352	$2427.02	$854,311.04
20-Feb	349	$2427.02	$847,029.98
20-Mar	346	$2427.02	$839,748.92
20-Apr	349	$2427.02	$847,029.98
20-May	352	$2427.02	$854,311.04
20-Jun	372	$2427.02	$902,851.44
20-Jul	373	$2427.02	$905,278.46
20-Aug	374	$2427.02	$907,705.48
20-Sep	375	$2427.02	$910,132.50
20-Oct	376	$2427.02	$912,559.52
20-Nov	371	$2427.02	$900,424.42
20-Dec	373	$2427.02	$905,278.46
21-Jan	372	$2427.02	$902,851.44
21-Feb	374	$2427.02	$907,705.48
21-Mar	384	$2427.02	$931,975.68
Total			**$26,836,375.10**

Table 2: RCHSD Monthly Enrollment and Quarterly Member Months

Demonstration Programs	Month 1	Month 2	Month 3	Quarter	Total Quarter Member Months
CCS	372	374	384	3	1,130

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

CCS Pilot Protocols

California's 1115 Waiver Renewal, Medi-Cal 2020 Waiver, was approved by the Federal CMS on December 30, 2015. The Waiver contains STCs for the CCS Demonstration. STC 54 required DHCS to submit to CMS updated CCS Pilot Protocols (Protocols) to include proposed updated goals and objectives and the addition of required performance measures by September 30, 2016. DHCS is awaiting approval for the CCS protocols, however DHCS received the formal approval package from CMS on November 17, 2017, for the CCS evaluation design.

Rady Children's Hospital of San Diego (RCHSD) Demonstration Pilot

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

Demonstration Schedule

The RCHSD CCS Demonstration Pilot implemented July 1, 2018.

Consumer Issues:

CCS Quarter Grievance Report

In August 2018, members began enrolling in RCHSD. In April 2021, RCHSD submitted their CCS Quarterly Grievance Report for reporting period January – March 2021. During the reporting period, RCHSD reported one grievance. The one member grievance was related to Pharmacy and the issue was resolved in the member's favor.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

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

To date, UCSF has provided its preliminary findings, inclusive of an analysis of claims/encounter data and eligibility records, as well as an analysis from interviews with key informants and families, in the CCS Pilots Interim Report submitted to CMS on August 31, 2020 as required. DHCS received comments and suggestions from CMS regarding the Interim Report and is working in conjunction with UCSF to provide a response and revise as necessary. DHCS is in the process of extending UCSF's contract to provide an additional year of assessment based on the one-year extension by CMS. Subsequently, the contract will now expire on December 31, 2022, and the Final Evaluation Report will be due to CMS on December 31, 2022.

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

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

CBAS was scheduled to continue as a CMS-approved benefit through December 31, 2020, under California’s 1115(a) “Medi-Cal 2020” waiver approved by CMS on December 30, 2015. With the delayed implementation of CalAIM due to the COVID-19 PHE, DHCS received approval from CMS for the 12-month extension on December 29, 2020.

<u>Program Requirements</u>

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

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

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

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

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

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

Enrollment and Assessment Information:

Per STC 52(a), CBAS enrollment data for both Managed Care Plans (MCPs) and Fee-for-Service (FFS) members per county for DY16-Q2 represents the period of October to December 2020. CBAS enrollment data is shown in Table 3, titled *Preliminary CBAS*

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

Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS. Table 4 titled *CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the first table.

CBAS enrollment data are self-reported quarterly by the MCPs, which sometimes results in data lags. As such, DHCS will report CBAS MCP data for DY16-Q3 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano are combined, as these are smaller counties, and they share the same population.

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

County	DY15-Q3 Jan -Mar 2020		DY15-Q4 Apr - Jun 2020		DY16-Q1 Jul-Sep 2020		DY16-Q2 Oct-Dec 2020	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	487	74%	467	75%	444	71%	443	71%
Butte	30	30%	33	32%	27	27%	32	31%
Contra Costa	207	56%	223	57%	175	47%	171	46%
Fresno	634	46%	625	35%	609	34%	719	38%
Humboldt	101	26%	93	16%	87	15%	86	15%
Imperial	365	61%	335	56%	323	54%	303	50%
Kern	52	8%	74	11%	72	11%	34	5%
Los Angeles	21,610	60%	18,384	50%	21,498	56%	22,335	57%
Merced	98	53%	58	28%	96	46%	105	50%
Monterey	119	64%	116	62%	111	60%	107	57%
Orange	2,579	62%	2,360	57%	2,399	58%	2,415	58%
Riverside	576	37%	444	28%	490	31%	502	32%
Sacramento	443	46%	445	36%	371	32%	409	36%
San Bernardino	691	69%	586	59%	624	62%	656	66%

County	DY15-Q3 Jan -Mar 2020		DY15-Q4 Apr - Jun 2020		DY16-Q1 Jul-Sep 2020		DY16-Q2 Oct-Dec 2020	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
San Diego	2,362	59%	2,283	59%	2,316	60%	2,466	61%
San Francisco	723	46%	735	47%	670	43%	741	47%
San Joaquin	33	14%	35	15%	40	17%	49	21%
San Mateo	76	33%	80	35%	74	32%	71	31%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	582	44%	574	43%	523	40%	551	42%
Santa Cruz	101	66%	92	60%	88	58%	88	58%
Shasta	*	*	*	*	*	*	*	*
Ventura	901	63%	907	63%	935	65%	931	65%
Yolo	283	75%	273	72%	267	70%	265	70%
Marin, Napa, Solano	76	15%	61	12%	70	14%	62	12%
Total	**33,172**	**57%**	**29,309**	**49%**	**32,339**	**53%**	**33,571**	**54%**
FFS and MCP Enrollment Data 12/2020								

***Note: Information is not available for DY16-Q3 due to a delay in the availability of data and will be presented in the next quarterly report.*

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

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

A majority of the counties unduplicated participants stayed at the same approximate level for DY16-Q2. There is only one county with a greater than 5% decline, which is a negative 6% change for Kern County. There were no new centers opening or closing during Q1 in this County, the significant fluctuation is likely a result of a decline in participation. Kern County does not have large participant total, so slight fluctuations yield higher percentages than other counties.

Overall, there is a 1% increase statewide as many counties continue to reflect a slight increase in unduplicated participants.

CBAS Assessments for MCPs and FFS Participants

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

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

Table 4: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY15-Q4 (04/01-06/30/2020)	438	419 (95%)	19 (5%)	0	0 (0%)	0 (0%)
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 (2.1%)	0	0 (0%)	0 (0%)
DY16-Q3 (01/01-03/31/2020)	*	*	*	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

*Note: *MCP assessment information is not reported for DY16-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. For DHCS, DY16-Q3 it was reported that zero participants were assessed for CBAS benefits under FFS. As indicated in the previous table, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care.

During the previous demonstration year, CBAS assessments in DY15-Q4 declined due to the COVID-19 PHE, as CBAS providers temporarily halted in-center congregate services and transitioned to CBAS Temporary Alternative Services (TAS). During this transition

providers were challenged with enrollment of new participants – some who were already in the process and were at varying levels of readiness to begin services and some who were brand new and for whom enrollment had yet to begin. All Center Letter (ACL) 20-11 was issued on May 13, 2020, providing requirements and guidance for provider assessment and enrollment of new participants, to document enrollment steps, and to allow for CDA monitoring of CBAS TAS for participants not previously served by traditional CBAS.

DY16-Q1 and Q2 data for MCP assessments reflects an increase in requests for new assessments. This is a significant increase from the DY15-Q4 period and is not reflective of the typical number of new assessments each quarter prior to the COVID-19 PHE.

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

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases the licensed capacity and enrollment while conversely new CBAS Center openings increase capacity and enrollment. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Table 5 titled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY16-Q2. As of DY16-Q3, the number of counties with CBAS Centers and the ADA of each center are listed below in Table 5. On average, the ADA at the 269 operating CBAS Centers is approximately 31,172 participants, which corresponds to 82 percent of total capacity. Provider-reported data identified in the table below, reflects data from January to March 2021.

Table 5: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	269
Non-Profit Centers	49
For-Profit Centers	220
ADA @ 265 Centers	31,172
Total Licensed Capacity	37,858
Statewide ADA per Center	82.3%

CDA - MSSR
Data 03/2021

Outreach/Innovative Activities:

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

In the past quarter, CDA distributed one newsletter and four ACLs, which included updates on the following topics: (1) CBAS program operations during the COVID-19 outbreak and PHE including revised incident reporting requirements, updates on COVID-19 vaccine eligibility and distribution, and a reminder that limited in-center individual services is permitted in CBAS TAS with the use of proper personal protective equipment (PPE) and other mitigation practices in accordance with public health guidance, (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) CBAS planning activities to prepare CBAS providers and participants for a safe transition to CBAS congregate services when specific conditions are met and public health guidance permits, knowing that the PHE flexibilities are temporary and will end, (4) Upcoming education and training opportunities including a webinar on February 18, 2021, to discuss current federal and state policy guidance on COVID-19 and the PHE, and to identify some of the actions CBAS providers will need to take before transitioning participants to some level of center-based services before the PHE ends, and (5) CMS approval of a temporary extension of California's 1115 Demonstration "Medi-Cal 2020" Waiver through December 31, 2021.

CDA continued to collaborate with CAADS and the Alliance for Leadership and Education (ALE) on their weekly webinar trainings for CBAS providers and MCPs. In January 2021, CDA initiated discussions with CAADS, ALE and CBAS providers on how to prepare CBAS center staff and participants for transitioning to CBAS congregate center services when the PHE and delivery of CBAS TAS will end. These discussions will continue.

CDA convenes triannual calls/outreach with all MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update them on CBAS activities and data including policy directives, and (3) request feedback on any CBAS provider issues requiring CDA assistance. CDA held its initial 2021 triannual call with MCPs on April 8, 2021.

CDA also convenes triannual calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. CDA convened a meeting on January 21, 2021, and discussed the following: (1) Publish on the CDA website Participant Characteristics Report (PCR) data submitted by CBAS providers to CDA twice per year (statewide, by county, and by center), (2) Determine what additional data could be collected to reveal the complexity and acuity of CBAS participants and the value of CBAS,

(3) Train providers on PCR reporting to ensure the quality and consistency of information reported, (4) Develop a user guide to educate consumers about what to look for when considering adult day health care, (5) Identify and promote educational and training opportunities on Person-Centered Care Practices and Multidisciplinary Team Best Practices via the CBAS Updates newsletter.

DHCS and CDA continue to work and communicate with CBAS providers and MCPs on an ongoing basis to provide clarification regarding CBAS benefits, CBAS operations, and policy issues. This includes conducting triannual calls with MCPs, distributing All Center Letters and CBAS Updates newsletters for program and policy updates, and responding to ongoing written and telephone inquiries.

The primary operational and policy development issues during this quarter were the following: (1) Continued response to the COVID-19 pandemic including promoting vaccinations for CBAS participants and staff, (2) CBAS center compliance with the federal Home and Community-Based Settings requirements, and (3) CBAS center compliance with CBAS TAS required services, staffing and documentation, and with CBAS certification standards.

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

CDA, in collaboration with DHCS, continues to implement the activities and commitments to CMS for compliance of CBAS centers with the federal Home and Community-Based (HCB) settings requirements by March 17, 2023, and thereafter on an ongoing basis. CDA determines CBAS center for compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS's directive in the CBAS sections of the 1115 Waiver (STC 48c), CDA developed the *CBAS HCB Settings Transition Plan* which is an attachment to California's *Statewide Transition Plan (STP)*. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the State's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions of the STP and CBAS Transition Plan before it will grant final approval. DHCS and CDA are in the process of revising the STP and CBAS Transition Plan in preparation for final approval. DHCS has not yet determined the submission date of the STP to CMS for final approval.

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

COVID-19 Pandemic and Public Health Emergency

Due to the COVID-19 pandemic, the federal Health and Human Services Secretary issued a public health emergency declaration on January 31, 2020, the President issued a March 13, 2020 national emergency declaration, and California Governor Newsom issued Executive Order N-33-20, a stay-at-home order to protect the health and well-being of all Californians and slow the spread of COVID-19. As a result of the Governor's stay-at-home order, CBAS centers were not able to provide services in a congregate setting beginning the second half of March 2020.

In response, DHCS and CDA developed a new CBAS service delivery model, known as TAS. Under this model, CBAS centers provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants.

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

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

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

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

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

Flexibility for DHCS and MCPs is to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home. On October 9, 2020, CMS sent a letter to DHCS approving the following CBAS program modifications effective from March 13, 2020, through March 12, 2021:

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

DHCS has requested confirmation from CMS of extension of the approved CBAS program modifications beyond March 12, 2021, for up to six months past the end of the PHE via Appendix K authority. DHCS has not yet received confirmation of approval. Pending this approval, CBAS continues to provide TAS services due to the continuing PHE.

Consumer & Provider Issues:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 52.e.iv)
DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the Press, and members of the Legislature on various aspects of the CBAS program. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBASinfo@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

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

Complaints collected by CDA and MCP vary from quarter to quarter. One quarter may have a number of complaints while another quarter may have none. CDA did not receive any complaints for DY16-Q3, as illustrated in Table 6, titled *Data on CBAS Complaints*. MCP complaint information for DY16-Q3 will be presented in the next quarterly report due to a delay in the availability of data.

Table 6: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY15-Q4 (Apr 1 - Jun 30)	0	0	0
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

CDA Data Complaints 03/2021

For complaints received by MCPs, the table below illustrates there were no new complaints, either from beneficiaries or providers reported to the Call Centers about CBAS. MCP complaint information for DY16-Q3 will be presented in the next quarterly report due to a delay in the availability of data. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Table 7: Data on CBAS Managed Care Plan Complaints

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

Plan data - Phone Center Complaints 12/2020

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Table 8 titled, "*Data on CBAS Managed Care Plan Grievances*," a total of three grievances were filed with MCPs during DY16-Q2. MCP grievance information for DY16-Q3 will be presented in the next quarterly report due to a delay in the availability of data. There was one grievance relating to CBAS providers and two categorized as "other CBAS Grievances." DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Table 8: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY15-Q3 (Jan1 - Mar 31)	0	0	0	1	1
DY15-Q4 (Apr 1 - Jun 31)	0	0	0	0	0
DY16-Q1 (Jul 1 - Sept 30)	4	1	0	5	10
DY16-Q2 (Oct1 – Dec 31)	1	0	0	2	3
Plan data - Grievances 12/2020					

Table 9: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY15 – Q3 (Jan1 –Mar31)	2	0	0	0	2
DY15 – Q4 (Apr 1 – Jun30)	1	0	0	0	1
DY16 – Q1 (Jul 1 – Sept 30)	2	0	0	0	2
DY16 – Q2 (Oct 1 – Dec 31)	3	0	0	1	4
		Plan data - Grievances 12/2020			

Note: MCP appeals information is not available for DY16-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.

During DY16-Q2, Table 9 titled "*Data on CBAS Managed Care Plan Appeals*"; shows there were three CBAS appeals filed with the MCPs as they pertain to a denial or limited services. There was one "other" category of appeals for DY16-Q2. MCP appeals information for DY16-Q3 will be presented in the next quarterly report due to a delay in the availability of data.

The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY16-Q3, there were no request for hearings related to CBAS services.

Financial/Budget Neutrality Development/Issues:

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

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

Quality Assurance/Monitoring Activity:

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. It is a five-year strategy plan. CDA continues to convene quarterly calls with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans and representatives from CAADS to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. Many of the initial quality goals and objectives have been achieved. CDA and the CBAS Quality Strategy Advisory Committee have established new quality goals and objectives to ensure ongoing quality improvement activities beyond October 2021.

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under Medi-Cal 2020. Table 10, titled *CBAS Centers Licensed Capacity*, indicates the number of each county's total licensed capacity since DY15-Q2. Overall utilization of licensed capacity by CBAS participants for DY16-Q2 will be presented in the next quarterly report due to a delay in the availability of data.

Table 10: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity					
	DY15-Q4 Apr-Jun 2020	DY16-Q1 Jul-Sep 2019	DY16-Q2 Oct-Dec 2020	DY16-Q3 Jan-Mar 2021	Percent Change Between Last Two Quarters	Capacity Used
Alameda	370	370	370	**370**	0.0%	**
Butte	60	60	60	**60**	0.0%	**
Contra Costa	220	220	220	**220**	0.0%	**
Fresno	1,062	1062	1132	**1132**	0.0%	**
Humboldt	349	349	349	**349**	0.0%	**
Imperial	355	355	355	**355**	0.0%	**
Kern	400	400	400	**610**	+52.5%	**
Los Angeles	21,715	22,770	23,140	**23,636**	+2.1%	**
Merced	124	124	124	**124**	0.0%	**
Monterey	110	110	110	**110**	0.0%	**
Orange	2,438	2,438	2,438	**2678**	+9.8%	**
Riverside	935	935	935	**935**	0.0%	**
Sacramento	729	680	680	**680**	0.0%	**
San Bernardino	590	590	590	**590**	0.0%	**
San Diego	2,278	2,278	2,383	**2,383**	0.0%	**
San Francisco	926	926	926	**926**	0.0%	**
San Joaquin	140	140	140	**140**	0.0%	**
San Mateo	135	135	135	**135**	0.0%	**
Santa Barbara	100	100	100	**100**	0.0%	*
Santa Clara	780	780	780	**780**	0.0%	**
Santa Cruz	90	90	90	**90**	0.0%	**
Shasta	85	85	85	**85**	0.0%	*
Ventura	851	851	851	**851**	0.0%	**
Yolo	224	224	224	**224**	0.0%	**
Marin, Napa, Solano	295	295	295	**295**	0.0%	**
SUM	**34,633**	**35,361**	**36,367**	**37,858**	+4.1%	**

**Pursuant to the Privacy Rule and the Security Rule contained in the Health Insurance*

Portability and Accountability Act, and its regulations 45 CFR Parts 160 and 164, and the 42 CFR Part 2, these numbers are suppressed to protect the privacy and security of participants.

***Capacity used information is not available for DY16-Q3 due to the delay in the availability of the data. Capacity used information for DY16-Q2, the latest quarter for which data is available, can be found in "Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS.*

STCs 52(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. No county experienced a decrease of more than 5 percent in licensed capacity during to DY16-Q3.

During DY16-Q3, Kern, Los Angeles and Orange Counties experienced an increase in licensed capacity as five new CBAS centers opened to increase licensing capacity, while one CBAS center closed.

<u>Access Monitoring (STC 52.e.)</u>

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the tables titled Preliminary CBAS unduplicated Participant – FFS and MCP enrollment Data with County Capacity of CBAS, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. Data for DY16-Q3 is not reflective in those tables due to a lack of availability, but will be reflected in the next quarterly report.

<u>Unbundled Services (STC 48.b.iii.)</u>

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

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY16-Q3, CDA had 269 CBAS Center providers operating in California. According to Table 11 titled "*CBAS Center History*," one CBAS Centers closed and five new centers were opened in DY16-Q3.

Table 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
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	265
November 2020	263	0	2	2	265
September 2020	258	0	4	4	262
August 2020	257	0	1	1	258
July 2020	258	2	1	-1	257
June 2020	258	1	1	0	258
May 2020	257	0	1	1	258
April 2020	256	0	1	1	257

Table 11 shows there was no negative change of more than five percent in DY16-Q3, from January to March 2021, so no analysis is needed to address such variances.

DENTAL TRANSFORMATION INITIATIVE (DTI)

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

Through DTI, DHCS aims to:

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

Medi-Cal beneficiaries are enrolled in one of the two dental delivery systems: Fee-for-Service (FFS) and Dental Managed Care (DMC). DMC plans are only in Sacramento and Los Angeles Counties. The Geographic Managed Care (GMC) plans are mandatory in Sacramento County. The Prepaid Health Plans (PHP) are voluntary in Los Angeles County. All beneficiaries can visit Safety Net Clinics (SNC) for dental encounters. All providers enrolled in FFS, and those providing services through SNCs, can participate in all Domains of the DTI. DMC providers are allowed to participate in other Domains with the exception of Domain 3.

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

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

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

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

With the delay in implementation of the CalAIM initiative due to the COVID-19 public PHE, DHCS submitted a one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) on September 16, 2020, which CMS approved on December 29, 2020, with a new demonstration date for PY 6 ending on December 31, 2021. DHCS' approved proposal included extension of Domains 1-3 of the DTI program for an additional 12 months after December 31, 2020.

Overview of Domains

Domain 1 – Increase Preventive Services for Ages 20 and under[3]
This Domain was designed to increase the statewide proportion of children under the age of 20 enrolled in Medi-Cal for 90 continuous days or more who receive preventive dental services. Specifically, the goal is to increase the statewide proportion of children ages one to 20 who receive a preventive dental service by at least ten percentage points over a five-year period.

Domain 2 – Caries Risk Assessment (CRA) and Disease Management[4]
This Domain is intended to formally address and manage caries risk. There is an emphasis on preventive services for children ages six and under through the use of CRA, motivational interviewing, nutritional counseling, and interim caries arresting medicament application as necessary. In order to bill for the additional covered services in this Domain, a provider rendering services in one of the pilot counties must take the DHCS approved training and submit a completed provider opt-in attestation form.

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

Domain 3 – Continuity of Care[5]
This Domain aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing ongoing relationships between a beneficiary and a dental provider in selected counties. Incentive payments are issued to dental service

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

office locations that have maintained continuity of care through providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods.

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

Domain 4 –LDPPs [6]

Since Domain 4 was not included in the one-year extension of the Medi-Cal 2020 Section 1115 Demonstration Waiver, operations for these efforts concluded December 31, 2020. The LDPPs have submitted all their final reports and invoices relative to PY5. Final payments are in process. While active, the LDPPs supported the aforementioned Domains through thirteen (13) innovative pilot programs to test alternative methods to increase preventive services, reduce early childhood caries, and establish and maintain continuity of care. The LDPPs were required to have broad-based provider and community support and collaboration, including Tribes and Indian health programs.

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

Enrollment Information:

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

Measure Period	1/2020-12/2020	2/2020-1/2021	3/2020-2/2021	4/2020-3/2021
Denominator[8]	5,261,963	5,244,996	5,253,656	5,243,653

[6] DTI Domain 4

[7] Data Source: DHCS Data Warehouse Management Information System/Decision Support System (MIS/DSS) Dental Dashboard April 2021. Utilization does not include one-year full run-out allowed for claim submission.

[8] Denominator: Three months continuous enrollment - Number of beneficiaries ages one (1) through twenty (20) enrolled in the Medi-Cal Program for at least three continuous months in the same dental plan during the measure year.

Measure Period	1/2020-12/2020	2/2020-1/2021	3/2020-2/2021	4/2020-3/2021
Numerator[9]	2,026,880	1,968,315	1,891,853	N/A[10]
Preventive Dental Service Utilization	38.52%	37.53%	36.01%	N/A[11]

Table 13: State Fiscal Year 2020-2021 Statewide Active Service Offices, Rendering Providers, and SNCs[12]

Delivery System and Plan[13]	Provider Type	December 2020	January 2020	February 2021	March 2021
FFS	Service Offices	5,954	5,951	5,965	5,965
FFS	Rendering	11,848	11,875	11,920	11,969
GMC	Service Offices	156	161	154	156
GMC	Rendering	282	335	287	296
PHP	Service Offices	907	896	888	898
PHP	Rendering	1,423	1,415	1,409	1,436
Both FFS and DMC	Safety Net Clinics	598	594	588	N/A[14]

[9] Numerator: Three months continuously enrolled beneficiaries who received any preventive dental service (Current Dental Terminology (CDT) codes D1000-D1999 or CPT code 99188 with safety net clinics' (SNCs) dental encounter with International Classification of Diseases (ICD)-10 diagnosis codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) during the measure year.
[10] Utilization for the third month of each quarter is not available due to claim submission time lag.
[11] Utilization for the third month of each quarter is not available due to claim submission time lag.
[12] Active service offices and rendering providers are sourced from enrollment and not claims submission. Source: FFS Dental reports PS-O-008M, PS-O-008N and DMC Plan deliverables. This table does not indicate whether a provider provided services during the reporting month. The count of SNCs is based on encounter data from the DHCS Data Warehouse MIS/DSS as of April 2021. Only SNCs that submitted at least one dental encounter within a year were included.
[13] Active GMC and PHP service offices and rendering providers are unduplicated among the DMC plans: Access, Health Net, and Liberty.
[14] The count of SNCs for the third month of each quarter is not available due to claim submission time lag.

Outreach/Innovative Activities:

DTI Small Workgroup

This workgroup meets on a quarterly basis, near the end of the calendar quarter. During this quarter, this workgroup had one meeting scheduled on March 18, 2021. Due to lack of agenda items, an email was sent to stakeholders in lieu of the meeting, which included updates on incentive payments, provider participation, and DTI program extension for Domains 1-3. The next DTI Small Workgroup meeting is scheduled on June 17, 2021.

DTI Clinic Subgroup

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

DTI Data Subgroup

The purpose of the DTI data subgroup is to provide an opportunity for stakeholders and DHCS to discuss various components of the DTI annual report and for opportunities to examine new correlations and data. The subgroup did not meet this quarter.

DTI Webpage

There was one update to the DTI webpage during this quarter. The 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.

DTI Inbox and Listserv

DHCS regularly monitored its DTI inbox and listserv during DY16-Q3. In this quarter, there were one hundred ten (110) inquiries in the DTI inbox. Most inquiries during this reporting period included, but were not limited to, the following categories: DTI program extension, county expansion, encounter data submission, opt-in form submissions, payment status and calculations, check reissuances resource documents, procedure codes, and Domain 2 billing and opt-in questions. There was an increase in Domain 1 inquiries regarding payments released in this quarter.

Table 14: Number of DTI Inbox Inquiries by Domain:

Domain	Inquiries
1	67
2	26
3	17
Total	**110**

Separately, the LDPP inbox for Domain 4 received eighty-eight (88) inquiries this quarter, with questions related to quarterly reports, closeout activities, invoice submission and reimbursement status.

Outreach Plans

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

- 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)

Operational/Policy Developments/Issues:

Domain 1

Domain 1 providers are paid semiannually at the end of January and July. The next payment in July 2021 is on schedule. Table 15 represents Domain 1 incentive claims paid for FFS, DMC, and SNC providers on February 1, 2021, which totals $33,280,820.50.

Table 15: Domain 1 Incentive Claims

County	FFS	DMC	SNC
Alameda	$475,023.75	$0	$0
Butte	$40,215.00	$0	$0
Colusa	$1,833.00	$0	$0
Contra Costa	$445,019.25	$0	$0
El Dorado	$167,305.50	$0	$0
Fresno	$1,242,285.00	$0	$0
Glenn	$3,360.00	$0	$0

County	FFS	DMC	SNC
Humboldt	$3,868.50	$0	$0
Imperial	$9,226.50	$0	$0
Kern	$945,395.25	$0	$0
Kings	$8,311.50	$0	$0
Los Angeles	$10,834,859.25	$232,802.25	$84,954.00
Madera	$223,192.50	$0	$0
Marin	$0	$0	$220.50
Mendocino	$4,164.00	$0	$1,575.00
Merced	$354,440.25	$0	$242,654.50
Modoc	$1,422.00	$0	$0
Monterey	$270,661.50	$0	$0
Napa	$20,998.50	$0	$0
Nevada	$3,190.50	$0	$16,750.50
Orange	$2,923,977.00	$0	$16,141.50
Placer	$288,680.25	$18,321.00	$0
Plumas	$66.00	$0	$0
Riverside	$2,145,666.00	$0	$0
Sacramento	$388,971.00	$657,072.00	$0
San Benito	$9,506.25	$0	$0
San Bernardino	$2,433,852.00	$0	$5,404.50
San Diego	$2,062,425.75	$0	$330.75
San Francisco	$376,414.50	$0	$0
San Joaquin	$1,007,342.25	$0	$0
San Luis Obispo	$78,621.75	$0	$0
San Mateo	$182,761.50	$0	$1,428.00
Santa Barbara	$550,166.25	$0	$0
Santa Clara	$610,708.50	$0	$0
Santa Cruz	$47,926.50	$0	$0
Shasta	$68,232.00	$0	$0
Solano	$584,388.75	$0	$0
Sonoma	$43,524.00	$0	$21,673.50
Stanislaus	$937,866.75	$0	$40,128.00
Sutter	$558,940.50	$0	$0
Tulare	$535,902.00	$0	$0
Tuolumne	$2,824.50	$0	$0
Ventura	$965,421.75	$61.50	$14,869.50
Yolo	$48,928.50	$17,673.00	$0
Yuba	$874.50	$0	$0
Total	**$31,908,760.50**	**$925,929.75**	**$446,130.25**

Domain 2

FFS providers are paid on a weekly basis while SNC and DMC providers are paid on a monthly basis. Table 16 represents Domain 2 incentive claims paid for FFS, SNC, and DMC providers during DY16-Q3, which totals $20,877,400.17 (for all Domain 2 benefits including CRA, Silver Diamine Fluoride (SDF) and preventive services) that are paid to 3,261 providers who opted-in to Domain 2. The incentive claims paid reflect the increased frequency allowances for preventive services allowed under Domain 2, beyond the frequency for preventive services covered in the Manual of Criteria (MOC). In addition, the incentive claims paid also reflect the CRA and SDF treatments which are not otherwise covered in the MOC.

Table 16: Domain 2 Incentive Claims

County	FFS	DMC	SNC
Contra Costa	$347,642.00	$0	$0
Fresno	$948,335.45	$0	$0
Glenn	$126.00	$0	$0
Humboldt	$0	$0	$0
Imperial	$17,106.00	$0	$0
Inyo	$0	$0	$0
Kern	$501,847.63	$0	$630.00
Kings	$4,788.00	$0	$0
Lassen	$0	$0	$0
Los Angeles	$7,397,358.23	$35,826.00	$62,178.00
Madera	$147,904.00	$0	$0
Mendocino	$0	$0	$0
Merced	$238,505.87	$0	$0
Monterey	$784,595.35	$0	$0
Orange	$2,065,291.90	$0	$20,147.00
Plumas	$0	$0	$0
Riverside	$158,530.65	$126.00	$32,553.00
Sacramento	$230,454.25	$347,802.00	$0
San Bernardino	$1,443,470.81	$0	$6,811.00
San Diego	$1,893,599.48	$0	$238,745.00
San Joaquin	$524,591.77	$0	$0
Santa Barbara	$458,554.50	$0	$0
Santa Clara	$491,872.45	$0	$0
Sierra	$0	$0	$0
Sonoma	$45,666.50	$0	$107,827.00
Stanislaus	$760,211.45	$0	$0
Tulare	$645,813.38	$0	$0
Ventura	$765,055.50	$0	$153,182.00
Yuba	$0	$252.00	$0
Total	**$19,871,321.17**	**$384,006.00**	**$622,073.00**

Table 17 represents incentive claims paid for FFS, SNC and DMC providers from the beginning of the Domain 2 program, February 2017, until the end of DY6-Q3 reporting period, March 2021. The total incentive claims paid for this period was $149,048,510.26.

Table 17: Domain 3 Incentive Claims

County	FFS	DMC	SNC
Contra Costa	$1,844,434.50	$0	$0
Fresno	$6,960,895.65	$252.00	$17,528.00
Glenn	$10,719.00	$0	$0
Humboldt	$70.00	$0	$126.00
Imperial	$107,364.50	$0	$0
Inyo	$0	$0	$43,218.00
Kern	$8,260,250.74	$126.00	$756.00
Kings	$44,564.00	$0	$0
Lassen	$0	$0	$0
Los Angeles	$44,784,120.81	$473,956.00	$2,117,764.00
Madera	$1,096,353.80	$0	$0
Mendocino	$0	$0	$754,739.00
Merced	$1,241,051.68	$0	$0
Monterey	$4,935,085.94	$0	$0
Orange	$11,098,289.40	$252.00	$714,024.00
Plumas	$0	$0	$0
Riverside	$7,288,068.86	$126.00	$48,895.00
Sacramento	$2,235,564.15	$5,658,137.00	$0
San Bernardino	$7,966,873.46	$252.00	$26,005.00
San Diego	$11,546,267.38	$0	$1,244,436.00
San Joaquin	$3,136,155.27	$504.00	$18,322.00
Santa Barbara	$2,731,697.92	$0	$0
Santa Clara	$2,844,624.33	$0	$28,875.00
Sierra	$0	$0	$0
Sonoma	$347,207.50	$0	$993,817.00
Stanislaus	$4,476,357.75	$126.00	$0
Tulare	$8,430,359.17	$0	$0
Ventura	$4,744,309.45	$252.00	$775,085.00
Yuba	$0	$252.00	$0
Total	**$136,130,685.26**	**$6,134,235.00**	**$6,783,590.00**

Domain 3

There were no payments issued during this quarter as Domain 3 annual payments are made annually in June. The Domain 3 payment for this year will be reported in the 1115 Waiver DY 16 Annual Report.

Outreach Efforts:

Although provider offices are open, there are still restrictions for in-person outreach. As a result of the COVID-19 PHE, the ASO outreach team modified their approach by substituting routine, in-person visits with emails, phone calls, and virtual meetings. Contact with participating dental providers is an opportunity to support them, encourage them to accept new patients, and share the dental benefits available to Medi-Cal members. Outreach efforts in this quarter included contacting 1,232 offices in 7 underserved counties and 33 non-underserved counties. The ASO outreach team provided COVID-19 PHE updates and offered their assistance and contact information. They also shared updated provider bulletins as most provider offices have re-opened their practices and many had questions regarding personal protective equipment (PPE) and safety protocols. The ASO outreach team will continue to follow up with each provider.

Domain 2

In this quarter, the ASO's outreach team contacted by telephone, twenty-three (23) of the twenty-nine (29) counties - Contra Costa, Fresno, Kern, Kings, Lassen, Los Angeles, Madera, Mendocino, Merced, Monterey, Orange, Plumas, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Sonoma, Stanislaus, Tulare, and Ventura. During these telephone calls, the ASO's outreach team provided information to Medi-Cal Dental offices within these counties in relation to the benefits available to Medi-Cal Dental providers who participate in DTI Domain 2. The expected outcome of these telephone calls is that provider participation in Domain 2 will increase after Medi-Cal Dental providers are informed of the additional benefits available to them via participation in the DTI Domain 2 program. The ASO continued to outreach to interested providers during their regular course of business. In this quarter, Domain 2 participation increased by 147 providers, bringing the total from 3,114 to 3,261.

Domain 3

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

Consumer Issues:

There were no consumer issues for this quarter.

Financial/Budget Neutrality Development/Issues:

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

Quality Assurance/Monitoring Activities:

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

Evaluation:

During DY16-Q3, Mathematica, the DTI independent evaluator, continued to complete tasks associated with the final evaluation of the DTI Program. Throughout DY16-Q3, Mathematica also continued to participate in bi-weekly conference calls with DHCS and completed their final interviews with LDPP lead agencies and a subset of their partners, totaling 48 interviews across the 13 LDPPs. Additionally, Mathematica will continue to participate in bi-weekly conference calls with DHCS and gather and analyze data for inclusion in the Final Evaluation Report. Given that DTI has been extended for one additional year (PY 6), Mathematica has been directed to include data from PY 6 in the final evaluation of the DTI Program. Accordingly, the due date by which Mathematica must submit the final evaluation to DHCS has been extended for one additional year, due November 30, 2022.

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

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

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

Enrollment Information:

Table 18: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY15-Q4	39,683	16,685	55,853
DY16-Q1	55,621	15,555	55,626
DY16-Q2	54,524	14,854	54,527
DY16-Q3	43,939	10,871	43,942

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

Member Months:

Table 19: ACA v. Non-ACA Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	31122	30921	31477	D15-Q4	39,683
	43026	42777	43396	D16-Q1	55,621
	43702	42918	40589	D16-Q2	54,524

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
	35738	30591	24032	D16-Q3	43,939
Non-ACA	13992	13972	13760	D15-Q4	16,685
	12418	12190	12126	D16-Q1	15,555
	12016	11924	11199	D16-Q2	14,854
	9010	7014	5578	D16-Q3	10,871

The decline in member months and expenditures are attributable to the timing of the data run. DY16-Q3 is 1/1/2021-3/31/2021. The data was run one month after the end of the quarter, so data is not yet complete. Counties have six months to submit their DMC claims, so we believe the numbers are lower because of the time of the data run (only one month after). The accurate enrollment numbers for DY16-Q3 will be provided in the next quarterly report.

Outreach/Innovative Activities:

Outreach and innovations for DMC-ODS include individual and all-county technical assistance (TA), webinars, and workgroups which cover a wide range of topics. Assistance is further offered on an ad hoc basis to address concerns and provide TA individually as necessary. For example, DHCS hosts all-county monthly calls which address issues including but not limited to the program's fiscal, clinical, technical, federal and state program policy requirements, and updates to the California Advancing and Innovating Medi-Cal (CalAIM) effort.

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM improvements are inclusive of, but not confined to, DMC-ODS. Additional details can be found on the DHCS CalAIM webpage linked below.

https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

On January 14, 2021, DHCS hosted a webinar with the seven counties in the DMC-ODS Regional Model and the PHC. This webinar focused on gathering successes and lessons learned during the first six months of implementation throughout seven counties. DHCS continues to hold a monthly meeting with the seven regional model counties and PHC to support their first-year of DMC-ODS implementation.

In January 2021 DHCS also initiated a DMC-ODS work group to encourage current DMC-State Plan counties to consider implementing the DMC-ODS model. DHCS hosted two webinars to provide information on DMC-ODS to current DMC-State Plan counties. These webinars were conducted on February 18, 2021, and February 19,

2021. Subsequently, in March 2021, DHCS surveyed DMC-State Plan counties to obtain any expression of interest to opt-in to the DMC-ODS service model. DHCS is currently analyzing the survey results and developing a TA plan for those counties who expressed interest in opting-in.

Recent activities including DMC-ODS guidance are listed below:

- January-March – DMC-ODS Meetings with DHCS & Aurrera
- January 11, 2021 – CA SMHS and DMC-ODS Monthly Monitoring Call
- January 12, 2021 – DMC-ODS Extension Discussion
- January 15, 2021 – CA 1115 Monthly Monitoring Meeting
- January 28, 2021 – DMC-ODS Meeting
- February 3, 2021 – DMC-ODS Regulations Package
- February 4, 2021 – DMC Doc Set Review
- February 5, 2021 – CA 1115 DMC-ODS Meeting
- February 8, 2021 – CA 1115 Monthly Monitoring Meeting
- February 22, 2021 – DHCS DMC-ODS Approach for CMS Meeting
- February 23, 2021 – CalAIM Administrative Integration SMH and SUD
- March 4, 2021 – Regional Model in ODS Meeting
- March 8, 2021 – CA SMHS and DMC-ODS Meeting
- March 22, 2021 – CalAIM SMH/SUD Integration Meeting

Operational/Policy Developments/Issues:

Due to the current COVID-19 PHE, many counties experienced staffing challenges due to the demands of responding to the emergency. Nevertheless, counties and providers quickly pivoted from in-person to telehealth services, where feasible. After a drop in service volume for the first three months of the emergency, service levels and number of visits continued to rise each quarter.

The DMC-ODS Regional Model counties are still working through various first-year operational activities and identifying barriers associated with the implementation of the DMC-ODS requirements. Through monthly webinars with the DMC-ODS Regional Model counties and PHC, DHCS continued to identify implementation barriers unique to the Regional Model, research possible solutions to barriers, and schedule topic-specific TA meetings.

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

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

DHCS postponed the planned implementation of the CalAIM initiative, originally scheduled for January 1, 2021, so that both DHCS and all of our partners could focus their limited resources on the needs arising from the PHE due to COVID-19. The CalAIM proposal was updated on January 8, 2021, and is linked below.

https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf

Additionally, DHCS received verbal approval from CMS for several policy changes/clarifications during the waiver extension period in key areas of the DMC-ODS waiver such as: access to Medication-Assisted Treatment; removal of limitations on residential services; access to treatment during the initial assessment period, medical necessity determination, and level of care placement; and recovery services. These changes and clarifications are specified in amendments to the special terms and conditions of the DMC-ODS waiver and are effective retroactively to January 1, 2021, continuing through December 31, 2021. DHCS is currently preparing a new waiver request that, if approved by CMS, would authorize the DMC-ODS waiver through December 2026.

Financial/Budget Neutrality Developments/Issues:

Table 20: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY15-Q4					
ACA	2789706	$86,630,988.25	$72,255,588.68	$8,669,210.82	$5,706,188.75
Non-ACA	1335794	$29,153,102.32	$14,642,920.55	$3,499,794.91	$11,010,386.86
DY16-Q1					
ACA	8781995	$320,701,080.24	$263,125,492.58	$32,690,241.19	$24,885,346.47
Non-ACA	1158495	$30,769,488.67	$16,197,227.08	$4,343,534.76	$10,228,726.83
DY16-Q2					
ACA	8530735	$319,465,677.82	$264,397,020.38	$32,402,430.79	$22,666,226.65
Non-ACA	1096747	$30,124,926.15	$16,889,403.55	$4,201,234.60	$9,034,288.00
DY16-Q3					
ACA	5743758	$231,474,669.51	$193,173,079.15	$23,772,908.01	$14,528,682.35
Non-ACA	601385	$19,040,887.17	$10,679,161.02	$3,179,478.99	$5,182,247.16

The decline in expenditures in DY16-Q3 are attributable to the timing of the data run. Accurate financial data will be provided in the next quarterly report.

Consumer Issues:

All counties that are actively participating in the DMC-ODS Waiver track grievances and appeals. An appeal is defined as a request for review of an action (e.g., adverse benefit

determination) while a grievance is a report of dissatisfaction with anything other than an adverse benefit determination. Grievance and appeal data is as follows:

Table 21: Grievances

County	Acess to Care	Quality of Care	Program Requirements	Failure to Respect Enrollee's Rights	Interpersonal Relationship Issues	Other	Totals	Appeals
Alameda	-	-	1	-	1	-	**2**	-
Contra Costa	1	-	-	-	-	3	**4**	-
El Dorado	-	-	-	-	-	-	**0**	1
Fresno	-	1	-	-	-	-	**1**	-
Humboldt*	-	-	2	-	2	-	**4**	4
Imperial	-	-	-	-	-	-	**0**	-
Kern	2	4	1	-	1	-	**8**	-
Lassen*	-	-	-	-	-	-	**0**	-
Los Angeles	1	-	-	-	-	3	**4**	66
Marin	-	-	-	-	-	-	**0**	-
Mendocino*	-	-	-	-	-	-	**0**	-
Merced	-	-	-	-	-	1	**1**	-
Modoc*	-	-	-	-	-	-	**0**	-
Monterey	-	-	-	-	-	-	**0**	-
Napa	-	-	-	-	-	-	**0**	-
Nevada	-	2	-	4	-	1	**7**	-
Orange	2	3	-	-	1	-	**6**	-
Placer	-	1	1	-	2	-	**4**	-
Riverside	2	5	-	-	-	2	**9**	1
Sacramento	-	1	-	-	1	-	**2**	-
San Benito	-	-	-	-	-	-	**0**	-
San Bernardino	-	3	-	-	-	-	**3**	-
San Diego	-	12	-	3	-	3	**18**	1
San Francisco	-	-	1	-	1	-	**2**	1
San Joaquin	-	15	1	3	1	3	**23**	-
San Luis Obispo	-	1	-	-	-	2	**3**	1
San Mateo	-	2	1	-	-	-	**3**	-
Santa Barbara	-	-	-	5	5	2	**12**	-
Santa Clara	-	-	-	-	-	-	**0**	-
Santa Cruz	1	-	-	-	-	1	**2**	-
Shasta*	-	-	-	-	3	-	**3**	-
Siskiyou*	-	-	-	-	2	-	**2**	-
Solano*	-	-	-	-	-	-	**0**	-
Stanislaus	-	3	-	-	-	6	**9**	-
Tulare	-	-	-	-	-	-	**0**	-
Ventura	-	-	-	-	-	-	**0**	-
Yolo	-	1	1	-	-	-	**2**	-

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

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

Los Angeles County reported a significant rise in appeals during this reporting quarter. DHCS is meeting with county representatives to get specific information regarding this increase and determine if TA or other actions may be warranted. A summary of findings and actions taken will be included in the upcoming quarterly report.

Table 22: Resolutions

	Resolution				Transition of Care		
County	**Grievances**	**Appeal**	**Appeal in favor of Plan**	**Appeal in favor of Beneficiary**	**Requests**	**Approved**	**Denied**
Alameda	1	1	1	-	-	-	-
Contra Costa	5	-	-	-	-	-	-
El Dorado	-	1	-	1	-	-	-
Fresno	1	-	-	-	-	-	-
Humboldt*	5	-	-	-	-	-	-
Imperial	-	-	-	-	-	-	-
Kern	8	-	-	-	-	-	-
Lassen*	-	-	-	-	-	-	-
Los Angeles	6	43	16	34	-	-	-
Marin	-	-	-	-	-	-	-
Mendocino*	-	-	-	-	-	-	-
Merced	1	-	-	-	-	-	-
Modoc*	-	-	-	-	-	-	-
Monterey	-	-	-	-	-	-	-
Napa	-	-	-	-	-	-	-
Nevada	2	-	-	-	-	-	-
Orange	7	-	-	-	-	-	-
Placer	4	-	-	-	-	-	-
Riverside	10	1	-	-	-	-	-
Sacramento	-	-	-	-	-	-	-
San Benito	-	-	-	-	-	-	-
San Bernardino	-	-	-	-	-	-	-
San Diego	7	2	2	-	-	-	-

	Resolution				Transition of Care		
San Francisco	2	1	1	-	-	-	-
San Joaquin	2	-	-	-	-	-	-
San Luis Obispo	1	1	-	2	-	-	-
San Mateo	4	-	-	-	-	-	-
Santa Barbara	1	-	-	-	-	-	-
Santa Clara	3	-	-	-	1	-	-
Santa Cruz	2	-	-	-	-	-	-
Shasta*	2	-	-	-	-	-	-
Siskiyou*	2	-	-	-	-	-	-
Solano*	-	-	-	-	-	-	-
Stanislaus	8	-	-	-	-	-	-
Tulare	-	-	-	-	-	-	-
Ventura	-	-	-	-	-	-	-
Yolo	2	-	-	-	-	-	-

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

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

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

Quality Assurance/Monitoring Activities:

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

In December 2020, in response to a surge of COVID-19 cases, staff shortages, and the need for counties and providers to focus on managing the crisis, DHCS placed all behavioral health auditing and oversight activities on hold through March 1, 2021. Counties were allowed to choose to proceed with scheduled reviews and/or continue working on reviews which were in progress. DHCS conducted compliance monitoring reviews for the following counties.

County	Date
Amador	January 2021
Placer	February 2021
Fresno	February 2021
Colusa	February 2021
Glenn	February 2021
San Diego	February 2021
San Mateo	March 2021
San Francisco	March 2021
Butte	March 2021

Throughout the PHE, DHCS continued to work with the counties to provide support and grant extensions as appropriate. DHCS continued receiving Corrective Action Plans (CAPs) from the counties, processed for acceptance and worked collaboratively with counties to resolve CAPs. DHCS continues to monitor CAPs through individual county's monthly TA calls and through ad hoc communications to address concerns individually as needed.

In addition, DHCS conducted a 6-month Post-Live monitoring assessment of the Regional Model counties' compliance with the 24-hour Access Line, Beneficiary Handbook, and Provider Directory requirements. Findings were shared with the counties and DHCS continues to monitor these activities via individual county's monthly TA calls.

Evaluation:

The University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), under contract with DHCS, has been evaluating the DMC-ODS demonstration project since 2016 according to a CMS-approved evaluation plan. The evaluation has focused on measures of treatment access, quality, and coordination of care. Each year, as counties have joined DMC-ODS from 2017-2020, UCLA ISAP has collected statewide data through stakeholder surveys, key informant interviews, client treatment perceptions surveys, a unique ASAM screening and assessment database created for DMC-ODS, and secret shopper calls to beneficiary access lines. UCLA ISAP has also conducted analyses of administrative data received from DHCS (Medi-Cal claims, treatment episode data). The 2021 DMC-ODS Evaluation Report Draft was submitted to DHCS for review on January 31, 2021 and the final version can be accessed at the link below.

http://www.uclaisap.org/dmc-ods-eval/assets/documents/DMC-ODS-FY-2020-Evaluation-Report-with-appendices-revised_2021-03-25.pdf

Overall, findings to date suggest DMC-ODS has had a positive impact on treatment access, quality, and coordination of care. Still, a number of challenges have also been identified, and the evaluation team has sought to target these challenges by producing case studies on stakeholders overcoming common challenges, recommending training topics based on stakeholder input, and filling specific needs, e.g. by developing free screening and assessment tools.

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

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Enrollment Information:

Not applicable.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

The Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of PHE. During DY16-Q2, the Secretary of Health and Human Services extended the COVID-19 PHE effective October 23, 2020. National public health emergencies are effective for 90 days unless extended or terminated. Due to this change, PY 6A IQ2 and IQ2B payment calculations were included at the increased FMAP percentages.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Table 23: DY16-Q3 Reporting for GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
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
Total	**$246,325,231.13**	**$191,975,891.87**		**$438,301,123.00**

DY16-Q3 reporting includes GPP payments made in January and February 2021. The payments made during this time period were for Program Year (PY) 6A, Interim Quarter (IQ) 2 (October 1, 2020 – December 31, 2020), and PY 6A, IQ2B (October 1, 2020 – December 31, 2020).

In PY 6A, IQ2, the PHCSs received $144,554,360.73 in federal funded payments and $112,659,804.27 in IGT funded payments for GPP.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (H.R. 133) was enacted, which postponed implementation of the Disproportionate Share Hospital (DSH) reduction until FFY 2024. The PY 6A IQ2B round payment was an out of cycle payment made to pay out the reduction amounts that were previously withheld from the GPP PY 6A IQ1 and IQ2 payments.

In PY 6A, IQ2B, the PHCSs received $101,770,870.40 in federal funded payments and $79,316,087.60 in IGT funded payments for GPP.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluation:

Nothing to report.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 11.35 million Medi-Cal beneficiaries in all 58 counties. DHCS provides six types of managed care models:

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

Enrollment Information:

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

Table 24: Total Member Months for Mandatory SPDs by County
January – March 2021

County	Total Member Months
Alameda	80,346
Contra Costa	49,698
Fresno	69,864
Kern	57,197
Kings	8,114
Los Angeles	529,417
Madera	6,877
Riverside	107,751
Sacramento	103,117
San Bernardino	115,188
San Diego	116,454
San Francisco	38,728
San Joaquin	47,246
Santa Clara	65,797
Stanislaus	32,758
Tulare	32,139
Total	**1,460,691**

Table 25: Total Member Months for Existing SPDs by County
January – March 2021

County	Total Member Months
Alameda	77,407
Contra Costa	37,051
Fresno	46,312
Kern	34,636
Kings	4,843
Los Angeles	1,057,426
Madera	4,931
Marin	19,800
Mendocino	17,714
Merced	51,228
Monterey	50,438
Napa	15,717
Orange	352,856
Riverside	120,739
Sacramento	76,175
San Bernardino	117,260
San Diego	202,023
San Francisco	51,663
San Joaquin	32,306
San Luis Obispo	26,094
San Mateo	42,719
Santa Barbara	49,300
Santa Clara	123,742
Santa Cruz	32,805
Solano	62,932
Sonoma	52,715
Stanislaus	19,770
Tulare	21,944
Ventura	92,480
Yolo	92,480
Total	**2,922,320**

Table 26: Total Member Months for SPDs in Rural Non-COHS Counties
January – March 2021

County	Total Member Months
Alpine	39
Amador	1,083
Butte	16,117
Calaveras	1,619
Colusa	821
El Dorado	5,157
Glenn	1,596
Imperial	10,839
Inyo	473
Mariposa	675
Mono	161
Nevada	3,046
Placer	10,603
Plumas	939
San Benito	347
Sierra	95
Sutter	6,045
Tehama	5,126
Tuolumne	2,442
Yuba	6,282
Total	**73,505**

Table 27: Total Member Months for SPDs in Rulral COHS Counties
January – March 2021

County	Total Member Months
Del Norte	8,270
Humboldt	26,830
Lake	19,894
Lassen	4,465
Modoc	2,301
Shasta	40,554
Siskiyou	11,607
Trinity	2,857
Total	**116,778**

WHOLE PERSON CARE (WPC)

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

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

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

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

Eighteen LEs began implementing and enrolling WPC beneficiaries on January 1, 2017. After approval of the initial WPC pilots, DHCS accepted a second round of applications both from new applicants and from LEs interested in expanding their WPC pilots. DHCS approved fifteen WPC pilot applications in the second round. The second round LEs began implementation on July 1, 2017.

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

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

The Centers for Medicare and Medicaid Services (CMS) has approved a temporary extension of DHCS' Medi-Cal 2020 Demonstration, which is set to expire on December

31, 2021, contingent upon DHCS' continued compliance with the Special Terms and Conditions (STC). This extension authorizes the WPC pilot program to operate for an additional year, known as Program Year (PY) 6, from January 1, 2021, to December 31, 2021. Additionally:

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

Enrollment Information:

The data reported below in Table 28 reflects the most current unique new beneficiary enrollment counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Enrollment data is updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly enrollment counts reflect the cumulative number of unique new beneficiaries enrolled in Quarter Two (Q2) of Demonstration Year (DY) 16. The total-to-date column reflects the cumulative number of unique new beneficiaries enrolled from beginning of the program, DY 12 (January 2017), to the most current data available, DY16-Q2 (October - December 2020). Due to a delay in the availability of data, DY16-Q3 data will be reported in the next quarterly report. Enrollment data is extracted from the LE's self-reported Quarterly Enrollment and Utilization (QEU) reports. The data reported is point-in-time as of March 23, 2021.

Table 28: New Beneficiary Enrollment Counts

LE	DY16-Q2 (Oct. - Dec. 2020)**	Jan. 2017 – Dec. 2020 Cumulative Total to Date
Alameda	1,840	23,657
Contra Costa	2,220	51,978
Kern	244	2,216
Kings*	26	762
LA	2,758	64,313
Marin*	23	1,845
Mendocino*	14	428
Monterey	28	687
Napa	20	606
Orange	273	12,808
Placer	6	475
Riverside	349	7,854

LE	DY16-Q2 (Oct. - Dec. 2020)**	Jan. 2017 – Dec. 2020 Cumulative Total to Date
Sacramento*	58	2,209
San Bernardino	33	1,361
San Diego	0	879
San Francisco	833	21,081
San Joaquin	236	2,427
San Mateo	76	3,857
Santa Clara	276	6,624
Santa Cruz*	15	581
SCWPCC*	0	143
Shasta	27	495
Solano	0	254
Sonoma*	574	3,388
Ventura	30	1,331
Total	**9,959**	**212,259**

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

*** Due to a delay in the availability of data, DY16-Q3 data will be reported in the next quarterly report. SCWPCC and Solano County have opted not to continue operations in 2021; therefore, they have zero enrollment during this reporting period.*

Member Months:

The data reported below in Table 29 reflects the most current member month counts available, including updated data files submitted by LEs after the publishing date of the prior quarterly report. Member months are updated during each reporting period to reflect retroactive changes to enrollment status and, as a result, may not match prior reports. Quarterly and cumulative total-to-date member months are reflected in the table below. The cumulative total-to-date column reflects the cumulative number of member months from the beginning of the program, DY 12 (January 2017), to the most current data available, DY16-Q2 (October – December 2020). Due to a delay in the availability of data, DY16-Q3 data will be reported in the next quarterly report. Member months are extracted from the LE’s self-reported QEU reports. The data reported is point-in-time as of March 23, 2021.

Table 29: Member Month Counts

LE	DY16-Q2 (Oct. - Dec. 2020) **	Jan. 2017 – Dec. 2020 Cumulative Total-to-Date
Alameda	58,968	355,819
Contra Costa	37,978	593,337
Kern	6,163	36,827
Kings*	532	5,434
LA	55,038	599,111
Marin*	4,984	36,266
Mendocino*	443	5,529
Monterey	713	6,132
Napa	708	7,853
Orange	7,625	141,105
Placer	304	5,283
Riverside	20,767	134,531
Sacramento*	2,796	26,431
San Bernardino	1,515	19,480
San Diego	985	9,991
San Francisco	32,350	391,775
San Joaquin	5,000	33,039
San Mateo	6,479	101,397
Santa Clara	9,483	119,733
Santa Cruz*	1,406	14,756
SCWPCC*	104	1,578
Shasta	195	3,050
Solano	113	3,186
Sonoma*	6,303	28,300
Ventura	1,546	24,934
Total	**262,498**	**2,704,877**

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

*** Due to a delay in the availability of data, DY 16-Q3 data will be reported in the next quarterly report. SCWPCC and Solano County have opted not to continue operations in 2021; therefore, these are the last member month counts reported for their Pilot.*

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Developments/Issues:

During this quarter, DHCS, along with the WPC Learning Collaborative (LC),

communicated with the LEs through webinars, virtual conference meetings, phone calls, and emails to better understand the issues that are of most interest and concern to guide DHCS' technical assistance (TA) and LC content. All in-person meetings are currently on-hold due to restrictions on large gatherings caused by the COVID-19 PHE.

DHCS held monthly virtual conference meetings with LEs focusing on administrative topics and TA to provide the opportunity for LEs to ask questions about DHCS' guidance and issues with reporting templates, deliverable deadlines, and expectations. As DHCS begins the transitions to CalAIM implementation on January 1, 2021, these monthly meetings also provide Enhanced Care Management (ECM) and In Lieu of Services (ILOS) TA for the LE transition process, as part of the CalAIM initiative. Monthly conference meetings were held on February 3rd, March 3rd, and March 17th. The following topics were discussed on the calls:

- Approval of the one year extension of the 1115 Demonstration Waiver WPC pilot program

PY 6 COVID-19 budget review and approval status

- Contract amendments between DHCS and LEs to extend the expiration date from June 30, 2021 to June 30, 2022
- Quarter 4 Enrollment and Utilization Report updated template and due date
- PY 5 Customized Invoice
- PY 5 Annual Report deliverables
- CalAIM webinar re-launch presentation
- ECM/ILOS Survey and transition planning discussion

DHCS drafted contract amendments for the 23 LEs who confirmed they will be operating Pilot programs through the end of 2021, as CMS has approved of the temporary extension of the Medi-Cal 2020 Demonstration through December 31, 2021. During this quarter, DHCS worked with the Office of Legal Services to draft appropriate language for the WPC contract amendments. DHCS released all drafts to the LEs for review, and anticipates all contracts will be fully executed by the next quarterly report.

The LC anticipates the focus of 2021 will be to support the sunset of the LE's pilot program and transition to the new Medi-Cal benefits and services under the state's CalAIM initiative, which includes ECM and ILOS. During this quarter, the LC surveyed the transition needs of the LEs, in order to structure the technical assistance (TA) support for the remaining year.

The LC advisory board met on February 2nd and March 2nd to discuss the transition needs under the CalAIM initiative. The advisory board emphasized their interest to join TA opportunities with MCPs and other stakeholders to prepare for the transition. The LC has combined efforts with CalAIM TA activities, and plans to host bi-weekly virtual meetings going forward. The LC did not host any in-person meetings this quarter.

COVID-19 Public Health Emergency:

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

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

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

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

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Developments/Issues:

As shown below in Table 30, during this quarter, no WPC payments were made. PY 5 Annual Invoices are due from LEs on April 1, 2021, with payments scheduled for May 2021.

Table 30: WPC Payments in DY 16

DY 16 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 1 (July 1 – Sept 30)	$96,573,902.01	$96,573,902.01	DY 16 (PY 4*)	$193,147,804.02
Qtr 2 (Oct 1 – Dec 31)	$274,365,422.90	$138,563,498.50	DY 16 (PY 5)	$316,355,019.41

DY 16 Payment	FFP	IGT	Service Period	Total Funds Payment
Qtr 3 (Jan 1 – Mar 31)_	$0	$0	DY 15 (PY 5)	$0
Total	**$274,365,422.90**	**$235,137,400.51**		**$509,502,823.43**

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

Quality Assurance/Monitoring Activities:

During this quarter, LEs submitted the following:

- Fourth quarter October 2020 – December 2020 PY 5 QEU (Due 1/31/2021)
- PY 5 Annual Customized Invoice Template (Due 2/17/2021)

Accurate reporting is fundamental to the success of WPC. These reports are tools for LEs and DHCS to assess the degree to which the LEs are achieving their goals. DHCS also uses these reports to monitor and evaluate the WPC pilot programs and to verify invoices for payment purposes.

Evaluation:

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

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

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

restricted to the period prior to COVID-19 along with separate analyses of the period impacted by COVID-19.

During the third quarter of DY 16, UCLA:

- Collected information on refined service categories through the LE Part II survey, which contained per-member-per-month (PMPM) and FFS categories from the most recent EUR. Survey data was cleaned, merged with PMPM and FFS pricing, and preliminary analysis was conducted to understand the distribution of services within and across LEs. UCLA will clear up discrepancies in the final report.
- Finalized the “report card” table based on conversations with DHCS and select MCPs. The policy brief includes data on enrollment strategies, care coordination approach, WPC services offered, partnership characteristics, enrollment, and enrollee health status, demographics, and health care utilization. The data can be used by MCPs and other organizations that are developing population health.
- Continued the process to finalize shadow pricing methodology, which will be used to analyze the cost impact of WPC in the final report.
- Continued conversations around anticipated COVID-19 impact on Medi-Cal claims data and subsequent UCLA analysis. UCLA started to document potential implications of COVID-19 on the evaluation and identify ways to address data collection and quality concerns, in line with CMS guidance. In order to isolate the impact of WPC, the final report will include analyses restricted to the period prior to COVID-19 along with separate analysis of the period impacted by COVID-19. UCLA explored options for presenting preliminary analysis, including descriptions of COVID-19 impacts on WPC implementation, enrollment and health care utilization, in an upcoming policy brief publication.
- Continued work on a supplemental grant from the Robert Wood Johnson Foundation to expand upon the WPC evaluation and better understand how organizations from different sectors have worked together to improve population health outcomes and health equity in the context of COVID-19. UCLA submitted a data application to use WPC data for this project in March 2021.
- Developed a preliminary draft of a LE survey instrument to update data collected in summer 2020.
- Developed a preliminary draft of a protocol for semi-structured interviews to follow-up with the LE survey described above.
- Further refined a draft manuscript on a novel prediction model to identify individuals experiencing homelessness or at-risk-of-homelessness using administrative and publicly available data.
- Finalized a manuscript that summarized the findings from a systematic literature review of care coordination across multiple sectors of care. The manuscript is currently in the “revise and resubmit” phase with the journal, Population Health Management.
- Coded and analyzed challenges, successes, and lessons learned related to (1) identifying, engaging, and enrolling clients, (2) care coordination, (3) data sharing, (4) outcomes and sustainability, and (5) biggest barriers to

implementation as discussed by LEs in PY 5 mid-year narrative reports. UCLA submitted a Narrative Report Update to DHCS in March 2021, highlighting key findings over time and for PY 5 mid-year. COVID-19 response and impact were key topics of the report.

- Recreated the Enrollment and Utilization (E/U) reports Chart Pack by summarizing new enrollment and enrollee descriptive findings using data from PY 5 Quarters 1 and 2. This report was submitted to DHCS in February 2021. UCLA began the process of incorporating new COVID-19-specific data elements from the E/U Report data in their data processing and analysis process.
- UCLA reviewed and summarized COVID-19 budget alternative narratives.
- UCLA compiled annual invoice data for presentation in the final report.

Enrollment Informantion:

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non ACA	Total
DY15-Q4	$ 39,683	16,685	55,853
DY16-Q1	55,621	15,555	55,626
DY16-Q2	54,524	14,854	54,527
DY16-Q3	43,939	10,871	43,942

Member Months:

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	31122	30921	31477	D15-Q4	39,683
	43026	42777	43396	D16-Q1	55,621
	43702	42918	40589	D16-Q2	54,524
	35738	30591	24032	D16-Q3	43,939
Non ACA	13992	13972	13760	D15-Q4	16,685
	12418	12190	12126	D16-Q1	15,555
	12016	11924	11199	D16-Q2	14,854
	9010	7014	5578	D16-Q3	10,871

Financial/Budget Neutrality Development/Issues:

Aggregate Expenditures: ACA and Non-ACA

Quarter	Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY15-Q4	ACA	2789706	$86,630,988.25	$72,255,588.68	$8,669,210.82	$5,706,188.75
	Non ACA	1335794	$29,153,102.32	$14,642,920.55	$3,499,794.91	$11,010,386.86
DY16-Q1	ACA	8781995	$320,701,080.24	##############	$32,690,241.19	$24,885,346.47
	Non ACA	1158495	$30,769,488.67	$16,197,227.08	$4,343,534.76	$10,228,726.83
DY16-Q2	ACA	8530735	$319,465,677.82	##############	$32,402,430.79	$22,666,226.65
	Non ACA	1096747	$30,124,926.15	$16,889,403.55	$4,201,234.60	$9,034,288.00
DY16-Q3	ACA	5743758	$231,474,669.51	##############	$23,772,908.01	$14,528,682.35
	Non ACA	601385	$19,040,887.17	$10,679,161.02	$3,179,478.99	$5,182,247.16

ACA Expenditures by Level of Care for DY15-Q4					
Level of Care	Units of Service	Approved Amoun	FFP Amount	SGF Amount	County Amount
1.0 Outpatient	349172	$11,591,094.20	$9,360,471.23	$980,334.11	$1,250,288.86
2.5 Partial Hospitalization	38	$5,785.50	$5,206.76	$0.00	$578.74
3.1 Residential	116529	$16,535,565.91	$14,139,305.36	$2,298,819.15	$97,441.40
3.3 Residential	883	$192,928.73	$166,247.77	$26,680.96	$0.00
3.5 Residential	98205	$18,509,341.92	$15,904,601.45	$2,551,991.40	$52,749.07
Additional MAT	9102	$301,826.62	$243,220.30	$0.00	$58,606.32
Case Management	153827	$4,371,808.08	$3,648,732.49	$0.00	$723,075.59
Intensive Outpatient	18128	$498,626.13	$400,510.27	$94,334.87	$3,780.99
MAT Dosing	41675	$835,199.37	$667,652.65	$0.00	$167,546.72
Methadone	1334185	$18,574,687.15	$15,168,546.57	$1,470,120.00	$1,936,020.58
Narcotic Treatment	537075	$8,433,281.07	$6,907,690.35	$673,796.25	$851,794.47
Physician Consultation	118	$10,311.40	$7,694.55	$0.00	$2,616.85
Recovery Support Services	21812	$630,168.07	$506,784.33	$0.00	$123,383.74
Residential Withdrawal Manag	11929	$2,786,204.26	$2,396,637.57	$0.00	$389,566.69

ACA Expenditures by Level of Care for DY16-Q1					
Level of Care	Units of Service	Approved Amoun	FFP Amount	SGF Amount	County Amount
1-Withdrawal Management	217	$10,144.75	$8,549.49	$0.00	$1,595.26
1.0 Outpatient	1081512	$46,772,659.93	$37,334,154.46	$3,681,207.94	$5,757,297.53
3.1 Residential	361632	$65,661,011.61	$55,592,224.58	$9,588,979.00	$479,808.03
3.3 Residential	4078	$1,024,494.65	$861,315.60	$163,179.05	$0.00
3.5 Residential	316207	$66,364,613.31	$56,010,981.75	$10,118,982.05	$234,649.51
Additional MAT	53631	$1,381,961.20	$1,138,570.39	$0.00	$243,390.81
Case Management	545926	$18,953,353.69	$15,609,832.99	$10,224.28	$3,333,296.42
Intensive Outpatient	88161	$2,595,583.07	$2,090,203.54	$476,217.02	$29,162.51
MAT Dosing	123747	$3,238,398.46	$2,576,719.65	$0.00	$661,678.81
Methadone	4090928	$57,475,806.59	$45,461,280.82	$4,174,705.63	$7,839,820.14
Narcotic Treatment	1710658	$29,082,593.36	$23,182,897.57	$2,246,372.64	$3,653,323.15
Physician Consultation	648	$52,855.86	$42,776.13	$2,414.07	$7,665.66
Recovery Support Services	88825	$3,408,290.17	$2,706,135.98	$0.00	$702,154.19
Residential Withdrawal Manag	42082	$11,467,264.99	$9,757,171.41	$16,903.28	$1,693,190.30

ACA Expenditures by Level of Care for DY16-Q2					
Level of Care	Units of Service	Approved Amoun	FFP Amount	SGF Amount	County Amount
1-Withdrawal Management	252	$11,781.00	$10,601.64	$0.00	$1,179.36
1.0 Outpatient	987095	$43,780,675.15	$35,232,186.45	$3,592,644.00	$4,955,844.70
3.1 Residential	373390	$67,671,886.44	$57,601,453.03	$9,613,543.58	$456,889.83
3.3 Residential	3577	$843,121.41	$715,728.21	$127,393.20	$0.00
3.5 Residential	324528	$67,169,672.38	$57,095,754.62	$9,906,529.52	$167,388.24
Additional MAT	36242	$1,108,233.62	$915,245.10	$0.00	$192,988.52
Case Management	532241	$18,870,027.97	$15,669,310.84	$27,205.42	$3,173,511.71
Intensive Outpatient	86359	$2,485,909.81	$2,015,438.96	$437,951.96	$32,518.89

MAT Dosing	129581	$3,372,932.28	$2,716,413.58	$0.00	$656,518.70
Methadone	4007743	$56,755,173.28	$45,589,838.39	$4,199,646.98	$6,965,687.91
Narcotic Treatment	1620618	$28,923,974.68	$23,321,541.76	$2,296,695.42	$3,305,737.50
Physician Consultation	521	$26,277.74	$21,526.32	$806.85	$3,944.57
Recovery Support Services	89954	$3,754,277.51	$2,998,006.43	$380.08	$755,891.00
Residential Withdrawal Manag	39812	$10,746,023.50	$9,111,783.92	$17,935.39	$1,616,304.19

ACA Expenditures by Level of Care for DY16-Q3

Level of Care	Units of Service	Approved Amoun	FFP Amount	SGF Amount	County Amount
1-Withdrawal Management	239	$11,173.25	$9,406.93	$0.00	$1,766.32
1.0 Outpatient	645955	$29,591,219.62	$23,851,398.96	$2,390,919.09	$3,348,901.57
2.5 Partial Hospitalization	165	$59,070.00	$49,896.00	$0.00	$9,174.00
3.1 Residential	242672	$45,753,131.45	$39,179,492.00	$6,389,569.60	$184,069.85
3.3 Residential	2148	$518,014.57	$444,237.45	$73,777.12	$0.00
3.5 Residential	214774	$44,904,585.54	$38,185,712.99	$6,670,145.70	$48,726.85
Additional MAT	5993	$501,473.21	$415,895.75	$0.00	$85,577.46
Case Management	401896	$15,640,253.37	$13,034,424.77	$2,997.26	$2,602,831.34
Intensive Outpatient	81734	$3,713,618.24	$3,056,789.43	$634,437.46	$22,391.35
MAT Dosing	92917	$2,270,356.14	$1,858,190.97	$0.00	$412,165.17
Methadone	2438282	$34,461,389.34	$28,125,628.60	$2,691,499.89	$3,644,260.85
Narcotic Treatment	956077	$17,127,928.88	$13,944,083.34	$1,387,054.39	$1,796,791.15
Physician Consultation	251	$12,492.60	$9,998.94	$0.00	$2,493.66
Recovery Support Services	113833	$2,904,881.43	$2,356,767.05	$117.33	$547,997.05
Residential Withdrawal Manag	30136	$7,805,256.12	$6,694,216.94	$6,802.32	$1,104,236.86

Non-ACA Expenditures by Level of Care for DY15-Q4					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
1.0 Outpatient	105849	$3,456,051.05	$1,725,117.12	$11,618.67	$1,719,315.26
2.5 Partial Hospitalization	45	$6,851.25	$3,425.40	$0.00	$3,425.85
3.1 Residential	18807	$2,810,675.25	$1,417,243.14	$1,279,227.20	$114,204.91
3.3 Residential	868	$183,316.34	$92,693.91	$90,622.43	$0.00
3.5 Residential	18659	$3,481,568.36	$1,760,526.25	$1,660,182.33	$60,859.78
Additional MAT	2343	$97,230.25	$48,663.58	$0.00	$48,566.67
Case Management	44938	$1,256,421.53	$634,862.43	$0.00	$621,559.10
Intensive Outpatient	6821	$123,160.25	$61,711.09	$58,035.54	$3,413.62
MAT Dosing	11570	$234,172.53	$117,808.71	$0.00	$116,363.82
Methadone	807992	$11,244,907.23	$5,639,717.35	$0.00	$5,605,189.88
Narcotic Treatment	279038	$4,375,454.92	$2,194,199.03	$0.00	$2,181,255.89
Physician Consultation	20	$1,740.03	$870.01	$0.00	$870.02
Recovery Support Services	9131	$277,410.91	$139,443.40	$0.00	$137,967.51
Residential Withdrawal Manageme	2673	$701,730.79	$353,245.99	$0.00	$348,484.80

Non-ACA Expenditures by Level of Care for DY16-Q1					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
1-Withdrawal Management	31	$1,449.25	$724.47	$0.00	$724.78
1.0 Outpatient	108328	$4,563,730.90	$2,404,424.09	$24,487.26	$2,134,819.55
3.1 Residential	17789	$3,435,770.18	$1,795,229.42	$1,471,041.48	$169,499.28
3.3 Residential	673	$165,029.24	$88,396.53	$76,632.71	$0.00
3.5 Residential	22273	$4,715,479.06	$2,490,760.48	$2,154,954.95	$69,763.63
Additional MAT	5134	$154,829.98	$83,793.94	$0.00	$71,036.04
Case Management	45309	$1,625,542.33	$857,570.43	$1,436.58	$766,535.32
Intensive Outpatient	8970	$206,667.48	$109,513.59	$88,251.06	$8,902.83
MAT Dosing	9580	$265,164.89	$139,685.26	$0.00	$125,479.63
Methadone	655597	$9,177,021.03	$4,825,175.59	$9,388.78	$4,342,456.66
Narcotic Treatment	248828	$4,142,958.40	$2,178,609.38	$50,657.95	$1,913,691.07
Physician Consultation	84	$5,038.26	$2,577.13	$255.85	$2,205.28
Recovery Support Services	11024	$420,352.97	$222,233.89	$0.00	$198,119.08
Residential Withdrawal Manageme	2697	$790,810.69	$417,992.87	$3,906.84	$368,910.98

Non-ACA Expenditures by Level of Care for DY16-Q2					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
1.0 Outpatient	97784	$4,287,502.69	$2,386,425.27	$36,991.70	$1,864,085.72
3.1 Residential	18110	$3,445,296.70	$1,932,298.61	$1,411,004.98	$101,993.11
3.3 Residential	495	$112,143.88	$63,024.25	$49,119.63	$0.00
3.5 Residential	23730	$5,038,994.03	$2,832,011.85	$2,132,617.19	$74,364.99
Additional MAT	4014	$115,017.15	$64,503.52	$0.00	$50,513.63
Case Management	44177	$1,538,302.16	$861,220.71	$2,417.65	$674,663.80
Intensive Outpatient	9559	$216,891.24	$120,756.58	$84,552.95	$11,581.71
MAT Dosing	9511	$269,054.73	$151,013.30	$0.00	$118,041.43
Methadone	622976	$8,754,298.31	$4,919,392.87	$12,326.07	$3,822,579.37
Narcotic Treatment	227531	$3,953,387.56	$2,220,387.57	$72,153.21	$1,660,846.78
Physician Consultation	60	$4,018.40	$2,258.33	$332.55	$1,427.52
Recovery Support Services	10805	$431,474.35	$241,016.20	$145.42	$190,312.73
Residential Withdrawal Manageme	2788	$837,986.26	$469,814.39	$2,695.48	$365,476.39

Non-ACA Expenditures by Level of Care for DY16-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
1-Withdrawal Management	41	$1,916.75	$1,077.07	$0.00	$839.68
1.0 Outpatient	60844	$2,823,300.42	$1,571,196.22	$14,015.18	$1,238,089.02
2.5 Partial Hospitalization	19	$6,802.00	$3,822.80	$0.00	$2,979.20
3.1 Residential	12466	$2,416,745.33	$1,358,186.43	$1,013,387.87	$45,171.03
3.3 Residential	283	$64,386.54	$36,185.31	$28,201.23	$0.00
3.5 Residential	14637	$3,061,928.56	$1,722,253.87	$1,316,391.59	$23,283.10
Additional MAT	551	$53,634.42	$30,142.59	$0.00	$23,491.83
Case Management	32247	$1,283,835.38	$718,413.92	$0.00	$565,421.46
Intensive Outpatient	7015	$331,917.05	$186,688.73	$135,439.60	$9,788.72
MAT Dosing	4904	$127,560.43	$71,687.72	$0.00	$55,872.71
Methadone	295284	$4,163,222.85	$2,340,026.26	$3,581.69	$1,819,614.90
Narcotic Treatment	109441	$1,951,761.28	$1,096,992.26	$32,104.97	$822,664.05
Physician Consultation	28	$1,542.60	$866.94	$0.00	$675.66
Recovery Support Services	14520	$320,095.67	$178,815.99	$0.00	$141,279.68
Residential Withdrawal Manageme	1557	$408,293.78	$229,462.42	$941.58	$177,889.78