CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) DEMONSTRATION (PROJECT NUMBER 11-W-00193/9)

SECTION 1115(A) WAIVER QUARTERLY REPORT

DEMONSTRATION/QUARTER REPORTING PERIODS:

DEMONSTRATION YEAR: TWENTY-ONE (JANUARY 1, 2025 - DECEMBER 31, 2025)

FIRST QUARTER REPORTING PERIOD: JANUARY 1, 2025 – MARCH 31, 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

On June 30, 2021, California submitted a renewal request for the CalAIM Section 1115 demonstration to the Centers for Medicare & Medicaid Services (CMS). This Section 1115 demonstration requested a five-year renewal of components of the Medi-Cal 2020 Section 1115 demonstration to continue improving health outcomes and reducing health disparities for individuals enrolled in Medi-Cal and other low-income populations in the state. In tandem, the Department of Health Care Services (DHCS or the Department) requested authority through a renewal of the state's longstanding Specialty Mental Health Services (SMHS) Section 1915(b) waiver. This request would transition nearly all Medi-Cal managed care delivery systems to a single authority, streamlining California's managed care programs and applying statewide lessons learned from previous Section 1115 demonstrations, as described below.

On December 29, 2021, CMS approved California's 1115(a) "CalAIM" demonstration, effective through December 31, 2026. The approval is part of the state's larger CalAIM initiative which includes transitioning Medi-Cal managed care from the demonstration into 1915(b) waiver authority. The demonstration aims to assist the state in improving health outcomes and advancing health equity for Medi-Cal members and other low-income people in the state.

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

- DY 18 January 1, 2022, through December 31, 2022
- DY 19 January 1, 2023, through December 31, 2023
- DY 20 January 1, 2024, through December 31, 2024
- DY 21 January 1, 2025, through December 31, 2025
- DY 22 January 1, 2026, through December 31, 2026

The overview below outlines: (1) Medi-Cal 2020 Section 1115 demonstration initiatives continued via the Medi-Cal State Plan or CalAIM Section 1915(b) waiver; (2) Medi-Cal 2020 Section 1115 demonstration initiatives renewed in the CalAIM Section 1115 demonstration; and (3) Current CalAIM Section 1115 demonstration initiatives.

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**
  - **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authorities** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
  - **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to

109 to 138 percent of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan. The sunset date for this authority was on December 31, 2021.

- **Dental Transformation Initiative (DTI)** authority as outlined under the Medi-Cal 2020 Section 1115 demonstration transitioned into a new statewide dental benefit for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

» Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Renewed in the CalAIM Section 1115 Demonstration:

- **Global Payment Program (GPP)** to renew California's statewide pool of funding for care provided to California's remaining uninsured populations, including streamlining funding sources for California's remaining uninsured population.
- **Substance Use Disorder (SUD) Institutions for Mental Disease (IMD)** authority to continue short-term residential treatment services to eligible individuals with a SUD in the Drug Medi-Cal-Organized Delivery System (DMC-ODS).
- **Coverage for Out-of-State Former Foster Care Youth** to continue Medi-Cal coverage for this population during the renewal period, up to age 26.
- **Community-Based Adult Services (CBAS)** to continue to authorize CBAS for eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.
- **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.
- **Designated State Health Programs (DSHP)** Expenditures for DSHPs, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in the CalAIM Standard Terms and Conditions (STCs).

» CalAIM Initiatives Currently Authorized in the CalAIM Section 1115 Demonstration:

- **Deemed SSI** expenditure authority to extend eligibility for individuals in Deemed SSI populations (the Pickle Group, Disabled Adult Child group, and Disabled Widow/Widower group) who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of ten household members as of July 1, 2022, and (2) no longer applying the asset test as of January 1, 2024.
- **Community Supports** to authorize short-term recuperative care and short-term post-transition housing via the CalAIM Section 1115 demonstration, as well as short-term rental assistance as further expanded under BH-CONNECT; 12 other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
- **Dually Eligible Enrollees in Medi-Cal Managed Care** expenditure authority allows the state to keep a member in an affiliated Medicaid plan once the member has selected a Medicare Advantage plan unless and until the member changes Medicare Advantage plans or selects Original Medicare. As part of CalAIM, DHCS is implementing policies to promote integrated care for members dually eligible for Medicare and Medi-Cal.
- **Providing Access and Transforming Health (PATH) Supports** expenditure authority to (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports, (2) enable the transition, expansion and development of capacity and infrastructure necessary for city, county, and other government agencies, county and community-based providers including but not limited to public hospitals, community-based organizations (CBOs), and Medi-Cal Tribal and Designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers; and (3) support justice-involved (JI) pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
- **Contingency Management** to offer Medi-Cal members, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
- **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, to provide this

service in DMC-ODS and Drug Medi-Cal (DMC) counties and county mental health plans (MHPs).

- **Pre-Release Services** authority via the CalAIM Section 1115 demonstration waiver for DHCS to partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process which will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.
- **Traditional Health Care Practices** expenditure authority to provide coverage for traditional health care practices, granting eligible Medi-Cal and CHIP members access to culturally based care provided by Indian Health Service (IHS) facilities, Tribal health clinics, and Urban Indian organization facilities through the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The WPC Pilots and HHP, which were implemented under the Medi-Cal 2020 Section 1115 demonstration, concluded on December 31, 2021, following approval of the CalAIM Section 1115 demonstration renewal. Under CalAIM, California launched new ECM and Community Supports which built on the successes of the WPC Pilots and HHP. ECM is authorized through Medi-Cal managed care authority, and the Community Supports are authorized through a combination of CalAIM Section 1115 demonstration authority and Medi-Cal managed care authority as effectuated through the Section 1915(b) waiver.

Since the initial approval of the CalAIM Section 1115 demonstration, CMS has approved several amendments which can be viewed on DHCS' website. During DY 21 Q1, CMS approved the Health Related Social Needs (HRSN) Community Supports Protocol on January 8, 2025, which was incorporated as Attachment X to the CalAIM STCs. Additionally, on January 17, 2025, CMS approved the Designated State Health Programs (DSHP) Sustainability Plan (Attachment AA) and new updates to the GPP Participating Public Health Care Systems (Attachment C). DHCS and CMS continue to finalize protocols and attachments related to CalAIM Section 1115 demonstration initiatives.

GENERAL REPORTING REQUIREMENTS

Special Terms and Conditions (STCs) Item 16.8: Monitoring Calls

During DY 21 Q1, the winter quarterly monitoring call scheduled for February 10, 2025 was canceled. DHCS and CMS are scheduled to reconvene in May 2025 for the spring quarterly monitoring call.

STCs Item 16.9: Post Award Forum

In DY 21 Q1, a meeting was held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting on February 19, 2025. The purpose of the SAC and BH-SAC is for stakeholders to provide DHCS with input on ongoing implementation efforts for CalAIM, the state's Section 1115 waiver, and behavioral health activities. DHCS provided updates on: the Birthing Care Pathway, Medi-Cal MCP and County Behavioral Health Plan Quality Ratings for 2023, BH-CONNECT Updates and Highlights, and Long-Term Services and Supports (LTSS) Dashboard. To view past meeting agendas, visit DHCS' website at DHCS Behavioral Health Stakeholder Advisory Committee Past Meeting Archive or DHCS Stakeholder Advisory Committee Past Meeting Archive.

During this quarter, DHCS Consumer-Focused Stakeholder Workgroup (CFSW) meetings also took place on February 7, 2025 and March 7, 2025. The meetings included a discussion of DHCS updates on: Continuous Coverage Unwinding, Hospital Presumptive Eligibility (HPE) Flyers, Part A Buy-In Starting January 1, 2025, Electronic Signatures Collected by a Third Party (ACWDL 24-18), Name and Gender-marker Changes for Medi-Cal Members, 1095 Mailings, Inter-County Transfers, Conlan Beneficiary Reimbursement Process, Medi-Cal Immigrant Eligibility and MC 13, Expanded Spousal Impoverishment, Asset Limit Elimination, and Share of Cost. The purpose of the CFSW meetings is to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment-related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on March 13, 2025. DHCS discussed the following topics: Community Reinvestment All Plan Letter Overview, Population Health Management Service: Medi-Cal Connect Updates, BH-CONNECT Overview, JI Initiative Overview, PATH CITED Round 4 Overview, Community

Supports Service Definitions Overview, Birthing Care Pathway Overview and Next Steps, and Community Advisory Committee (CAC) Overview. The purpose of the MCAG is to facilitate active communication between the managed care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders, advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

The meetings were conducted in accordance with the Bagley-Keene Open Meeting Act, and public comment occurred at the end of each meeting. Stakeholder members are recognized experts in their fields, including, but not limited to member advocacy organizations and representatives of various Medi-Cal provider groups.

PROGRAM UPDATES

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 21 Q1, as required in item 16.5[1] of the CalAIM 1115 demonstration STCs. For each program area, this section describes program highlights, performance metrics, outreach activities, operational updates, consumer issues and interventions, quality control/assurance activity, budget neutrality and financial updates, and progress on evaluations with interim findings. Key program areas described in this section include:

- Community-Based Adult Services (CBAS)
- Drug Medi-Cal-Organized Delivery System (DMC-ODS)
- Global Payment Program (GPP)
- Providing Access and Transforming Health (PATH)
- Community Supports: Short-Term Recuperative Care and Short-Term Post-Transition Housing
- Dually-Eligible Enrollees in Medi-Cal Managed Care

[1] The Department of Health Care Services, CalAIM 1115 Demonstration & 1915(b) Waiver, January 17, 2025, CalAIM Approval Letter Technical Corrections and Attachments.

COMMUNITY-BASED ADULT SERVICES

On December 29, 2021, CMS approved California's CalAIM Section 1115 demonstration waiver, effective through December 31, 2026, which included the CBAS benefit. The following information was included in the CMS approval letter: "Under the 1115 demonstration, the state will also continue the CBAS program to eligible older adults and adults with disabilities in an outpatient facility-based setting while now also allowing flexibility for the provision and reimbursement of remote services under specified emergency situations, i.e., Emergency Remote Services (ERS). This flexibility will allow beneficiaries to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization."

Program Requirements

CBAS is an outpatient, facility-based program, licensed by the California Department of Public Health (CDPH) and certified by CDA to participate in the Medi-Cal program. The CBAS benefit is provided to eligible Medi-Cal members who meet CBAS criteria and includes the following services: professional/skilled nursing care, personal care, social services including family/caregiver training and support, therapeutic activities, therapies such as occupational therapy, physical therapy, speech therapy, behavioral health services, dietary/nutrition services including a meal, and transportation to and from the CBAS members' place of residence and the CBAS center when needed. CBAS participants have chronic medical, cognitive, mental health, and/or intellectual developmental disabilities and are at risk of needing institutional care. The overarching goals of the CBAS program are to support community living, promote health and well-being, and prevent hospitalization and institutionalization.

CBAS providers are required to: (1) meet all applicable licensing/certification and Medicaid waiver program standards; (2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed person-centered Individual Plans of Care (IPCs); (3) adhere to the documentation, training, and quality assurance requirements as identified in the CalAIM 1115 demonstration waiver; and (4) maintain compliance with the requirements listed above.

Initial eligibility for the CBAS benefit is traditionally determined by a Medi-Cal Managed Care Plan (MCP) by conducting a face-to-face assessment, using a standardized tool and protocol approved by DHCS. The assessment is conducted by a registered nurse with level-of-care determination experience. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the MCP possesses. The eligibility for ongoing receipt of the CBAS benefit is determined at least every six months through a reauthorization process, or every 12 months for individuals

determined by the MCP to be clinically appropriate. Reauthorization is the process by which CBAS providers reassess members to assess if their needs are being met with the services they are receiving.

The state must maintain CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012. Effective April 1, 2012, eligible participants can receive "unbundled services" if there is insufficient CBAS center capacity to satisfy the demand. Unbundled services refer to parts of the CBAS benefit delivered outside of centers with a similar objective of supporting participants and allowing them to remain in the community. Unbundled services include local senior centers to engage members in social and recreational activities; coordination with home-delivered meals programs; 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 (ADL) or Instrumental Activities of Daily Living (IADL). If the participant is enrolled in a MCP, the MCP will be responsible for facilitating the appropriate services on the members' behalf.

CBAS Emergency Remote Services (ERS) is a new service delivery method approved by CMS 1115 waiver renewal in 2022 to provide time-limited services in the home, community, via doorstep, and/or telehealth during specified emergencies for individuals already receiving CBAS. ERS are provided to protect continuity of care and provide immediate assistance to participants experiencing public emergencies caused by state or local disasters, such as wildfires and power outages; or personal emergencies caused by illness/injury, crises, or care transitions. CDA collaborated with DHCS, MCPs, and CBAS providers, to develop ERS policy guidance, reporting templates, and processes to support compliance with CalAIM 1115 waiver requirements, including compliance with the Electronic Visit Verification System (EVV) requirements for the provision of personal care services (PCS) and home health services in accordance with Section 12006 of the 21st Century CURES Act. The state incorporated lessons learned from the implementation and operation of CBAS TAS during the PHE to assist with constructing processes and parameters that keep the CBAS benefit as a congregate, facility-based service, while providing the ERS flexibility when specific criteria are met. ERS enable the facilitation of immediate interventions with CBAS participants and their caregivers at the onset of the emergency and for its duration, as needed, to promote a smooth transition back to the CBAS congregate program, if possible, with continued access to services.

Operational Updates

Qualitative Findings

Challenges

The devastating wildfires impacting Los Angeles and Ventura counties in January 2025 represented a significant challenge in DY 21-Q1. While no CBAS centers sustained direct fire damage, the state of emergency impacted operations at a total of 52 CBAS centers. Most of these centers had to temporarily close due to loss of power, poor air quality, and/or mandatory evacuations. 42 centers were directly impacted and had to temporarily close at some point in time, all of which have since reopened. Ten centers were indirectly impacted as they remained open. CDA received feedback from a few providers who mentioned staffing challenges triggered by the fires. Providers reported the biggest challenge was staff members inability to either travel to the center or help initiate the ERS due to evacuation priorities involving their families. ERS was initiated for approximately 3,828 participants, allowing centers to continue providing vital services during this time of crisis. For centers that remained open, ERS was also provided to participants who had restricted access to the center due to displacement or other unsafe conditions but were still in need of services.

The fires highlighted the critical role that CBAS centers play in providing an immediate response to participants' needs during a public emergency. CDA recognizes that their ERS procedures were written with the nuances of a pandemic in mind and a public emergency such as a fire presents additional challenges. For example, fires may trigger power outages, rendering centers unable to access electronic data and reporting responsibilities related to ERS. Additionally, fires present mandatory evacuation orders which may leave staff with conflicting priorities between immediate center needs and immediate family obligations. Over the coming months CDA will be communicating with affected centers and MCPs to obtain recommendations for ways to improve ERS procedures when faced with a state of emergency such as a fire.

Successes/Accomplishments

A key achievement in DY 21-Q1 was the opening of six new CBAS centers in the following counties: Los Angeles, Orange, and Sacramento. CDA attributes this success to continuously assessing and reassessing current processes and making improvements to ensure participants have access to CBAS services in more counties across California. CDA also continues to closely monitor and track applicants in the queue to become CBAS certified and offer added support, guidance, and technical assistance to ensure centers are certified timely. The CBAS team is also continuously creating boilerplate language to communicate with applicants effectively and with regulatory consistency. Lastly,

prescreening and initial certification training videos/resources for applicants were updated and are used as a comprehensive tool used to impart information regarding CBAS program requirements.

Performance Metrics

Quantitative Findings

CDA continued to facilitate the Quality Strategy Advisory Committee meetings in DY 21-Q1, which includes members of the CDA Executive Team, CBAS staff, CDA providers, DHCS, MCPs, and other stakeholders. The committee meets monthly if performance measures have feedback and further development as required in STC 5.8. In addition, per STC 5.8, "The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually."

In DY 21-Q1, the committee furthered its efforts to develop performance measures. The CBAS Quality Advisory Committee members received the drafted performance measures for review, discussion, and to solicit feedback. On February 25, 2025, the Advisory Committee met and discussed that the final draft performance measurements are highly compliance based (per CMS requirements and the addition of sub-assurances). The committee expressed future intention to include additional measurements previously developed that are quality based, adding additional valuable data collection and analysis of program performance. This is something the committee may develop further, after CMS compliance measurements have been approved and implemented. The final draft performance measurements were sent to DHCS for review and forwarded to CMS for final review on March 24, 2025. Once the committee receives CMS approval, work groups will be formed to address data collection tools and strategies. DHCS continues to stay in communication with CMS regarding deadline expectations. Upon finalization of the performance measures, CDA and DHCS will proceed with fulfilling STC 5.9, which includes reporting the findings and status of the Home and Community-Based Services (HCBS) quality assurances and measures.

Program Highlights

Outreach Activities

CDA provides ongoing outreach and program updates to CBAS providers, MCPs, CAADS, and other interested stakeholders via multiple communication strategies, including the following:

- CBAS Quarterlies
- CBAS ACLs and CBAS Updates
- CBAS webinars
- CAADS conferences
- CDA meetings with MCPs that contract with CBAS centers
- CDA meetings with the CBAS Quality Advisory Committee
- CAADS Education Committee Meetings

The following are CDA's outreach activities during DY 21-Q1:

- CBAS Quarterlies **(1)**
- CBAS Updates **(9)**
- CAADS Education Committee Meetings **(3)**
- CDA-MCP meetings **(1)**
- CBAS Quality Advisory Committee Workgroup Meetings **(1)**
- CDA DHCS meetings **(3)**
- CDA CDPH quarterly meetings **(0)**
- Responses to CBAS Mailbox Inquiries **(663)**

In addition to the outreach activities mentioned above, CDA also responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders. Outreach, education, and training activities focused on the following topics: (1) notification to the CBAS centers regarding Los Angeles County fire impact and available resources; (2) grant opportunities; (3) California Home and Community-Based Services Gap Analysis Report; (4) CBAS reimbursement rates; (5) opportunities such as Aging and Disability Advisory Board seats for individuals with lived experience; and (6) CAADS 2025 Spring Conference registration information.

CBAS Webinar Updates

In DY 21-Q1, CDA released two updated training webinars for prospective CBAS applicants titled:

- CBAS History & Center Pre-Screening Package (PSP) Overview – content of this training includes the basics of the CBAS program history and model, components and requirements of the PSP and where to access resources.
- CBAS Initial Application Certification Overview – content of this training includes the components and requirements of the CBAS Initial Certification application process and where to access resources.

The trainings are required for prospective CBAS applicants to ensure they are well informed regarding the process.

In DY 21-Q1, CDA launched a Managed Care Plan Pilot Program. CDA/CBAS created a new feature in the CBAS database and granted direct access to a few managed care plans (MCPs) to view ERS data and reports. This pilot program was designed to test and refine access to ERS information before rolling it out to all MCPs. This enhancement aims to streamline processes and provide a centralized hub for ERS information that can be easily accessed. CDA/CBAS held a kick-off webinar on Wednesday, March 12, 2025, for the participating MCPs involved in the ERS pilot. During the webinar, attendees discussed access to Peach, ERS reports, and CDA answered questions from the participating plans.

CAADS Education Committee Meetings

In DY 21-Q1, CDA attended three monthly CAADS Education Committee meetings to discuss and assist with planning the CAADS Spring Conference 2025, including dates and location, conference schedule, speaker line-up, CDA presentations, and exhibitors/sponsors. This meeting forum is also used to collaborate and plan future webinars.

MCP Meetings with CDA

CDA convenes quarterly meetings with MCPs that contract with CBAS providers to: (1) promote communication between CDA and MCPs on issues of concern by the MCPs; (2) update MCPs on CBAS activities, data collection, policy directives, and the number, location, and approval status of new center applications; and (3) request feedback from MCPs on CBAS provider issues that require CDA assistance.

During DY 21-Q1, CDA convened with the MCPs on January 13, 2025. The purpose of this meeting was to discuss the impact the Southern California fires had on the CBAS centers. CDA reported challenges and difficulties the centers were facing due to fire impact. CDA and the MCPs recognized and flagged a need for future improved administrative processes that are less burdensome to the centers when faced with states of emergency; namely, timeframes involved in the required submission of the CBAS Emergency Remote Services Initiation Form (CEIF). Future meetings will include continued discussions and collaboration around improved administrative processes required by both CDA and the MCPs during a state of emergency.

CBAS Quality Strategy Advisory Committee Meetings

The CBAS Quality Assurance and Improvement Strategy (dated October 2016) was developed through a year-long stakeholder process and was released for comment on September 19, 2016, beginning implementation in October 2016. This paved the way for CDA to establish the CBAS Quality Advisory Committee, to review/evaluate progress on achieving the Quality Strategy's original goals and objectives, as well as to identify new goals and objectives that will support and promote the delivery of quality services. This continuous quality improvement effort is designed to support CBAS providers in meeting program standards while continuing to develop and promote new approaches to improve service delivery.

This meeting series is comprised of various stakeholders, including members of the CBAS Executive Team, CBAS providers, MCPs, DHCS, and representatives from CAADS. The quality strategy has two overarching goals: (1) to assure CBAS provider compliance with program requirements through improved state oversight, monitoring, and transparency activities, and (2) to improve service delivery by promoting CBAS best practices, including person-centered and evidence-based care, which continue to guide CBAS program planning and operations.

Throughout DY 21-Q1, the CBAS Quality Advisory Committee provided input and feedback on the draft key Performance Measures (PMs). Please refer to the section of this report titled: "Qualitative Findings/Performance Metrics" for the status of the PMs. The committee continues to move the PMs forward, with submissions to DHCS and CMS occurring on an ongoing flow basis. The ongoing formal discussions and recommendations from the CBAS Quality Advisory Committee on prioritization and implementation of PMs are to comply with the 1115 Waiver requirements.

CBAS Mailbox Inquiries

During DY 21-Q1, CDA responded to 663 CBAS mailbox inquiries. Some commonly submitted inquiries included: (1) Emergency Remote Service activation and temporary pause in service technical assistance due to fires; (2) questions pertaining to PSP/initials applications; (3) CBAS reimbursement rates; (4) survey evaluation questions; and (5) CBAS center staff training guidance.

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

Per STC 5.1(c), CDA, in collaboration with DHCS, continues to implement the activities and commitments required for CBAS centers to demonstrate compliance with the federal HCB Settings Final Rule as of March 17, 2023, and thereafter on an ongoing basis. CDA determines CBAS center compliance with the federal requirements during each center's onsite certification renewal survey process every two years. Per CMS' directive in the CBAS sections of the 1115 Waiver, CDA developed the CBAS HCB Settings Transition Plan (CBAS Transition Plan/CTP), as an attachment to California's Statewide Transition Plan (STP). On February 23, 2018, CMS granted initial approval of California's STP and the CTP, based on the state's revised systemic assessment and proposed remediation strategies. CMS requested additional revisions of the STP and CTP before granting final approval. CDA responded to additional revisions as requested. DHCS informed CDA in June 2023 that CMS granted the STP final approval.

Public and Personal Emergencies Experience

Services via ERS modality is available under certain circumstances to ensure participant continuity of care. All CBAS centers can offer clinical support to CBAS participants who may be experiencing either a public or personal emergency as defined in ERS policy. The ERS events are broken down into two categories: public emergencies and personal emergencies. In January 2025, CDA received 4,983 ERS events, 773 personal emergencies, and 4,210 public emergencies. The vast majority of personal emergencies were due to serious illness and a majority of the public emergencies were due to Southern California fire impact which included evacuation orders, power outages and challenges due to extremely poor air quality. In February 2025, CDA received 1,626 ERS events, 813 personal emergencies, and 813 public emergencies with causation remaining similar to the previous month. As of March 26, 2025, CDA received 1,033 ERS events, 542 personal emergencies, and 491 public emergencies. Both categories were predominantly related to personal illness or infectious disease outbreaks. CDA continues

to see the successful utilization, implementation, and value that ERS brings to the CBAS providers and participants.

HCBS Electronic Visit Verification System

Per STC 5.7, the CalAIM 1115 Waiver directs the state to demonstrate compliance with the EVV requirements for the provision of in-home PCS and Home Health Care Services (HHCS) to CBAS participants utilizing the CBAS ERS benefit. In compliance with the federal mandate established by Section 12006 of the 21st Century CURES Act (2016), CDA continues to support the implementation of EVV for Medicaid-funded PCS and HHCS.

During Q1, CDA sustained and promoted a multi-departmental collaboration with the DHCS, the Department of Developmental Services (DDS), CDPH, the Department of Social Services (CDSS), and the Office of Technology and Solutions Integration (OTSI). Through this partnership, CDA helped support 173 jurisdictional entities—including MCPs, municipal and county governments, state regional centers, and nonprofit organizations. Collectively, EVV facilitates service delivery verification for over 5,500 provider agencies, serving more than 183,000 care recipients across California.

Training remained a key focus area in DY 21-Q1. CDA participated in a series of eight online teaching events: two in January, two in February, and four in March. To further expand training accessibility, CDA partnered in new planning efforts for an ambitious in-person "Training Road Show" (TRS) that will take place in 2025 and 2026. This TRS initiative will include 30 onsite events held at various venues throughout California. The TRS will feature a mobile computer lab, providing attendees with a real-world, hands-on learning experience with the EVV system. In addition to practical system training, participants will receive tools, resources, and state guidance on EVV compliance, including provider roles and responsibilities.

Budget Neutrality and Financial Updates

The CalAIM Section 1115 Demonstration waiver, approved by CMS on December 29, 2021, 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.

Enrollment and Assessment Information

Per STC 5.6(a), Figure 1 demonstrates the number of CBAS FFS and managed care beneficiaries, as well as the capacity of each county. Each quarter, the MCPs self-report enrollment data, which results in data lags. In addition, some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

See the next pages for Figure 1.

Figure 1: CBAS Unduplicated Participant and MCP Enrollment Data with CBAS County Capacity

County	DY 20–Q1		DY 20–Q2		DY 20–Q3		DY 20–Q4	
	Jan – Mar 2024		April – June 2024		July – Sept 2024		Oct – Dec 2024	
	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	382	66%	386	67%	379	70%	368	60%
Butte	21	35%	23	28%	28	37%	45	37%
Contra Costa	77	44%	76	42%	80	46%	89	45%
Fresno	1,092	66%	1,111	65%	1,113	61%	1,127	59%
Humboldt	94	18%	94	17%	90	18%	101	17%
Imperial	262	56%	260	57%	260	56%	256	52%
Kern	392	39%	419	41%	398	42%	452	40%
Los Angeles	25,662	67%	26,133	68%	27,044	70%	28,314	70%
Madera	N/A	N/A	N/A	N/A	0	0%	0	0%
Merced	115	64%	116	46%	104	42%	114	40%
Monterey	95	59%	104	64%	97	62%	97	61%
Orange	3,061	65%	2,972	62%	3,064	67%	3,510	64%
Riverside	589	40%	592	33%	570	33%	684	37%
Sacramento	390	57%	413	60%	450	62%	453	61%
San Bernardino	893	42%	1,005	47%	1,084	53%	1,155	53%
San Diego	1,916	49%	1,981	49%	1,978	51%	2,133	48%
San Francisco	730	62%	746	64%	751	65%	834	65%
San Joaquin	0	N/A	0	N/A	0	N/A	0	N/A
San Mateo	39	15%	45	15%	71	22%	112	25%
Santa Barbara	69	30%	71	31%	73	35%	86	32%
Santa Clara	632	50%	635	52%	680	55%	688	57%
Santa Cruz	92	51%	99	56%	105	56%	131	53%
Shasta	55	41%	50	40%	59	43%	70	40%

Stanislaus	**	**	**	**	**	**	**	**
Ventura	***	***	***	***	***	***	***	***
Yolo	261	75%	254	70%	254	69%	269	72%
Marin, Napa, Solano	130	39%	129	40%	124	40%	149	68%
Total	**37,657**	**61%**	**38,228**	**61%**	**39,458**	**63%**	**41,932**	**63%**
CBAS capacity data by County – FFS and MCP Enrollment Data								

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 1 data will be submitted one quarter in the rear due to the reporting delays.*

***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 small counts are suppressed to protect the privacy and security of participants.*

****Complimentary cell suppression*

Figure 1 depicts a few fluctuations in the data for DY 20-Q4 as there are increases greater than five percent in capacity used. Of note, when the Average Daily Attendance (ADA) of a center change, or a new center opens, there may be an increase in overall capacity. However, most new centers take time to build up their ADA, so a new center may also bring utilization rates or ADA down temporarily until the center builds its census.

Figure 1 presents several data points that warrant explanation. For instance, Alameda County experienced a center closure on December 13, 2024, which decreased utilization. Additional fluctuations include Marin, Napa, and Solano Counties which tend to fluctuate significantly due to the small number of participants served. Overall, totals in DY 20-Q4 show unduplicated participants increased by 2,474 from Q3, while capacity used remains unchanged.

Figure 2: CBAS Participants Enrolled in Enhanced Care Management & Community Supports

Demonstration Year and Quarter	Number of CBAS Participants	Enrolled in Enhanced Care Management (ECM)	Enrolled in Community Supports (CS)	Enrolled in Enhanced Care Management (ECM) & Community Supports (CS)
DY 20-Q1 (Jan – Mar 2024)	39,776	2,482	2,224	613
		6.24%	5.59%	1.54%
DY 20-Q2 (Apr – Jun 2024)	41,812	3,059	2,386	812
		7.32%	5.71%	1.94%
DY 20-Q3 (Jul – Sep 2024)	43,427	3,677	2,626	1,074
		8.47%	6.05%	2.47%
DY 20-Q4		3,649	2,649	1,110

Demonstration Year and Quarter	Number of CBAS Participants	Enrolled in Enhanced Care Management (ECM)	Enrolled in Community Supports (CS)	Enrolled in Enhanced Care Management (ECM) & Community Supports (CS)
(Oct – Dec 2024)	43,253	8.44%	6.12%	2.57%
				DHCS Data 12/2024

**Information is not yet reported for DY 21-Q1 due to a delay in the availability of the data, and it will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 2 data will be submitted one or two quarters in the rear due to the reporting delays.*

Figure 2 displays the number of CBAS participants who also receive Enhanced Care Management (ECM) and Community Supports (CS) through their Medi-Cal MCPs. ECM and CS are a new statewide Medi-Cal benefit as part of CalAIM. ECM is available to select "Populations of Focus" that will address the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet members wherever they are (e.g., on the street, in a shelter, in their doctor's office, or at home). Members receiving ECM have a lead care manager who coordinates care and services among the physical, behavioral, dental, developmental, and social services delivery systems. Community Supports are designed to address social drivers of health (factors in people's lives that influence their health). All Medi-Cal MCPs are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services. DY 20-Q4 presents a slight decrease and of the 43,253 CBAS participants, 8.44 percent continue to be enrolled in ECM services since Q3. During Q3, CS services show a slight increase from 2,626 to 2,649 participants in Q4. Additionally, participants with both CS and ECM services have increased from 1,074 in Q3 to 1,110 in Q4.

Assessments for MCPs and FFS Participants

Requests for CBAS are collected and assessed by the MCPs and DHCS. Individuals who request CBAS 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 was met based on medical information and/or history the plan possesses.

Figure 3 illustrates the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the figure are reported by DHCS.

Figure 3: CBAS Assessments Data for MCPs and FFS

Demonstration Year and Quarter	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 20-Q1 (Jan – Mar 2024)	3,098	3,042	56	0	0	0
		98%	2%		0%	0%
DY 20-Q2 (April – June 2024)	3,717	3,686	31	0	0	0%
		99%	1%		0	0%
DY 20-Q3 (July – Sep 2024)	2,986	2,940	46	0	0	0
		98%	2%		0%	0%
DY 20-Q4 (Oct – Dec 2024)	3,065	3,018	47	0	0	0%
		98%	2%		0	0%
5% Negative change between last Quarter	No	No	No	No	No	No

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 3 data will be submitted one quarter in the rear due to the reporting delays.*

Per STC 5.6(a), Figure 3 presents quarterly data for the total determined eligible and ineligible beneficiaries per county. DHCS FFS members in DY 20-Q4 present zero assessments performed for CBAS benefits, with zero percent for both eligible and ineligible. MCP members in DY 20-Q4 demonstrate a total of 3,065 assessments

performed and 3,018 or 98 percent, being eligible. Additionally, DY 20-Q4 data displays 47 participants of 3,065 new assessments were determined to be ineligible. Figure 3 demonstrates no reported negative change greater than five percent from quarter to quarter. The data for participants who were ineligible has remained about the same from DY 20-Q3 to DY 20-Q4. Figure 3 displays an increase in new assessments, from 2,986 to 3,065 assessments, and an increase in eligible participants from 2,940 to 3,018 since DY 20-Q3 to DY 20-Q4. The number of CBAS FFS participants has been consistently low for the last four quarters, as a significant quantity of participants are in a MCP.

See the next page for Figure 4.

Figure 4: CDA and CBAS Provider Self-Reported Data

DY 20-Q1

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	296
Non-Profit Centers	46
For-Profit Centers	250
ADA at 294 Centers	27,169
Total Licensed Capacity	44,853
Statewide ADA per Center	92
CDA – Monthly Statistical Summary Report (MSSR) Data 03/2024	

DY 20-Q2

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	300
Non-Profit Centers	46
For-Profit Centers	254
ADA at 296 Centers	27,840
Total Licensed Capacity	45,689
Statewide ADA per Center	93
CDA - MSSR Data 06/2024	

DY 20-Q3

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	27
Total CA Counties	58

CDA - CBAS Provider Self-Reported Data	
Number of CBAS Centers	300
Non-Profit Centers	45
For-Profit Centers	255
ADA at 300 Centers	28,835
Total Licensed Capacity	45,760
Statewide ADA per Center	96
	CDA - MSSR Data 09/2024

DY 20-Q4

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	28
Total CA Counties	58
Number of CBAS Centers	303
Non-Profit Centers	43
For-Profit Centers	260
ADA at 300 Centers	29,197
Total Licensed Capacity	46,498
Statewide ADA per Center	96
	CDA - MSSR Data 12/2024

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 4 data will be submitted one quarter in the rear due to the reporting delays.*

As previously noted, the opening or closing of a CBAS center affects the CBAS enrollment and ADA. CBAS center closures decrease enrollment and ADA, while new CBAS center openings increase ADA and enrollment capacity. While a new CBAS center will increase overall center capacity for that county, most new centers take a while to build their ADA. Therefore, a new center opening may also bring utilization rates down temporarily. The CDPH licenses CBAS centers, and CDA certifies the centers to provide CBAS benefits. The CDA also facilitates monitoring and oversight of the centers.

Per STC 5.6(b), Figure 4 identifies the number of counties with CBAS centers and the ADA for the past four quarters: DY 20-Q1, DY 20-Q2, DY 20-Q3, and DY 20-Q4. The Statewide ADA per center reflects how many participants, on average, were served on any given day at an individual CBAS center. In DY 20-Q4, ADA at 303 operating CBAS centers there were approximately 29,197 participants, indicating that, on average, 96 participants were served on any given day. In DY 20-Q3 ADA at 300 CBAS centers was approximately 28,835 participants, indicating that, on average, 96 participants were served at each center. The provider self-reported data identified in Figure 4 for the previous four quarters reflects data through December 2024.

The differences between DY 20-Q4 and DY 20-Q3 are: (1) an increase in the number of CBAS centers from 300 to 303; (2) the number of for-profit centers increased by five; (3) the number of CA Counties with CBAS centers increased by one as a new CBAS center opened in Madera; (4) the number of non-profit centers decreased by two; (5) ADA at CBAS centers increased by 362; and (6) the total licensed capacity increased by 738.

In DY 21-Q1 CDA released two updated training webinars for prospective CBAS applicants titled:

- CBAS History & Center Pre-Screening Package (PSP) Overview – content of this training includes the basics of the CBAS program history and model, components and requirements of the PSP and where to access resources.
- CBAS Initial Application Certification Overview – content of this training includes the components and requirements of the CBAS Initial Certification application process and where to access resources.

These trainings are required for prospective CBAS applicants to ensure they are well informed regarding the process.

Stakeholder Complaints and Interventions

Policy Development/Issues

Process improvements are ongoing to support the initial CBAS certification application processes for applicants who desire to open a new CBAS Center. CDA also restructured the pre-screening phase of the initial certification application process. Desirable outcomes include greater efficiency and reduced timeframes to certify new centers, resulting in more CBAS participants being served more quickly and an increase in new centers being certified.

During on-site recertification surveys in DY 21-Q1, CDA continued to identify CBAS centers that were not adhering to ERS policy requirements. To ensure remediation of the deficient practices identified, specific issues were addressed with individual centers through the plan of correction process.

CBAS Member/Provider Call Center (FFS/MCP)

DHCS and CDA continue to respond to issues and questions from CBAS participants, providers, MCPs, and members of the Legislature on various aspects of the CBAS program. Additionally, stakeholders may refer to DHCS and CDA webpages for CBAS updates and information. CBAS providers and members can submit their inquiries to CBASCDA@aging.ca.gov for assistance.

The number of issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are received via telephone or email by MCPs and CDA for research and resolution. Figures 5 and 6 present complaint data received by CDA and MCPs from CBAS members and providers.

Figure 5: Data on CBAS Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 20-Q1 (Jan – March 2024)	3	0	3
DY 20-Q2 (April – June 2024)	0	1	1
DY 20-Q3 (July – Sept 2024)	0	0	0
DY 20-Q4 (Oct – Dec 2024)	0	0	0
CDA Data – Complaints 12/2024			

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 5 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 6: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 20-Q1 (Jan – Mar 2024)	3	0	3
DY 20-Q2 (Apr – Jun 2024)	4	5	9
DY 20-Q3 (Jul – Sep 2024)	0	0	0
DY 20-Q4 (Oct – Dec 2024)	0	0	0
Phone Data – Phone Center Complaints 12/2024			

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 6 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 5 shows complaints received by the CDA team for DY 20 which continues to indicate a decrease in overall complaints in Q3 and Q4, with both quarters displaying zero complaints. Figure 6 presents complaints reported to the MCP call center. MCPs recorded zero complaints from providers and members during the quarters, DY 20-Q3 to DY 20-Q4. According to the MCP and CDA's findings, there were no complaints collected in DY 20-Q4.

CBAS Grievances/Appeals (FFS/MCP)

Grievances and appeals are recorded by the MCPs and reported to DHCS. Grievances data collection range from issues with access and availability of services to inconveniences of travel to access CBAS, and provider grievances. Individuals are entitled to appeal the issues like denials for eligibility or requests for specific providers; appeals may also include issues with limited services or excessive travel to acquire CBAS services. Figures 7 and 8 display the recorded data from MCPs for grievances and appeals.

Figure 7: 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
DY 20-Q1 (Jan – Mar 2024)	10	1	0	7	18
DY 20-Q2 (Apr – Jun 2024)	5	0	0	8	13
DY 20-Q3 (Jul – Sep 2024)	3	0	0	24	27
DY 20-Q4 (Oct – Dec 2024)	5	0	0	19	24
MCP Data - Grievances 12/2024					

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 7 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 8: 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
DY 20–Q1 (Jan – Mar 2024)	7	0	0	1	8
DY 20–Q2 (Apr – Jun 2024)	11	0	0	1	12
DY 20–Q3 (Jul – Sep 2024)	16	1	0	2	19

DY 20-Q4 (Oct – Dec 2024)	23	0	0	8	31
MCP Data - Appeals 12/2024					

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 8 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 7 displays the CBAS grievances recorded by the MCPs. DY 20-Q3 and DY 20-Q4 data present similarities as most grievances are in the "CBAS Providers" column and the "Other CBAS Grievances". Among the 19 other CBAS grievances during DY 20-Q4, MCPs reported the other grievances were primarily due to access and availability. Additionally, a few other grievances involved access to care, attitude/service, and billing or finance. DHCS collected data from the MCPs who reported a total of 31 appeals during DY 20-Q4, with the "Denials or Limited Services" column presenting 23 appeals. Of the eight appeals in the "Other CBAS Appeals", seven were reported to involve CBAS access and availability, and one appeal was dismissed.

CBAS FFS and Managed Care Access Monitoring

Per STC 5.6(e), CDA reported the access/capacity in every county where CBAS exists. Additionally, the data collection will demonstrate overall utilization of newly opened and closed centers. Figure 9 on the next page accounts for 29 counties with CBAS centers, detailing the capacity used for CBAS centers. Figure 10 displays CBAS operating centers that experienced openings and closures, demonstrating the net losses and gains. DHCS and CDA continue to monitor the overall utilization of CBAS, including the opening and closing of CBAS centers since April 2012, when CBAS became operational.

Figure 9: CBAS Centers Licensed Capacity

CBAS Centers Licensed Capacity						
County	**DY 20-Q1 (Jan-Mar 2024)**	**DY 20-Q2 (Apr-June 2024)**	**DY 20-Q3 (July – Sept 2024)**	**DY 20-Q4 (Oct– Dec 2024)**	**Percent Change Between Last Two Quarters**	*****Capacity Used**
Alameda	370	370	370	370	0.0%	67%
Butte	60	60	60	60	0.0%	28%
Alameda	370	370	370	370	0.0%	60%
Butte	60	60	60	60	0.0%	37%
Contra Costa	130	130	130	130	0.0%	45%
Fresno	1,297	1,297	1,297	1,297	0.0%	59%
Humboldt	349	349	349	349	0.0%	17%
Imperial	355	355	355	355	0.0%	52%
Kern	805	805	805	805	0.0%	40%
Los Angeles	28,006	28,301	28,597	28,730	+0.5%	70%
Marin	0	0	0	0	N/A	N/A
Madera	0	0	210	210	0.0%	0%
Merced	124	175	175	175	0.0%	40%
Monterey	110	110	110	110	0.0%	61%
Napa	100	100	100	100	0.0%	45%
Orange	3,501	3,711	3,636	3,906	+7.4%	64%
Riverside	1,025	1,225	1,225	1,225	0.0%	37%
Sacramento	520	520	520	520	0.0%	61%
San Bernardino	1,446	1,446	1,446	1,446	0.0%	53%

CBAS Centers Licensed Capacity						
County	**DY 20-Q1 (Jan-Mar 2024)**	**DY 20-Q2 (Apr-June 2024)**	**DY 20-Q3 (July – Sept 2024)**	**DY 20-Q4 (Oct– Dec 2024)**	**Percent Change Between Last Two Quarters**	*****Capacity Used**
San Diego	2,359	2,439	2,439	2,574	+5.5%	48%
San Francisco	926	926	926	931	0.5%	65%
San Joaquin	0	0	0	0	N/A	N/A
San Mateo	245	245	245	245	0.0%	25%
Santa Barbara	180	180	180	180	0.0%	32%
Santa Clara	820	820	820	820	0.0%	57%
Santa Cruz	120	120	120	120	0.0%	53%
Shasta	85	85	85	85	0.0%	40%
Solano	120	120	120	120	0.0%	36%
Stanislaus	510	510	510	510	0.0%	10%
Ventura	1,066	1,066	1,066	1,066	0.0%	39%
Yolo	224	224	224	224	0.0%	72%
SUM	**44,853**	**45,689**	**45,760**	**46,498**	**+ 1.6%**	**63%**

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 9 data will be submitted one quarter in the rear due to the reporting delays.*

****Capacity Used measures the average number of total individuals receiving CBAS at a given CBAS center daily (average daily attendance [ADA]) versus the maximum capacity available.*

As shown in Figure 9, in DY 20-Q4, Orange County shows an increase of 7.4 percent between DY 20-Q3 and Q4 as a new center opened on December 6, 2024. San Diego County shows an increase of 5.5 percent between DY 20-Q3 and Q4 as a new center opened on October 29, 2024. Data reported in Figure 9 for DY 20, did not indicate any other fluctuations of five percent in licensed capacity by county.

Figure 10: CBAS Center History

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
Dec 2024	302	1	2	+1	299
Nov 2024	301	0	1	1	303
Oct 2024	300	0	1	1	302
Sept 2024	298	0	2	1	301
Aug 2024	297	0	1	2	300
July 2024	299	2	0	1	298
Jun 2024	298	1	2	-2	297
May 2024	298	0	0	1	299
Apr 2024	296	0	2	0	298
Mar 2024	295	0	1	2	298
Feb 2024	295	0	0	1	296
Jan 2024	294	0	1	0	295

**Information is not reported for DY 21-Q1 due to a delay in the availability of the data and will be presented in the DY 21-Q2 Quarterly Report. For future reports, Figure 10 data will be submitted one quarter in the rear due to the reporting delays.*

According to the data in Figure 10 above, DY 20-Q4 (October 2024 – December 2024) includes four new center openings, one in San Diego County, one in Los Angeles County, one in Orange County, and one in Tulare County. The center that opened in Tulare County is the first in the county. The data for Q4 shows one center closure in Alameda County. Figure 10 shows there were no negative changes of more than five percent in DY 20-Q3 and Q4, therefore, no analysis is needed to address such variances.

Unbundled Services

Per 5.6(e)(i), CDA certifies and provides oversight of CBAS centers. DHCS continues to review and monitor any possible impact on participants due to CBAS center closures. For counties that do not have a CBAS center, the MCPs will work with the nearest available CBAS center to provide the necessary services. This may include, but not be limited to, the MCP contracting with a non-network provider, to ensure that continuity

of care continues for the participants if they are required to enroll in managed care. Members 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, the CBAS center is required to notify CDA and their contracted MCPs of their planned closure date and conduct discharge planning for each of the CBAS participants to whom it provides 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 served by CBAS can choose an alternate CBAS center within their local area.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD who reside in a county who elect to participate in the DMC-ODS (hereafter referred to as DMC-ODS members). Under the DMC-ODS program, all California counties have the option to participate in the program to provide their resident Medi-Cal members with a range of evidence-based SUD treatment services in addition to those available under the traditional Drug Medi-Cal (DMC) program.

The DMC-ODS program was originally authorized in 2015 by the Medi-Cal 2020 Section 1115(a) demonstration. However, as a part of CalAIM, on June 30, 2021, DHCS submitted a 1915(b) waiver renewal to CMS to consolidate Medi-Cal managed care delivery system programs previously authorized under California's Medi-Cal 2020 Section 1115(a) demonstration – Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS – with Specialty Mental Health Services (SMHS) under the 1915(b) waiver in 2022. On December 29, 2021, CMS approved the reauthorization of DMC-ODS, shifting the managed care authority to the consolidated CalAIM 1915(b) waiver and using the Medicaid State Plan to authorize the majority of DMC-ODS services. The authority to provide reimbursable Medi-Cal services for DMC-ODS members residing in institutions for mental disease (IMDs), Medi-Cal Peer Support Services, and Contingency Management remain authorized under the Section 1115 demonstration through December 31, 2026. This CalAIM demonstration continues to provide the state with the ability to claim federal financial participation (FFP) for high-quality, clinically appropriate SUD treatment services for DMC-ODS members who are short-term residents in residential and inpatient treatment settings that qualify as IMD. Critical elements of the DMC-ODS continue to include providing a continuum of care, patient assessment, and placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria.

Contingency Management Updates

On March 28, 2023, DHCS approved the first site to offer Contingency Management (CM) services as part of the Recovery Incentives Program. Since the launch of the program through March 31, 2025, 6,957 members have received CM services.

In addition to these sites, ten new sites have completed the required Implementation Training and are working to complete the Readiness Assessment prior to launching CM services. Additional sites will be approved on a rolling basis as they complete the Implementation Training and Readiness Assessment process.

CM acknowledges positive behavioral change, as verified by negative drug tests that have tested negative for stimulants, and reinforces that behavior through motivational incentives. As part of the Recovery Incentives Program, urine drug tests (UDTs) are used

to qualify a member for motivational incentives. In Q1 2025, 27,803 UDTs were administered, of which 26,967 tested negative for stimulants. As a result, members testing negative earned $413,965.50 in gift cards (i.e., motivational incentives). The DHCS Incentive Manager (IM) portal lets members redeem their gift cards immediately or 'bank' them for a larger reward later. Of the total incentives earned, $362,056.50 was disbursed in Q1. When redeeming a gift card, members may choose from a list of pre-approved vendors. In Q1, the most frequently redeemed cards were Walmart ATF Restricted (48 percent), Chevron and Texaco US (14 percent), and Nike (seven percent). DHCS continues to process the intake of CM data, which will be used for incentive payment processing, evaluation activities, creation of reports, and dashboard metrics.

In August 2024, DHCS released Behavioral Health Information Notice (BHIN) 24-031, which supersedes BHIN 23-040. This revised BHIN allows any DMC-ODS county to participate in the Recovery Incentives Program a streamlined Implementation Plan for DHCS approval. Program expansion aims to reach the remaining DMC-ODS Medi-Cal population and populations disproportionately afflicted with stimulant use disorder (e.g. rural and tribal communities).

Throughout Q1 of 2025, the DHCS Recovery Incentives Program team held weekly planning meetings with the CM training and technical assistance provider, University of California, Los Angeles (UCLA), and the IM vendor, Q2i. Oversight and monitoring activities included ongoing fidelity reviews and coaching calls that assessed adherence to the CM protocol. In September 2024, DHCS provided the county leads and Behavioral Health Director's with a Quarterly Progress Report (QPR) Template to track oversight activities. The first of four QPRs covering October through December 2024 was due to DHCS by January 31, 2025. The program team is conducting a quantitative and qualitative analysis of the QPRs to inform and support program quality and expansion.

Per BHIN 24-031, counties participating in the Recovery Incentives Program must submit quarterly reports for a total of four consecutive quarters. The program team is currently evaluating the QPRs using both quantitative and qualitative methods.

The Recovery Incentives Program team responded to questions from participating counties and provider sites, refined training materials for counties and providers, and coordinated with CDPH for expedited processing of Clinical Laboratory Improvement Amendments (CLIA) waivers.

Recovery Incentives: California's Contingency Management Program – Training and Technical Assistance Activities, DY 21-Q1

DY 21-Q1 (January 1, 2025 – March 31, 2025)

Statewide CM pilot training curriculum, readiness review, and fidelity assessment tool development activities: Key activities accomplished during DY 21-Q1 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and once every six months thereafter for the duration of the Recovery Incentives Program. The Fidelity Monitoring Self-Study and Interview #1 are completed 2-3 months following Program launch, Fidelity Monitoring Self-Study and Interview #2 are completed 4-6 months following Program launch, Fidelity Monitoring Self-Study and Interview #3 are completed 8-10 months after Program launch, and Fidelity Monitoring Self-Study and Interview # 4 are completed 14-16 months after program launch. Fidelity Monitoring Self-Study #1 through #4 are on file at DHCS. Scheduling these regularly required fidelity reviews (inclusive of both the Self-Study and Interview) ensures the Recovery Incentives Program is being delivered consistently and rigorously over time and allows the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of seven Fidelity Monitoring #1 interviews, 26 Fidelity Monitoring #2 interviews, 14 Fidelity Monitoring #3 interviews and six Fidelity Monitoring #4 interviews were completed during the reporting period.
    - All Fidelity Monitoring Self-Study interview templates were updated to include the 7th approved UDT test, the Clinical Laboratory Improvement Amendments (CLIA) Waived, Inc., Rapid Test Cup "RTC" + Fentanyl.
    - All the approved UDT tests can be found at Approved UDTs for the Recovery Incentives Program.
- **Outreach Efforts:** To increase enrollment, sites were encouraged to utilize Sample Messages as outlined in the Provider Outreach & Communications Toolkit on the Recovery Incentives Program website. These messages include website text, email newsletter, and social media posts. Additional outreach materials include the Recovery Incentives Program flyer, wallet cards, and a frequently asked questions (FAQ) document. Site-specific recruitment strategies are discussed during the Fidelity Monitoring Interviews and during monthly coaching calls.
- **Site-Level CLIA Waiver/State Lab Registration**: A cumulative total of 137 State Lab Registration Applications, and 127 CLIA Certificate Applications have been

identified as completed/approved. A total of 143 Site Lab Directors has been identified as completed/approved.

- **Recovery Incentives Program Website:** The Recovery Incentives Program website was updated as materials were refined. Website updates included the Implementation Training registration links, PowerPoint slides, handouts, and the IM Portal Gift Card List. The Program Manual with Appendices was also updated.
- **CM Overview Training (On-Demand):** A total of 80 individuals completed the CM Overview Training on-demand course between January 1- March 31, 2025.
- **Two-Part CM Implementation Training:** UCLA Integrated Substance Abuse Programs (ISAP) conducted 12 Implementation Trainings (with 163 total participants) from 17 of the 23 counties.
- **Coaching Calls:** UCLA ISAP conducted 30 interactive Zoom Coaching Calls with a total of 475 attendees.
- **Readiness Assessment:** UCLA ISAP conducted two Readiness Assessment interviews, and seven outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by ten sites; the sites received a link to the Qualtrics self-study to initiate the Readiness Assessment process.

Medi-Cal Peer Support Services Updates

Medi-Cal Peer Support Services is an optional behavioral health Medi-Cal benefit that can be implemented within DMC-ODS, DMC, and/or SMHS delivery systems. As of March 31, 2025, 5,228 individuals are certified as Medi-Cal Peer Support Specialists through the California Mental Health Services Authority (CalMHSA) certification program. CalMHSA is currently the sole county-selected and DHCS-recognized certification program for Medi-Cal Peer Support Specialists (see Figure 11 for a breakdown of new applicants by application/certification status). As of March 31, 2025, 52 out of 58 California counties provide Medi-Cal Peer Support Services, including 33 DMC-ODS programs, 52 MHPs, and ten DMC counties. DHCS provides the opportunity for counties to opt-in to provide Medi-Cal Peer Support Services on an annual basis.

Figure 11: Medi-Cal Peer Support Specialist Applications and Certifications Status

Applications & Certifications per Quarter[2]	DY Q1 (1/1/25-3/31/25)
New Applications submitted	1797
New Certifications	587

Throughout DY 21-Q1, DHCS conducted stakeholder engagement on program implementation, addressed stakeholder questions on service delivery, billing, claiming, scope of services, certification, updates for Medi-Cal Peer Support Specialists in the Provider Information Management System, and coordinated regularly with CalMHSA to ensure responsiveness to stakeholders and alignment with policy. DHCS is finalizing the draft all-inclusive Medi-Cal Peer Support Services BHIN that incorporates stakeholder feedback, as well as accompanying FAQs; both of which are expected to be finalized and released in DY 21-Q2.

DHCS continues to gather information and feedback from stakeholders to inform policy development around requiring Medi-Cal Peer Support Specialists and other unlicensed providers to obtain a National Provider Identifier (NPI) number. NPI guidance is expected to be developed no sooner than summer of 2025.

Performance Metrics

Prior quarters have been updated based on new claims data. The performance metrics below consist of preliminary data since California counties have 12 months to submit claims, which can lead to lower reported numbers when data is pulled prior to the claiming deadline. Accurate enrollment numbers are updated and provided in subsequent quarterly report cycles.

[2] Source: California Mental Health Services Authority Peer Certification Data

Figure 12: Quarterly Count of Unduplicated DMC-ODS Members with FFP Funding

Quarter	ACA	Non-ACA	Total
DY20-Q2	11,457	3,485	14,942
DY20-Q3	10,882	3,220	14,102
DY20-Q4	8,256	2,423	10,679
DY21-Q1	3,930	1,064	4,994

**Affordable Care Act (ACA)*

Figure 13: Member Enrollment

Population	Quarter	Month 1	Month 2	Month 3	Current Enrollees (to date)
ACA	DY20-Q2	6,504	6,625	6,511	11,457
	DY20-Q3	6,507	6,397	5,049	10,882
	DY20-Q4	4,977	4,348	4,251	8,256
	DY21-Q1	3,228	1,513	92	3,930
Non-ACA	DY20-Q2	1,907	1,945	1,731	3,485
	DY20-Q3	1,810	1,782	1,453	3,220
	DY20-Q4	1,385	1,263	1,128	2,423
	DY21-Q1	863	397	26	1,064

Figure 14: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY20-Q2					
ACA	454,352	$106,098,953.75	$95,400,162.64	$9,394,465.62	$1,304,325.49
Non ACA	116,628	$27,460,152.70	$13,775,839.06	$11,347,781.12	$2,336,532.52
DY20-Q3					
ACA	439,441	$101,811,023.53	$91,545,588.57	$8,819,880.89	$1,445,554.07
Non ACA	112,662	$26,025,643.65	$13,052,177.57	$10,570,370.12	$2,403,095.96
DY20-Q4					
ACA	320,060	$78,425,773.50	$70,555,402.08	$6,704,719.46	$1,165,651.96
Non ACA	79,323	$19,512,528.19	$9,774,620.02	$7,962,485.38	$1,775,422.79
DY21-Q1					
ACA	96,041	$23,226,762.72	$20,897,374.30	$1,895,500.81	$433,887.61
Non ACA	23,053	$5,582,649.44	$2,795,012.58	$2,193,559.25	$594,077.61

Traditional Health Care Practices (THCP) Update:

On October 16, 2024, the Centers for Medicare & Medicaid Services (CMS) approved DHCS to cover traditional health care practices (THCP) provided by Indian Health Care Providers (IHCPs) for Medi-Cal members in DMC-ODS counties through December 31, 2026, unless extended or amended. DHCS held a tribal consultation on February 3, 2025.

DHCS released BHIN 25-007 with an effective date of March 21, 2025, stating that DMC-ODS counties shall provide coverage for THCP received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations (Tribal Facilities) under the Indian Self-Determination and Education Assistance Act, and facilities operated by urban Indian organizations (UIO facilities) under Title V of the Indian Health Care Improvement Act to Medi-Cal members who receive covered services delivered by or through these facilities and meet DMC-ODS access criteria.

Effective March 21, 2025, DHCS is accepting opt-in packages from eligible IHCPs on a rolling basis. IHCPs must submit an opt-in package to DHCS and receive approval prior to providing billable THCP services.

DHCS continues to collect feedback from tribal partners and stakeholders to inform policy guidance. DHCS is also preparing TA support for IHCPs and counties. In Q1, DHCS scheduled a tribal consultation and webinar on April 22, 2025, and will provide an update on this meeting in the next DMC-ODS quarterly report.

Performance Metrics Enclosures/Attachments

The attachment, CalAIM 1115 Waiver Progress Report DY21-Q1_ODS-RES_4-1-2025, contains the Enrollment data, Member Month data, and Aggregate Expenditures data referenced in this section of the report. Additionally, the attachment contains the ACA and Non-ACA Expenditures reported for DY 21-Q1 as of January 1, 2025.

Outreach Activities

- DHCS held monthly calls with each participating DMC-ODS county to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including status updates on Corrective Action Plans (CAPs) and reports.
- DHCS issues weekly Behavioral Health Stakeholder Updates via email to stakeholders. The information provided includes announcements of finalized and draft BHINs, upcoming webinars, and other relevant information.

- DHCS held webinars through the monthly All County Behavioral Health Call to provide technical assistance and program updates regarding contractual and regulatory compliance. The dates of these webinars and the topics presented are as follows:
- January 15, 2025
  - 1915(b) Appeals and Grievance Report FY 2024-25 Quarter 2 Updates
- February 19, 2025
  - Prop 30 Funds for Administrative Costs related to Implementing Interoperability Requirements.
- March 19, 2025
  - Interoperability

Operational Updates

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including 1) updates to the criteria to access SMHS; 2) implementation of standardized statewide screening and transition tools; 3) behavioral health payment reform; and 4) streamlining and standardizing clinical documentation requirements through documentation reform. DMC-ODS counties are utilizing policy guidance that was released from December 2021 through September 2024 (related to these items) to update and implement policies and procedures.

The following Behavioral Health Information Notices (BHINs) were updated during this quarter:

- 25-001 - Update to Protocols for Collecting and Reporting Discharge Data in California Outcomes Measurement System Treatment (CalOMS Tx)
- 25-003 - Certification of Alcohol and Other Drug Programs
- 25-006 - Provision of Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Access, Reform and Outcomes Incentive Program
- 25-007 - Traditional Health Care Practices Benefit Implementation

Consumer Issues and Interventions

DHCS continues to respond to issues and concerns related to DMC-ODS counties delivering DMC-ODS services. DHCS received two issues during DY 21-Q1 and both

issues have been resolved.

Quality Control/Assurance Activity

DHCS conducts annual compliance reviews of each county that participates in the provision of DMC-ODS services. During DY 20 Q3, DHCS scheduled the annual DMC-ODS compliance review dates for DY 21 Q1 and began sending counties the FY 2024-25 DMC-ODS review document request. DHCS requested the counties' supporting documentation to demonstrate compliance with federal regulations, state regulations, program requirements and contractual obligations.

DHCS completed 11 compliance reviews with counties during DY 21 Q1. Once a review is completed, a Findings Report is issued to the county. The county is required to submit a CAP for each area of non-compliance within 60 days of receipt of the compliance report for review, acceptance, and follow-up. DHCS follows up with each county to periodically check on the status of the CAP and provide technical assistance for resolution of CAP items until resolved. The Findings Reports are posted to the DHCS website on the County Performance Reports webpage.

Figure 15 demonstrates when County DMC-ODS compliance reviews were completed during DY 21 Q1.

Figure 15: DY 21-Q1 Compliance Reviews

County	Month/Year
San Diego	January 2025
San Francisco	January 2025
Stanislaus	January 2025
Ventura	January 2025
Napa	January 2025
Marin	January 2025
El Dorado	February 2025
Sacramento	March 2025
Nevada	March 2025
San Benito	March 2025

County	Month/Year
Placer	March 2025

DHCS continues to provide technical assistance and support to DMC-ODS counties to resolve outstanding CAPs. There are no major activities updates to report regarding quality control/assurance during DY 21 Q1.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

The DMC-ODS evaluation contractor, UCLA Integrated Substance Use and Addiction Programs (UCLA-ISAP) continued activities on the 1115 waiver evaluation, as described below:

Survey and Interview Data Collection

CM/Recovery Incentives Evaluation Activities

- Provider Surveys: During Q1 of 2025, UCLA-ISAP continued disseminating Provider Surveys at approved/launched programs. At the end of this reporting period, 252 surveys were received, with a 95 percent response rate. Findings from these surveys will be analyzed and merged with findings from the first round of provider interviews conducted in previous quarters to generate further insights into Recovery Incentives Program implementation.

- Executive Interviews: UCLA-ISAP analyzed quantitative data to identify individual programs for participation in provider executive interviews based on program size and Recovery Incentives Program enrollment. UCLA-ISAP conducted interviews with 12 provider executives in the past quarter and has transcribed them in preparation for analysis, which will be completed in the coming months.

- County Administrator Interviews: UCLA-ISAP reviewed quantitative data to identify counties for participation in county administrator interviews, developing an interview sample that includes counties from different regions of the states, varying levels of urbanicity, and different levels of Recovery Incentives Program reach (as defined by the approximate share of county StimUD clients who are receiving Recovery Incentives Program services). Based on this review, UCLA-ISAP identified ten counties to participate in interviews, completed interviews with representatives from seven counties during the past quarter, and has transcribed

them in preparation for analysis. Provider interviews will be completed, fully transcribed, and analyzed in the coming months.

- Member Interviews: The client/member interviews will collect insights from enrolled clients/members about their experiences across various points in time in the protocol but will also focus on clients/members who did not complete the program. The client/member interviews are anticipated to be conducted in in the coming year in conjunction with longitudinal client surveys.

- Longitudinal Client Surveys: During Q1, UCLA-ISAP determined strategies to recruit approximately 100 members who are starting the Recovery Incentives Program to provide feedback about their experiences as they go through the 24-week program. On March 1, 2025, UCLA-ISAP asked sites who had at least two active members in the Recovery Incentives Program to engage in the upcoming survey collection effort. UCLA-ISAP plans to provide surveys to members at four points in time: Week 0/1 (baseline), week six, week 14, and week 28. Participating sites will only be asked to assist with survey collection for week 0/1 (baseline). UCLA-ISAP will then contact each member who has consented to the follow-up surveys to collect the remaining data points and compensate members for completing the surveys. Baseline surveys are expected to begin for a one-week period at each provider site, commencing on a rolling basis starting May 5, 2025 and ending June 16, 2025.

- Check-in reminders of upcoming surveys will also be sent to members to increase response rates. During Q1, a baseline survey was drafted and sent for review by DHCS.

1115 Waiver Evaluation Activities

- During Q1 of 2025, UCLA-ISAP began preparing the 2025 County Administrator Survey to SUD/BH County Administrators of DMC-ODS counties. This annual survey aims to continue measuring the impact of the DMC-ODS program on SUD service delivery as well as addressing priority areas addressed under CalAIM (e.g., contingency management, harm reduction efforts, etc.). Data collection for this survey is expected to commence in mid-2025.

- Traditional Health Care Practices (THCP) Benefit: On October 16, 2024, CMS approved the THCP benefit, enabling DHCS to cover THCP provided by Indian Health Care Providers (IHCP) for Medi-Cal members in DMC-ODS counties through December 31, 2026. UCLA-ISAP is in the process of developing the THCP evaluation design with the University of Southern California (USC), DHCS, and tribal partners. DHCS will submit this evaluation design to CMS on August 29, 2025.

Administrative Data Analysis

- During Q1 of 2025, UCLA-ISAP continued to receive administrative datasets required to conduct the DMC-ODS Waiver Evaluation. Specifically, refreshed datasets received included: ASAM data, California Outcomes Measurement System (CalOMS) files, and Incentive Manager data. Analysis is underway and preliminary findings were summarized in an early-findings report to DHCS on Contingency Management, and in the 1115 DMC-ODS Mid-Point Assessment Report, which was submitted to CMS at the end of February 2025.

Reporting of Initial Findings

- UCLA-ISAP revised and submitted a new version of the DMC-ODS Mid-Point Assessment Evaluation Report during the reporting period, which found California is largely on track to meet its milestones. UCLA-ISAP is collecting data for the Interim Evaluation Report, which will be submitted later this year.
- On January 8, 2025, UCLA-ISAP presented at the County Behavioral Health Directors Association Substance Use Prevention and Treatment virtual meeting in Sacramento, California. UCLA-ISAP presented data from the Recovery Incentives Program Evaluation and collected feedback from the administrators.

Statewide Perception Surveys

- Treatment Perception Survey (TPS)/Substance Use – During Q1 of 2025, UCLA-ISAP analyzed data from the Q4 2024 data collection period and produced a statewide report, which was submitted to DHCS for review on 3/27/2025. The latest updates and additional information regarding the TPS can be found on the TPS website.

Additional Activities/Technical Assistance

ASAM Criteria Assessments

- UCLA-ISAP continues to work with ASAM to update assessment guides to the standards in the 4th Edition of the ASAM Criteria.
- In January 2025, the 4th Edition ASAM Level of Care Assessment Guide was released by ASAM and became freely available for public use. In the upcoming quarter, UCLA-ISAP will amend its website to include links to the new tools and implementation resources for the 4th edition of The ASAM Criteria Assessments as they become available.
- Throughout the reporting period, UCLA ISAP met with ASAM to begin drafting The ASAM Criteria Treatment Planning Assessment Guide. This guide is intended to be a companion to The ASAM Level of Care Assessment Guide that will

capture biological, psychological, social, and cultural factors to be considered in individualized treatment plans. This guide is intended to be administered either concurrently with The ASAM Level of Care Assessment Guide (which collects just enough information across dimensions to select an appropriate level of care) or in a subsequent session after the patient has been referred to the appropriate level of care and is ready for treatment planning.

- ASAM and UCLA-ISAP are working with DHCS to coordinate the Statewide transition process to move from the 3rd Edition to the 4th Edition of the ASAM Criteria, which is used to determine the most appropriate Level of Care for SUD treatment under the DMC-ODS program.

Initial Placement Screener

- UCLA-ISAP continues to support the utilization of the Brief Questionnaire for Initial Placement (BQuIP), both English and Spanish versions. The BQuIP tool is a fast and free web-based tool designed to generate recommendations for initial SUD treatment placement for adult individuals seeking SUD treatment. UCLA ISAP also continued to support counties interested in connecting this tool with their Electronic Health Records.
- During this reporting period, UCLA-ISAP has developed and is now testing algorithms to update the BQUIP to the 4th edition standards of the ASAM Criteria. Although as a brief screening tool, the BQUIP does not result in an ASAM Level of Care recommendation, it results in a recommendation for treatment modality (for example, residential, intensive outpatient, outpatient, Opioid Treatment Program or Office Based Opioid Treatment) in line with 4th edition standards. More information, resource support, and access to the BQuIP can be found on the BQuIP website.

GLOBAL PAYMENT PROGRAM

The Global Payment Program (GPP) assists public health care systems (PHCS) that provide health care to the uninsured. The GPP focuses on value rather than the volume of care provided. The purpose is to support PHCS in their key role of providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. In addition to providing value-based care, the GPP incorporates services that are otherwise available to the state's Medi-Cal members under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. Under the CalAIM waiver, GPP continues the work accomplished under the Medi-Cal 2020 waiver and has added services that aim to address health disparities for the uninsured population, as well as to align GPP service offerings with those available to Medicaid members.

The funding for GPP is a combination of a portion of California's federal Disproportionate Share Hospital (DSH) allotment and Uncompensated Care Pool (UC Pool) funding.

Performance Metrics

Nothing to report.

Outreach Activities

Nothing to report.

Operational Updates

The Affordable Care Act requires a reduction in national DSH allotments, which were previously scheduled to take effect on October 1, 2013, but has been continuously postponed. On March 15, 2025, House Resolution (HR) 1968 (2025-2026), was enacted, which eliminated the DSH reduction for FFY 2025 and postponed implementation until September 30, 2025, for the FFY 2026 reduction. Reductions are scheduled to occur through FFY 2026, FFY 2027, and FFY 2028, impacting GPP PYs 11 and 12.

Consumer Issues and Interventions

Nothing to report.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Figure 16: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 9 Final Reconciliation	$42,926,034.86	$42,926,034.86	DY 19	$85,852,069.72
Total	**$42,926,034.86**	**$42,926,034.86**		**$85,852,069.72**

DY 21-Q1 reporting activities include payments made in February 2025 for the GPP PY 9 Final Reconciliation. The PHCS received $42,926,034.86 in federally funded payments and $42,926,034.86 in intergovernmental transfer (IGT) funded payments. In the PY 9 Final Reconciliation round, PHCS earned the full GPP global budget of $2.8 billion. As a result, there were no overpayments nor recoupments from the PHCS.

Evaluation Activities and Interim Findings

Throughout DY 21-Q1, DHCS worked collaboratively with The Regents of University of California on behalf of its Los Angeles campus and RAND Corporation (UCLA-RAND), the California Association of Public Hospitals and Health Systems (CAPH), and the PHCS. DHCS continues to conduct bi-weekly conference calls with CAPH to discuss programmatic activities, budgets, and trends in reported data.

PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH)

California's Section 1115 waiver renewal includes expenditure authority for the PATH initiative to maintain, build, and scale services, capacity, and infrastructure necessary to ensure successful implementation of the CalAIM initiative. PATH funding aims to support community level service delivery networks to participate in the Medi-Cal delivery system as California widely implements ECM, Community Supports, and Justice-Involved Services under CalAIM. PATH funding is available for various entities such as providers, counties, cities, local government agencies, former WPC Lead Entities (LEs), community-based organizations (CBOs), hospitals, Medi-Cal Tribal and designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

- JI Capacity Building to maintain and build pre-release services to support implementation of a full suite of statewide CalAIM JI initiatives starting in 2023, and
- Support for implementation of ECM and Community Supports (In Lieu of Services (ILOS)), which are foundational elements of CalAIM at the community level, and support for the expansion of access to services that will enable the transition from Medi-Cal 2020 to CalAIM.

PATH includes the following four initiatives:

1. WPC Services and Transition to Managed Care Mitigation Initiative – PATH funding will directly support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM on or before January 1, 2024. PATH funding will also directly support former WPC Pilot LEs to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Medi-Cal services for JI populations will launch starting October 1, 2024 based on county.

2. Technical Assistance (TA) Marketplace Initiative – PATH funding is available for the provision of TA for qualified applicants that intend to provide ECM and/or Community Supports.

3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH Third-Party Administrator (TPA) to establish collaborative planning and implementation efforts that support the CalAIM launch.

4. Capacity and Infrastructure Transition, Expansion and Development (CITED)

Initiative – PATH funding will enable transition, expansion, and development of ECM and Community Supports capacity and infrastructure.

The anticipated implementation timelines for the PATH Initiatives are as follows:

Figure 17: PATH Implementation Timelines

PATH Initiatives	2022				2023				2024				2025				2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
WPC Services and Transition																				
TA Initiative																				
Collaborative Planning and Implementation																				
CITED																				
JI Planning and Capacity Building																				

Performance Metrics

In DY 21-Q1, TA Marketplace recipients and vendors submitted progress reports for the period of DY 20-Q3. During this reporting period, 43 TA Vendors responded across 451 TA Projects and 198 TA Recipients responded across 417 TA Projects. Of the 451 TA Projects, 339 had successfully achieved milestones on time. A majority of the projects were identified as completed or on track for completion, with 31 projects facing challenges. The PATH Collaborative Planning and Implementation (CPI) collaboratives have supported DHCS' Action Plan for driving improvements for ECM and Community Support implementation. They have organized deliberate collaboration at the local level working with Medi-Cal Managed Care Plans (MCPs), provider partners, counties and stakeholders to support focused areas of actions identified in the plan, including: In 1) Standardizing eligibility, 2) Streamlining and standardizing referral and authorization processes, 3) Expanding provider networks and improving payment processes, 4) Strengthening market awareness, 5) Improving data exchange. Ultimately the Action Plan outlines activities to increase the availability and uptake of ECM and Community Supports for Medi-Cal members who need

these services. In DY 21-Q1, the TPA and CPI facilitators submitted the Q4 Progress Report. During this quarter, CPI Facilitators continued convenings, office hours and workgroups to bring MCPs, providers, stakeholders together to discuss, address and resolve topical implementation issues in CalAIM implementation of ECM and Community Supports with intentional attention given to the DHCS Action Plan. TCPI Facilitators are able to work with implementors and stakeholders to smooth implementation challenges and provide DHCS with valuable insights into areas for potential policy and operational improvements. The CPI Facilitators were assigned to collaborate with the collaboratives in developing a 2025 project plan, which they were required to submit as part of their quarterly deliverables. Each facilitator provided a detailed overview of the major activities associated with each respective focused area, along with corresponding sub-activities that outlined the specific tasks required to accomplish each major activity. CPI collaborative participation has continued to show stability with notable growth patterns across several regions this quarter.

Facilitators are actively implementing innovative approaches to maintain engagement. For example, one collaborative reports particularly strong engagement this quarter with a new high of 76 attendees in December (52 unique organizations), representing an increase in unique organization attendance from January 2024. Several collaboratives continue to see robust in-person participation, such as Indian Health collaborative showing steady increases (32 in-person in October, 82 virtual in November, 65 virtual in December). Between Q3 and Q4 of 2024, registration numbers have increased by approximately eight percent for individual participants and ten percent for organizational participants. While the increase in utilization may not be attributable solely to these collaborative efforts, it has been instrumental in accelerating implementation.

Throughout DY 21-Q1, the TPA and DHCS review project activities and milestones of active CITED awardees to assess whether CITED Round One and Round Two awardees are on track to complete their projects by the end of their award term. For example, if an awardee has not begun activities relevant to specific milestones tied to the progress report, the TPA and DHCS conduct outreach to understand their status for meeting their immediate milestones as well as project goals; and what barriers or challenges they face. If for any reason an awardee determines they will be unable to complete all components of their awarded project, they are required to submit an updated project and return unused funding. According to the Round One Quarter 8 progress reporting period, 80 awardees or 57 percent of awardees, have fully completed their projects. 37 awardees or 27 percent of awardees are on track to completing their projects; and 23 awardees or 16 percent of awardees have received targeted outreach as described above. According to the Round Two Quarter 4 progress reporting period, 14 awardees or ten percent of awardees, have fully completed their projects. 101 awardees or 70 percent are on track to completing their projects; and 29 awardees or 20 percent have received targeted outreach as described

above.

Operational Updates

WPC Services and Transition to Managed Care Mitigation Initiative

WPC Transition funding was available to support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM until January 1, 2023, or later. Funding was also available to support LEs to pay for existing WPC services to the JI population prior to release before those services are transitioned into managed care, which launched October 1, 2024, based on county.

There were seven LEs with services adopted in CalAIM earlier than originally anticipated in DY 18, and only one LE is currently providing pre-release services that has not fully transitioned to CalAIM. During DY 21-Q1, two payments were made to this currently active LE, and payments were made to two LEs that had maximized their original allocated budgets but had remaining eligible claims. One awardee submitted two PATH Utilization Reports to DHCS for activities from July 1, 2023, to December 31, 2023.

TA Marketplace

The PATH TA Marketplace initiative provides funding for providers, CBOs, counties, and others to obtain TA resources to establish the infrastructure needed to implement ECM and Community Supports. The TA Marketplace allows organizations to "shop" for TA support by vendors ("TA Vendors") vetted and approved to participate in the TA Marketplace.

Organizations interested in receiving TA ("TA Recipients") must complete an initial Recipient Eligibility Application. This application is standardized and allows entities to establish an online account for each applicant organization. Once approved, entities can shop the website for TA resources, select a Vendor, and apply for a Project. Applying for a TA Project requires the applicant to fill out the standardized TA Project Eligibility Application on the TA Marketplace website. The TPA and DHCS will then review the submitted applications. Once approved, entities will be able to contract with the selected TA Vendor to develop a Scope of Work that describes the requested project along with corresponding budget, deliverables, and milestones.

The TA Marketplace website went live in January 2023. Recipient registration and project applications windows have remained open throughout the duration of the TA Marketplace and applications are reviewed on a rolling basis.

As of March 31, 2025, 671 entities have registered and have been approved by the TPA to actively pursue projects through the TA Marketplace. As of March 31, 2025, 1,716

projects have been approved or fully executed, with 473 approved in DY 21-Q1.

As of DY 21-Q1, there are 526 approved off-the-shelf projects, and 116 vendors approved to provide hands-on TA projects.

Currently, there are 116 approved vendors from four rounds of vendor procurement. In DY 21-Q1, during the fifth round of vendor procurement, there were new vendors added to the TA Marketplace and existing TA Vendors that expanded their offerings available through the Marketplace. The Vendors area of focus included:

- Rural Areas Justice Involved Tribal
- Maternal and Child Serving
- Short-Term Rental Assistance (Transitional Rent) Provider

TA Vendors are able to offer support across the seven TA domains as listed below.

- Domain 1: Building Data Capacity: Data Collection, Management, Sharing, and Use
- Domain 2: Community Supports: Strengthening Services that Address the Social Drivers of Health
- Domain 3: Engaging in CalAIM through Medi-Cal Managed Care
- Domain 4: ECM: Strengthening Care for ECM "Population of Focus"
- Domain 5: Promoting Health Equity
- Domain 6: Supporting Cross-Sector Partnerships
- Domain 7: Workforce

Each domain must also incorporate a focus on rural communities to support technical assistance and capacity building in rural and frontier areas, which are typically underserved or have limited provider capacity.

Collaborative Planning and Implementation (CPI) Initiative

CPI provides funding and support for planning efforts to drive implementation of ECM and Community Supports, including identifying needs and gaps, surfacing solutions, and sharing best practices across regions. There are 26 regional collaborative groups throughout California, which are led by nine facilitators selected by DHCS and administered by the PATH TPA. The collaborative groups were established based on regional location, size, and with consideration to preserving existing collaboratives. The

TPA and facilitators continue to meet monthly to review updates, provide outreach, discuss deliverables, address gaps in services, share ideas, and discuss challenges and successes. Facilitators hold roundtables with their collaborative groups monthly. From August 2022 through March 2025, the TPA registered a total of 2,425 organizations to participate with CPI. CPI participant registrations are accepted on a continual basis and participants are connected with selected facilitators.

In DY 21-Q1, DHCS and the TPA collected and reviewed 182 Q4 Facilitator deliverables bringing the total deliverables collected to 364. A DY 20-Q4 lookback analysis indicated the TPA collected and reviewed 182 Q4 deliverables, conducted 30 one-on-one coaching sessions with facilitators, and held 78 collaborative convenings across the state, plus 78 collaborative office hours bringing the total collaborative convenings and office hours across the state to 156.

For DY 21-Q1 DHCS and the TPA hosted three CPI Monthly Facilitator Support Meetings on January 14, February 11, and March 11, 2025, for all PATH CPI Facilitators to discuss implementation challenges, solutions and best practices learned. CPI Facilitator Support meetings covered topics, such as operationalizing measurement strategies for CPI, identification of core measures to standardize across CPI, performance measurement tools, best practices, and discussions on CalAIM awareness strategies, sustainability for ECM and Community Supports, Indian health providers engagement, data measurement, and strategies for supporting workforce resiliency. CPI Facilitators have developed job aids, resource guides, provider rosters, and convened workgroups to identify training and capacity development needs of participating organizations.

CPI Facilitators continue to meet with stakeholders monthly and quarterly to request feedback from providers during PATH CPI meetings and surveys. The collaboratives have highlighted the Children & Youth population through several methods including provider spotlights, connecting children and youth community providers, and hosting Child and Youth – focused workgroups/task forces. Facilitators are working diligently to connect with regional hospitals in their collaborative. Some collaboratives are working on mapping tools to identify sustainability strategies, common referral partners (to/from), micro-geographies, network validation by the type of service, and Population of Focus identity service goals. Visualization products map who providers refer to and where they receive referrals from, helping stakeholders understand who provides ECM or Community Supports in a specific area of the county.

CITED Initiative

The CITED initiative provides funding to enable the transition, expansion, and development of ECM and Community Supports capacity and infrastructure. Applicants

are encouraged to coordinate applications with local MCPs that they contract with or intend to contract with to provide ECM/Community Supports services. Applicants who wish to receive CITED funding must submit an application and funding request to DHCS' TPA describing how they intend to use CITED funding. The DHCS-contracted PATH TPA will support the administration and management of the CITED initiative.

On January 6, 2025, DHCS launched the CITED Round 4 application. CITED Round 4 funding priorities include county-specific ECM and Community Supports gaps, statewide ECM and Community Supports gaps, including Birth Equity, Justice-Involved, and Short-Term Rental Assistance (Transitional Rent), tribal entities and entities serving tribal members, rural counties, entities operating in counties with lower funding in prior CITED rounds, entities serving individuals whose primary language is not English, and local CBOs. Awardees that receive CITED funding must be actively contracted with the Medi-Cal MCP to provide ECM/Community Supports or have a signed attestation from the MCP that they intend to contract with to provide ECM/Community Supports in a timely manner. MCPs are not eligible to receive CITED funding.

Through CITED-IGT, a total of $85 million in total computable unencumbered funds ($42.5 million from federal funding and $42.5 million non-federal share contributed by IGT eligible entities) are available. During DY 21-Q1, DHCS began review of the first Round Two IGT Progress Reports requesting payment for completed milestones, will complete review in DY 21-Q2, and begin processing IGT Payments.

JI Capacity Building Program

The application period for PATH JI Round Two closed on March 31, 2023, with $151 million allocated for the round. A total of 42 applications were received with an initial total funding request of $62.6 million. The PATH JI Round Two award notifications were released on a rolling basis. As of the end of DY 20-Q3, $65.1 million was approved and awarded. The Interim Progress Report from PATH JI Round Two awardees were due on March 1, 2024. The first Executive Progress Report from PATH JI Round Two awardees were due January 10, 2025. DHCS continued review of the Progress Reports in DY 21-Q1.

The application period for PATH JI Round Three is still open. DHCS and the TPA completed review of all applications received to date and are pending final items for approval. DHCS is now working with stakeholders to develop implementation plans for the Round Three funding. As of the end of DY 21-13, DHCS and the TPA have reviewed a total of 173 applications for Round Three and have approved applications for 148 agencies, for a total of $424 million in awarded funds. DHCS and the TPA will make

office hours available to these entities in 2025 to provide another avenue to obtain direct TA assistance.

DHCS released the Policy and Operational Guide for planning and implementing the CalAIM JI Reentry Initiative for stakeholder comment in DY 19-Q2. DHCS is reviewing additional comments and feedback on the new draft guidance.

TPA Support Activity

Public Consulting Group, LLC serves as the TPA to administer, market, facilitate, develop support tools, and implement the following PATH initiatives:

- TA Marketplace
- CPI
- CITED
- JI Planning and Capacity Building- Reentry Demonstration Initiative Planning and Implementation Program

The TPA has been actively working with DHCS as the TPA to ensure the various PATH initiatives are implemented in a timely manner. The TPA has provided communication to stakeholders about funding opportunities, and organized informational webinars relating to application processes, timelines, and deliverables. The TPA has kept track of applications and held weekly meetings with DHCS on status updates for each of the initiatives, sent documents out for reviews, addressed questions from stakeholders and organizations, and updated stakeholders on products the TPA has been developing.

Stakeholder Engagement

As part of the Outreach and Engagement workstream efforts conducted by the TPA, the following activities were conducted:

- The TPA published and distributed three monthly CalAIM PATH Newsletters in DY 21-Q1. The newsletters are provided to all TA vendors and recipients, CITED awardees, CPI facilitators and participants, PATH JI participants, and other subscribed stakeholders to provide a snapshot on activities and opportunities to engage through PATH. Each edition announces news, upcoming events, funding opportunities, new resources, and more, ensuring all PATH stakeholders are well-informed and up-to-date. The TPA released a quarterly MCP Toolkit to support MCPs with sharing PATH engagement opportunities with their networks.

- In DY 21-Q1, 12 email blasts were sent out through DHCS' Office of Communications to DHCS' extensive stakeholder Listserv to communicate key opportunities to engage in PATH.

JI Initiative

- DHCS and the California Department of Corrections and Rehabilitation (CDCR) meet on a monthly basis to discuss the pre-release application process, policy and technical issues, and progress towards implementation of mandatory pre-release.
- The Medi-Cal Eligibility Incarceration Workgroup, formerly named JI Pre-Release Application Sub-Workgroup meets bi-monthly as of January 2025 but previously met bi-monthly beginning in January 2024. DHCS uses this forum to provide additional guidance and technical assistance to implementation partners to support the ongoing efforts regarding the broader pre-release Medi-Cal enrollment and suspension processes mandate. The sub-workgroup participants include county agencies, county correctional agencies, advocates, and stakeholders.
- The Inmate Workgroup meets monthly and consists of county sheriffs from all 58 counties, representatives from the California Statewide Automated Welfare System, California Work Opportunity and Responsibility to Kids Information Network (CalWIN[3]), and the Chief Probation Officers of California.
- The Data Sharing Workgroup meets with county social services departments throughout the state and all Medi-Cal providers to gain knowledge on issues relating to data-sharing among agencies. The feedback from these agencies is assisting in the drafting of a new data-sharing agreement in compliance and alignment with the HIPAA rules and regulations.
- DHCS and the TPA conducted review of PATH JI Round Three implementation plans during months of May and June, 2024. Office hours will be available in 2025 to begin discussion of PATH JI Round Three progress reports and provide an avenue for TA.

[3] CalWIN is an online system that administers public assistance programs which include but are not limited to Medi-Cal, employment services, childcare, in-home support services, general assistance, foster care, and food stamps.

- In DY 21-Q2, DHCS will release the updated Policy and Operational Guide for Planning and Implementing the CalAIM JI Initiative Guide, which includes DHCS policy updates to Pharmacy and Readiness Assessment requirements for correctional facilities.

CITED Initiative

- During DY 21-Q1, the TPA and DHCS hosted nine virtual progress report office hours for CITED Round One, CITED Round 2, CITED-IGT Round 2, and CITED Round 3 award recipients, both prior to and during their quarterly progress reporting period. The structure of these office hours consisted of providing a brief formal presentation about the resources that are available to CITED awardees, including where to find important announcements, reference materials, and guidance documents for progress reports. In addition, the presentation includes guidance to address commonly asked questions. The office hours address questions that are raised by individual awardees regarding their specific circumstances and provide an opportunity to provide real-time TA.
- During DY 21-Q1, the TPA hosted seven office hours sessions to assist and guide prospective applicants with the CITED Round 4 application process. These sessions included open time for applicants to ask questions as well as provided collaboration opportunities with CPI, TA Marketplace, and JI initiatives. DHCS and the TPA are actively working on identifying opportunities for engagement of historically marginalized populations. DHCS and the TPA continue to implement the outreach and engagement plan geared toward optimizing engagement efforts to tribal entities.
- On January 7, 2025, DHCS and the TPA hosted a CITED Round 4 informational session. This session provided applicants with information about the CITED funding, how to apply for CITED Round 4 funds, and answered frequently asked questions.
- On January 16, 2025, DHCS and the TPA hosted the "CITED How to Improve Your Grant Application" Webinar Part 1. This session provided additional support for applicants by sharing tips for writing a strong grant application, explaining the scoring approach, and clarifying the funding goals for CITED Round 4.
- On January 27, 2025, DHCS and the TPA hosted a CITED Round 4 Transitional Rent informational webinar. This session offered applicants information regarding the eligibility criteria for the new fifteenth Community Support under CalAIM,

Transitional Rent, CITED funding eligibility, and the CITED Round 4 application process and considerations.

- On February 3, 2025, DHCS and the TPA hosted the "CITED How to Improve Your Grant Application" Webinar Part 2. This session offered further guidance to applicants by clarifying DHCS guidelines and strategies for creating a budget.

TA Marketplace

- On March 19, 2025, DHCS and the TPA hosted a quarterly TA Recipient Webinar. During this webinar, updates were provided for the Short-Term Rental Assistance (Transitional Rent) policy, a refresh of TA Marketplace process, how to submit a strong Project and Eligibility Application, and TA Marketplace Recipient policies and guidance updates. The TA Recipient Webinars are open to all currently approved TA recipients and eligible organizations interested in applying to receive TA services.

CPI Initiative

- The TPA launched a monthly Facilitator Newsletter that is sent to all nine facilitators on a weekly basis. It is a vehicle for information sharing and includes information on upcoming webinars, meetings, notice of comment periods, updated resources, TPA requests, reminders, policy updates, cross-PATH initiative updates, and other relevant information.
- DHCS and the TPA host monthly facilitator support meetings to discuss implementation challenges, potential solutions, and facilitate communication and collaboration between DHCS, the TPA and the facilitators. In DY 21-Q1, these meetings were held on January 14, February 11, and March 11, 2025.
- On December 6, 2024, DHCS and the TPA hosted the fourth Best Practices Webinar titled “Hospital Engagement in CalAIM: Supporting Connection to ECM Services Among Eligible Medi-Cal Members.” The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing ECM and Community Supports, increase providers’ successful participation in CalAIM, and improve collaboration between MCPs, state and local government agencies, and others to build and deliver quality support services to Medi-Cal members. The objective of this webinar was to state the value of hospitals engaging with CalAIM providers in their region, recognize opportunities for improved collaboration on discharge planning between hospital staff and ECM or Community Supports

providers, identify opportunities to deliver short-term rental assistance, and identify opportunities for warm handoffs and other coordination strategies between hospital staff and ECM providers to improve eligible member connection to ECM and Community Supports services. Over 1,588 individuals registered to attend this webinar, of which 875 Attendees, 46 percent of attendees were ECM Providers, and 28 percent were Community Supports Providers.

- DHCS and TPA work with CPI facilitators to address stakeholder inquiries and concerns on the implementation of ECM, Community Supports, and the JI initiatives. TPA continues to track lessons learned raised in collaborative workgroups related to community referrals, CalAIM education, contracting barriers, and duplication of services for welfare-involved youth. CPI collaborative workgroups also offer ideal opportunities for providers in the county to network, discuss best practices, and elevate more complex concerns that may be brought to a more diverse gathering, such as a monthly collaborative meeting.

Quality Control/Assurance Activity

The TPA conducts ongoing cross-initiative collaboration to ensure there is no duplication or inappropriate use of funds. For example, upon review of CITED applications there is a review step to track whether the applicant has applied or received funds from CITED prior. Moreover, there is a check on whether the applicant has applied for the TA Marketplace. In some instances, an applicant's request may be better suited for the TA Marketplace. Such applicants are referred to apply to the TA Marketplace. Additionally, when reviewing TA Marketplace project applications, there is a review to ensure no aspects of the project are funded through CITED. Applicants awarded for CITED are also directed to view the TA Marketplace to explore any additional resources that can support with activities approved through CITED and are encouraged to join local CPI collaboratives to build relationships with other local providers to support the referral network.

Budget Neutrality and Financial Updates

For the WPC Mitigation Initiative, services are claimed through invoicing biannually. Out of the ten Lead Entities (LEs) involved, three are still eligible to submit claims through this initiative. During DY 21-Q1, payments of approximately $29.5 million were made for three entities for the period covering January through June 2023. For the period July through December, a payment was made to one LE for $11.38M. For the CPI Initiative in DY 20, there are nine facilitators, and one policy improvement coordinator contracted to oversee 26 collaborative planning groups. Some facilitators oversee multiple collaboratives across different counties/regions. During this quarter, payments for

meeting milestones were made to facilitators for approximately $3.1 million.

The CITED Initiative awarded funds are only disbursed for completed milestones. Awarded applicants are required to submit quarterly progress reports detailing movement toward goals, purchases made, challenges encountered, and milestones accomplished. During DY 21-Q1 DHCS reviewed and approved CITED Progress Reports for Round 1A/1B, Round Two, and Round three approved applicants. As of March 31, 2025, about $153 million has been paid to Round One entities, approximately $69 million has been paid to Round Two entities, and approximately $16.3 million has been paid to Round Three awarded entities.

During DY 21-Q1, payments totaling $12.7 million were made to vendors for completion of milestones for approved TA projects via the TA Marketplace Initiative.

PATH JI Capacity Building efforts have awarded over $4.5 million across 39 counties, including CDCR, to support initial planning efforts in Round One of the initiative. In DY 21-Q1, approximately $213 thousand in funds were approved for payments to Round Two approved applicants and over $17 million was approved for payments to Round Three approved applicants for completion of milestones. DHCS is also still reviewing remaining applications for JI Round Three and ongoing awards are expected to be announced in DY 21-Q1.

Amounts provided in the table below have been updated including those for previous quarters to reflect corrected amounts. In previous submissions, some amounts were payment amounts completed in the quarter and not award amounts as intended. The CITED, TA Marketplace, and JI amounts reflect awards per quarter. For WPC Mitigation and Collaborative Planning, the amounts reflect payments made in each quarter.

Figure 18: PATH Initiative Amounts

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
DY 18-Q1				
n/a	$0	$0	$0	$0
DY 18-Q2				
n/a	$0	$0	$0	$0
DY 18-Q3				
JI	$775,000	$387,500	$387,500	$0
DY 18-Q4				
JI	$3,775,952.95	$1,887,976.50	$1,887,976.48	$0
WPC Mitigation	$16,314,792.73	$8,157,321.37	$0	$8,157,321.37
Collaborative Planning	$1,450,000	$725,000	$725,000	$0
CITED	$0	$0	$0	$0
DY 19-Q1				
JI	$0	$0	$0	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$207,433,952.46	$103,716,976.23	$103,716,976.23	$0
DY 19-Q2				
JI	$25,900,805.59	$12,950,402.80	$12,950,402.80	$0

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
WPC Mitigation	$19,778,113.42	$9,889,056.71	$0	$9,889,056.71
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$0	$0	$0	$0
DY 19-Q3				
JI	$328,020,299.18	$164,010,149.59	$164,010,149.59	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$1,745,065.40	$872,532.70	$872,532.70	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$0	$0	$0	$0
DY 19-Q4				
JI	$41,126,412.94	$20,563,206.47	$20,563,206.47	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$5,653,846.60	$2,826,923.30	$2,826,923.30	$0
Collaborative Planning	$3,142,538,47	$1,571,269.24	$1,571,269.24	$0
CITED	$182,860,223.91	$91,430,111.96	$72,216,916.50	$19,213,195.46
DY 20-Q1				
JI	$4,021,594.00	$2,010,797.00	$2,010,797.00	$0

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$7,075,947.69	$3,537,973.85	$3,537,973.85	$0
Collaborative Planning	$3,677,251.93	$1,838,625,96	$1,838,625,96	$0
CITED	$0	$0	$0	$0
DY 20-Q2				
JI	$8,500,000.00	$4,250,000.00	$4,250,000.00	$0
WPC Mitigation	$17,573,156.09	$9,670,545.04	$0	$7,902,611.05
TA Marketplace	$18,398,041.01	$9,199,020.51	$9,199,020.51	$0
Collaborative Planning	$2,043,307.21	$1,021,653.8	$1,021,653.8	$0
CITED	$0	$0	$0	$0
DY 20-Q3				
JI	$7,803,310.00	$ 3,901,655.00	$3,901,655.00	$0
WPC Mitigation	$15,698,223.77	$8,822,401.76	$0	$6,875,822.01
TA Marketplace	$25,808,098.59	$12,904,049.30	$12,904,049.30	$0
Collaborative Planning	$6,188,538.46	$3,094,269.23	$3,094,269.23	$0
CITED	$171,553,745.85	$73,288,086.84	$85,776,872.93	$12,488,786.09

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
DY 20-Q4				
JI	$30,332,976.00	$15,166,488.00	$15,166,488.00	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$28,222,224.53	$14,111,112.27	$14,111,112.27	$0
Collaborative Planning	$0	$0	$0	$0
CITED	$0	$0	$0	$0
DY 21-Q1				
JI	$4,611,823.00	$ 2,305,911.50	$2,305,911.50	$0
WPC Mitigation	$40,927,028.75	$22,368,062.40	$0	$18,558,966.63
TA Marketplace	$54,602,299.23	$27,301,084.18	$27,301,084.18	$0
Collaborative Planning	$3,136,299.23	$1,568,149.62	$1,568,149.62	$0
CITED	$0	$0	$0	$0

Figure 19: Total Approved Payments by PATH Initiative, DY 21-Q1

PATH Initiative	Total Payment
JI	$17,561,270.26
WPC Mitigation	$40,927,028.75
TA Marketplace	$17,379,590.69
Collaborative Planning	$3,136,299.23
CITED	$46,889,279.94
TPA	
Public Consulting Group LLC	$3,700,341.90
TOTAL	**$129,593,810.77**

Evaluation Activities and Interim Findings

CMS requires DHCS to contract with an independent program evaluator to assess initiatives authorized under the CalAIM Section 1115 waiver, as stipulated in the STCs accompanying the waiver. On February 7, 2024, DHCS submitted evaluation designs to CMS for the four CalAIM initiatives: the PATH Initiative, GPP, Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process (Duals), and the Reentry Demonstration Initiative (REENTRY). On June 5, 2024, CMS provided a revised evaluation design with comments and questions for DHCS to consider. In response, DHCS finalized and approved the CalAIM 1115 PATH, GPP, Duals, and Reentry evaluation designs, addressing CMS feedback in the CMS Response Memo. The revised evaluation design was submitted to CMS on February 28, 2025. During the first quarter of 2025, the UCLA-RAND evaluation team made significant progress in data acquisition, collection, and preliminary analysis for the interim report.

COMMUNITY SUPPORTS: SHORT-TERM RECUPERATIVE CARE AND SHORT-TERM POST-TRANSITION HOUSING

California's Section 1115 waiver renewal authorizes expenditures for two pre-approved "In Lieu of Services" – short-term recuperative care and short-term post-transition housing – and as approved in December 2024 under the BH-CONNECT waiver authority, short-term rental assistance. These optional services, integrated into Medi-Cal managed care contracts with the DHCS, enable MCPs to provide cost-effective alternatives to services or settings covered under the Medicaid State Plan. Community Supports are designed to address members' HRSN, including physical, behavioral, developmental, long-term care (LTC), oral health, and social drivers of health more effectively and efficiently, with the aim of improving health outcomes, enhancing member independence, and reducing avoidable health care costs. While MCPs may elect to offer these services, participation remains optional for both plans and members. As discussed in the prior section, the state is prioritizing providers seeking to deliver short-term rental assistance as a new Community Support through the PATH initiative to expand access to this service. MCPs are prohibited from mandating Community Supports in place of State Plan services, ensuring member choice is preserved.

Pursuant to 42 Code of Federal Regulations (CFR) 438.3 and requirements in the MCP contract, MCPs must obtain DHCS approval before implementing Community Supports. This approval process requires MCPs to demonstrate compliance with federal and state regulatory requirements, including cost-effectiveness and service delivery standards. Once approved, the Community Support is incorporated into the MCP's contract and DHCS lists it on the ECM & Community Supports website as a state-approved offering specific to that MCP. MCPs are then obligated to arrange and deliver these services to members in a timely manner, consistent with contract terms. Members are informed of available Community Supports through the Member Handbook, and MCPs must include network providers who are Community Support providers in the Provider Directory.

As of this reporting period, the adoption and impact of Community Supports continue to evolve, reflecting MCPs' strategic priorities, regional needs, and operational capacities – insights that will be further detailed with updated utilization data in subsequent sections.

The full list of Community Supports includes:

1. **Housing Transition Navigation Services** - Assistance and support for individuals in transitioning from homelessness to stable housing
2. **Housing Deposits** - Financial assistance for housing deposits to help individuals secure stable housing

3. **Housing Tenancy & Sustaining Services** - Services aimed at helping individuals maintain their housing stability, such as ongoing support for rent and tenancy-related needs
4. **Short-Term Post-Transition Housing** - Provision of temporary housing for individuals who require it after a hospitalization
5. **Short-Term Recuperative Care (Medical Respite)** - Care services for individuals who need a safe and stable place to recover after a medical procedure or illness
6. **Respite Services (for caregivers)** - Temporary relief and support for caregivers of individuals with disabilities or special needs
7. **Day Habilitation Programs** - Programs that provide structured activities and support for individuals with disabilities during the day
8. **Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly** - Support for transitioning individuals from nursing facilities to assisted living facilities like Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities
9. **Community Transition Services/Nursing Facility Transition to a Home** - Assistance for individuals transitioning from nursing facilities to community-based living arrangements
10. **Personal Care and Homemaker Services** - Assistance with personal care and homemaking tasks for individuals who need support to remain independent in their homes
11. **Environmental Accessibility Adaptations** - Modifications to homes to make them accessible and safe for individuals with disabilities
12. **Medically Tailored Meals** /Medically Supportive Foods- Provision of specialized meals or food for individuals with specific medical conditions
13. **Sobering Centers** - Facilities that provide a safe environment for individuals under the influence of alcohol or substances to sober up and receive support
14. **Asthma Remediation** - Services and support aimed at addressing environmental factors that contribute to asthma
15. **Short-Term Rental Assistance (Transitional Rent)** – Financial assistance to cover short-term rent payments for individuals transitioning to stable housing, supporting housing retention during critical periods.

These services prioritize high-need Medi-Cal members – particularly those at risk of hospitalization and/or institutionalization – by bridging gaps in social drivers of health, such as housing stability, which strongly correlates with healthcare utilization. For instance, individuals experiencing homelessness exhibit elevated rates of chronic conditions like diabetes, hypertension, and HIV, leading to more frequent hospital admissions, readmissions, and extended stays compared to the general population.

Under 42 CFR 438.3(e)(2), MCPs may provide these state-approved Community Supports, with the Section 1115 demonstration granting specific expenditure authority for Short-Term Post-Transition Housing and Recuperative Care. These two services are integral to California's care continuum, offering medically appropriate alternatives to hospitalization or institutionalization for members without stable housing, including those homeless or at risk. They provide safe settings for recovery and continuity of care, delivering essential medical and behavioral health support post-inpatient stay, reducing the need for prolonged institutional care.

Monitoring efforts track implementation through metrics such as MCP adoption rates, provider network development, and service utilization. The state collects performance metrics data related to the state's Short-Term Recuperative Care and Short-Term Post-Transition Housing services, to assess their role in addressing access barriers in historically under-resourced communities impacted by economic or social marginalization due to race, ethnicity, or other factors.

The independent evaluation, conducted by UCLA, examines whether these services reduce emergency department visits, hospital admissions/readmissions, and long-term placements, alongside a thorough cost-effectiveness analysis as required by the demonstration. Analyses are stratified, where feasible, by demographics (e.g., age, sex, race), region, and other variables to evaluate impacts on health inequities and member outcomes.

Future quarterly reports will provide progress updates on this evaluation, offering insights into how Short-Term Post-Transition Housing and Recuperative Care address HRSN while leveraging cost-effective settings. These findings will inform ongoing efforts to enhance access, improve health outcomes, and reduce disparities across California's Medi-Cal population.

Performance Metrics

To monitor ECM and Community Supports implementation, DHCS developed the Quarterly Implementation Monitoring Report (QIMR), requiring MCPs to submit data across multiple domains. For Community Supports specifically, MCPs report services requested, approved, utilized, and denied, alongside provider capacity metrics. This data enables DHCS to track the rollout of ECM and Community Supports, assess MCP performance, and inform the development of performance incentives. DHCS continues to oversee MCPs offerings and implementation, including adjustments related to the

2024 MCP transition in select counties,[4] Ensuring continuity and adaptation as the program evolves.

From July 2023 to January 2025, DHCS has observed a sustained increase in Community Supports elected by MCPs statewide. As of July 2024, an additional 81 services were elected across various plan-county combinations during that implementation phase, building on earlier growth. By January 2025 there was further expansion, with six services – Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Respite Services, Personal Care and Homemaker Services, and Medically Tailored Meals – available in all 58 counties, up from earlier partial coverage for some. Short-Term Post-Transition Housing and Recuperative Care are now available in 56 counties, while Day Habilitation Programs and Adaptations now reach members in 42 counties. The two Nursing Facility Transition services and Asthma Remediation are now available in 39 counties each, with Sobering Centers lagging slightly behind at 26 counties, reflecting slower uptake for that particular service in more rural parts of the State.

Figures 20 and 21 on the next page illustrate the proliferation of counties where at least one MCP offers all 14 Community Supports: 11 counties in July 2023, 19 in January 2024, and 24 in July 2024. This trend is continuing into DY 21 (CY 2025) with 25 counties now offering the full suite, driven by increased MCP elections and further network development in urban and suburban regions like Los Angeles and Sacramento. This growth aligns with utilization trends from 2023 to 2024, where unique members served across this period rose substantially, with high-demand services like Medically Tailored Meals and Housing Transition Navigation leading uptake. DHCS anticipates further stabilization in 2025 as MCPs refine provider capacity and continue to address 2024 transition impacts, particularly for services like Housing Tenancy and Sustaining Services, which saw temporary declines.

[4] See the list of 2024 Medi-Cal MCPs (https://www.dhcs.ca.gov/CalAIM/Pages/MCP-RFP.aspx).

Figure 20: Number of Community Supports, by County, Live as of July 2023 and January 2024

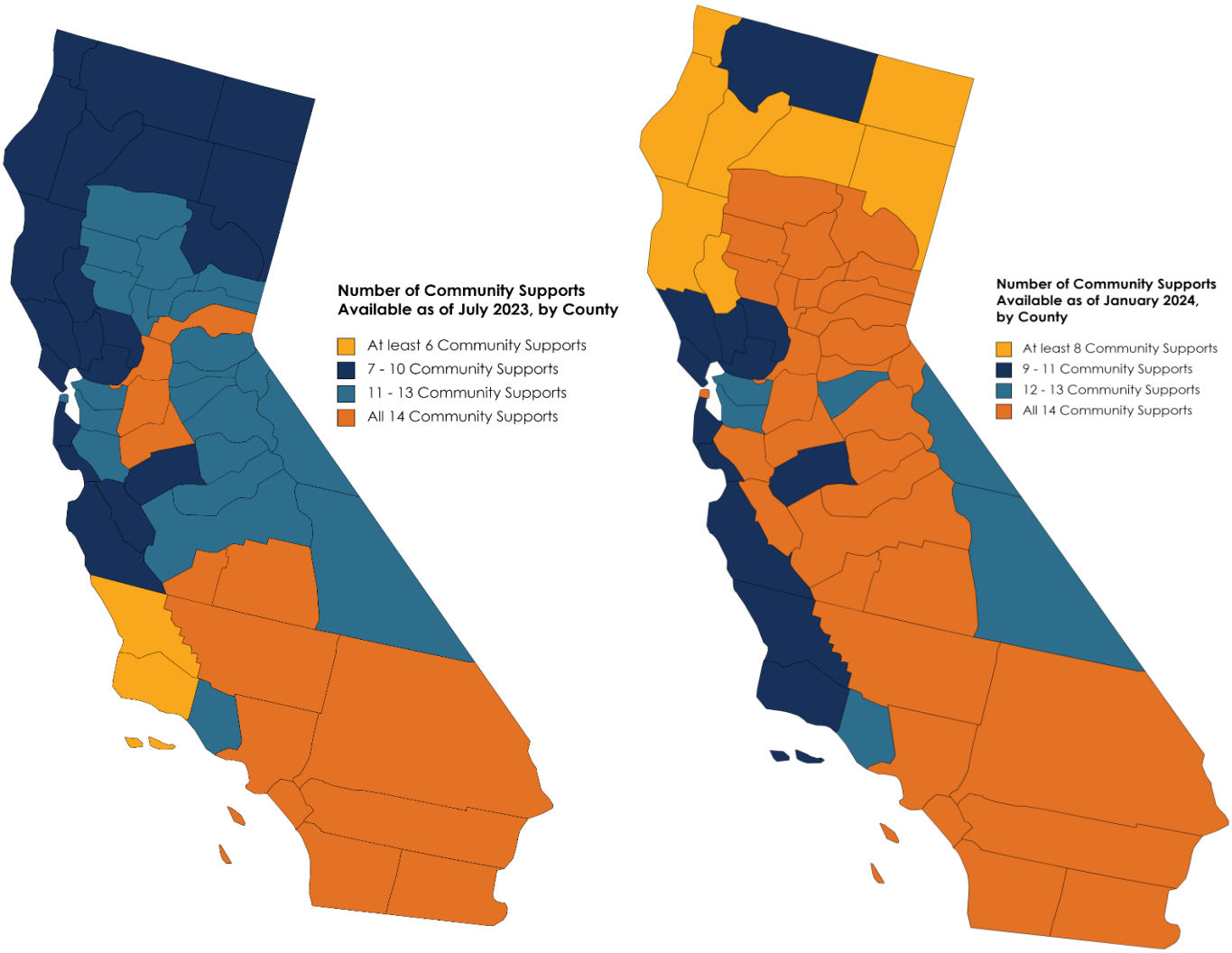

Figure 21: Number of Community Supports, by County, Live as of July 2024 and January 2025

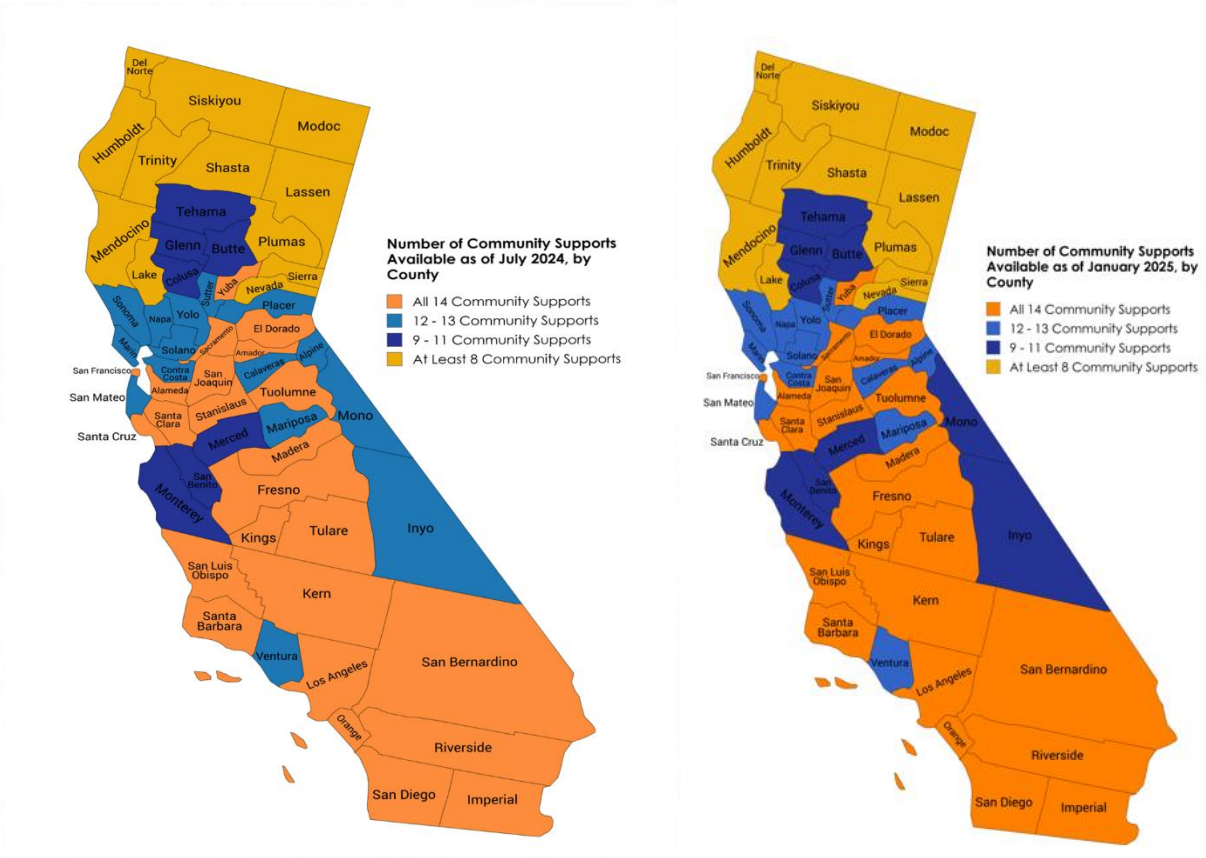

Figure 22 below displays currently available data as of January 2025, indicating the number of providers and counties where services are available throughout California for the following Community Supports:

Figure 22: Number of Providers and Counties Offering Community Supports, as of January 2025

Community Supports	Number of Providers	Number of Counties Offering the Community Support
Housing Transition Navigation Services	1,256	58
Housing Tenancy & Sustaining Services	860	58
Housing Deposits	868	58
Personal Care and Homemaker Services	493	58
Medically Tailored Meals	571	58
Respite Services	494	58
Short-Term Post-Transition Housing	225	56
Short-Term Recuperative Care (Medical Respite)	266	56
Day Habilitation Programs	106	43
Environmental Accessibility Adaptations	127	42
Nursing Facility Transition/Diversion to Assisted Living Facilities	93	39
Community Transition Services/Nursing Facility Transition to a Home	90	39
Asthma Remediation	122	39
Sobering Centers	50	26

Source: Quarterly Implementation Monitoring Report (QIMR) data submitted by Medi-Cal Managed Care Plans to DHCS for the Q4 2024 reporting period.

At least one plan in all 58 California counties has elected to offer 6 of the 14 preapproved Community Supports services, representing a strong foundation of statewide availability. These universally adopted services include the trio of housing-related supports – Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services – along with Respite Services (for Caregivers), Medically Tailored Meals, and

Personal Care and Homemaker Services, reflecting a consistent priority on addressing housing stability and essential HRSN across all regions.

Short-Term Recuperative Care has seen significant expansion and is, as of January 1, 2025, available in 56 counties, with only Inyo and Mono lacking MCP elections for this service – a notable increase from earlier coverage levels. Similarly, Day Habilitation Programs have progressed, now accessible in 43 counties, up from the 30 counties reported at the beginning of last year, indicating steady growth in support for individuals with disabilities. Environmental Accessibility Adaptations stand at 42 counties, while the two Nursing Facility Transition services (to Assisted Living Facilities and to a Home) and Asthma Remediation are each offered in 39 counties, showing moderate but not yet statewide adoption. Sobering Centers trail with availability in 26 counties, primarily in urban areas with higher substance use needs.

Current data demonstrate that robust provider networks continue to develop and strengthen, particularly for the housing-related Community Supports, which maintain universal coverage across all 58 counties. The "Housing Trio" – Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services – reflects efforts to use the role of stable housing in addressing healthcare utilization. Short-Term Post-Hospitalization Housing, closely tied to this focus, now reaches members in 56 counties, reinforcing its role in the care continuum.

All 58 counties now have at least eight Community Supports active in various combinations, reflecting diverse MCP strategies tailored to regional needs. Within 24 counties, multiple MCPs have elected to offer all 14 preapproved services, a figure indicative of concentrated efforts in high-demand areas such as Los Angeles, San Diego, and Sacramento. This widespread adoption highlights ongoing progress in expanding access to Community Supports, though gaps in rural counties like Inyo and Mono for services like Short-Term Recuperative Care and Short-Term Post-Transition Housing suggest opportunities for further network development.

Utilization Data for Community Supports

Figure 23 below reflects current available data indicating the following number of unique individuals served across DY 21 (Q4 2023 – Q3 2024) for DHCS' available Community Supports.

Figure 23: Unique Individuals Served Across DY 19 Q4 – DY 20 Q3:

Community Support	2023 Q4	2024 Q1	2024 Q2	2024 Q3	Grand Total
Housing Transition/ Navigation Services	23,953	24,500	30,441	36,968	66,768
Housing Deposits	1,301	1,587	2,004	3,027	7,084
Housing Tenancy and Sustaining Services	17,087	11,217	14,872	9,093	26,405
Short-Term Post-Hospitalization Housing	521	749	944	1,570	2,507
Short-Term Recuperative Care	1,614	2,677	3,416	3,746	7,699
Respite Services	405	550	677	1,649	2,241
Nursing Facility (NF) Transition/Diversion to Assisted Living Facility	375	480	429	588	906
Community Transition Services/Nursing Facility Transition to a Home	172	183	241	256	365
Personal Care and Homemaker Services	1,288	2,005	2,683	3,969	6,096
Day Habilitation Programs	536	1,251	1,156	1,836	3,184
Environmental Accessibility Adaptations	665	431	583	873	1,520

Community Support	2023 Q4	2024 Q1	2024 Q2	2024 Q3	Grand Total
Medically Tailored Meals/ Medically Supportive Food	42,957	65,070	79,410	83,791	156,292
Sobering Centers	953	811	910	1,102	3,015
Asthma Remediation	758	567	459	609	2,317
Grand Total of Unique Members[5]	**22,988**	**33,629**	**54,835**	**61,759**	**95,143[6]**

Source: Quarterly Implementation Monitoring Report (QIMR) data submitted by Medi-Cal Managed Care Plans to DHCS for the Q4 2023 to Q3 2024 reporting periods.

As illustrated by the quarterly utilization data, the number of unique members accessing Community Supports has increased steadily from 22,988 in DY 19 Q4 to 61,759 in DY 20 Q3, reflecting significant expansion over the reporting period. This growth, culminating in 95,143 unique members served across all services by DY 20 Q3, for the previous year, underscores the rising demand and enhanced availability of these offerings. Notable increases include:

- Medically Tailored Meals/Medically-Supportive Food, which grew from 42,957 unique members in DY 19 Q4 to 83,791 in DY 20 Q3 – a 95 percent increase over the year.
- Personal and Homemaker Services, which rose from 1,288 in DY 19 Q4 to 3,969 in DY 20 Q3 – a 208 percent increase.

[5] Total unique members are the overall unique count of members across all Community Support services. Each member is counted once if multiple services are used. For example, most members who use on Housing Transition / Navigation Services will also use Housing Tenancy and Sustaining Community Support services. The Grand Total of unique members de-duplicates the totals so that each member is only counted once. Each Quarter's total is independent of the other.

[6] Grand total may not equal the sum of the individual totals due to some members receiving more than one (1) Community Support service.

- Environmental Accessibility Adaptations, which increased from 665 in DY 19 Q4 to 873 in DY 20 Q3 – a 31 percent rise.

Medically Tailored Meals/Medically-Supportive Food exhibited the most substantial growth in absolute numbers, with 156,292 unique members served across the period, reflecting its universal availability in all 58 counties. This 95 percent increase from DY 19 Q4 to DY 20 Q3 likely stems from heightened demand, greater member and provider awareness, and operational scaling, possibly amplified by seasonal needs in colder months. This expansion signals the service's success in meeting nutritional needs tied to chronic conditions, supporting CalAIM's goals of reducing healthcare costs and improving outcomes.

Rapid growth in Personal Care and Homemaker Services (208 percent) and Environmental Accessibility Adaptations (31 percent from DY 19 Q4, with earlier spikes) aligns with their broader adoption – 58 counties for Personal Care, 42 for Environmental Adaptations – and may tie to the ECM rollout for nursing facility transition populations since January 2023. These services bolster independence for high-need members, with increased utilization reflecting improved delivery and community awareness.

The Housing Trio – Housing Transition Navigation Services (58 counties), Housing Deposits (58 counties), and Housing Tenancy and Sustaining Services (58 counties) – showed varied trends. Housing Transition Navigation grew steadily from 23,953 in DY 19 Q4 to 36,968 in DY 20 Q3 (54 percent), and Housing Deposits surged from 1,301 to 3,027 (133 percent), indicating robust demand and network enhancement. However, Housing Tenancy and Sustaining Services declined from 17,087 in DY 19 Q4 to 9,093 in DY 20 Q3 (-47 percent), with a grand total of 26,405 unique members. This drop, most pronounced from DY 19 Q4 to DY 20 Q1 (11,217), generally aligns with the 2024 MCP Transition effective January 1, 2024, when exiting MCPs coordinated with new entrants to maintain service continuity. While members could retain authorizations, the decrease likely reflects transitions to alternative services or graduations, not systemic barriers. DHCS expects stabilization in future quarters and will investigate further to ensure uninterrupted access.

Short-Term Post-Transition Housing (56 counties) grew from 521 in DY 19 Q4 to 1,570 in DY 20 Q3 (201 percent), serving 2,507 unique members. This steady rise reflects increasing recognition among healthcare providers of its role in preventing readmissions by stabilizing housing post-discharge, particularly for those experiencing homelessness. Its integration with Short-Term Recuperative Care (56 counties, 1,614 to 3,746, 132 percent increase) and Housing Transition Navigation enhances the care continuum, addressing critical gaps for 7,699 unique Short-Term Recuperative Care users.

Recuperative Care's growth contrasts with Asthma Remediation (39 counties), which dipped from 758 in Q4 2023 to 609 in Q3 2024 (-20 percent), with a grand total of 2,317 unique members. The prior report noted a decline from 937 in Q2 2023 to 567 in Q1 2024; this trend persists, possibly due to lower awareness or access barriers, which DHCS is addressing. Sobering Centers (26 counties) grew modestly from 953 to 1,102 (16 percent), serving 3,015 unique members, with fluctuations suggesting variable demand.

Respite Services (58 counties) increased from 405 to 1,649 (307 percent), serving 2,241 unique members, likely due to enhanced caregiver awareness and universal availability. Day Habilitation Programs (42 counties) rose from 536 to 1,836 (243 percent), with 3,184 unique members, while Nursing Facility Transition services (39 counties each) showed steady gains: Diversion to Assisted Living from 375 to 588 (57 percent, 906 total) and Transition to a Home from 172 to 256 (49 percent, 365 total).

DHCS continues analyzing these trends to assess external influences (e.g., seasonal demand, MCP transitions) and policy impacts. High-growth areas like Medically Tailored Meals, Personal Care, and Short-Term Recuperative Care signal strong alignment with CalAIM objectives, while declines in Housing Tenancy and Asthma Remediation warrant further evaluation for potential policy adjustments. Ongoing monitoring will inform technical assistance and guidance to optimize service delivery and health equity across California's 58 counties.

Outreach Activities

DHCS is committed to maintaining open lines of communication, employing a continuous improvement strategy, and providing guidance on this unique and innovative set of services on a statewide basis. DHCS actively considers stakeholder input and continuously refines its approach to drive effective implementation. As part of this commitment, DHCS regularly updates and shares its Action Plan[7] with MCPs, Community Supports Providers, and stakeholders, offering visibility into planned activities designed to streamline implementation and enhance service delivery.

DHCS tracks stakeholder feedback and indicators in the marketplace, including comments received from providers and members of the public, to effectively gauge the scope and

[7] The ECM and Community Supports Action Plan is available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Action-Plan-Updates-Fall-2024.pdf

severity of challenges in implementing Community Supports. Beginning in 2022, DHCS initiated a comprehensive effort to establish reliable provider feedback loops, including a Statewide Listening Tour that fostered direct engagement with a diverse array of stakeholders. These forums have been instrumental in surfacing barriers to implementation, including operational complexities, data reporting challenges, and gaps in provider readiness, while also highlighting opportunities for innovation and shared problem-solving.

Throughout the year, DHCS has hosted numerous webinars and meetings to facilitate dialogue, share updates, and address emerging issues. Key activities include:

- **Bi-Monthly CalAIM Implementation Advisory Group**
  This advisory group is composed of select MCPs, counties, and other stakeholders engaged in ECM and Community Supports. It plays a pivotal role in ensuring DHCS maintains real-time visibility into the rollout of newly launched benefits. The group provides:
  - Critical input to address implementation challenges and inform DHCS decision-making;
  - Detailed review of policy decisions, draft documents, and communications prior to broader dissemination;
  - Recommendations for the development of infrastructure investments supported by performance incentives and PATH funding opportunities;
  - Guidance on technical assistance needs in the marketplace to support providers and MCPs.

  Topics of discussion include:
  - Implementation Experience: Feedback from MCPs and providers on the rollout of ECM and Community Supports, highlighting successes and areas for improvement.
  - Member Experience: Insights into how members are accessing and benefiting from ECM and Community Supports services.
  - Provider Contracting: Updates on the progress of contracting between MCPs and providers to expand service delivery networks.
  - Referrals and Authorizations: Challenges and opportunities in facilitating timely and appropriate referrals and authorizations for members eligible for Community Supports.
- **Monthly MCP Technical Assistance and Guidance Webinars:**
  These webinars are designed specifically for health plan executives and personnel

responsible for the implementation of Community Supports. They provide a vital forum for addressing operational challenges, delivering policy updates, and reinforcing best practices. Key highlights of these sessions include:

- Detailed guidance and clarifications on DHCS policies to ensure MCPs have a clear understanding of their responsibilities, as well as the standards for implementing Community Supports.
- Presentations from subject matter experts on practical implementation strategies, addressing topics such as referral workflows, data reporting requirements, and member engagement, providing DHCS with valuable operational insights.
- Spotlights on MCPs and providers who share their experiences, challenges, and successes, enabling attendees to learn from one another and adopt proven effective practices.
- An open forum where MCP representatives can ask questions directly to DHCS staff, which helps foster transparency and real-time problem-solving.

These webinars have proven instrumental in equipping MCPs with the tools and knowledge needed to navigate the complexities of Community Supports implementation while aligning with DHCS program objectives.

» **Weekly meetings with the Local Health Plans of California (LHPC) and the California Association of Health Plans (CAHP):**
Weekly meetings with LHPC and CAHP serve as an essential touchpoint for ongoing engagement and updates regarding the implementation of ECM and Community Supports. These sessions help ensure consistent communication and collaboration between DHCS and the associations representing MCPs statewide. Key aspects of these meetings include:

- Regular reporting on the progress of ECM and Community Supports implementation, including status updates on contracting, access, member engagement, and provider onboarding.
- A platform for LHPC and CAHP to relay feedback from their member plans, helping DHCS identify and address systemic issues promptly.
- Collaborative discussions on emerging policy needs and considerations, ensuring that updates and refinements reflect real-world implementation challenges.
- Opportunities to align efforts across health plans, DHCS, and community

providers, which help foster a unified approach to delivering these innovative services.

These opportunities have been crucial, allowing DHCS to remain agile in addressing implementation challenges while advancing the broader goals of the CalAIM initiative.

Throughout the year, DHCS engaged with several MCPs to address and reconcile discrepancies identified in their authorization policies for newly implemented Community Supports services. These discussions helped in reducing policy variations across plans and counties, helping DHCS ensure greater consistency in service delivery and access for beneficiaries.

Other key activities and events over the course of Q1 2025 (DY 21) include the following:

On January 23, 2025, DHCS convened its monthly CalAIM MCP Technical Assistance call for January 2025. The agenda featured a briefing on the CalAIM Academy for Hospitals and Health Systems, an overview of Closed-Loop Referral Implementation Guidance requirements, a brief terminology update to ECM Referral and Authorization Policy, and JavaScript Object Notation (JSON) Exchange updates for ECM, Community Supports, and Complex Care Management (CCM). Additional topics included a Community Supports Quarterly Monitoring Process update, progress on Community Supports service definition refinements, an announcement of the BH-CONNECT Section 1115 Waiver approval with Short-Term Rental Assistance (Transitional Rent) updates, revisions to Housing Community Supports following CMS adjustments to the HRSN Framework, and findings from the 2024 Local Health Jurisdiction (LHJ) Survey on MCP collaboration for Community Health Assessment, Community Health Improvement Plan, and Population Needs Assessment alignment.

On January 24, 2025, DHCS connected with stakeholders for the CalAIM Implementation Advisory Group Meeting, which featured updates on recent federal approvals for Medi-Cal transformation and Short-Term Rental Assistance, an ECM monitoring overview, an introduction to Medi-Cal Connect, a Community Supports quarterly monitoring update, and a highlight around the release of the Q1–Q2 2024 ECM and Community Supports Quarterly Implementation Report.

On February 11, 2025, DHCS hosted a webinar on Flexible Housing Subsidy Pools (“Flex Pools”), featuring an overview of DHCS initiatives to address homelessness and

partnerships for permanency, a review of Flex Pools, upcoming technical assistance for Flex Pools, and a Q&A session.

On February 12, 2025, DHCS participated in the California Health Care Foundation (CHCF)-funded CalAIM Academy for Hospitals and Health Systems webinar series, designed to enhance hospital and health system leaders' understanding and utilization of CalAIM tools to improve value-based care and population health outcomes. The session focused on building awareness of CalAIM's importance, articulating its business case and sustainability models – including PATH CITED Round 4 – developing partnership capabilities within broader ecosystems, and fostering connections among health system champions, targeting executives and staff engaged or seeking deeper involvement with CalAIM, a critical yet underutilized partner group in scaling the initiative statewide.

On February 19, 2025, DHCS engaged with the Sobering Centers Advisory Group for a presentation and overview of their "Blueprint for Sobering: Landscape Analysis" report and a draft financial planning tool, seeking input from DHCS and other stakeholders. The analysis covered political factors, including interagency relationships and partnerships with Emergency Medical Services, law enforcement, and key entities; economic factors, such as financial mechanisms, sustainability challenges, and limitations of current funding and reimbursement structures; legal and regulatory factors, encompassing the policy landscape, CalAIM provisions, and geographic reimbursement restrictions; social factors, including community attitudes, stigma around substance use, and public perceptions; and practical factors, such as facility location, staffing models, and administrative infrastructure.

On February 21, 2025, DHCS joined the Center for Health Care Strategies for its Medicaid HRSN Implementation Learning Series Monthly Virtual Session, a forum for participants to explore high-priority implementation topics through peer-to-peer learning and expert insights. The agenda featured a discussion on Short-Term Recuperative Care.

On February 26, 2025, DHCS attended the CHCF CalAIM Academy webinar, reinforcing CalAIM's value and partnership opportunities for hospitals and health systems.

On February 27, 2025, DHCS convened its monthly CalAIM MCP Technical Assistance Meeting for February 2025. The agenda featured a save-the-date announcement for the Birthing Care Pathway Webinar, a detailed review of Closed-Loop Referral requirements, an update on Community Supports service definition refinements highlighting the

upcoming February release, Phase 4 JSON Exchange updates for ECM, Community Supports, and CCM, as well as a forward-looking review of MCP milestones.

On February 28, 2025, DHCS met with the National Institute for Medical Respite Care (NIMRC) to discuss collaborative efforts. The agenda featured updates on NIMRC projects, including certification, an ADL Assistance Pilot, and expansion of the Learning Network Model; challenges with authorizations and past-due claims alongside implications of the waiver approval for Housing-Related Social Needs; and alignment of DHCS and NIMRC initiatives to enhance Short-Term Recuperative Care service delivery.

On March 3, 2025, DHCS hosted the CA PATH CPI Quarterly DHCS/CPI Facilitator Meeting to enhance the quality of ECM and Community Supports implementation. The meeting focused on providing CPI Facilitators with timely DHCS policy and implementation updates while facilitating dialogue to discuss policy implications, share promising practices, address barriers, and explore innovative solutions from CPI collaboratives. The agenda featured updates on Short-Term Rental Assistance (Transitional Rent) and Flex Pools, 2025 Community Supports service definitions, and Closed-Loop Referral Guidance; a discussion on Referral Standards and Streamlined Authorization implemented in January 2025, including field insights; a focus group on Children & Youth California Children's Services (CCS) to gather input on technical assistance development; and an overview of the 2025 Best Practices Roadmap Strategic Plan, covering progress, timelines, and planned outputs.

On March 5, 2025, DHCS team members conducted an on-site visit to Project Open Hand in San Francisco, joined by the CalFIMC executive director, to identify promising practices in MCP, health system, and organizational referrals for Medically Tailored Meals/Medically Supportive Foods. Discussions explored whether the high demand for this service among pregnant and postpartum individuals, as reported by MCPs, aligns with Project Open Hand's experience; strategies to address barriers in delivering Medically Tailored Meals to members experiencing or at risk of homelessness; observations on the transition from Whole Person Care to Community Supports, particularly regarding access for members with chronic conditions; and any pain points in collaborating with MCPs or hubs.

On March 12, 2025, DHCS joined the CHCF CalAIM Academy webinar, with the session focusing on sustainability models and ecosystem collaboration for health system leaders.

On March 20, 2025, DHCS hosted its March CalAIM Implementation Advisory Group (IAG) Meeting. The meeting featured an overview of the Tulare/Kings Knowledge Management Page to support peer-to-peer learning, resource curation, and collaboration with MCPs and public health; updates on select Community Supports service definition refinements; and a session on Short-Term Rental Assistance (Transitional Rent) policy design updates with feedback collection.

On March 26, 2025, DHCS participated in the CHCF CalAIM Academy webinar, advancing hospital and health system engagement with CalAIM tools and networks.

On March 27, 2025, DHCS reported to the Managed Long-Term Services and Supports and Duals Integration Workgroup with updates on Community Supports, featuring dual members' utilization data with demographic stratifications for DY 20 Q2 and DY 20 Q3, and a spotlight on select service definition updates for several services.

Also on March 27, 2025, DHCS convened its monthly CalAIM MCP Technical Assistance Webinar for March 2025. The agenda featured an overview of the Tulare King Web Portal Knowledge Management Website as part of the Kings/Tulare Connected Communities of Care Pilot jointly funded by MCPs, a discussion on addressing knowledge gaps among primary care providers, a Q&A session on Phase 4 JSON Exchange updates for ECM, Community Supports, and CCM, an update on new six-month annual time limits for DHCS Community Supports services related to HRSN, a recap of Asthma Remediation service definition refinements, and a Best Practices Spotlight presented by Regional Asthma Management and Prevention with accompanying discussion.

2024 MCP Transition

DHCS worked to monitor activities related to the transition of Medi-Cal managed care plans which were leaving and newly operating as a Prime MCP in certain counties, effective January 1, 2024. A particular focus was for continuity of care for Community Supports. Specifically, DHCS monitored active service authorizations[8] for Community Supports to support continuity of providers and services. The Transition Policy for Community Supports was built on and aligned with the Community Supports Policy

[8] Members did not have to be actively receiving Community Supports on December 31, 2023 to qualify.

Guide and the Continuity of Care provisions contained therein, as well as Section V, Continuity of Care of the Transition Policy Guide.[9]

Receiving MCPs were to honor existing authorizations and maintain continuity of care for Community Support services. The Receiving MCP must maintain all authorizations for no less than the length of time originally authorized by the Previous MCP; however, the Receiving MCP was not required to maintain the authorization for more than 12 months beyond January 1, 2024, unless it chose to do so. These, and related expectations were outlined in Section V, Continuity of Care of the Transition Policy Guide. In some instances, the Transition Policy for Community Supports offered enhanced protections beyond those for other services.

DHCS closely monitored MCP adherence to this Transition Policy for Community Supports to prevent disruptions in Community Supports authorizations, provider relationships, and/or services in affected counties. As of the end of DY 20 Q4, MCPs have fulfilled their obligations under this policy and have confirmed automatically authorizing services for eligible members and contracting with all eligible out-of-network providers who had already previously been providing the same services within the county under a previous MCP.

Quarterly Implementation Monitoring Report

DHCS is committed to transparency and works to produce and publish program data at the earliest opportunity, while adhering to strict privacy and confidentiality standards. On average, DHCS requires approximately eight weeks to validate, process, and visualize quarterly data submissions. This includes performing rigorous quality checks, reconciling discrepancies, and ensuring data completeness. Once validated, the data is visualized using Microsoft Power Business Intelligence (Power BI), which provides a dynamic and user-friendly platform for monitoring program performance.

Dashboards are currently internal and for Department use only, but DHCS has created external versions utilizing the ArcGIS StoryMaps solution to share program data publicly through the newly established Quarterly Implementation Report reporting cycle.

In addition to quarterly reporting, DHCS has initiated efforts to cross-validate QIMR data

[9] Transition Policy Guide available at: https://www.dhcs.ca.gov/Documents/Managed-Care-Plan-Transition-Policy-Guide.pdf

with other sources, such as encounter and claims submissions through the Post Adjudicated Claims & Encounters System (PACES). This approach provides a more comprehensive and accurate picture of program performance and ensures alignment across reporting mechanisms.

DHCS continues working to ensure a high level of data quality covering the first three years of implementation and recognizes the gaps that continue to exist in new providers' reporting capabilities, which MCPs are helping to address. DHCS currently has 11 quarters of data available for Community Supports and is still processing and validating DY 20 Q4 data, but MCPs have consistently communicated caution due to the significant data lag they are experiencing with their providers, many of whom are brand new to Medi-Cal and/or the managed care delivery system.

DHCS acknowledges that outstanding challenges with timely and accurate data collection remain, particularly as Community Supports represent a novel and transformative addition to Medi-Cal. These challenges are further compounded by the complexity of onboarding a diverse array of community-based providers and other non-traditional provider types who may be new to Medi-Cal's reporting and administrative requirements. Many of these providers are simultaneously navigating the operational intricacies of managed care for the first time, which necessitates ongoing technical assistance, capacity building, and support from DHCS and MCPs.

Recognizing these dynamics, DHCS is committed to actively addressing barriers to implementation and fostering a robust infrastructure for Community Supports. For example, DHCS has invested in statewide initiatives, such as the Community Supports Spotlight Series conducted in CY 2022 (DY 18), which provided targeted training on critical service areas. These sessions facilitated a shared understanding of program requirements, highlighted successful strategies and encouraged open dialogue between MCPs, providers, and DHCS. By emphasizing practical solutions and collaborative problem-solving, these forums have laid the groundwork for continued program enhancements.

In addition to technical assistance, DHCS continues to refine its approach to provider engagement by developing new tools and resources tailored to the specific needs of Community Supports providers. This includes creating step-by-step guides for navigating Medi-Cal systems, offering simplified templates for documentation and billing, and providing real-time support to address common administrative hurdles. These efforts aim to reduce burdens on providers, improve data submission accuracy, and enhance overall program efficiency.

As DHCS looks ahead, the focus remains on sustaining these initiatives and scaling up support to meet the evolving needs of the program. The challenges of data collection

and operationalization are not viewed as static issues but rather as opportunities for continuous improvement and innovation. By fostering strong partnerships with MCPs and community stakeholders, DHCS seeks to build a more resilient and effective infrastructure that maximizes the potential of Community Supports to improve health outcomes and address social determinants of health for Medi-Cal beneficiaries statewide.

Already, in DY 21 Q1, DHCS is beginning to offer additional targeted technical assistance to support MCPs and providers in implementing and operationalizing upcoming refinements to select Community Supports service definitions. This effort is prioritizing services such as Medically Tailored Meals, Asthma Remediation, and Community Transition Services/Nursing Facility Transition to Assisted Living Facilities, but further technical assistance will be provided for each of the fourteen services over the course of the next year.

Through these efforts, DHCS aims to ensure MCPs and providers can fully align their operations with the updated definitions, enhance service delivery, and improve beneficiary outcomes. Planned activities include hosting focused webinars and training sessions, distributing updated policy guidance, and providing individualized support to address implementation challenges. Additionally, DHCS facilitates peer-to-peer learning opportunities to share strategies, highlight promising practices, and foster collaboration across stakeholders. These initiatives are part of a broader commitment to advancing the integration of innovative, community-driven services within Medi-Cal, strengthening the program's capacity to meet the diverse HRSN of beneficiaries statewide.

JavaScript Object Notation (JSON) Transition

The transition to JSON began in January 2024, when DHCS officially began transitioning the quarterly reporting performed via the QIMR Excel Reports by requiring additional monthly JSON file submissions. JSON, or JavaScript Object Notation, is an open standard file format that streamlines the collection and transmission of implementation data and is utilized by the Department for other mandatory reporting purposes. Currently, QIMR data lags real-time implementation by approximately four to six months; the transition to JSON is expected to significantly reduce lag on data collection.

It is important to note that the introduction of JSON monthly reporting does not immediately replace, or remove, Excel-based reporting requirements. MCPs are required to continue submitting QIMR Excel reports within 45 days of the end of each quarter. During the transition period, MCPs must adopt the JSON monthly process while maintaining Excel-based reporting for at least 12 to 18 months, or until DHCS determines that the JSON data is sufficiently robust to serve as the sole reporting

mechanism. This dual-reporting period ensures data continuity and reliability as the new system is implemented. The next QIMR, which will include data through DY 21 Q2, is due to DHCS by May 15, 2025.

The transition from QIMR Excel reports to JSON submissions is being executed in multiple phases, each designed to build on the previous one to ensure a smooth and effective implementation. These phases allow for iterative improvements and the resolution of any issues as they arise, supporting MCPs in adapting to the new reporting standards and requirements:

- **Phase 1 (January 2024):** CCM enrollment status.
    - Phase 1 was successfully adopted in January 2024 and all MCPs have been producing and submitting monthly JSON files beginning on February 10 (for the reported month of January). DHCS has worked with MCPs to identify and address technical issues and continues to provide additional technical assistance.
- **Phase 2 (July 2024):** ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
    - Phase 2 was successfully implemented in July 2024 and all MCPs have been producing and submitting monthly JSON files with the additional required data elements beginning on August 10 (for the reported month of July). DHCS continues to work with MCPs to identify and address technical issues and continues to provide additional technical assistance in preparation for Phase 3.
- **Phase 3 (January 2025):** ECM Care Manager & Provider Facility Details
    - Phase 3 was successfully implemented in January 2025 and all MCPs have been producing and submitting monthly JSON files with the additional required data elements beginning on February 10 (for the reported month of January).
- **Phase 4 (July 2025):** All remaining QIMR data elements specific to Community Supports, including member-level details, utilization, authorizations, and provider networks. Closed Loop Referral (CLR) reporting will also be included for the first time, with details captured around referral and authorization decision dates, referral status, and date(s) services are received. ECM CLR Reporting & Presumptive Authorization details will also be introduced in this phase.
    - Phase 4 design elements are fully developed and are undergoing validation by DHCS' internal teams. MCPs will be able to submit "practice" files for

testing starting in June.

DHCS has produced accompanying Technical Documentation through an available Technical Assistance Companion Guide, containing technical information (including data dictionaries, file layouts, JSON Schemas, and details on response files) required for MCPs to be able to submit one data file to DHCS monthly. A data dictionary is also available, describing the required data values as well as the validation edits performed on specific data elements.

To strengthen data quality and reporting, DHCS has undertaken a detailed analysis of discrepancies between plan-submitted data on the QIMRs and PACES. This analysis is providing critical insights into data accuracy and completeness, allowing DHCS to identify specific areas where additional technical guidance or oversight may be warranted. The ongoing transition to JSON-based reporting, scheduled for phased implementation through 2024 and 2025, represents a significant step forward in standardizing data submission, enhancing analytical capacity, and improving the timeliness and integrity of data across reporting mechanisms.

Operational Updates

DHCS regularly updates its ECM and Community Supports webpage with guidance materials and program documents, in timely response to stakeholder and consumer feedback. DHCS restructured the page in April 2024 to ensure key policy and guidance documents are highlighted while at the same time archiving some of the older, more outdated guidance. All program documentation, including historic documentation, remains, and will continue to remain accessible to the general public.

On January 1, 2025, DHCS received final updated Models of Care (MOCs) and final July 2025 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections are posted on the DHCS website once DHCS issues its final approval for all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually. Technical assistance and guidance webinars are recorded and hosted on the DHCS website and are updated regularly. DHCS also maintains a regularly updated FAQs document on its ECM and Community Supports webpage, which highlights several FAQs from MCPs, providers, and stakeholders. The FAQs document also includes answers and policy clarifications provided by DHCS.

Moving forward, DHCS will publish its Quarterly Implementation Reports on a regular cadence to relay data publicly on Community Supports, including member characteristics,

service utilization metrics, and network development. On March 27, 2025, DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for DY 20 Q3[10] along with the following message and press release:

DHCS Releases Latest Enhanced Care Management and Community Supports Quarterly Report

On March 27, DHCS released the latest Enhanced Care Management (ECM) and Community Supports quarterly report summarizing utilization data from July 2024 through September 2024. Key highlights from the report include:

- ***Consistent growth**: Since ECM launched in January 2022, 279,824 unique Medi-Cal members have successfully enrolled in ECM benefits. In the third quarter of 2024 alone, 143,188 unique members accessed ECM benefits, an increase of 13 percent from the second quarter of 2024.*
- ***Youth participation**: In Q3 2024, 28,342 children and youth under age 21 accessed ECM benefits, marking a 13 percent increase from Q2 2024.*
- ***Community Supports usage**: Approximately 296,500 unique Medi-Cal members have utilized Community Supports, with more than 754,000 total services delivered. In the third quarter of 2024 alone, 136,031 unique members received Community Supports, an increase of 7.5 percent from the second quarter of 2024.*
- ***Increased service access**: By Q3 2024, nearly 90 percent of Medi-Cal members had access to at least 10 of the 14 Community Supports services. More than 41 percent of members have access to the full suite of services.*
- ***Key services utilized**: More than 61 percent of members using Community Supports accessed Medically Tailored Meals/Medically Supportive Foods, and approximately 32 percent used one or more services from the Housing Trio (Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits).*

This latest ECM and Community Supports implementation report shows a sustained increase in utilization quarter-over-quarter as additional populations of focus have become eligible for ECM and additional Community Supports services are offered in counties across the state. DHCS expects to see more enrollment growth across ECM and Community Supports in the coming months and years. In 2025, DHCS is continuing to

[10] Report available at: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

support and sustain this growth through expanded ECM and Community Supports program monitoring efforts, robust stakeholder engagement, and policy design refinements.

Finally, DHCS continues to finalize policy refinements to clarify ongoing, planned, and future activities related to Community Supports, aiming to enhance standardization of services and delivery across counties where appropriate. Over the past year, DHCS has pursued efforts to standardize the ECM and Community Supports programs, seeking to reduce administrative burden, boost uptake, and ensure consistent service delivery.

Other Monitoring Activities

DHCS is committed to ensuring that members and providers can easily access information about ECM and Community Supports. As such, it has established clear requirements for making information about the programs publicly available. Per the Community Supports Policy Guide, MCPs' websites must include the following easily accessible member- and provider-facing information:

- **Community Supports**: As required in A.B. 133 14184/206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021), up-to-date information about Community Supports services being offered by the MCP, including, at minimum:
    - A short description of each available service that is consistent with the service definitions listed in the Community Supports Policy Guide (terminology should not differ from DHCS' terminology).
    - The eligible population(s) for each service, inclusive of any DHCS approved approach to narrow or limit the eligible populations.
    - Any such limitations must meet the requirements in the CalAIM Waiver STCs, must be approved (in writing) by DHCS, and must be included in member handbooks.
    - Member and provider facing information about how to access the Community Supports offered by the MCP.
- **Community Supports Provider Networks**: MCPs are required to list all Network Providers who are Community Supports providers in their provider directories as follows:
    - MCPs are to list all Network Community Support providers in the provider

directories as “Other Services Providers,” and should specify if a provider is an ECM, Community Supports provider, or both.

- MCPs must add a disclaimer in their provider directory stating that Community Supports require prior authorization and are limited to members who meet specific eligibility criteria.
- MCPs may use symbols denoting Community Supports providers that may be listed in other sections of their provider directories in lieu of listing providers multiple times.

Recognizing the importance of provider engagement, DHCS continues to invest in Community Supports provider education. Efforts include expanding opportunities to connect with prospective Community Supports providers, facilitating peer-to-peer knowledge-sharing among current and emerging providers, and developing resources to orient non-traditional providers to the operational requirements of Medi-Cal and Community Supports. These efforts aim to reduce barriers to entry for non-traditional providers, such as housing or food service organizations, and foster greater alignment with Medi-Cal’s unique requirements.

DHCS conducts focused reviews of MCP websites to ensure that all required information relevant to Community Supports is available and accessible to members and providers. Reviews for all MCP websites are conducted on a semiannual basis as Community Supports elections are updated. The latest reviews, completed in October 2023, confirm:

- Up-to-date member and provider facing information about Community Supports and how to request access to Community Supports.
- Up-to-date information about all Community Supports being offered by the MCP, including, at minimum: A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS’ terminology.
- The eligible population(s) for each service. Beginning on January 1, 2024, MCPs were required to fully align with the DHCS Community Supports service definitions and had to remove any language about previously approved modifications and/or restrictions from its website.

Over the 13 full quarters of Community Supports implementation, the number of Community Supports elected by MCPs across California's 58 counties has significantly

increased. Now that MCPs have had sufficient time to ramp up their processes, DHCS' primary focus is increased monitoring in addition to the following regular activities:

- Data monitoring, aggregation, and analysis;
- MOC reviews (every six months);
- Surveys/interviews to discuss IPP investments;
- Fact sheets and program report development;
- Ad hoc meetings with MCPs based on individual plan needs;
- Oversight of IPP earned funding and provider investments;
- Workgroups/Office Hours with MCPs (with a focus on sharing best practices as well as providing support and technical assistance).

Opportunities for Improvement and Implementation of the Action Plan

DHCS has identified several outstanding challenges facing Community Supports through the feedback loops it has created, including:

- CBOs being unfamiliar with billing or Medi-Cal requirements.
- Scarcity of infrastructure and resources in some parts of the state.
- Fewer contracted providers than needed to meet the current demand for some community support services
- Broad need for alignment in authorization processes.
- Protected data exchange.
- Variation in outreach and engagement.
- MCPs engagement of local CBOs to serve as contracted providers.

To address these concerns, DHCS has developed an ECM and Community Supports

Action Plan[11] that addresses the following key areas:

- Clarifying eligibility
- Streamlining and standardizing referral/authorization processes
- Enhancing service definitions
- Strengthening market awareness
- Improving data exchange

The goal of all these efforts is to increase the availability and uptake of Community Supports for Medi-Cal Members who need them.

Looking ahead, DHCS has identified additional areas for improvement, including optimizing the integration of HRSN services within MCP networks, refining performance monitoring frameworks to capture meaningful outcome data, and addressing ongoing challenges in beneficiary access and service utilization. DHCS remains committed to collaboration with MCPs, providers, and stakeholders to address these opportunities and to further strengthen the delivery of Community Supports statewide.

Consumer Issues and Interventions

Nothing to report.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

CMS requires DHCS to contract with an independent program evaluator to conduct an evaluation of initiatives authorized under the CalAIM Section 1115 waiver. This

[11] See the ECM and Community Supports Action Plan Overview and Updates (Updated December 2024). Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

requirement is part of the STCs that accompany the waiver. On February 7, 2024, DHCS submitted evaluation designs to CMS for the four CalAIM initiatives: the PATH Initiative, GPP, Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process (Duals), and the and REENTRY. On June 5, 2024, DHCS received additional guidance from CMS to incorporate the Community Supports. CMS advised DHCS on the timing and content of required the Community Supports evaluation reports on June 5. DHCS executed a contract amendment with UCLA-RAND for this effort on September 11 and began drafting the evaluation design immediately thereafter. DHCS was required to submit an evaluation design to CMS by October 3, 2024. However, in its final review phase DHCS leadership identified substantive concerns and requested a 2-week extension from CMS. DHCS submitted the Community Supports Evaluation Design to CMS on October 17, 2024.

Enclosures/Attachments

Community Supports Elections (by MCP and County)[12] – PDF chart showing the Community Support Elections MCPs have elected to offer, current as of July 2024.

Community Supports Policy Guide[13] – The operational document for CalAIM's Community Supports, which builds on the contractual requirements for Community Supports, and outlines Community Supports policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines. DHCS updates the Community Supports Policy Guide.

[12] Community Supports Elections (by County and MCP) (Updated December 2024). Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

[13] Community Supports Policy Guide and Community Supports: Select Service Definition Updates (February 2025). DHCS posts updates to the Policy Guide when key updates are made. Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

DUALLY-ELIGIBLE ENROLLEES IN MEDI-CAL MANAGED CARE

California's Section 1115 waiver includes flexibilities to support the state's effort to integrate dually eligible populations statewide into Medi-Cal managed care through the 1915(b) waiver prospectively, as well as support integrated care by allowing the state, in specific counties with multiple Medicaid plans, to keep a member in an affiliated Medicaid plan once the member has selected a Medicare Advantage (MA) plan.

Members impacted by this expenditure authority are able to change Medicaid plans by selecting Original Medicare or a new MA plan at time periods aligned with federal Medicare policy, either once a month or during other Medicare election periods. A dually eligible member's Medicaid plan is aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. This policy is known as the Medi-Cal Matching Plan policy. DHCS has implemented the Medi-Cal matching plan policy in 17 counties, effective January 1, 2024, and continuing in 2025: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Stanislaus, and Tulare.

DHCS has a webpage to provide stakeholders with more detailed information about the Medi-Cal matching plan policy. In addition, DHCS updated the member notice regarding this policy to explain it more clearly, effective January 1, 2023.

In a separate but related policy, DHCS requires Medicaid plans, in a phased approach, to operate Exclusively Aligned Enrollment (EAE) Dual-Eligible Special Needs Plans (D-SNPs). This policy was initially implemented in the seven Coordinated Care Initiative (CCI) counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under EAE D-SNPs, (known as Medi-Medi plans in California), members can enroll in a D-SNP for Medicare benefits and will be enrolled in an MCP for Medi-Cal benefits, both operated by the same parent organization for better care coordination and integration. For these plans, DHCS is committed to implementing integration through integrated member materials, integrated appeals and grievances, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also reduce inappropriate billing, improve the alignment of Medicare and Medicaid networks, and improve access to care. For the contract year 2025, beginning January 1, 2025, Medi-Medi plans are operated by Medicaid plans in 12 counties: Fresno, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, Santa Clara, and Tulare.

Two other related policy changes were implemented on January 1, 2023: 1) all dually eligible members statewide were required to enroll in Medi-Cal managed care, except for those with a share of cost (SOC) who were not in a LTC facility; and 2) all dually eligible members residing in LTC facilities, including those with a SOC, were required to enroll in Medi-Cal managed care. As of 2022, most dually eligible members in 27

counties (COHS counties and the seven CCI counties) were already enrolled in Medi-Cal managed care plans. Expanding this policy for the remaining 31 counties is intended to help meet the statewide goals of improving care integration and person-centered care for dually eligible members, under both CalAIM and the California Master Plan for Aging.

As a result of the policy changes described above, the Medi-Cal matching plan policy applied to more members in 2023, as more were enrolled in Medi-Cal managed care. Also, for the Medi-Cal plans in CCI counties in 2023 with delegated Medi-Cal plans affiliated with an EAE D-SNP, the Medi-Cal matching plan policy applies to the delegated Medi-Cal plans. This policy change also results in additional members where the Medi-Cal matching plan policy applies.

DHCS developed member notices for these transitions, in coordination with CMS and stakeholders. DHCS also conducted stakeholder meetings to discuss all aspects of these transitions related to member communication, TA impacts on any system changes, continuity of care, and provider network adequacy and reporting requirements.

As part of post-transition monitoring, DHCS is reviewing feedback from the Medi-Medi Ombudsman program, the successor to the Cal MediConnect Ombudsman. DHCS is also continuing stakeholder meetings as part of the monitoring efforts.

Performance Metrics

DHCS reports annually on the matching plan policy and on the number of members enrolled in MA plans that request to change MCPs and are referred to the MA plan in the matching plan counties.

Outreach Activities

DHCS hosts and participates in various meetings to engage with stakeholders about the current Medi-Cal matching plan policy and future Medi-Medi plan expansion counties. DHCS also meets regularly with California's State Health Insurance Assistance programs, known as the Health Insurance Counseling and Advocacy Program (HICAP) in California, as well as Medicare agents and brokers, to provide information about the Medi-Cal matching plan policy.

Operational Updates

DHCS implemented the waiver authority provisions to enroll a member in an affiliated Medicaid plan once the member selected a MA plan in the 17 counties identified above.

Consumer Issues and Interventions

DHCS continues to meet monthly with advocates and health plans regarding any reported consumer issues with the Medi-Cal matching plan policy, and resolves any reported issues promptly. No widespread issues have been reported in 2025.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

Nothing to report.