CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

March 25, 2024

THIS LETTER SENT VIA EMAIL

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

ANNUAL PROGRESS REPORT FOR THE REPORTING PERIOD OF JANUARY 1, 2023, THROUGH DECEMBER 31, 2023 OF CALIFORNIA'S SECTION 1115(A) DEMONSTRATION TITLED CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) (PROJECT NUMBER 11-W-00193/9)

Dear Ms. Young:

The Department of Health Care Services is officially submitting the Demonstration Year (DY) Nineteen (19) Annual Progress Report (Report) to the Centers for Medicare & Medicaid Services. The DY 19 Annual Progress Report covers the reporting period of January 1, 2023, through December 31, 2023, including fourth quarter reporting. The Report is required by Section 15.5 of the Special Terms and Conditions of California's Section 1115 Waiver, titled "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) (the "Demonstration").

Enclosed are the following report attachments:

1. CalAIM 1115 DY 19 Annual Report Cover Letter
2. CalAIM 1115 DY 19 Annual Report
3. CalAIM 1115 DY 19 – CBAS Annual Report Attachment
4. CalAIM 1115 DY 19 – ODS-RES

For any questions regarding this report, please contact Jade Lemus, Associate Governmental Program Analyst, Office of Compliance, by email at Jade.Lemus@dhcs.ca.gov.

Sincerely,

[redacted]

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

SECTION 1115(A) WAIVER

DEMONSTRATION YEAR (DY) 19

FINAL REPORT

DEMONSTRATION YEAR: NINETEEN (JANUARY 1, 2023 - DECEMBER 31, 2023)

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

CalAIM Amendment and Renewal

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 a part of the state's larger CalAIM initiative that includes the transition of the 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; (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 percent 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 Med-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 with a focus on addressing social needs and responding to the impacts of systemic racism and inequities.
  - **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 DMC-ODS.
  - **Coverage for Out-Of-State Former Foster 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:**

  - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration. Twelve 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; and, mostly recently approved in January 26, 2023, (2) support justice-involved pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.

  - **Contingency Management (CM)** 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).

  - **Justice-Involved** authority via the CalAIM Section 1115 demonstration waiver was

most recently approved on January 26, 2023. DHCS will partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process that will assist people leaving incarceration connect to the physical and behavioral health services they need prior to release.

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 that 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.

On January 26, 2023, CMS approved a new federal Medicaid 1115 demonstration waiver to offer a targeted set of Medicaid services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. California became the first state in the nation approved for this waiver and DHCS will partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process that will assist people leaving incarceration in connecting with the physical and behavioral health services they need prior to release. In addition, the waiver authorizes $410 million for PATH, Justice-Involved Capacity Building grants to support collaborative planning, and IT investments intended to support implementation of pre-release and reentry planning.

On March 17, 2023, CMS approved the COVID-19 PHE amendment to the CalAIM demonstration to assist the state in delivering the most effective care to its members in light of the COVID-19 PHE, and to ensure renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes member burden and promotes continuity of coverage at the end of the COVID-19 PHE.

On August 23, 2023, CMS approved an amendment to the CalAIM demonstration to permit the state to limit choice of managed care plans in in Metro, Large Metro, and Urban Counties in California and implement county-authorized managed care programs.

DHCS continues to negotiate with CMS on CalAIM Section 1115 demonstration initiatives that were requested as part of the Section 1115 renewal but not yet approved by CMS. For example, as part of the March 2022 amendment for the justice-involved initiative, DHCS seeks expenditure authority for Traditional Healer and Natural Helper services to provide culturally appropriate treatment options and improve access to substance use disorder

(SUD) treatment for Medicaid members receiving SUD treatment services through Indian health care providers (IHCPs).

GENERAL REPORTING REQUIREMENTS

Amendment Process (STCs 3.8 and 3.13)[1]

During the reporting period of January 1, 2023, through December 31, 2023, DHCS submitted three CalAIM 1115 waiver amendments to CMS, detailed below:

Reentry Demonstration Initiative Amendment:

On June 30, 2021, DHCS submitted a CalAIM Section 1115 renewal and amendment request, which included Services for Justice-Involved Populations 90-Days Pre-Release. On January 26, 2023, CMS approved California's request to Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. No. 115-271) directed the Secretary of Health and Human Services, through the CMS Administrator, to issue a State Medicaid Director Letter (SMDL), based on best practices identified by stakeholders convened by the Department of Health and Human Services, regarding opportunities to design demonstrations under section 1115 of the Act to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible for Medicaid.

COVID-19 Public Health Emergency (PHE) Amendment:

On July 6, 2022, California submitted a request for an amendment to the CalAIM Section 1115(a) demonstration to address the COVID-19 PHE and to promote continuity of coverage during the unwinding of the COVID-19 PHE. On March 17, 2023 CMS approved the amendment, which served as a time-limited approval to provide continuous coverage for children aging out of CHIP and specified formerly pregnant individuals. This approval was authorized retroactively from March 1, 2020, through the end of the unwinding period or until all redeterminations were conducted during the unwinding period. The COVID-19 PHE Amendment was expected to help California furnish medical assistance in a manner intended to protect the health, safety, and welfare of individuals affected by COVID-19 and allowed California to align its policies for young adults, children, and pregnant individuals, and prevent gaps in coverage during the PHE to align its policies for young adults, children, and pregnant individuals,

[1] The December 20, 2023 version of the STC's are referenced throughout this report: CalAIM STCs following approval of Attachment M.

and prevent gaps in coverage during the PHE.

Managed Care Amendment:

On November 4, 2022, DHCS submitted a request to CMS seeking the CalAIM Section 1115 and 1915(b) amendment approvals to implement county-based model changes in its Medi-Cal Managed Care (MCMC) program. From August 12 to September 12, 2022, California held a public comment period for the draft CalAIM Section 1115 amendment and CalAIM Section 1915(b) amendment overview. During the 30-day period, DHCS received 82 public comments that can be viewed here.

On August 23, 2023, CMS approved the amendment. Approval of this demonstration amendment allows the state to limit choice of managed care plans in specified geographic regions and implement county-authorized managed care programs. These new county-authorized managed care programs are like those that already exist in other counties in California, which have proven to be an effective model for providing Medicaid coverage for adults and youth.

Out of State Former Foster Youth (STC 4.1a)

CMS and DHCS met on January 30, 2024, to discuss Out of State Former Foster Youth (OOS FFY). CMS reported that the temporary extension period provided to OOS FFY through the CalAIM Waiver was not included in the Final Evaluation Report submitted in 2023. For that reason, CMS is requiring a reporting for Calendar Year (CY) 2021, and any members that exited foster care before January 1, 2023.

CMS has granted DHCS additional time to obtain the data required to produce the annual report for CY 2021. As in past years, the report will include enrollment and utilization measures, accompanied by a narrative for each reporting area.

Tribal UCC for Chiropractic Services (STCs 3.15 and 17.12)

Indian Health Services (IHS) Uncompensated Care Supplemental Payments are Certified Public Expenditure (CPE) based waiver payments for uncompensated care to support participating IHS and 638 facilities. Under this program, DHCS makes encounter-based payments at a flat rate to the California Rural Indian Health Board (CRIHB). CRIHB then makes supplemental payments to participating IHS and 638 facilities that incurred uncompensated care costs. Supplemental payments will be computed based on the uncompensated cost for services that were eliminated from Medi-Cal coverage through

State Plan Amendment (SPA) 09-001. Providers furnish these services to individuals enrolled in the Medi-Cal program and for which no state funds are involved. Tribal UCC benefits are the only current services approved to be covered by DHCS because the other services eliminated through SPA 09-001 are now covered. For each eligible service encounter, DHCS pays the published Federal Register, IHS Outpatient Per Visit Rate (excluding Medicare). Payments are offset by any third-party payments received for eligible encounters. The program is capped at $1,550,000 total computable per year.

The IHS global encounter rate is updated on the Federal Register for each CY. The IHS global encounter rate for CY 2023 is $654. Figure 1 below shows IHS payment activity in the order of occurrence during DY 19.

Figure 1: DY 19 IHS Payment Activity

Service Month/Year	FFP	Number of Encounters
January-March 2023	$84,366.00	129
April-June 2023	$118,374.00	181
July-September 2023	$96,792.00	148
Total	**$299,532.00**	**458**

IHS encounter claims are paid on a quarterly basis. October-December 2023 encounters, and any remaining encounters not already paid for January-December 2023, are expected to be paid in May 2024.

DSHP (STCs 10-10.6)

On January 26, 2023, CMS approved California's request to claim federal matching funds for state-funded DSHP to "free-up" state funding for Medicaid coverage initiatives. California will use DSHP claiming to support portions of the PATH program. DSHP is effective January 1, 2023, to December 31, 2026. The total claimable federal financial participation (FFP) for the four-year period is $646,425,000.

DSHP consist of State Only Medical Programs and Workforce Development Programs. Allowable DSHP expenditures will be applied against each DY using the date of service information from each claim paid through the approved DSHP listed below.

State Only Medical Programs
California Children's Services Program
Genetically Handicapped Persons Program
Medically Indigent Long-Term Care
Breast & Cervical Cancer Treatment Program
Lanterman Development Disabilities Act
Prostate Cancer Treatment Program
Workforce Development Programs
Department of Health Care Access and Information · Song-Brown Health Care Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program

Although the DSHP proposal within the CalAIM Section 1115 Demonstration renewal was approved by CMS, claiming cannot begin until details are finalized in the attachments to the STCs: Attachment Y: Approved DSHP List, and Attachment Z: DSHP Claiming Protocol. Figure 2 below shows estimated claiming for DY 19.

Figure 2: DY 19 Estimated Claiming

DY 19 Service Month/Year	FFP
January-March 2023	$40,401,562.50
April-June 2023	$40,401,562.50
July-September 2023	$40,401,562.50
October-December 2023	$40,401,562.50
Total	**$161,606,250.00**

Dually-Eligible Enrollees in Medi-Cal Managed Care (STC 5.26)

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 can change Medicaid plans by selecting a new MA plan or original Medicare once a quarter. A dually eligible member's Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. In the counties where the state is authorizing the exclusively aligned enrollment (EAE) Dual-Eligible Special Needs Plan (D-SNP) model, known as Medicare Medi-Cal 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 alignment of Medicare and Medicaid networks, and improve access to care.

DHCS has implemented the waiver authority provisions to enroll a member in an affiliated Medicaid plan once they have selected a MA plan, known as the Medi-Cal matching plan policy, in 17 counties, effective January 1, 2024: 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. On January 1, 2023, members of the federal financial alignment initiative known as Cal MediConnect (CMC) transitioned into EAE D-SNPs (Medicare Medi-Cal plans) and matching MCPs, 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, 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. In addition, effective January 1, 2023, all dually eligible members statewide that were not already enrolled in Medi-Cal managed care were mandatorily enrolled in Medi-Cal managed care, except for those with a Share of Cost who are not in a LTC facility.

Figure 3, on the next page, provides the total number of members, broken out by CY quarter, enrolled in MA plans (including D-SNPs) that request to change Medi-Cal managed care plans (MCPs) and are referred to the MA plan or 1-800-MEDICARE in the 12 counties in 2023 where DHCS aligned Medi-Cal plan enrollment with Medicare plan

choice: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus. The January 2023 figure is significantly higher than the other months in 2023 because of the mandatory enrollment of dual eligible members in Medi-Cal managed care who were not already enrolled.

Figure 3: DY 19 Matched Members Requesting Transfer into an Unmatched Plan and Referred to Medicare

Month	Matched Members Requesting Transfer into an Unmatched Plan and Referred to Medicare
1/1/2023	6,411
2/1/2023	321
3/1/2023	218
Q1 Total	**6,950**
4/1/2023	140
5/1/2023	132
6/1/2023	98
Q2 Total	**370**
7/1/2023	126
8/1/2023	121
9/1/2023	113
Q3 Total	**360**
10/1/2023	130
11/1/2023	107
12/1/2023	83
Q4 Total	**320**
2023 Grand Total	**8,000**

Deemed SSI Population (STCs 4.1, 11, and 17.7)

California State Assembly Bill 133 directed DHCS to seek federal approval to implement a two-phased approach to increase and eliminate the asset limits for Non-Modified Adjusted Gross Income (Non-MAGI) coverage groups. On November 24, 2021, DHCS received approval for State Plan Amendment (SPA) 21-0053 that gave DHCS the authority to implement the resource disregard to increase the asset limits for most Non-MAGI coverage groups. Since the authority to apply disregards under section 1902(r)(2) of the Social Security Act is limited to certain enumerated coverage groups, the approved SPA did not apply to the Deemed SSI groups, specifically those mandatory Medi-Cal eligibility groups comprised of individuals who would be eligible for Medicaid if they were receiving Supplemental Security Income (SSI) and/or State Supplementary Payments (SSP), but are no longer receiving such payments and are thus "deemed" eligible for Medi-Cal. On April 6, 2022, the state submitted an amendment to the CalAIM demonstration to assure access to and provide parity with the asset disregard policy for the populations under the approved SPA.

On June 29, 2022, DHCS received federal approval of California's two-phased approach to increase, and eventually eliminate, asset limits for the Deemed SSI groups through the CalAIM Section 1115 Demonstration waiver amendment. This subgroup of the Non-MAGI Medi-Cal member population has historically been limited in the amount of property they can own and retain, and still be eligible for Medi-Cal.

Effective July 1, 2022, asset limits for Non-MAGI Medi-Cal programs increased to $130,000 for one person and $65,000 for each additional household member. The prior asset limits were $2,000 for one person and $3,000 for two persons. Members were able to keep additional resources, resulting in increased financial stability and improved quality of life. This increase in asset limits made Medi-Cal coverage accessible to a larger number of potentially vulnerable Californians, including elderly and disabled individuals. The elimination of asset limits implemented on January 1, 2024, significantly improves access to Medi-Cal coverage for these vulnerable populations as well.

The CalAIM Asset Test approval letter can be viewed on the DHCS website.

Figure 4, on the next page, outlines the expenditure information for individuals in the Deemed SSI groups during DY 19.

Figure 4: Deemed SSI Groups DY 19 Expenditures

Reporting Period	Total Expenditures	Federal Funding	Total Federal Expenditures for DY 19
Quarter 1 1/1/2023-3/31/2023	$32,365.82	56.2%	$18,189.59
Quarter 2 4/1/2023-6/30/2023	$54,745.74	55%	$30,110.16
Quarter 3 7/1/2023-9/30/2023	$54,274.47	52.5%	$28,494.10
Quarter 4 10/1/2023-12/31/2023	$49,155.90	51.5%	$25,315.29
DY 19 Totals	**$190,541.93**	**N/A**	**$102,109.14**

Reentry Demonstration & Pre-Release Services (STCs 5.13, 5.15, and 9.1-9.11)

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities (YCFs) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by CMS, DHCS will partner with state agencies, counties, providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities. The initiative will help California address the unique and considerable health care needs of justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state. Correctional facilities can begin delivering pre-release services no sooner than October 1, 2024.

Providing Access and Transforming Health (PATH)

To support planning for and implementation of pre-release Medi-Cal applications, DHCS provided two rounds of capacity building PATH grant funding to correctional facilities

and social services agencies/offices. The first round of capacity building grant funding supported collaborative planning activities (e.g., collaborative planning sessions, identification of operational gaps, and hiring processes for staff to support pre-release application processing). The second round of capacity building grant funding supported implementation and administration activities related to pre-release Medi-Cal applications (e.g., IT systems upgrades, physical infrastructure modification, development of protocols and procedures, and staff training to coordinate pre-release applications).

PATH JI Round 3 is a planning grant funding opportunity that provides small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support both planning and implementation of justice-involved re-entry services, including investments in capacity and IT systems that are needed to effectuate Medi-Cal justice-involved re-entry services. The application period for PATH JI Round 3 was open from May 1, 2023, through July 31, 2023. One hundred twenty applications were submitted and approved, and $330,518,594.94 were initially awarded.

Pre-Release Enrollment

Effective January 1, 2023, all California county social services agencies/offices were required to suspend, rather than terminate, Medicaid coverage for both adults and youth during the duration of an individual's incarceration. State guidance, published in November 2022, provides information related to implementing DHCS' Medicaid benefit suspension and unsuspension (activation) policies, including guidance on suspension timelines for individuals with short-term stays.

The following summarizes the State's policy and operational approach:

- Through the benefit suspension process, the correctional facility reports the member's incarceration status to the county; the social services agency/office will change an individual's Medi-Cal status from "active" to "suspended." While in the suspension period, the individual will be eligible to receive inpatient hospitalization and pre-release services (for no more than 90 days) only. Individuals receive a notice of action when their Medi-Cal coverage is suspended and again upon reactivation.
- If inpatient hospital services are required during an individual's incarceration, the correctional facility can apply for the county or State Medi-Cal Incarceration Eligibility Program (MCIEP). MCIEP occurs at both a state and county level and allows Medi-Cal reimbursement for inpatient hospital stays of 24 or more hours for incarcerated

individuals who are determined eligible for Medi-Cal.

- All individuals found eligible for pre-release services, including individuals who were incarcerated for 28 days or less, will be assigned a specific aid code that will ensure the only services that will be provided and paid for are Reentry Demonstration Initiative services. DHCS required social services agencies/offices, County Sheriff's Departments and County Probation Departments to complete and submit readiness assessments in November 2022, through which they attested to their readiness to implement pre-release Medi-Cal application processes. DHCS also implemented a monitoring plan to assess compliance with the mandate, including suspension and unsuspension processes, and ongoing implementation of the mandate.

DHCS required social services agencies/offices, County Sheriff's Departments and County Probation Departments to complete and submit readiness assessments in November 2022, through which they attested to their readiness to implement pre-release Medi-Cal application processes. DHCS also implemented a monitoring plan to assess compliance with the mandate, including suspension and unsuspension processes, and ongoing implementation of the mandate.

Stakeholder Engagement

DHCS has taken a multi-pronged approach to improving stakeholder awareness about Medi-Cal and the Reentry Demonstration Initiative. Since 2021, DHCS has hosted 11 advisory group webinars about the Reentry Demonstration Initiative to inform the key stakeholders about design decisions, program requirements, and key milestones; these webinars were also open to the public and allowed a chance for non-advisory group members to provide feedback on the Reentry Demonstration Initiative. DHCS has also regularly facilitated meetings of a cross-sector stakeholder advisory group to inform program design, with representation from corrections systems, community supervision entities, health care providers and provider organizations, county entities, and social services organizations. DHCS has also pursued targeted engagement of an array of stakeholders to provide one-on-one ongoing education and technical assistance (e.g., meeting weekly with the State prison system, establishing a small working group of correctional facilities and providers to inform the initiative's billing and claiming approach).

DHCS released formal policy and guidance to support program implementation. In 2022, DHCS released guidance to help correctional agencies, county social service agencies/offices, and other entities fulfill their obligation to support incarcerated

individuals in completing an application for Medi-Cal coverage prior to their release. In 2023, DHCS also released state guidance to correctional agencies on how to access a tool to verify an individual's enrollment in Medi-Cal. Most recently, DHCS finalized the release of the Policy and Operational Guide based on extensive stakeholder feedback.

DHCS System Readiness

DHCS has identified the need to develop and update eligibility and enrollment and billing and claiming systems to implement pre-release services. System development and updates will occur in 2024 and the next annual report will reflect these system updates.

Policy and Operational Planning

On October 20, 2023, DHCS released a final Policy and Operational Guide to implement reentry services. This guidance memorializes policy and operational requirements for implementing the Medi-Cal JI Reentry Initiative. The draft guidance is intended to lay out to implementing stakeholders – correctional facilities, behavioral health agencies, providers, CBOs, and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.

Throughout 2023, DHCS worked with CMS to finalize the Reentry Demonstration Implementation Plan and Reinvestment Plan. The Implementation Plan describes (1) a summary of how the State already meets any expectation and specific activities related to each milestone, and (2) any actions needed to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions and the timelines and activities the State will undertake to achieve the milestone. The Implementation Plan will be approved in 2024. In 2023, CMS approved DHCS' Reentry Reinvestment Plan, which defines the total amount of reinvestment required and types of reinvestments that will be made over the term of the Demonstration.

Successes and Barriers

DHCS has achieved considerable success in the planning phase of the JI Initiative:

- Release of final Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative on October 20, 2023.
- Finalization and publication of several ECM-related Justice-Involved items, including:

    - JI ECM Model of Care Template;
    - Provider Capacity Attachment;
    - Provider Exception Question Attachment; and
    - Managed Care Plan Contract Amendment
- Readiness Assessment: Release of draft Correctional Facility Readiness Assessment Template for stakeholder feedback on October 20, 2023, and the final template on February 15, 2024.
- IT Systems: Considerable progress made on JI Portal, developing care management bundles, confirming payment policy.
- PATH JI Round 3: DHCS approved 120 applications and awarded $330,518,594.94.

DHCS has identified the following barriers through the implementation of the JI Initiative:

- **Unknown Release Dates:** Given the prevalence of short-term stays and unpredictable release dates, particularly in county jails and county youth correctional facilities, correctional facilities will likely face operational challenges in screening all individuals who are incarcerated for only a short period of time and providing them with reentry services.
- **Supporting CFs in building systems to bill/claim Medicaid:** Implementation partners that have not traditionally billed Medi-Cal (e.g., correctional facilities and community-based providers that will be providing in-reach and post-release care management services) will be enrolling in Medi-Cal and setting up new billing and claiming processes for the first time and may face challenges navigating related requirements (e.g., need for EHR/system updates, intensive technical assistance on provider enrollment and billing processes).
- **Workforce Capacity:** Managing workforce shortages for in-reach providers (especially BH providers and case managers) with relevant experience; capacity of correctional facility staff needed to move people to appointments as well as provide healthcare.

SUD Health IT Plan (STC 6.3 or Attachment E)

The SUD monitoring protocol was submitted to CMS for review on November 1, 2022, and was approved on February 10, 2023. As part of the SUD monitoring protocol, DHCS

reported data on three different Health IT metrics as part of the Other Annual Metrics for DY 18 (January 2022 – December 2022). This is the state's first annual reporting for these metrics.

- **Health IT Q1 - Number of checks**: For January 1, 2022 – December 31, 2022, the total number of CURES Patient Activity Report searched was 75,956,689.
- **Health IT Q2 - Number of web updates**: For the January 1, 2022 – December 31, 2022, the total number of online CURES resources information updates published was 23.
- **Health IT Q3 - Number of corrections live**: For January 1, 2022 – December 31, 2022, the total number of connection corrections systems to the SUD delivery system for incarcerated individual release to the community was three.

DHCS plans to report data on three different Health IT metrics as part of the Other Annual Metrics for DY 19 (January 2023 – December 2023).

Managed Care in County Organized Health Systems (STC 12.2-12.6)

DHCS provided the "1115a STC 12.1-12.6_Comprehensive Report" to CMS on December 29, 2023, that outlined DHCS' compliance activities and monitoring with STC 12.1 – 12.6. In addition to the pre-launch report, DHCS is submitting monthly reports on Member PCP retention in accordance with the monthly reporting requirement for STC 12.2.c. DHCS submitted its first monthly PCP retention report to CMS on February 29, 2024. DHCS provides the update below in response to CMS' written request to provide additional feedback on the transition of the managed care entities within the different counties.

DHCS deployed a multi-pronged monitoring approach including a bi-weekly data submission from all MCPs involved in the transition. The monitoring data includes data on PCP retention, Continuity of Care (CoC) requests, and special populations provider outreach, among other data points. Data collected via monitoring processes indicates the transition is going well and most MCPs are demonstrating compliance with DHCS transition requirements. DHCS analyzes monitoring data for trends that indicate the potential for concern, including high CoC request denial rates, low PCP retention, low provider outreach, or low network provider agreement/CoC for Provider agreement totals. When a potential concern is identified, DHCS alerts the MCP, and schedules technical assistance calls to provide guidance and affirm requirements. DHCS escalates issues to MCP leadership when technical assistance calls do not achieve the desired outcome and issues Corrective Action Plans (CAPs) for continued non-compliance. To

date, DHCS has placed a CAP on PHC for non-compliance with the PCP retention requirements, as detailed in our inaugural PCP retention report submitted on February 29, 2024. Please reference the "1115a STC 12.1-12.6_Comprehensive Report" for additional information on PCP retention.

Figure 5 below shows transition monitoring data, representing cumulative totals as of February 11, 2024, for both special population provider outreach and Member CoC for providers requests. Member CoC requests are agreements achieved via Out-of-Network (OON) provider outreach and are dependent on the MCP and the provider coming to an agreement. Once the CoC request is received by the MCP, they must contact the eligible provider and make a good faith effort to enter into an agreement for the member's care within 30 days, in most cases. MCPs will deny a request if the providers are unresponsive or if the provider declines to contract or enter into a CoC for providers agreement.

Figure 5: Special Populations Provider Outreach Totals

MCP Name	Reporting Unit/ County	Total Out-of-Network Providers Contacted/ Outreached	Total Provider Contracts/CoC Agreements established	Total Out-of-Network Providers who are non-responsive or declined to contract	Total CoC for provider agreements or provider contracts Pending/In-process
AAH	Alameda	338	19	319	0
CCAH	Mariposa	28	12	11	5
CCAH	San Benito	43	19	23	1
CCHP	Contra Costa	121	54	65	2
CHPIV	Imperial	10	10	0	0
PHC	Butte	1176	852	271	53
PHC	Colusa	554	423	117	14
PHC	Glenn	327	260	50	17
PHC	Nevada	1060	681	331	48
PHC	Placer	2429	1290	1070	69
PHC	Plumas	257	156	80	21
PHC	Sierra	50	37	0	13
PHC	Sutter	1251	837	380	34

MCP Name	Reporting Unit/ County	Total Out-of-Network Providers Contacted/ Outreached	Total Provider Contracts/CoC Agreements established	Total Out-of-Network Providers who are non-responsive or declined to contract	Total CoC for provider agreements or provider contracts Pending/In-process
PHC	Tehama	688	522	144	22
PHC	Yuba	1332	934	354	44

Figure 6: Total CoC Member Requests and Total Approved

MCP Name	Reporting Unit/County	Total Number of Member CoC Requests	Number of Agreements Established	Number Approved Because Provider is Already in Network	Number of Pending Member CoC Requests	Number of Denied Member CoC Requests
AAH	Alameda	2493	429	1885	154	25
CCAH	Mariposa	40	12	0	28	0
CCAH	San Benito	67	15	0	**	*
CCHP	Contra Costa	548	428	*	**	44
CHPIV	Imperial	*	*	0	*	0
PHC	Butte	**	*	757	59	36
PHC	Colusa	93	0	77	**	*
PHC	Glenn	148	*	**	*	*
PHC	Nevada	444	16	322	48	58
PHC	Placer	2250	92	1559	346	253
PHC	Plumas	44	*	33	*	*
PHC	Sierra	*	0	*	0	0
PHC	Sutter	**	*	462	43	27
PHC	Tehama	306	*	278	**	*
PHC	Yuba	**	*	311	49	36

**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.*

*** Complementary cell suppression.*

STC 12.5 states that DHCS "must submit 60 days after of the end of each quarter, appeals and grievance data for all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section 1115(a) demonstration launching on or after January 1, 2024." DHCS is currently submitting a Quarterly Appeals and Grievance report to CMS in response to the 1915(b) Waiver STC 14 on the template provided by CMS, which began in 2023.

Post Award Forum (STC 15.9)

The DHCS Stakeholder Advisory Committee (SAC) provides DHCS with valuable input on ongoing CalAIM implementation efforts, as well as helps DHCS further its efforts to provide members with high-quality, accessible, and equitable care. SAC members are recognized stakeholders/experts in their fields, including, but not limited to, member advocacy organizations and representatives of various Medi-Cal provider groups.

The DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) is a broad-based body to disseminate information and receive coordinated input regarding DHCS BH activities. It was created as part of the ongoing DHCS effort to integrate BH with the rest of the health care system and incorporates existing groups that have advised DHCS on BH topics. Following the model of the SAC, the BH-SAC advises the DHCS Director on the BH components of the Medi-Cal program as well as BH policy issues more broadly.

Joint Sac/BH-SAC hybrid meetings are conducted in accordance with the Bagley-Keene Open Meeting Act, and public comment occurs at the end of each meeting. In DY 19, four joint SAC/BH-SAC meetings were convened on the following dates: February 16, 2023, May 24, 2023, July 20, 2023, and October 19, 2023. DHCS agenda items included:

- COVID-19 PHE Unwinding
- CMS Approval of CalAIM Justice-Involved Initiative
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens Education Campaign
- Update on Integration of Dual Eligibles into Managed Care
- Medications for Addiction Treatment in Residential SUD Care

- Youth SUD Prevention
- New Waiver for California Behavioral Health Community-Based Continuum Demonstration
- Contingency Management
- Behavioral Health Bridge Housing
- Behavioral Health Continuum Infrastructure Program
- Behavioral Health Payment Reform
- Documentation Redesign
- CARE Act Update
- Opioid Settlement Fund

To view past meeting agenda's visit DHCS' website at DHCS Behavioral Health Stakeholder Advisory Committee Past Meeting Archive or DHCS Stakeholder Advisory Committee Past Meeting Archive.

Monitoring Reports (STC 15.5)

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 19, DHCS submitted three quarterly reports to CMS electronically on the following dates:

Quarter	Reporting Timeframe	Submitted to CMS	CMS Approval
One	January 1 – March 31, 2023	May 30, 2023	October 13, 2023
Two	April 1 – June 30, 2023	August 28, 2023	November 29, 2023
Three	July 1 – September 30, 2023	November 27, 2023	February 23, 2024

Per CMS' guidance, the fourth quarterly reporting information has been folded into the annual reports beginning in DY15.

Monitoring Calls (STC 15.8)

During DY 19, CMS and DHCS mutually agreed to hold jointly CalAIM 1115/1915(b) waiver monitoring calls. During DY 19-Q1, DHCS and CMS held a monitoring call on January 9, 2023, and discussed CalAIM 1115 specific items related to SUD, PATH, and

GPP protocols; SUD, Contingency Management and PATH/GPP/Duals Evaluation Designs; quarterly reporting; and budget neutrality. During DY 19-Q2, DHCS and CMS mutually agreed to cancel the CalAIM 1115 portion of the monitoring call and instead share updates via email. During DY 19-Q3, DHCS and CMS held a monitoring call on August 14, 2023, and discussed the Community Supports Maintenance of Effort Baseline State Funding Plan; CBAS-HCBS Performance Measure Development; and Community Supports. During September 2023, DHCS and CMS mutually agreed to cancel the CalAIM 1115 portion of the monitoring call during the months of September and October and move forward with quarterly calls for the 1115 portion of the demonstration only. The fall quarterly call during DY 19-Q4 took place on November 13, 2023. DHCS and CMS discussed PATH – Justice Involved (JI) Initiative/Stakeholder Engagement and Rate Development for the Health-Related Social Needs (HRSN) Policy. As needed, DHCS and CMS also held separate meetings to discuss waiver deliverables, with key subject matter experts in attendance.

Financial Reporting Requirements (STCs 15.5c and 17.1-17.8)

The expenditures related to CalAIM's section 1115 populations for DY 19 were claimed on the CMS-64: Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program forms. Some of the expenditures were claimed under CMS 64.9: Quarterly Medicaid and CHIP Budget and Expenditure Reporting for the Medical Assistance Program, Administration and CHIP forms because the State is still working on the CalAIM waiver break down information. The figure below shows expenditures reported to CalAIM waivers for DY 18 and DY 19.

Figure 7: MAP Waivers

Waiver: 11W00193				
Waiver Name	DY 18		DY 19	
	Total Computable	Federal Share	Total Computable	Federal Share
Asset Test MAP	12,217	6,763	0	0
Asset Test MC	0	0	139,610	75,900
CBAS	615,522,526	349,528,550	818,453,360	441,906,553
DMC-ODS	365,286,040	297,949,515	131,494,365	106,262,546
Global	2,403,435,121	1,336,248,797	2,094,568,113	1,108,711,953
OOS FFCY MC	340,900	191,586	328,323	176,667
UC - IHS	359,040	359,040	202,740	202,740

DHCS reported administrative costs associated with this demonstration on the CMS 64.10 Waiver Path Supports. Per STC 17.10, "The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS." The figure below shows expenditures reported to CalAIM waiver PATH Supports for DY 18 and DY 19.

Figure 8: ADM Waivers

Waiver: 11W00193				
Waiver Name	DY 18		DY 19	
	Total Computable	Federal Share	Total Computable	Federal Share
PATH Supports ADM	40,643,709	20,321,857	0	0

Monitoring Budget Neutrality (STCs 18.1-18.13) and Medicaid Expenditure Groups (STCs 17.9-17.10)

The State has complied with all quarterly reporting requirements for monitoring budget neutrality set forth in the STCs and is providing an updated budget neutrality workbook with this report. This workbook will work serve as the annual monitoring report for DY 19 and utilizes the template most recently supplied by CMS. The following paragraphs describe key changes or caveats affecting expenditures specific to the Medicaid Expenditure Groups (MEGs).

For most MEGs, expenditure data for DY 18 and DY 19 is now reflected on Schedule C, reducing the need for manual adjustments to expenditures.

PATH: The different PATH initiatives under the PATH Program have undergone various program design evolutions to refine the application processes, award processes, contract structure, reporting requirements, and payment processing. As before, most funds are projected to be expended in DY 20 and DY 21, with expenditures trending down in DY 22. Award funding is tied to milestones that are achieved by the awardees. For example, CITED awardees have up to two years to complete milestones and activities will extend beyond the end of DY 19. In addition, the start of the Reentry Demonstration Initiative has been delayed to October 2024, with associated changes in

projected expenditure timing.

Global Payment Program (GPP) and DSH: GPP expenditures and projections listed under the With-Waiver Total Expenditures are inclusive of both Adjusted DSH allotment and UC Pool (formerly known as Safety Net Care Pool) federal funding ($472 Million total computable annually). Projections for DSH payments also under the With-Waiver Total Expenditures include NDPH and UC DSH hospital payments, also known as Traditional DSH, funded only by the federal DSH allotment and various non-federal funding sources (IGTs, CPEs, & General Fund). DSH program years are consistent with the State Fiscal Year (Jul-Jun), rather than the Demonstration Year (Jan-Dec). Expenditures reported on Schedule C for DSH are expenditures associated with the Federal Fiscal Year (and DSH program year) beginning within the given Demonstration Year.

GPP and DSH projections have been updated to reflect the stepdown of enhanced FMAP authorized by the Consolidated Appropriations Act (CAA 2023). GPP and DSH projections reflect updated NDPH DSH allocation estimates given changes in hospital data trends, as well as updated UC DSH allocation percentages resulting from the transition of UCLA from DSH to GPP participation.

For GPP, the DY 18 Final Reconciliation payment, scheduled to be paid in February 2024, is included as a DY 18 projection.

For DSH, the SFY 2022-23 recoupments and payments associated with UCLA's transition to GPP are scheduled to occur in February and March, respectively. Recoupments and payments are included as a DY 18 projection.

Contingency Management: In August 2023, DHCS began receiving Contingency Management encounter claims. Currently, in DY 19, counties are in the process of implementing system changes to align with the new CalAIM billing requirements. Consequently, we anticipate delays in claims submissions as counties update their billing systems and processes. DHCS has held constant the DY 19 Q3 projections for Contingency Management. Projections will be updated to reflect final expenditures in subsequent quarterly reporting once billing delays are resolved.

DSHP: The DSHP proposal within the CalAIM Section 1115 Demonstration renewal was approved by CMS on January 26, 2023. However, claiming cannot begin until the Approved DSHP List identifying the specific state programs is approved by CMS.

CBAS: CBAS per-capita expenditures for DY 19 are higher than the $6.90 PMPM projection in the STCs. In accordance with STC 18.7, the actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. Both member months and expenditures are reduced from the DY 19 Q3 report due to the ongoing process of redeterminations following the end of the PHE. We expect to see a further decline in member months in DY 20 but, for the time being, have held member month projections for DY 20 through DY 22 at the level observed for DY 19.

OOS FFCY: OOS FFCY member months and expenditures continue to align with trends observed in DY 18. Expenditures remain lower than the hypothetical budget neutrality per-capita expenditure limit.

DMC-ODS: IMD: In DY 19, counties underwent system change implementation to align with new CalAIM billing requirements. Consequently, delays in claims submissions occurred as counties updated their billing systems and processes. Significant projections have been retained for DY 19 to account for anticipated expenditures that will continue to occur; projections will be resolved in subsequent quarterly reporting. In accordance with STC 18.7, the actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project.

IHS Chiropractic Services: IHS encounter claims are paid on a quarterly basis. The DY 19 Q3 payment was calculated for processing in January 2024 while the DY 19 Q4 encounters and any remaining encounters for DY 19 are expected to be paid in May 2024. The IHS global encounter rate is updated on the Federal Register for each calendar year (CY). The IHS global encounter rate for CY 2023 (DY 19) is $654. Total expenditures for DY 19 are below the annual limit of $1,550,000.

HRSN Services: With the demonstration amendment approved by CMS on January 26, 2023, HRSN Services are now subject to a Capped Hypothetical Budget Neutrality Test. In DY 19, HRSN Services (Recuperative Care and Short-Term Post Hospitalization Housing) actual expenditures fall below the approved capped hypothetical amount of $371,919,141.

Asset Test: Total expenditures throughout DY 19 have remained fairly stable and are consistent with DY 19 Q3 reporting. Projections for DY 20 through 22 were slightly adjusted to reflect more current data. In accordance with STC 18.7, the actual expenditures for the Deemed SSI asset limit increase and elimination will be included in the expenditure limit for the demonstration project.

PROGRAM UPDATES

The Program Updates section describes key activities and data across CalAIM 1115 program initiatives for DY 19, as required in the CalAIM 1115 demonstration Special Terms and Conditions (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 evaluation interim findings. Key program areas described in this section include:

- **GPP**: (STCs 14-14.15)
- **CBAS**: (STCs 5.1-5.12)
- **DMC-ODS**: Residential and Inpatient Treatment for Individuals with substance use disorder (SUD) (STCs 6.1-6.7), including **CM** (STCs 7.1-7.5)
- **PATH Supports**: (STCs 5.13-5.25)
- **Community Supports**: Recuperative Care & Short-Term Post Hospitalization (STCs 8.1-8.15)

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 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 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) funds, and Uncompensated Care Pool (UC Pool) funding.

Successes/Accomplishments

DHCS continues to conduct bi-weekly conference calls with the California Association of Public Hospitals and Health Systems (CAPH) to discuss programmatic activities, budgets, and trends in reported data.

On February 16, 2023, CMS approved the GPP Funding and Mechanics Protocol (Attachment K), Valuation Methodology Protocol (Attachment L), and Disproportionate Share Hospital (DSH) Coordination Methodology (Attachment Q) as attachments to the STCs.

On September 7, 2023, CMS approved a 10 percent reduction of GPP system thresholds for program year (PY) 8, CY 2022. The threshold reduction provides relief to PHCS who experienced low hospital utilization due to the PHE.

On November 8, 2023, CMS approved the transition of University of California Los Angeles (UCLA) from the DSH program to GPP. UCLA will be paid through GPP beginning with PY 9, CY 2023. In addition, CMS approved an inflationary increase to the GPP point values for certain services.

On December 20, 2023, CMS approved the Health Equity Metrics Monitoring Protocol (Attachment M).

Program Highlights

The Families First Coronavirus Response Act (FFCRA) provided increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA-increased FMAP was effective January 1, 2020, and extended through December 31, 2023. Within DY 19, the FFCRA impacted payments for GPP PY 7, PY 8, and PY 9.

On December 29, 2022, House of Representatives 2617 Consolidated Appropriations Act (2023) was enacted, which amended the FFCRA by implementing a step-down of increased FMAPs through December 31, 2023. The FMAP was increased by 6.2 percentage points until March 31, 2023, five percentage points between April 1 and June 30, 2023, 2.5 percentage points between July 1 and September 30, 2023, and 1.5 percentage points between October 1 and December 31, 2023.

On September 29, 2023, CMS released the draft final ARP-adjusted Federal share DSH allotment for Federal Fiscal Year (FFY) 2022, the revised preliminary ARP-adjusted DSH allotment for FFY 2023, and the draft unreduced preliminary DSH allotment for FFY 2024. GPP received the DSH allotments for FFY 2022, FFY 2023, and FFY 2024, which resulted in updated associated GPP budgets for PY 8, PY 9, and PY 10.

On September 30, 2023, PHCS began submitting PY 8 encounter-level data with equity-related data fields to allow for more robust stratification and improved evaluation of disparities. DHCS collaborated with PHCS to update reporting structure and added two new equity-related data fields: preferred language and sexual orientation. In addition, DHCS expanded existing fields for multiple race categories and gender identity reporting. Reporting of the equity-related data will continue through PY 12 on an annual basis as part of the existing GPP encounter data reporting process. In alignment with the Health Equity Monitoring Metrics Protocol (Attachment M) goals, DHCS will continue to collaborate with PHCS to improve the ability to stratify and evaluate disparities within GPP. Beginning with PY 9 (DY 19), DHCS will begin reporting on the progress of the Health Equity Monitoring Metrics Protocol to CMS in the Annual Monitoring Report.

Qualitative Findings

Nothing to report.

Quantitative Findings

DHCS received, reviewed, and approved PHCS PY 7 final year-end encounter-level data reports and completed the PY 7 final reconciliation and redistribution process on February 15, 2023. Overall, the PHCS final year-end reports indicated that one hospital was overpaid during the program's four quarterly payments and needed to return its excess payment to be redistributed to other eligible hospitals. As a result, DHCS recouped $1,149,195.37 in total funds from Zuckerberg San Francisco General Hospital and redistributed those funds, along with the remaining GPP budget, to other eligible PHCS for a net final reconciliation payment of $72,159,685.09. Through the final reconciliation, GPP paid out the maximum PY 7 total fund budget of $2,503,321,094.22.

On February 15, 2023, PHCS submitted the PY 8 Interim aggregate reports, which showed that PHCS were impacted by low service utilization rates and were unable to claim the anticipated level of GPP budgets due to the PHE and its impact to the delivery of GPP services during CY 2022. On September 7, 2023, CMS authorized an overall 10 percent reduction of GPP system point thresholds, from 243,705,662 to 219,335,096 total points. Prior to the authorization of the 10 percent reduction, PHCS were meeting 83 percent of the projected global point budget, and the threshold reduction allowed them to claim 92 percent of the PY 8 global point budget. The point threshold reduction resulted in an additional off-cycle payment adjustment allowing the State to claim and distribute the resulting earned funds.

PY 8 final reports were submitted to DHCS from all participating GPP PHCS by September 30, 2023. The reports included PY 8 final year-end aggregate and encounter level data. DHCS reviewed the encounter-level data for accuracy, completeness, reasonability, timeliness, and compliance and worked with PHCS to correct or improve data as needed. Upon completion of PY 8 aggregate and encounter-level data review, PHCS were found to have met 108 percent of the GPP budgeted point threshold which will allow GPP to expend the entire GPP budget.

On November 8, 2023, CMS approved an inflationary increase to GPP point values for certain services which incentivizes PHCS to provide more of certain lower cost, higher value services, and less of certain more costly and avoidable services. Therefore, point values for PY 9 reflected an inflationary increase of 8.52 percent for Outpatient ER, Mental health ER/crisis stabilization, IP Med/Surg and IP Mental Health, and an increase of 9.52 percent for all other categories of service. The inflationary increase was a one-time adjustment applied against the existing PY 8 point values and impacts PY 9

through PY 12.

Figure 9 below shows the GPP payments made to the PHCS in the order that they were paid during DY 19.

Figure 9: DY 19 PHCS GPP Payments

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 7 Final Reconciliation	$40,553,743.02	$31,605,942.07	DY 17	$72,159,685.09
PY 8 Q4 (October 1, 2022 – December 31, 2022)	$164,045,492.81	$134,219,039.58	DY 18	$298,264,532.39
PY 8 Q4 (Threshold Reduction Payment)	$119,464,292.54	$112,505,207.54	DY 18	$231,969,500.08
PY 9 Q1 (January 1, 2023 – March 31, 2023)	$363,440,258.16	$297,360,211.22	DY 19	$660,800,469.38
PY 9 Q2 (April 1, 2023 – June 30, 2023)	$361,271,298.15	$326,864,507.85	DY 19	$688,135,806.00
PY 9 Q3 (July 1, 2023 – September 30, 2023)	$384,000,396.79	$361,631,441.63	DY 19	$745,631,838.42
Total	**$1,432,775,481.48**	**$1,264,186,349.88**		**$2,696,961,831.36**

Policy/Administrative Issues and Challenges

Throughout DY 19, DHCS worked collaboratively with CAPH, PHCS, and CMS through changes to existing and new STC attachments. CMS approved all STC attachments, K, L, M, and Q, that are required for the implementation of the GPP. As a result of the approval, DHCS continues to perform updates to ensure program operations during the CalAIM waiver period align with the approved CalAIM STC attachments.

The Affordable Care Act requires a reduction in national DSH allotment which was previously scheduled to take effect on October 1, 2013, but has been continuously postponed. House Resolution (HR) 133 (2020), enacted on December 27, 2020, eliminated the DSH reductions for FFY 2021 through FFY 2023, lowered the overall aggregate national reduction to $32 billion, and postponed the implementation until FFY 2024. On September 20, 2023, HR 5860 (2023) again postponed implementation until November 18, 2023. On November 16, 2023, HR 6363 (2023) postponed implementation until January 20, 2024. Implementation is currently postponed until March 9, 2024, pursuant to HR 2872.

COMMUNITY BASED ADULT SERVICES

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

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

CBAS was a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver. With the delayed implementation of CalAIM due to the COVID-19 PHE, DHCS received approval from CMS on December 29, 2020, for a 12-month extension through December 31, 2021.

On December 29, 2021, CMS approved California's CalAIM Section 1115 demonstration waiver, effective through December 31, 2026, which includes 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 members 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 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 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) through a face-to-face assessment which is conducted by a registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the MCP possesses. Eligibility for ongoing receipt of CBAS 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 ensure their needs are being met with the services they are receiving.

On October 9, 2020, CMS approved DHCS' disaster 1115 amendment, which allows flexibilities pertaining to the delivery of CBAS Temporary Alternative Services (TAS) and permits CBAS TAS to be provided telephonically, via telehealth, live virtual video conferencing, or in the participant's home (if proper safety precautions are implemented). These flexibilities are described in greater detail below.

The state must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012.[2] From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service (FFS) benefit.

On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing

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

CBAS as a benefit. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model, (available in 14 counties), Geographic Managed Care Plans (available in two counties), and the final COHS County (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

Effective April 1, 2012, eligible participants were able to receive "unbundled services" if there is insufficient CBAS Center capacity to satisfy the demand. Unbundled services refer to component parts of CBAS delivered outside of centers with a similar objective of supporting participants 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 residing in a Coordinated Care Initiative (CCI) County and is enrolled in managed care, the MCP will be responsible for facilitating the appropriate services on the member's behalf.

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

However, in accordance with Executive Order N-11-22 issued June 17, 2022, and the CDPH All Facility Letter (AFL) 20-34.7, issued on June 30, 2022, all licensed ADHCs are required to be open and providing all basic services in the center as of September 30, 2022. CDA issued All Center Letter (ACL) 22-02 notifying all CBAS providers that CBAS TAS flexibilities in effect during the COVID-19 pandemic would end on September 30, 2022. DHCS submitted an updated 1115 waiver Attachment K on July 8, 2022, requesting to end the TAS flexibility effective October 1, 2022, prior to the

previously approved flexibility period of six-months post the end of the federal PHE. In ending the CBAS TAS flexibility, the state is not altering or reducing the eligibility criteria, available services, or rate of payment for the CBAS benefit. All services included in the CBAS TAS flexibility were included in the core service package and additional services package. These service packages are what is included in the CBAS in-center services, which comprise the per diem rate.

On September 8, 2022, CMS confirmed the approval of California's request to revise the end date of the CalAIM demonstration authorities in the state's Attachment W to allow the state to resume normal operations for CBAS beginning on October 1, 2022. This was incorporated into the demonstration's STCs as an updated Attachment W and superseded the June 9, 2021, Attachment, which had previously allowed TAS and virtual assessment activities through six months after the end of the public health emergency. The authorities that the state requested in the Attachment W were effective from March 13, 2020, through September 30, 2022. These authorities applied in all locations served by the demonstration for anyone impacted by COVID-19 who received home and community-based services through the demonstration. CBAS TAS ended on September 30, 2022, and CBAS ERS was implemented as of October 1, 2022.

CBAS ERS is a new service delivery method approved by CMS in the 2022 1115 waiver renewal to provide time-limited services in the home, community, via doorstep and/or telehealth during specified emergencies for individuals already receiving CBAS. The provision of ERS is to ensure continuity of care and provide immediate assistance to participants experiencing state or local disasters such as wildfires, power outages, or personal emergencies due to illness/injury, crises, or care transitions. CDA collaborated with DHCS, MCPs, and CBAS providers to develop ERS policy guidance, reporting templates, and processes to ensure compliance with the CalAIM 1115 waiver, 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 used lessons learned from the implementation and operation of CBAS TAS during the PHE to assist with constructing processes and parameters that keep the CBAS Program as a congregate facility-based service while providing the ERS flexibility when specific criteria are met. ERS enables 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 with continual access to services.

Successes/Accomplishments

In November of 2023, various members of the CBAS team presented six CBAS trainings at the annual California Association for Adult Day Services (CAADS) Fall conference. Presentation topics included: "CBAS Documentation Challenges: How to Avoid Plans of Correction;" "Secrets to Creating a Successful Plan of Correction;" "Fundamentals of CBAS Documentation: Best Practices;" "Do's and Don'ts: CBAS Care Planning and Daily Documentation;" "CBAS Surveys: On Your Mark, Get Set, Go!" and "Emergency Remote Services (ERS): Data, Policy Review, and Best Practices." The goal of participating in the CAADS Fall Conference was to demonstrate to CBAS Providers how to successfully complete required documentation as proof of practice while providing quality care to participants, and to ensure the completion of CMS and CBAS program requirements. During the Conference, documentation was identified as a primary cause of CBAS centers requiring a Plan of Correction (POC). Emphasis was placed on individualized measurable needs, interventions to mitigate problems and/or resolve needs, and ensure goals related to the needs are measured through successful documentation practices. Other highlights presented included information on positive trends in data, which showed an increase in newly certified CBAS centers in 2023, rising from 276 to 293, a six percent increase from 2022. Trends in ERS usage throughout the year were also presented, as outlined below in the "Program Highlights" section.

Throughout 2023 CBAS providers, alongside CDA, continued to navigate: preparing facilities and staff for return to in-center congregate services; learning new policies and procedures for ERS; properly initiating ERS when outbreaks occur and pausing in-center services; and safely triaging participants to home. In addition, CDA assisted CBAS providers in registering and successfully implementing EVV, as well as resolving ongoing challenges with staffing and transportation shortages.

Program Highlights

Effective March 23, 2023, the CalEVV system began supporting CDA and CBAS providers to ensure compliance with CBAS ERS EVV requirements. The EVV system is utilized when providing participants with professional services such as clinical nursing services, personal care services to support activities of daily living, physical and occupational therapy, and a meal when prepared in the home.

One of the significant program updates that occurred during DY19 was the end of TAS program flexibilities. October 1, 2023 marked the one-year anniversary of the return of

participants to receive services in a full congregate setting as well as the beginning of ERS being available to all CBAS participants.

The new ERS modality is in full operation. All CBAS centers can offer clinical support to CBAS participants who may be experiencing either a public or personal emergency as defined in the fully developed ERS policy. This program benefit was emphasized during the 2023 Fall CAADS Conference in which the following data was presented. As of the one-year mark of ERS implementation (October 1, 2022-October 1, 2023) there were 22,104 ERS events initiated. The ERS events are broken down into two categories, with public emergencies totaling 58 percent and personal emergencies at 42 percent. To further breakdown public and personal emergencies: 48 percent were due to epidemic/infectious disease outbreaks; 36 percent due to serious illness/injury; 6 percent were related to personal crisis or care transition; and 10 percent were due to floods, power outages, and other public emergencies. Such ERS events prove the successful utilization, implementation, and value ERS brings to the CBAS providers and participants.

In December 2023, CDA convened the CBAS Quality Advisory Committee. The kickoff meeting included CBAS providers, MCPs, DHCS, and CDA team members. The goal of the kickoff meeting was to level-set the committee and establish priorities based on the requirements in the 1115 Waiver. The meeting cadence was established to be monthly and feedback or insights from all stakeholders was welcomed. Future meetings will be held to ensure performance measures are developed and monitored to ensure compliance.

Qualitative Findings

Outreach Activities

CDA provides ongoing outreach and program updates to CBAS providers, MCPs, CAADS, and other interested stakeholders. Communication modalities include CBAS ACLs, CBAS News Alerts, CBAS webinars, CAADS conferences, CAADS/CDA webinars, CAADS/ALE Vision Team Meetings (includes CDA, CBAS staff, and CBAS providers, CAADS/ALE MCP meetings (includes CDA, CBAS staff, and CBAS providers), CDA meetings with MCPs that contract with CBAS Centers, and CDA meetings with the CBAS Quality Advisory Committee. In addition, CDA responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders.

The following are CDA's outreach activities during DY 19: CBAS ACLs (2); CBAS News

Alerts (82); CBAS webinars (3); CAADS/ALE Vision Team meetings (9); CDA MCP meetings (4); CAADS/ALE MCP meetings (3); CBAS Quality Advisory Committee Workgroup meeting (1); DHCS/CDA meetings (12), CDPH/CDA meetings (3) and Responses to CBAS Mailbox Inquiries (618 in Q4).

These outreach and educational/training activities focused on the following topics: (1) an EVV onboarding and self-registration webinar; (2) a comprehensive training regarding ERS, including a one year look back of best practices and revised policy guidance; (3) Revised policy guidance per CDA ACLs on updated ERS policies and procedures; (4) Education and training opportunities to promote quality of care and to comply with CBAS program requirements. In addition, CDA (in collaboration with DHCS) provided training on EVV that included a program launch announcement, guidance on CBAS core and additional services eligible for EVV, notification of the newly established ERS EVV billing and reimbursement codes, and important EVV facts for CBAS providers. CDA held a webinar in collaboration with DHCS for EVV, which included guidance on the EVV onboarding and registration process for CBAS providers.

CBAS Webinars

CDA presented three webinars during DY 19 to provide updates on the following topics: (1) The EVV onboarding and registration process for CBAS providers which included an introduction of EVV, a demonstration of best practices and how to accurately register for EVV, and a focus on the submission of EVV data for specified ERS provided in the home which are subject to EVV. (2) An ERS Initiation Form webinar, which provided an overview of enhancements made to the CBAS provider portal, specifically on how to implement a bulk initiation of participants in the event of a public emergency. This webinar also included recommended best practices to be used during a public emergency. (3) A webinar on ERS and how to update Medi-Cal participants in the CBAS provider portal, the introduction of other system enhancements including an alternative method of uploading ERS days, and a new participant section. All CBAS webinar recordings and slides are posted on the CDA CBAS Training webpage.

CAADS/ALE Vision Team Meetings

CDA continues to collaborate with the CAADS/ALE Vision Team (which includes CDA, CBAS staff, and CBAS providers) in the revision of ERS policy guidance and the planning of webinars for CBAS providers, MCPs, and other interested stakeholders. During these meetings, attendees shared priorities for the coming year related to CBAS and the Vision's Team charter to address post-crisis issues that continue to emerge connected to

the COVID impact on center operations and participant health and safety. This forum also serves to address priorities such as the monitoring of ERS implementation and identification of emerging trends, issues related to the MCP contract transition (October 2023 through March 2024), the creation of program efficiencies to address burdensome paperwork or processes that detract from participant care, the identification of system issues, emerging trends, and resolution of such that are related to COVID, disasters, and participant health and safety.

MCP Meetings with CDA

CDA convenes 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 any CBAS provider issues requiring CDA assistance.

During DY 19, CDA convened four meetings with the MCPs. The purpose of the meetings was to re-establish monthly planning between the CBAS program and the MCP's, placing focus on overall CBAS operations, coordination and information sharing; as well as to discuss CBAS ERS and the ERS Initiation Form updates, MCP status of communications with CBAS providers on dual transitions, and the status of CBAS center compliance with MCP requirements for discharge planning. Further updates were also given on the EVV Go Live scheduled for March 23, 2023, Medi-Cal Manual billing, and MCP coding and system updates for ERS-EVV with modifier. In addition, the CDA/MCPs also covered topics related to MCP communications with CBAS providers in transition, hours of operations and Saturday hours, discharge plans, ERS events, and data for the past 90 days. One final meeting was held to provide an update to the MCP's on CBAS activities.

MCP Meetings with CAADS/ALE

CDA participated in three meetings convened by CAADS and ALE with MCPs for collaborative discussions about: recent programming changes that make it challenging for CBAS providers to verify eligibility; status of HealthNet members delegated to Molina causing some members to proactively change plans; additional plan changes on the horizon for 2024; and CBAS readiness to accept the new ERS EVV reimbursement codes.

CBAS Quality Strategy Advisory Committee Meetings

On December 5, 2023, CDA reconvened the first meeting with the CBAS Quality Strategy Advisory Committee since the ending of the PHE. This comprised of various stakeholders, which included members of the CBAS Executive Team, CBAS providers, MCPs, DHCS, and representatives from CAADS. The goal of the meeting was to level-set and re-launch the Quality Strategy Advisory initiative. Stakeholders provided input on possible new key Performance Measures (PMs) to monitor. Since this meeting, a draft of PMs for consideration have been identified and are currently being vetted. Additional details about the CBAS Quality and Improvement Strategy and the CBAS Quality Advisory Committee are provided in the "Quality Control/Assurance Activity" section of this report.

CBAS Mailbox Inquiries

During DY 19, CDA responded to 1,931 CBAS mailbox inquiries. Below is a breakdown of the email inquiries by quarter:

Quarter	Inquiries
Quarter 1	580
Quarter 2	333
Quarter 3	400
Quarter 4	618

The subjects of the inquiries and responses included: (1) general CBAS program operations; (2) the use of ERS; (3) EVV registration; and (4) requests on how to properly document public emergencies related to centers' physical locations (such as floods and fires).

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

CDA, in collaboration with DHCS, continued to implement the activities and commitments to CMS for compliance of CBAS Centers with the federal HCB Settings Requirements through 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. As background, per CMS' directive in the CBAS Sections of the 1115 waiver, CDA developed the CBAS HCB Settings Transition Plan which is an attachment to California's Statewide Transition Plan (STP). On February 23, 2018, CMS granted initial approval of California's STP and the Draft CBAS Transition Plan based on the state's revised systemic assessment and proposed remediation strategies. CMS requested additional revisions of the STP and Draft CBAS Transition Plan before granting final approval. CDA responded to additional revisions as requested. DHCS informed CDA in June 2023 that CMS granted STP final approval.

Operational Updates

Public and Personal Emergencies Related to ERS Implementation

Public and personal emergencies continued to occur over the past 12 months. Implementation of ERS has reinforced the value of the CBAS ERS benefit. CBAS providers continue to utilize ERS for participants experiencing public emergencies that include issues related to power outages, extreme weather conditions and flood related events.

In addition, CBAS providers also initiated ERS for participants experiencing personal emergencies including serious illness/injury (falls, decline in health, and surgery); personal crisis (includes transportation issues, loss of caregiver, and deterioration of health) and care transition related events which include hospitalization. As CBAS center participants transitioned back to in-center services, during DY 19 Q1, CBAS providers reported a rise in COVID-19 and influenza infections resulting in individual personal emergencies for some and a temporary pause of in-center services at specific CBAS centers. As the year progressed into Q2, disease outbreaks and weather-related emergencies declined, and the percentage of ERS reported events shifted to personal emergencies. Seventy-five percent of the active ERS events at the end of June 2023 were personal emergencies experienced by CBAS participants that required continuity of care while they were temporarily unable to attend the center due a decline in overall health during the pandemic. Percentages of ERS events related to public emergencies shifted again during DY 19 Q3 to their highest point since January 2023 because of increased COVID-19 outbreaks. By the end of Q3, reported outbreaks again trended down slightly. At the end of Q4, there were 2,143 active ERS events which indicates a downward trend of 63 percent from the previous year in Q4. The CBAS teams continue to monitor ERS usage by reviewing weekly data and analyzing trends during bi-weekly ERS Huddle

meetings.

Covid-19 Public Health Emergency

May 11, 2023, marked the formal end of the COVID-19 PHE. During DY 19, the CBAS Program worked continuously to remain vigilant about communicating with stakeholders such as DHCS, MCPs, CBAS center providers and CAADS representatives to guide the CBAS program through all the transitions that occurred. This included collaborating on policy updates, providing guidance on in-center congregate services, and facilitating online webinars and trainings to ensure a smooth transition for all CBAS centers. As the end of the PHE approached, the CBAS program was able to transition the focus to improving CBAS program operations.

New CBAS Centers by County

During DY 19 CBAS certified 17 new CBAS centers that are open, active, and operating. This is a historic milestone for the CBAS Program, marking the highest number of center openings since 2017. The increase in new centers for DY 19 went from 276 active centers to 294; a six percent increase. The breakdown of new centers by County is represented below:

- Eight CBAS centers opened in Los Angeles County;
- Three in Orange County;
- One in Stanislaus County;
- Two in San Bernardino County;
- One in San Mateo County;
- One in Kern County and;
- One in San Diego County.

Operational improvements and streamlined initial certification processes were implemented to support the CBAS initial certification application process and the pre-screening phase of that process. In addition, the CBAS team received approval for three new positions to help support the initial certification of new centers to ensure expeditious approval. Newly opened CBAS centers are assigned a Registered Nurse (RN) and a Program Analyst who provide technical support, guidance, and training to ensure

new centers are successful and fully prepared for the re-certification process.

All Center Letters (ACL)

All Center Letters (ACLs) are issued to CBAS centers to communicate operational and policy changes. In DY 19, two ACLs were issued. The first ACL 23-01 was issued on February 15, 2023, titled "Pre-Approval Process for CBAS Change Application Packets." The purpose was to summarize the process to obtain CDA pre-approval for changes to center administrators, license capacity, location, ownership, or shareholder. A portion of this updated process included CDA notifying the CBAS provider of its determination and forwarding copies of the change application packet to CDPH along with a notice of CDA's recommendation.

The second ACL was issued on June 30, 2023, titled "Participant Characteristics Report (PCR) – Revised Reporting Period." The purpose of this ACL was to inform CBAS providers of a change in the PCR reporting period. Previously providers were required to provide aggregate data twice a year for each DY, which included the June 1-30 and December 1-31 reporting periods. The PCR data is used by CDA, DHCS, and other stakeholders for analysis, program monitoring, and oversight. CDA determined that one annual PCR submission is sufficient and provides adequate data to serve the intended purpose. The reporting period is December 1-31, with the report due January 31. The decision to reduce the reporting period to once annually was also based on the analysis of previous years' data which indicated there was little to no change in the data. The PCR data includes total participants; diagnoses; participant status/needs; and type of CBAS service being provided.

Summary of Challenges and Actions Taken

Since the end of the PHE in May of 2023 and the implementation of ERS, CBAS providers face a few new challenges which include: the continuous/ongoing assessment of participants who are frail due to a decline in health during the pandemic and the decision to discharge participants who may need a higher level of care; the ongoing need to understand proper initiation of ERS during a personal or public emergency; and the occasional COVID outbreak at the centers forcing the need to pause in-center congregate services for up to two weeks. CDA continues to provide revised ERS policy guidance, trainings, webinars, and technical support to guide CBAS providers through this process and support regulatory requirements and compliance.

CDA will continue to provide guidance to CBAS providers and MCPs on ERS utilization

and program support-through ongoing webinars, via responses to CBAS mailbox inquiries, and during the ongoing meetings with CBAS providers and MCPs described in the Outreach Activities section of this report.

Quantitative Findings

Performance Metrics

CDA reconvened the Quality Strategy Advisory Committee in Q4 of DY 19 which included members of the CDA Executive team, CBAS staff, DHCS, MCPs, and other stakeholders. The committee plans to meet monthly, and this meeting forum will be utilized to develop performance measures required in STC 5.7. 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." Future updates and established performance measures will be forthcoming and communicated in future reports.

Enrollment and Assessment Information

Per STC 5.5(a), CBAS enrollment data for both MCP and FFS participants per county is shown in Figure 10 on the next page. The CBAS Center's licensed capacity by county is also incorporated into the same figure.

CBAS enrollment data is self-reported quarterly by the MCPs, which sometimes results in data lags. Of note, 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.

Figure 10: Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS

County	DY19 - Q1 Jan – Mar 2023		DY19 - Q2 Apr – Jun 2023		DY19 – Q3 Jul – Sep 2023		DY19 – Q4 Oct – Dec 2023	
	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	448	71%	436	70%	417	67%	405	65%
Butte	24	24%	20	20%	20	20%	25	25%
Contra Costa	116	53%	81	37%	78	35%	80	36%
Fresno	1,009	46%	962	44%	1,062	48%	9650	44%
Humboldt	88	15%	101	17%	112	19%	110	19%
Imperial	278	46%	298	50%	285	47%	122	20%
Kern	191	18%	231	22%	236	23%	225	17%
Los Angeles	22,838	52%	17,008	38%	20,099	45%	19,504	41%
Merced	110	52%	137	65%	119	57%	126	60%
Monterey	91	49%	89	48%	93	50%	110	59%
Orange	2,638	48%	2,578	46%	2,834	50%	2,992	53%
Riverside	602	35%	648	37%	653	38%	646	37%
Sacramento	451	51%	403	46%	460	52%	427	48%
San Bernardino	829	54%	926	-60%	917	37%	997	41%
San Diego	2,252	70%	2,193	59%	2,055	51%	2,398	60%
San Francisco	959	61%	922	59%	950	61%	886	56%
San Joaquin	*	*	*	*	*	*	*	*
San Mateo	138	136%	121	119%	126	124%	133	32%
Santa Barbara	13	8%	**	**	16	5%	13	4%
Santa Clara	554	40%	486	35%	462	33%	458	33%
Santa Cruz	74	49%	74	49%	77	51%	117	58%
Shasta	44	31%	47	33%	45	31%	50	35%
Stanislaus	*	*	*	*	*	*	*	*
Ventura	821	55%	840	56%	859	57%	840	56%
Yolo	244	64%	246	65%	246	65%	239	63%
Marin, Napa, Solano	48	10%	50	13%	54	14%	638	17%
Total	**34,927**	**50%**	**28,917**	**41%**	**32,288**	**45%**	**31,905**	**43%**
FFS and MCP Enrollment Data 12/2023								

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

**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.*

***Complementary cell suppression.*

The data provided in the previous figure demonstrates the enrollment numbers varying per quarter for the previous 12 months. For instance, enrollment for Q1 was approximately 50 percent, while Q2, Q3, and Q4 were 41 percent, 45 percent, and 43 percent respectively.

Most counties maintained consistent enrollment and capacity utilization that did not experience fluctuations greater than five percent. However, counties such as Contra Costa, Imperial, Los Angles, San Bernardino, San Diego, and San Mateo reported fluctuations in enrollment greater than five percent throughout DY 19 due to various center openings, closures, and capacity increases.

Figure 11: 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	Enrolled in Enhanced Care Management (ECM) & Community Supports
DY 19 – Q1 (Jan – Mar 2023)	34,463	494	473	65
		1.43%	1.37%	0.19%
DY 19 – Q2 (Apr – Jun 2023)	34,183	993	959	54
		2.90%	2.81%	0.16%
DY 19 – Q3 (Jul – Sep 2023)	35,945	1,514	1,396	219
		4.21%	3.88%	0.61%

				DHCS Data 12/2023

**ECM/Community Supports information is not reported for DY 19-Q4 due to a delay in the availability of the data and will be presented in the DY 20 Q-1 Report.*

Figure 11 displays the number of CBAS participants who also received ECM and Community Supports through their Medi-Cal managed care plans. Beginning DY 18 Q-4, DHCS will be including this information for quarterly and annual reports. ECM and Community Supports are a new statewide Medi-Cal benefit as a part of CalAIM. ECM is available to select "Populations of Focus" that will address 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. As of DY 19-Q3, there were a total of 35,945 CBAS participants – 1,514 received ECM, 1,396 received Community Supports, and 219 received both benefits.

Assessments for MCPs and FFS Participants

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 is met based on medical information and/or history the plan possesses.

Figure 12 below 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 12: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY19-Q1 (Jan-Mar 2023)	3,036	2,988 (98.4%)	48 (1.6%)	2	1 (50%)	1 (50%)
DY19-Q2(Apr-Jun 2023)	3,225	3,155 (97.8%)	700 (2.2%)	2	0 (0%)	2 (100%)
DY19-Q3(Jul-Sep 2023)	3,238	3,184 (98.3%)	54 (1.6%)	0	0 (0%)	0 (0%)
DY19-Q4(Oct-Dec 2023)	3,352	3,285 (98.0%)	67 (1.99%)	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

Requests for CBAS are collected and assessed by the MCPs and DHCS. Figure 12 notates that 12,851 assessments were completed by the MCPs, of which 12,612 were determined to be eligible, and 239 were determined to be ineligible. For FFS four assessments were performed for CBAS benefits, one was determined to be eligible and three were ineligible. As indicated in the previous figure, the number of CBAS FFS participants are low, given that most participants are in a managed care plan, although there are occasional requests for CBAS FFS.

CBAS Provider-Reported Data (STC 5.6.b)

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases licensed and enrollment capacity while conversely, new CBAS Center openings increase licensed and enrollment capacity. CDPH licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring, compliance, and oversight of the centers.

Figure 13 identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY 19-Q4. As of DY 19-Q4, the number of counties with CBAS Centers and the ADA of each center are listed in Figure 13. On average, the ADA at the

294 operating CBAS Centers is approximately 26,097 participants, which corresponds to 89 percent of the total capacity. Provider-reported data identified in Figure 13 on the next page reflects data through December 2023.

Figure 13: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	294
Non-Profit Centers	45
For-Profit Centers	249
ADA @ 294 Centers	26,097
Total Licensed Capacity	44,242
Statewide ADA per Center	89
CDA - MSSR Data as of 12/2023	

Consumer Issues and Interventions

CBAS Member/Provider Call Center Complaints (FFS/MCP) (STC 5.6.e.iv)

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. No member complaints were collected by CDA or MCPs. However, four complaints were received from CDA Providers, while six complaints were received from MCPs. The reported issues are related mainly to center operations and one wrongful termination. See Figures 14 and 15 for complaint data received by CDA and MCPs from CBAS members and providers.

Figure 14: Data on CBAS Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY19-Q1 (Jan – Mar 2023)	0	0	0
DY19-Q2 (Apr – Jun 2023)	0	0	0
DY19-Q3 (Jul – Sep 2023)	0	1	1
DY19-Q4 (Oct – Dec 2023)	0	3	3
CDA Data – Complaints 12/2023			

Figure 15: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY19-Q1 (Jan – Mar 2023)	0	4	4
DY19-Q2 (Apr – Jun 2023)	0	0	0
DY19-Q3 (Jul – Sep 2023)	0	1	1
DY19-Q4 (Oct – Dec 2023)	1	0	1
Phone Data – Phone Center Complaints 12/2023			

CBAS Grievances/Appeals (FFS/MCP) (STC 5.6)

Grievance and appeals data are provided to DHCS by the MCPs. The data provided in Figure 16 reflects a total of forty-one grievances that were filed with MCPs during DY 19. Twenty-four of the grievances were solely regarding CBAS providers, three were

regarding contractor assessment or reassessments, two were regarding excessive travel time, and thirteen grievances were designated as "other". Overall, there were 41 total grievances filed in DY 19, the same amount filed in DY 18. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

Figure 16: 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
DY19-Q1 (Jan – Mar 2023)	6	0	1	1	8
DY19-Q2 (Apr – Jun 2023)	4	1	0	2	7
DY19-Q3 (Jul – Sep 2023)	7	1	1	6	14
DY19-Q4 (Oct – Dec 2023)	7	1	0	4	12
MCP Data - Grievances 12/2023					

Figure 17: 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
DY19 – Q1 (Jan – Mar 2023)	1	0	0	0	1
DY19 – Q2 (Apr – Jun 2023)	4	1	0	0	5

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
DY19 – Q3 (Jul – Sep 2023)	4	0	0	0	4
DY19 – Q4 (Oct – Dec 2023)	7	2	0	0	9
MCP Data - Grievances 12/2023					

During DY 19, Figure 17 shows there were 19 CBAS appeals filed with an MCP. Sixteen appeals were related to "denial of services or limited services" and three appeals were related to a "denial to see requested provider."

The California Department of Social Services (CDSS) continues to facilitate the state fair hearings/appeals processes, with Administrative Law Judges hearing all cases filed. CDSS reports the fair hearings/appeals data to DHCS. For DY 19, there was one request for a hearing related to CBAS which is pending.

Figure 18: Total Number of State Fair Hearings

Demonstration Year and Quarter	Number of Requested State Fair Hearings
DY19 – Q1 (Jan – March)	0
DY19 – Q2 (Apr – June)	0
DY19 – Q3 (July – Sept)	0
DY19 – Q4 (Oct – Dec)	1
Total Number	**1**

Quality Control/Assurance Activity

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. 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.

CDA established the CBAS Quality Advisory Committee, comprised of the CDA Executive team, CBAS staff, CBAS providers, MCPs, DHCS, and representatives from CAADS to review/evaluate progress on achieving the Quality Strategy's original goals and objectives and to identify new ones that will support and promote the delivery of quality CBAS. This is a continuous quality improvement effort designed to support CBAS providers in meeting program standards while continuing to develop and promote new approaches to improving service delivery.

CDA reconvened the Quality Strategy Advisory Committee in December 2023 (DY 19 Q4). This meeting was to kick off, level set, discuss the previous goals and objectives and review the excerpt from the 1115 Waiver which states, "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. The performance measures shall include the following components: Administrative Authority; Level of Care of Eligibility based on 1115 Requirements; Qualified Providers; Service Plan; Health and Welfare; and Financial Accountability." CDA and the Quality Strategy Advisory Committee will meet monthly and continue to establish and develop performance measures in alignment with 1115 Waiver requirements.

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under CalAIM. Figure 19 illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 19, Qs 1-4.

Figure 19: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity					
	DY19-Q1 Jan-Mar 2023	DY19-Q2 Apr-Jun 2023	DY19-Q3 Jul-Sep 2023	DY19-Q4 Oct-Dec 2023	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	370	0.0%	76%
Butte	60	60	60	60	0.0%	24%
Contra Costa	130	130	130	130	0.0%	32%
Fresno	1,297	1,297	1,297	1,297	0.0%	41%
Humboldt	349	349	349	349	0.0%	14%
Imperial	355	355	355	355	0.0%	45%
Kern	610	610	805	805	0.0%	31%
Los Angeles	26,083	26,520	27,175	27,755	+2%	59%
Marin	75	0	0	0	N/A	N/A
Merced	124	124	124	124	0.0%	53%
Monterey	110	110	110	110	0.0%	59%
Napa	100	100	100	100	0.0%	88%
Orange	3,241	3,321	3,321	3,321	0.0%	60%
Riverside	1,025	1,025	1,025	1,025	0.0%	30%
Sacramento	520	520	520	520	0.0%	55%
San Bernardino	911	911	1,446	1,446	0.0%	85%
San Diego	1,903	2,186	2,359	2,359	0.0%	46%
San Francisco	926	926	926	926	0.0%	56%
San Mateo	60	60	60	245	308%	81%
Santa Barbara	100	100	180	180	0.0%	11%
Santa Clara	820	820	820	820	0.0%	46%
Santa Cruz	**	**	**	**	**	**
San Joaquin	0	0	0	0	0.00%	0%
Shasta	*	*	*	*	*	*
Solano	120	120	120	120	0.0%	54%

County	CBAS Centers Licensed Capacity					
	DY19-Q1 Jan-Mar 2023	DY19-Q2 Apr-Jun 2023	DY19-Q3 Jul-Sep 2023	DY19-Q4 Oct-Dec 2023	Percent Change Between Last Two Quarters	Capacity Used ***
Stanislaus	510	510	510	510	0.0%	33%
Ventura	886	886	886	886	0.0%	55%
Yolo	224	224	224	224	0.0%	60%
SUM	**41,084**	**41,809**	**43,447**	**44,242**		

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

**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.*

***Complementary cell suppression.*

Figure 19 reflects that the average licensed capacity used by CBAS participants is 55 percent statewide. Overall, most CBAS Centers have not operated at full or near-to-full capacity except for Alameda, San Bernardino, Napa, and San Mateo. These counties operated between 76 and 88 percent capacity. Licensing capacity allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. San Joaquin County had one center closure in DY 19-Q1 which was the only CBAS Center in this County; therefore, the data reflects zero.

STC 5.6(a) requires DHCS to provide probable cause upon a negative five percent change from quarter-to-quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. During DY 19, no counties experienced such variance.

Please see section titled "New CBAS Centers Open by County" for a breakdown of new CBAS Centers for DY 19.

Access Monitoring (STC 5.6.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Figure 10, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers.

Unbundled Services (STC 5.1.b.iii.)

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 into 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, a CBAS Center is required to notify CDA and their contracted MCPs of their planned closure date and to conduct discharge planning for each of the CBAS participants to whom they provide services. CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties can choose an alternate CBAS Center within their local area.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA have continued to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 19, CDA had 294 CBAS Center providers operating in California. According to Figure 20, three CBAS Centers closed and 17 new CBAS centers opened in DY 19.

Figure 20: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
January 2023	280	0	0	0	280
February 2023	280	2	0	-2	278
March 2023	278	0	3	+3	281
April 2023	281	1	2	+1	282
May 2023	282	0	1	+1	283
June 2023	283	0	0	0	283

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
July 2023	283	0	1	+1	284
August 2023	284	0	2	+2	286
September2023	286	0	4	+4	290
October 2023	290	0	1	+1	291
November 2023	291	0	2	+2	293
December 2023	293	0	1	+1	294

Figure 20 shows there was no negative change of more than five percent in DY 19, thus, no analysis is needed to address such variances.

Budget Neutrality and Financial Updates

MCP payment relationships with CBAS Centers have not affected the center's capacity to date and adequate networks remain for this population.

The CalAIM Section 1115 demonstration waiver, 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.

Policy/Administrative Issues and Challenges

Areas of operations were assessed, and it was determined that new applicants applying for CBAS initial certification would benefit by CDA streamlining internal initial certification processes. Process improvements were implemented to support the initial CBAS certification application processes for applicants desiring 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. Additionally, CDA identified internal staffing shortages-and therefore three new full-time positions were established to better support the initial certification processes. The recruitment process was successful and created the ability for CDA to process initial certifications in a more

efficient and expeditious manner.

One main challenge identified by CBAS in DY 19 were documentation challenges. During onsite recertification surveys, CBAS identified CBAS Centers that lacked documentation or displayed inaccurate documentation practices. Documentation challenges were addressed with individual centers through adequate plans of correction, as well as providing extensive training during DY 19-Q4 at the CAADS Fall Conference. CDA facilitated five training courses in which one focused on addressing documentation challenges. This training was well received by CBAS Centers and was posted on the CBAS website to allow all providers access.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM AND CONTINGENCY MANAGEMENT

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of SUD services to Medi-Cal eligible individuals with a SUD that reside in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS members). Since the DMC-ODS pilot program began in 2015, all California counties had 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 Medi-Cal State Plan.

Originally authorized by the Medi-Cal 2020 demonstration, some components of DMC-ODS services are authorized under California's Section 1115 CalAIM demonstration approved through December 31, 2026 (for expenditure authority for services provided to DMC-ODS members receiving short-term SUD treatment in Institutions of Mental Diseases [IMDs]), for expenditure authority for contingency management (CM)], California's Section 1915(b) CalAIM waiver (for service delivery within a regional managed care environment), and California's Medicaid State Plan (for benefits coverage), as of January 1, 2022. This CalAIM demonstration will continue to provide the state with authority to claim 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 an 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.

Successes/Accomplishments

In January 2023 the Recovery Incentives Program Manual was completed and on February 15, 2023, DHCS' Training and Technical Assistance contractor, the University of California, Los Angeles (UCLA), started offering a two-part Implementation Training required for all CM staff prior to implementation. Trainings occurred at least weekly throughout 2023. In March 2023, the first site located in Los Angeles County was approved to offer CM services through the Recovery Incentives Program and service delivery began in April 2023. Required monthly coaching calls for participating providers began in April 2023 and continued to be offered multiple times a month throughout 2023. The Fidelity Monitoring Tool was finalized in July 2023 and required Fidelity Monitoring interviews began in August 2023 and continued throughout 2023. On August 18, DHCS issued Behavioral Health Information Notice (BHIN) 23-040 providing updated policy guidance for the Recovery Incentives Program. As of December 31, 2023, 66 sites in 14 counties were providing CM services to over 800 Medi-Cal members. These 14 counties cover 67 percent of Medi-Cal members and once all 24 DMC-ODS

Plans who have opted into the Recovery Incentives Program are providing CM services, 88 percent of Medi-Cal members will live in a county offering CM. Between April and December 2023, a total of 1,598 Medi-Cal members received CM services through Recovery Incentives Program.

On November 20, 2023, DHCS released BHIN 23-068 providing updates to the CalAIM Behavioral Health policy initiative Documentation Redesign, inclusive of DMC-ODS Services. These updates were made to update Medi-Cal behavioral health documentation requirements to improve the member experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person centered care; promote safe, appropriate, and effective member care; address equity and disparities; and ensure quality and program integrity. In addition, DHCS began the DMC-ODS opt-in processes for three additional California counties who are newly seeking to participate in the DMC-ODS program: Mariposa, Lake and Sonoma. Per BHIN 24-001, Mariposa, Lake, and Sonoma County have successfully submitted their Implementation Plan. Mariposa officially began offering DMC-ODS services on July 1, 2023. Lake and Sonoma are both pending DHCS and board approvals. Both Lake and Sonoma are tentatively scheduled to "go live" with implementing DMC-ODS services on July 1, 2024. As of July 2023, 38 of California's 58 counties are actively providing DMC-ODS services, representing 97 percent of the Medi-Cal population statewide.

Program Highlights

DHCS provided support and guidance to the DMC-ODS Plans through policy and the implementation of various initiatives. Program highlights in DY 19 include, but are not limited to: implementing a risk-based approach to the Behavioral Health Audits (Behavioral Health Information Notice (BHIN) 23-044), updating the DMC-ODS Beneficiary Handbook template requirements (BHIN 23-048), providing Memorandum of Understanding (MOU) clarifications for DMC-ODS Plans and Medi-Cal Managed Care Plans (MCPs) (BHIN 23-057), providing guidance and collecting the first 1915(b) Quarterly Appeals and Grievance reports (BHIN 23-062), and submitting the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 demonstration application to CMS. For the Behavioral Health Audits, DHCS is utilizing a risk-based approach to conduct targeted audits for DMC-ODS Plans to prioritize reviews of systemic deficiencies and DMC-ODS Plans' performance as MCPs. The risk-based audit approach will be individualized for each DMC-ODS plan based on audit review trends, past audit reports, corrective action plans, oversight and monitoring history, grievances and appeals, and information from DHCS Behavioral

Health staff pertaining to each DMC-ODS plan. The new risk-based audit for DMC-ODS Plans achieves further alignment with the risk-based audit scope and methodology that DHCS uses for Medi-Cal managed care plans, consistent with the strategic priority of alignment across managed care delivery systems under CalAIM. The new audit approach has been implemented for State Fiscal Year 2023-24 and DHCS continues to look for opportunities to improve the process to provide support to counties.

DHCS provided guidance regarding updated requirements related to the Beneficiary Handbooks for the 2024 calendar year. DHCS, as part of its annual review, is currently reviewing Beneficiary Handbooks submitted by DMC-ODS Plans to ensure compliance with applicable standards.

The counties received guidance on the requirements for Medi-Cal MCPs and DMC-ODS Plans to enter into an MOU. DHCS provided guidance to address the oversight, compliance, and reporting requirements to ensure that MOUs are regularly reviewed and updated. For counties that did not execute their MOUs by January 1, 2024, DHCS is providing technical assistance through regularly scheduled monthly calls and requiring those counties to submit quarterly reports to provide updates regarding their MOU execution status.

DHCS began collecting quarterly appeals and grievance data from DMC-ODS Plans and is working towards utilizing this information to identify trends that DHCS can address with the counties to provide support. Additionally, DHCS submitted its second MCPAR report to CMS.

On July 1, 2023, DHCS implemented the CalAIM Behavioral Health Payment Reform initiative for DMC-ODS plans. The CalAIM Behavioral Health Payment Reform initiative consists of three different transitions:

- Reimbursement Structure: End cost-based reimbursement and implement fee-for-service payments to county BH plans.
- Financing Mechanism: Transition to Intergovernmental Transfers (IGTs) to finance Medi-Cal county BH plan payments.
- Provider Billing: Implement CPT Coding Transition.

The CalAIM Behavioral Health Payment Reform initiative moves DMC-ODS plans away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal members.

On October 20, 2023, DHCS submitted its application for a new Medicaid Section 1115 demonstration to increase access to and improve mental health services for Medi-Cal members statewide. The BH-CONNECT Section 1115 demonstration application, takes advantage of Centers for Medicare & Medicaid Services' (CMS') 2018 guidance and associated federal funding aimed at improving care for Medi-Cal members living with significant behavioral health needs. This demonstration builds on California's historic commitment to creating a full continuum of care for substance use disorder treatment and recovery services through the DMC-ODS.

This demonstration will allow DMC-ODS Plans to cover community-based services and evidence-based practices such as Community Health Worker services and Supported Employment services on an opt-in basis. A statewide incentive program will be established to strengthen counties' quality monitoring infrastructure and an opt-in incentive program will be established to strengthen the continuum of community-based services available to Medi-Cal members living with significant behavioral health needs, inclusive of DMC-ODS plans.

DHCS continues to create opportunities for access to 24/7 low-barrier SUD treatment in emergency departments (EDs) through CA Bridge. As of January 2024, DHCS has invested $71.6 million in total funding for 282 hospitals to serve as primary access points for evidence-based treatment of behavioral health symptoms through:

- Expanding access to low barrier medications for addiction treatment (MAT).
- Providing navigation and support.
- Facilitating direct referrals for continued care in the community.

This project has seen great outcomes with:

- Over 300,000 patients seen for a substance use and/or mental health condition.
- Over 240,000 patients seen were identified as having an opioid use disorder.
- Over 97,000 encounters in the ED occurred where MAT was prescribed or administered.

A recent CA Bridge implementation study compared outcomes between adult patients discharged from EDs with cocaine, alcohol, and opioid use-related diagnoses who received care from a BH Navigator to those who did not. The study found that patients who had the BH Navigator intervention were three times more likely to engage in treatment within 30 days of discharge compared to those who did not.

To support long-term sustainability of CA Bridge, DHCS has collaborated intensively

with Medi-Cal managed care plans, hospitals, and the CA Bridge program to support the successful implementation of the Community Health Worker benefit for Medicaid reimbursement for BH navigator services. In 2023, DHCS drafted requirements for the MCPs to implement a billing pathway for supervising providers, including contracted hospitals, to claim provisions of CHW services during an ED visit and as outpatient follow-up to that ED visit. The BH-CONNECT demonstration, pending CMS approval, will expand the CHW benefit to DMC-ODS counties.

Qualitative Findings

During the DY 19 reporting period, DHCS performed periodic reviews of counties to ensure compliance with program requirements. When counties were found out of compliance, DHCS provided technical assistance and as needed, issued Corrective Action Plans (CAPs) to address outstanding issues. These reviews include but are not limited to: Annual County Monitoring Activities (ACMA), Beneficiary Handbooks, MOUs for Medi-Cal Managed Care and DMC-ODS Plans, and CAP Resolutions from DHCS Audits.

DHCS is in the process of providing technical assistance to the DMC-ODS Plans for non-compliance items identified through the ACMA review. For items of non-compliance that are not resolved in the specified timeframe, the county will be issued a CAP and will continue to be monitored until resolution of the CAP.

DHCS continues to monitor and oversee outstanding CAPs related to DHCS Audit Reviews. This is completed through regular communication with the county through phone calls and e-mails to follow up on the status of their CAP Resolution.

Outreach Activities

- DHCS held monthly calls with each participating DMC-ODS Plan to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including status updates on CAPs and reports.
- DHCS hosted All County Behavioral Health monthly meetings with counties and stakeholders to address various upcoming and published Behavioral Health Informational Notices. Additional assistance and guidance are provided during these meetings.
- DHCS issues weekly Behavioral Health Stakeholder Updates and Information

Notices communication via email to stakeholders. The information provided includes announcements of finalized and draft BHINs, as well as upcoming webinars.

- For counties that express interest in opting in to offer DMC-ODS, DHCS provides technical assistance to address any barriers they may have raised related to opting into DMC-ODS.

- In December 2023, DHCS provided a webinar training to Behavioral Health Programs to assist with understanding the federal interoperability technical documentation requirements for Patient Access and Provider Director Application Programming Interfaces.

Q1 – Q3 Activities, Including CalAIM Demonstration Guidance

- No All County Calls were conducted in Quarter 1.
- April 17, 2023, April All County Call
    - Fiscal Year 23/24 Behavioral Health Compliance Review
- May 15, 2023 – May All County Call
    - CalAIM Performance Monitoring: Program Implementation Feedback
- June 19, 2023 – June All County Call
    - Behavioral Health Documentation Redesign
- July 17, 2023 – July All County Call
    - Screening and Transition of Care Tool
    - Provider Integration Project
    - Child Adolescent Need and Strengths (CANS) Assessment Data
- August 2023 – No Meeting
- September 18, 2023 – September All County Call
    - Medi-Cal Mobile Crisis Services Benefits
    - Medi-Cal Peer Support Specialist H00050 Short-Doyle Update
    - Performance Monitoring – Key Informant Interviews
    - Documentation Redesign FAQ Update
    - Screen and Transition Tools: Translation Update

Recent Activities, Including CalAIM Demonstration Guidance

- October 18, 2023 – October All County Call
    - 1915(b) Quarterly Appeals and Grievance Quarter 1 Report
    - Translated Screening Tool
    - CalAIM Performance Monitoring
    - Behavioral Health Memorandum of Understanding (MOU)

        - Medi-Cal Mobile Crisis Services Benefits
- November 15, 2023 – November All County Call
    - Screening and Transition of Care Tool: Translation and Performance Monitoring Survey
    - Payment Reform: Questions and Answers
- December 20, 2023 – December All County Call
    - MOU Requirements for DMC-ODS
    - 2025 Integrated Member Handbook
    - CalAIM BHQIP Incentive Program
    - Screening Tool Translation and Feedback
    - Documentation Redesign

Quality Control/Assurance Activity

DHCS conducts annual compliance reviews of each county that participates in the provision of DMC-ODS services. The annual compliance reviews of all counties during SFY 2022-23 were completed on June 30, 2023. Once a review is completed, a Findings Report is issued to the county. The county is then required to submit a CAP for each area of non-compliance within 60 business days of receipt of the 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.

During SFY 2022-23 and DY 19-Q2, DHCS announced to counties that compliance reviews are scheduled to begin for SFY 2023-24 in July 2023. DHCS began conducting the FY 2023-24 compliance reviews by requesting supporting documentation demonstrating compliance with federal and state regulations, requirements, and contractual obligations. DHCS began reviewing documentation received from the counties in preparation for DMC-ODS compliance reviews scheduled to start within DY 19-Q3.

Figure 21 demonstrates when County DMC-ODS compliance reviews were completed during DY 19.

Figure 21: DY 19 Monitoring Reviews

County	Dates
San Bernardino	January 2023

County	Dates
Stanislaus	January 2023
Fresno	January 2023
San Mateo	January 2023
San Francisco	February 2023
Contra Costa	February 2023
Tulare	February 2023
Santa Clara	February 2023
San Benito	February 2023
Alameda	March 2023
Ventura	March 2023
Merced	March 2023
Imperial	March 2023
Sacramento	March 2023
Marin	April 2023
Riverside	April 2023
San Diego	April 2023
San Joaquin	April 2023
San Luis Obispo	April 2023
Monterey	April 2023
Placer	April 2023
Los Angeles	May 2023
Kern	May 2023
Orange	May 2023
Humboldt	June 2023
Nevada	June 2023
Lassen	June 2023
Mendocino	June 2023
Modoc	June 2023
Santa Barbara	June 2023
Santa Cruz	June 2023
Shasta	June 2023
Siskiyou	June 2023
Solano	June 2023
Tulare	June 2022

County	Dates
Yolo	June 2023
Napa	June 2023
Merced	August 2023
Placer	September 2023
San Mateo	September 2023
Contra Costa	September 2023
Ventura	October 2023
Tulare	October 2023
San Joaquin	October 2023
Orange	November 2023

Sacramento County Access to Care CAP

Sacramento County's Access to Care CAP, which was issued on June 3, 2022, and revised on February 2, 2023, was officially resolved and closed on June 20, 2023. Sacramento County was issued a CAP Resolution Letter. The evidence provided by Sacramento County during the CAP monitoring period satisfied the CAP requirements set forth by DHCS. DHCS met regularly with Sacramento County to ensure the waitlist for residential SUD treatment services and residential SUD withdrawal managements services was eliminated.

Operational Updates

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access SMHS, implementation of standardized statewide screening and transition tools, behavioral health payment and documentation reform, and streamlining and standardizing clinical documentation requirements. DMC-ODS Plans are utilizing policy guidance released from January 2023 through December 2023 related to these items to update and implement policies and procedures.

Behavioral Health Information Notices requiring updates to policies and procedures released in Q1 – Q3 of DY 19 are listed below:

- 23-001 – Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirement for the Period of 2022 – 2026

- 23-005 – Updated Guidance for CalAIM Behavioral Health Quality Improvement Program (BHQIP)
- 23-006 – Ongoing Monitoring Activities Process for MHP and DMC-ODS Plans
- 23-013 – CalAIM Behavioral Health Payment Reform Readiness Check list
- 23-017 – Specialty Mental Health Services and Drug Medi-Cal Services Rates
- 23-018 – Update Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal
- 23-020 – Rollback of Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and the Statewide Maximum Allowance (SMA) Rates for Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Non-Narcotic Treatment Program (non-NTP) Services Due to the End of the COVID-19 Public Health Emergency (PHE)
- 23-024 – Drug Medi-Cal Organized Delivery System (DMC-ODS) Treatment Perception Survey (TPS)
- 23-025 – Medi-Cal Mobile Crisis Services Benefit Implementation
- 23-030 –Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System Postpartum Claiming
- 23-032 – Interoperability and Patient Access Final Rule Compliance Monitoring Process
- 23-035 – Supersedes BHIN 23-005. Updated Guidance for the California Advancing and Innovating Medi-Cal Initiative (CalAIM) Behavioral Health Quality Improvement Program (BHQIP)
- 23-036 – CalAIM Behavioral Health Payment Reform Allocation
- 23-040 – Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit
- 23-041 – Supersedes BHIN 22-033. 2023 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery

System (DMC-ODS) Plans

- 23-042 – County Drug Medi-Cal Organized Delivery System 274 Provider Network Data Reporting
- 23-044 – Behavioral Health Audit for Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, and Drug Medi-Cal Counties (DMC) Services for Fiscal Year (FY) 2023-2024
- 23-045 – California Ethical Treatment for Persons with Substance Use Disorder (SUD) Act: Implementation of Senate Bill 349 (SB 349)
- 23-047 – Supersedes 22-043. Annual County Monitoring Activities (ACMA) for Mental Health Plans (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Drug Medi-Cal (DMC) for Fiscal Year (FY) 2022/23.
- 23-048 – Supersedes 22-060. Mental Health Plan and Drug Medi-Cal Organized Delivery System Beneficiary Handbook Requirements and Templates
- 23-049 – Administration and Utilization Review/Quality Assurance (UR/QA) Reimbursement Under Payment Reform (Revised 9/22/2023)

Behavioral Health Information Notices requiring updates to policies and procedures released in DY 19-Q4 are listed below:

- 23-057 – provides guidance on Memorandum of Understanding (MOU) requirements for MCPs and DMC-ODS Plans.
- 23-062 – provides guidance and direction to DMC-ODS Plans about existing and additional appeals and grievance data requirements for completing CalAIM Section 1915(b) Waiver, STC A(13) & A(14) Appeals and Grievance Quarterly Reports to CMS.
- 23-068 – provides guidance for updates to documentation requirements for DMC-ODS services.

Policy/Administrative Issues and Challenges

For the 1915(b) Waiver, STC A(13) & A(14) Appeals and Grievance Quarter 1 Report submission, DHCS requested an extension with CMS to give counties and DHCS additional time to collect and aggregate the data for submission. The Quarter 1 Report

was submitted to CMS by the revised date. DHCS is working with internal partners to streamline future submissions of the quarterly report to CMS.

For MOU requirements, DHCS did not receive executed MOUs from DMC-ODS Plans by January 1, 2024. DHCS will provide technical assistance to counties and will collect the quarterly reports from each county until all required MOUs are executed.

Consumer Issues and Interventions

DHCS continues to respond to issues, complaints, and grievances related to DMC-ODS Plans delivering DMC-ODS services. For Q1 through Q3, all issues, complaints, or grievances reported to DHCS have been resolved. In Q4 of 2023, DHCS received one incident regarding an issue, complaint, and grievance from a Medi-Cal member. Issues received by DHCS are prioritized to ensure timely responses to members.

Quantitative Findings

Due to CalAIM initiatives, county reporting of DMC-ODS services may be further delayed when compared to prior years, thus affecting reported values. Figure 22: Demonstration Quarterly Report Members with FFP Funding was determined by unique members with DMC-ODS residential claims from the Short-Doyle billing system. Figure 23: Member Enrollment was determined by Medi-Cal monthly membership based on the presence of a claim within the reporting period. However, membership is credited not only for the month of the claim but any month of eligibility during the reporting period. This is because, for example, a member can enroll in Medi-Cal for a month, receive some DMC services, drop out of Medi-Cal for a month or two, then enroll again to receive a service, etc., but the member is enrolled for the full reporting period of eligibility. As such, the numbers for this chart represent enrollment months and the same Medi-Cal member can be represented in multiple months of the report data based on eligibility records.

Performance Metrics

The following performance metrics depict preliminary data for DMC-ODS residential services authorized by the demonstration. Prior quarters have been updated based on new claims data. For DY 19-Q3 and DY 19-Q4, only partial data is available since counties have up to six months to submit claims after the month of service.

Figure 22: Demonstration Quarterly Report Members with FFP Funding

Quarter	ACA	Non-ACA	Total
DY19-Q1	9,098	3,446	12,544
DY19-Q2	9,172	3,415	12,587
DY19-Q3	3,885	1,398	5,283
DY19-Q4	722	221	943

**Affordable Care Act (ACA)*

Figure 23: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (To date)
ACA	12,555	12,677	12,890	DY 19-Q1	13,087
ACA	12,990	13,087	13,148	DY 19-Q2	13,381
ACA	13,142	13,102	12,979	DY 19-Q3	13,412
ACA	12,894	12,777	12,696	DY 19-Q4	13,134
Non-ACA	5,352	5,327	5,213	DY 19-Q1	5,621
Non-ACA	5,177	5,094	5,049	DY 19-Q2	5,404
Non-ACA	5,012	4,995	5,055	DY 19-Q3	5,383
Non-ACA	5,093	5,138	5,141	DY 19-Q4	5,460

Figure 24: Aggregate Expenditures for ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	328,474	$56,087,376.30	$49,613,322.26	$5,643,078.03	$830,976.01	DY 19-Q1
Non-ACA	124,238	$19,798,599.32	$11,136,209.45	$7,237,461.16	$1,424,928.71	DY 19-Q1

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	310,159	$52,017,216.60	$46,108,312.02	$5,138,696.92	$770,207.66	DY 19-Q2
Non-ACA	118,741	$18,008,310.58	$9,915,751.48	$6,689,544.15	$1,403,014.95	DY 19-Q2
ACA	102,909	$25,503,938.28	$22,457,347.93	$2,729,607.37	$316,982.98	DY 19-Q3
Non-ACA	35,144	$8,574,464.53	$4,531,513.04	$3,549,901.87	$493,049.62	DY 19-Q3
ACA	15,584	$3,746,007.57	$3,305,204.43	$401,768.36	$39,034.78	DY 19-Q4
Non-ACA	4,009	$999,108.09	$525,721.98	$404,900.77	$68,485.34	DY 19-Q4

The performance metrics above consist of preliminary data: Counties have six 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.

Performance Metrics Enclosures/Attachments

The attachment, CalAIM 1115 Waiver Progress Report DY19-Annual_ODS-RES V2.xlsx, 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 19 as of December 31, 2023.

Recovery Incentives Program

Between the launch of CM services in April 2023 and December 2023, 14 DMC-ODS Plans have implemented CM services. These counties include Contra Costa, Fresno, Imperial, Kern, Los Angeles, Marin, Nevada, Orange, Riverside, San Diego, San Francisco, Santa Barbara, Santa Clara, and Ventura. Collectively, these counties cover 67 percent of Medi-Cal members. As of December 31, 2023, among these 14 counties, there are 66 approved sites providing CM services to over 800 members. Contra Costa County has one approved site, Fresno County has one approved site, Imperial County has four approved sites, Kern County has two approved sites, Los Angeles County has 37 approved sites, Marin County has two approved sites, Nevada County has one approved site, Orange County has two approved sites, Riverside County has five approved sites, San Diego County has three approved sites, San Francisco County has three approved

sites, Santa Barbara County has three approved sites, Santa Clara County has one approved site, and Ventura County has one approved site. In total, 24 DMC-ODS Plans have opted into the Recovery Incentives Program, covering 88 percent of Medi-Cal members.

In addition to the 66 sites offering CM services, there are 32 sites, located in seven additional counties, that 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.

As part of the Recovery Incentives Program in 2023, $276,808 in gift cards (motivational incentives) was earned by eligible members for meeting the treatment goal of submitting a urine drug test (UDT) which tests negative for stimulants. DHCS' incentive manager (IM) portal allows members to redeem their gift card immediately when earned, or they can choose to 'bank' the incentive amount to save up for a larger gift card to be disbursed at a later date. Of the total incentives earned, 83 percent were redeemed in 2023, and 17 percent remained banked to be redeemed later. The most common incentive delivery method was printed voucher (63 percent), followed by text (28 percent), and email (nine percent). When a member chooses to redeem a gift card, they can choose from a list of pre-approved vendors. The most common gift card redemption vendors include Walmart (69 percent), Nike (11 percent), and Marshalls (four percent).

DHCS has finalized the processes for the intake of CM data, which will be used for a multitude of purposes to include incentive payment processing, evaluation activities, and creation of reports and dashboard metrics. The CM measures will be included in Phase I of the CalAIM dashboard, set to be published in 2024.

Recovery Incentives: California's Contingency Management (CM) Program – Training and Technical Assistance Activities, DY 19, Quarters 1-4

DY 19-Q1 (January-March 2023)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities were focused on the continued development of the Recovery Incentives website. A total of 189 individuals completed the CM Overview Training on-demand course between January 1, 2023, and March 31, 2023. Fourteen Implementation Trainings were delivered (with 295 total participants), 19

Readiness Assessment calls were made, and one site was approved to initiate providing CM Services. We also conducted five one-hour Zoom office hours for Readiness Assessment preparedness. The two-step Readiness Assessment process was finalized, and 27 sites received a link to the Qualtrics self-study to initiate the Readiness Assessment process. Five point-of-care UDT kits were evaluated for potential inclusion into the UDT protocol. None of the products were deemed to meet the requirements of the Program. Development of the Fidelity Monitoring Tool has not yet commenced.

DY 19-Q2 (April-June 2023)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities included working closely with staff from Q2i to make slight refinements to the IM Portal slides that are presented in the Part II Implementation Training. The sample beneficiary consent form, Recovery Incentives Program Manual, and Implementation Training slides were updated. Additional activities included determination of the Clinical Laboratory Improvement Amendments (CLIA) Certificate and State Lab Registration status of proposed sites. The Recovery Incentives website was updated as materials were refined. A total of 136 individuals completed the CM Overview Training on-demand course between April 1, 2023, and June 30, 2023. Eighteen Implementation Trainings were delivered (with 328 total participants), 21 Readiness Assessment interviews were conducted, and 18 new sites were approved to initiate providing CM Services (for a total of 19 sites) and there are approximately 182 members enrolled. We also conducted nine one-hour Zoom office hours and 35 outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was finalized, and 46 sites received a link to the Qualtrics self-study to initiate the Readiness Assessment process. The Fidelity Monitoring tool is drafted and is in its final review stages at DHCS.

DY 19-Q3 (July-September 2023)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities included working closely with staff from Q2i to make slight refinements to the IM Portal slides that are presented in the Part II Implementation Training and conducting Fidelity Monitoring interviews. The Recovery Incentives Program Manual, and Implementation Training slides were updated. Additional activities included determination of the CLIA Certificate and State Lab Registration status of proposed sites. The Recovery Incentives website was updated as materials were refined. A total of 79 individuals completed the CM Overview Training

on-demand course between July 1, 2023, and September 30, 2023. Thirteen Implementation Trainings were delivered (with 250 total participants), 30 Readiness Assessment interviews were conducted, and 43 sites are providing CM Services and there are approximately 562 members enrolled. We also conducted two one-hour Zoom office hours and 26 outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by 25 sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process). The Fidelity Monitoring tool was approved by DHCS, and 13 fidelity monitoring interviews were completed.

DY 19-Q4 (October 1 – December 31, 2023)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities included distributing a new Consent Form to launched sites. The update was to ensure the Medi-Cal members who are seeking to enroll in the Recovery Incentives Program are not concurrently enrolled in Residential Services. Additionally, a full materials audit and revision was completed to replace all written references of "beneficiary" and "beneficiaries" to "member" and "members." The Fidelity Monitoring Part II Qualtrics tool was finalized and approved by DHCS. A total of 108 State Lab Registration Applications and 103 CLIA Certificate Applications have been identified as completed/approved. A total of 131 Site Lab Directors have been identified. The Recovery Incentives website was updated as materials were refined. A total of 99 individuals completed the CM Overview Training on-demand course between October 1, 2023, and December 31, 2023. Ten (10) Implementation Trainings were delivered (with 149 total participants) from 14 of the 24 counties. Twenty-Two interactive Zoom Coaching Calls were conducted with a total of 272 attendees. Nineteen (19) Readiness Assessment interviews were conducted, and Sixty-Six (66) sites are providing CM Services and there are approximately 801 members enrolled. DHCS also conducted eight outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by eight sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process). There were 17 Part I, and nine Part II Fidelity Monitoring interviews completed.

DY 19 Q1 - Q4 (January 1 – December 31, 2023)

During DY 19 (January 1-December 31, 2023), the Statewide CM pilot training program completed the following activities:

- A total of 503 individuals completed the CM Overview Training on-demand

course. Fifty-five Implementation Trainings were delivered (with 1,022 total participants). Forty-nine interactive Zoom Coaching Calls were conducted with a total of 506 attendees. Seventy-one Readiness Assessment interviews were conducted, and sixty-six sites are providing CM Services and there are approximately 801 members enrolled. DHCS also conducted 194 outreach calls for Readiness Assessment preparedness. There were 30 Part I, and nine Part II Fidelity Monitoring interviews completed.

- During the early months of DY 19, the UCLA team focused on project planning, training curriculum and material development of the content for the two-part Implementation Training, Program Manual, and Readiness Assessment. Materials were finalized and the trainings were launched in February 2023. The UCLA team continued to engage with participating counties and sites to help prepare them for Program launch. Throughout the year, the UCLA team continued to remind participants of the program requirements, including the need to register for both CM Implementation trainings, and to complete the required post-test. During the Readiness Assessment self-study survey, some sites encountered difficulty in correctly entering the three practice cases into the IM Portal Sandbox. The UCLA team continues to provide one-on-one technical assistance and support to help CM Team Members make the necessary corrections to the practice cases. During Coaching Calls, sites shared member success stories, listed below are two examples:[3]

    - One member went from being released from jail to enrolling in residential treatment, transitioning to outpatient, and enrolling in the Recovery Incentives Program. _ now has a full-time job in the outpatient treatment program working on the site's maintenance crew.

    - A _ involved _ _ in _ treatment plan. _ had each _ pick a gift card vendor from the IM Portal. One _ picked Game Stop and the other Walmart. Every time _ came home from _ CM visits, _ kids would ask "how much did we get today?" The _ did not want to disappoint the kids which keeps _ motivated to continue to test negative for stimulants and earn incentives to share with _ _.

[3] The two examples of member success stories include redactions to protect the privacy and security of participants.

Medi-Cal Peer Support Services Updates

Medi-Cal Peer Support Specialist services are an optional behavioral health Medi-Cal benefit that can be implemented within DMC-ODS, DMC, and/or the Specialty Mental Health Services (SMHS) delivery systems. As of December 31, 2023, 4,592 individuals applied for Peer Support Specialist Certification through the California Mental Health Services Authority (CalMHSA). CalMHSA is currently the sole DHCS-recognized certification program for Medi-Cal Peer Support Specialists (see Figure 25 for a cumulative breakdown of applicants by application/certification status). As of December 31, 2023, 50 out of 58 California counties provide Medi-Cal Peer Support Services, including 32 DMC-ODS, 49 MHP, and 10 DMC programs. Approximately 98.5 percent of the Medi-Cal population is represented in the MHP counties and approximately 91.8 percent in the DMC-ODS plans, based on enrollment data.[4] DHCS provides the opportunity for counties to opt-in to provide Medi-Cal Peer Support Services on an annual basis.

Figure 25: Peer Support Specialist Applications and Certifications

Applications/ Certifications by Status	Q1	Q2	Q3	Q4
Certified	534	1,031	1,956	2,506
Approved to take certification exam	36	942	1,037	849
Certification exam not passed	39	91	141	91
Training in progress	1,228	1,226	1,228	941
Application in revision	451	298	200	205
Total	**3,222**	**3,588***	**4,562**	**4,592**

The data in this figure is a representation of the cumulative totals at the end of each quarter.

* Q2 Total as of May 15, 2023. The total above does not include applications pending payment or denied applications.

Throughout DY 19 (2023), DHCS conducted stakeholder engagement on program implementation, addressed stakeholder questions on service delivery and billing, ASAM requirements, workforce development, plan of care documentation, and coordinated

[4] Medi-Cal total enrollment data as of December 2023

regularly with CalMHSA to ensure responsiveness to stakeholders and alignment with policy. DHCS released guidance related to eligibility criteria for Medi-Cal Peer Support Specialist grandparenting applications, deadlines for certification programs to implement trainings for additional areas of specialization, and approval criteria for Medi-Cal Peer Support Specialist Certification Program fee schedules. DHCS also published FAQs providing clarification on certification standards, lapsed certification, opting-in, billing and claiming requirements, behavioral health professional supervision requirements, telehealth, professional development for peers, and Provider Application and Validation for Enrollment. DHCS continued to gather feedback from internal and external 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 by early 2024. DHCS also integrated stakeholder feedback into an all-inclusive Medi-Cal Peer Support Services BHIN, which is expected to be released in the first quarter of 2024.

SUD Monitoring Protocol (STC 6.5)

On February 10, 2023, DHCS obtained CMS approval to provide data on the SUD Monitoring Protocol. DHCS received CMS approval to provide data from January to March 2023 as CMS develops more refined guidance for the SUD Monitoring Protocol. DHCS will present trends retrospectively in future reports once CMS' new guidance has been released.

The figure below outlines the agreed-upon performance measures to depict progress on SUD monitoring activities for members with SUD diagnoses served in an SUD program for the first three months of 2023.

Figure 26: Number of SUD Members Served by Performance Measure

Population	January 2023	February 2023	March 2023
#3: Medicaid Members with SUD Diagnosis	482,062	484,348	485,326
#6: Number of members enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	130,732	121,206	125,237
#7: Early Intervention; Number of members	645	601	648

Population	January 2023	February 2023	March 2023
who used early intervention.			
#8: Outpatient Services	71,150	65,029	65,466
#9: Intensive Outpatient and Partial Hospitalization Services	1,835	1,537	1,489
#10: Number of members who use residential and/or inpatient services for SUD during the reporting period.	8,502	6,996	6,936
#11: Number of members who use withdrawal management services (such as outpatient, inpatient, or residential) during the reporting period.	1,589	1,315	1,247
#12: Medication-Assisted Treatment (MAT)	51,070	46,720	47,685
#23: Total number of ED visits for SUD per 1,000 members in the measurement period.	2.06%	1.88%	2.10%
#24: Inpatient Stays for SUD per 1,000 Medicaid	1.15%	1.12%	1.12%

PROVIDING ACCESS AND TRANSFORMING HEALTH SUPPORTS

California's Section 1115 waiver renewal includes expenditure authority for the Providing Access and Transforming Health (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 by ensuring access to health care services and improving health outcomes, with particular attention to communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors. PATH funding is available for various entities such as providers; county, city, and local government agencies; former WPC Lead Entities (LEs), community-based organizations (CBOs), public hospitals, Medi-Cal Tribal and Designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

- Justice-Involved (JI) Capacity Building, to maintain and build pre-release services to support implementation of a full suite of statewide CalAIM JI initiatives in 2023, and;

- Support for implementation of Enhanced Care Management (ECM) and Community Supports (previously known as In Lieu of Services (ILOS)), which are vital elements of CalAIM on the community level, and support for the expansion of access to services that will enable the transition from Medi-Cal 2020 to CalAIM.

The PATH program design for the implementation of ECM and Community Supports includes the following four initiatives:

1. WPC Services and Transition to Managed Care Mitigation Initiative (Mitigation Initiative) – PATH funding will directly support former WPC Pilot Lead Entities (LEs) to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal managed care health plans (MCPs) under CalAIM on or before January 1, 2024.

2. Technical Assistance (TA) Initiative – PATH funding is available for the provision of TA for qualified applicants that intend to provide ECM and/or Community Supports. DHCS will engage a Third-Party Administrator (TPA) to launch and administer the TA Marketplace.

3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH TPA to establish collaborative

planning and implementation efforts that support the CalAIM launch.

4. Capacity and Infrastructure Transition, Expansion and Development Initiative (CITED) – PATH funding will enable transition, expansion and development of ECM and Community Supports capacity and infrastructure. The TPA will administer and facilitate this initiative.

JI Capacity Building Program will provide funding to support collaborative planning as well as IT system modifications necessary to implement pre-release Medi-Cal application and suspension processes. Funding will be structured in multiple rounds:

- **Round 1** is a planning grant funding opportunity that will provide small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support collaborative planning with county departments of social services and other enrollment implementation partners to identify processes, protocols, and IT modifications that are necessary to support implementation of pre-release enrollment and suspension processes.

- **Round 2** is an implementation grant funding opportunity that will provide larger application-based grants to support entities as they implement the processes, protocols, and IT system modifications that were identified during the Round 1 planning phase. While entities do not need to participate in Round 1 to apply for funding in Round 2, the Round 1 planning grant funds provide an opportunity to support the development of a comprehensive application for Round 2 funding.

DHCS contracted with Public Consulting Group LLC (PCG) to serve as the TPA to implement and administer the multiple initiatives under PATH. The TPA is serving as a program administrator that will market, facilitate, develop support tools, and ensure successful implementation of the following PATH initiatives:

- TA Marketplace
- Collaborative Planning and Implementation
- CITED
- JI Planning and Capacity Building

The implementation timelines for the PATH Initiatives are as follows:

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																				

Successes and Accomplishments

WPC Services and the Transition to Managed Care Mitigation Initiative were implemented on January 1, 2022. Ten county LEs were awarded funding under this initiative and mitigation services are provided until a managed care plan fulfills their commitment to add the service as a Community Support. Under the WPC Services and Transition to Managed Care Mitigation Initiative, services provided by former WPC Pilots are funded until the services transition to managed care coverage under CalAIM. This ensures members have access to services and that delivery models developed under WPC Pilots are sustained until the services are transitioned. MCPs implemented many services sooner than initially projected and only six LEs had services not launched by MCPs when submitting annual invoices for 2022 in Q2 of 2023. Annual invoices for 2022 were processed and payments were made by Q3 of 2023. Three LEs had approved budgets for activities in 2023. Midyear invoices have been received for all three LEs and targeted for payment in early 2024.

The TA Marketplace launched on January 31, 2023. Eligible entities can browse 118 Hands-On Projects and 70 Off-the-Shelf Projects from 47 approved TA Vendors as of December 2023. Eligible TA Recipients can register through the TA Marketplace website and submit Project Eligibility Applications (PEAs) as of February 28, 2023. Available TA

options continued to expand throughout 2023. The second TA Marketplace Vendor Application cycle opened from March 28, 2023, through April 28, 2023. With the second round came 32 newly approved TA Vendors, along with an additional 73 Hands-On Projects and 136 Off-the-Shelf Projects added to the Marketplace. The third TA Marketplace Vendor Application cycle opened from October 1, 2023, through October 31, 2023. Following the third Application cycle, 13 newly approved TA Vendors, along with 64 Hands-On Projects and 177 Off-the-Shelf Projects were added to the Marketplace in Round 3. To date, there are a total of 92 approved TA Vendors and 177 approved TA Recipients. Recipient Eligibility Applications and PEA windows are continuously open, and applications are reviewed on a rolling basis. Through December 31, 2023, 255 PEAs were submitted. Of these, 118 projects have been executed for approximately $6.6 million.

The Collaborative Planning and Implementation (CPI) participant registration form was released on August 22, 2022. The initial Collaborative Planning facilitator selection process was completed, and contracts were executed by December 2022. On September 1, 2023, the Statewide Indian Health Collaborative was added for a total of 26 collaborative groups in operation. As of December 1, 2023, there are 983 participants registered across the collaboratives. Additionally, all year-two contracts have been executed. In 2023, CPI also began hosting public Best Practice Webinars. The goals of these webinars are to highlight best practices for implementation of ECM and Community Supports, increase providers' successful implementation of CalAIM, and improve collaboration with MCPs, state and local government agencies, and others to build and deliver quality services for Medi-Cal members. Participant surveys have shown these webinars to be successful and beneficial to organizations offering or intending to offer ECM and Community Supports.

The CITED application for Round 1 was released on August 1, 2022, and closed on September 30, 2022. DHCS received over 200 applications for a total request of $526 million. Funding for Round 1 was expanded and includes Round 1A and Round 1B. Round 1A awards were announced on January 30, 2023, and Round 1B awards on March 24, 2023. Between Round 1A and 1B, 139 entities were awarded over $203 million in funding. The Round 2 application period was open between February 28, 2023 through May 31, 2023. There were 301 applicants totaling $615 million in requests. Awards were announced on October 30, 2023, and 146 entities were awarded over $144 million in funding. Additionally, the availability of WPC Transition funding and increased demand for CITED initiative grants presented an opportunity for DHCS to leverage WPC Transition funds to support funding for CITED and maximize funding across the

programs. DHCS leveraged unclaimed WPC Transition funds in the amount of $85 million and created a specific CITED-Intergovernmental Transfer (IGT) Round to be available for eligible entities who were eligible to contribute the non-federal share of funds via IGT. In November 2023, CITED entities selected via the CITED-IGT Round were notified of their award. These capacity and infrastructure grants will help build the capacity of counties, local agencies, community-based organizations, and others to deliver key support services to Medi-Cal members statewide. This brings the total funding awarded through the CITED initiative to over $350 million.

DHCS reopened the JI Planning and Capacity Building Round 2 application in January 2023 and the deadline for submission was extended to March 31, 2023. A total of 97 agencies were approved for approximately $64 million to support implementation of processes, protocols, and IT modifications necessary for pre-release enrollment and suspension processes. The JI Planning and Capacity Building Round 3 application window opened on May 1, 2023. While the formal application window closed on July 31, 2023, Round 3 remains open to eligible correctional and county behavioral health agencies to implement behavioral health linkages. As of December 2023, 117 eligible agencies have been awarded over $330 million to support investments in personnel. capacity, and IT systems to effectuate pre-release service processes.

Public Consulting Group (PCG) serves as the PATH third-party administrator (TPA) to administer, market, facilitate, develop support tools, and implement the following PATH initiatives:

- TA Marketplace
- Collaborative Planning and Implementation Program
- CITED Program
- JI Planning and Capacity Building

In November 2023, DHCS amended the TPA contract with PCG to administer CITED-IGT. The amended contract was executed on November 7, 2023, and PCG is on track with completing their contract deliverables.

Program Highlights:

Managed care plans initiated many Community Supports services aligned with mitigation services sooner than initially projected and only three LEs remain with

approved budgets for activities in 2023. Annual invoices for 2023 will be received during Q1 2024.

- To support eligible entities with their CITED application, DHCS hosted informational webinars and office hour sessions throughout 2023, which provided detailed information on CITED funds and the application process, including time for participants to ask questions.

- On October 27, 2023, DHCS hosted CPI Best Practices Number 1: ECM and Community Supports Provider Peer Support and Contracting Self-Assessment, a webinar that is first in a series. The goal of the webinar series of bi-annual PATH Collaborative Planning and Implementation Best Practices webinars is to highlight best practices for implementation of ECM and Community Supports, increase providers' successful participation in CalAIM, and improve collaboration with MCPs, state and local government agencies, and others to build and deliver quality services for Medi-Cal members. There were 599 attendees at this webinar. This webinar focused on engaging in peer-to-peer support and conducting an organizational self-assessment to determine organizational readiness and capacity gaps for CalAIM participation.

- On December 7, 2023, DHCS hosted Best Practices Number 2: Relationship Building with Organizations in the CalAIM Environment, the second in the Best Practices webinar series. This webinar covered referral mapping to enhance relationship building with organizations in the CalAIM environment and provided tools for participants to share the unique value of organizations and how they are a strategic partner for key stakeholders within CalAIM.

Qualitative Findings

In DY 19, DHCS and PCG held weekly meetings for each PATH initiative to develop program outlines, public facing documents, applications, review processes, outreach strategies, and quality assurance and monitoring activities. PCG develops weekly presentations that outline all outstanding deliverables, implementation accomplishments and identified risks that impact implementation timelines. PCG also provides a weekly summary of updates on PATH grantee activities, such as the number of registered participants for Collaborative Planning, number of applicants received for PATH JI, tracking log for CITED awardee funding and disbursement, TAM recipient, vendor, and project approvals, as well as all communication releases for the week.

Following CITED Round 1, post-award analysis identified Populations of Focus (POF) that were not represented in the original applicant pools. One of these POFs identified following CITED Round 1 was the Medi-Cal Tribal and Indian Health Programs. During DY 19, PATH began outreach measures to Tribal partners through collaborative meetings, Tribal focused webinars, and the development of Tribal CPI Collaborative to foster engagement.

Funding through Round 1 of the CITED initiative has already supported organizations that provide ECM and Community Supports. As one of the success stories, Homeward Bound of Marin shared how funding has allowed their organization to be better equipped to provide high-need residents within their supporting housing program with quality, in-person care management outside traditional hospitals and other healthcare settings. This organization shared one example of a resident at their La Casa Buena permanent supportive housing program in Corte Madera. The resident has been able to effectively manage his chronic obstructive pulmonary disease (COPD) due to having housing and care management from provider staff, which has included arranging for him to see a pulmonologist several times and working with him to adjust his medications with input from his doctor. The housing and care he received from Homeward Bound of Marin's program allowed him to alleviate the breathing issues he was experiencing.

DHCS hosted multiple webinars during this reporting year to engage and solicit feedback from stakeholders on CalAIM ECM and Community Supports, PATH, JI implementation, program timelines, initiative specific applications, and program designs. Many of the informational webinars provided updates and TA to potential applicants interested in applying for the various PATH initiatives. Webinars that took place in DY 19 are listed below:

- DHCS and PCG hosted quarterly TA Vendor Informational Webinars and TA Vendor Onboarding Webinars to assist new TA Vendors with questions related to the TA Marketplace initiative.
- DHCS and PCG hosted quarterly TA Marketplace Recipient Informational Webinars to assist new TA Recipients with questions related to the TA Marketplace.
- On February 9, 2023, DHCS and PCG hosted the PATH JI Round 2 Application Webinar to assist prospective JI Round 2 applicants with questions and technical assistance.

- On March 3, 2023, DHCS and PCG hosted the CITED Round 2 Informational Session to provide an overview of CITED Round 2, targeted POFs, and goals. Additionally, this session provided prospective applicants with the information needed to apply for CITED Round 2 funding.

- On March 7 and April 6, 2023, DHCS and PCG hosted the TA Marketplace Vendor Informational Webinar to assist prospective TA Vendor applicants with the upcoming Round 2 Vendor application period.

- On March 8, 2023, DHCS and PCG hosted the CPI Facilitators and DHCS Convening Lessons Learned debrief to learn about key takeaways and implementation issues that have been identified in the initial collaborative convenings.

- From March 10, 2023, to May 26, 2023, DHCS and PCG hosted weekly CITED Office Hours to assist CITED awardees with questions.

- On March 24 and March 28, 2023, DHCS and PCG hosted two CITED Improve Your Grant Application Webinars to assist prospective CITED applicants with tips and provide TA on completing their CITED application.

- Starting April 4, 2023, DHCS and PCG hosted a quarterly series of CITED Progress Reports Office Hours session to assist CITED awardees with questions related to Progress Reporting.

- On April 14, 2023, DHCS and PCG hosted the CITED: Tribal Entities Informational Webinar to provide background on CalAIM, PATH, PATH CITED and information on how Tribal Entities can best engage with these initiatives and apply for funding to support the transition, development, and expansion of Medi-Cal Infrastructure.

- On May 8, 2023, DHCS and PCG hosted the CITED/JI Overview Webinar to share information on how JI agencies may be eligible for PATH CITED funds.

- On October 27, and December 7, 2023, DHCS and PCG hosted the first two of a bi-annual series CPI Best Practices Webinars to share emerging and established best practices that have been identified throughout the CPI initiative.

- On December 22, 2023, DHCS, PCG, and CPCA hosted the CITED-Clinic Round Informational Webinar to provide qualified clinics with an overview of the CITED

Clinic Round application process, allowable costs, and timeline.

DHCS developed and released updated guidance memos for the PATH Initiatives, addressing refinements as the program continues. The guidance memos provide a policy outline of the different PATH initiatives, eligibility criteria, application process and approach, sample uses of funding, allocation methodology, role of the TPA, oversight, next steps, and anticipated timeline. The PATH JI Round 3 draft guidance was released April 2023, and updated guidance released in September 2023. Updated TA Marketplace guidance was released May 2023. The Collaborative Planning guidance memo was updated and released in June 2023. The CITED Round 3 guidance was released in December 2023. Additional guidance for CITED Progress Reports for Round 1 and Round 2 was also released in December 2023.

Quantitative Findings:

In DY 19, DHCS awarded funding to multiple eligible entities across all PATH Initiatives. During DY 19, $10,312,302 were claimed. As of the end of DY 19 only three LEs are eligible for claiming under WPC Mitigation.

- The CPI Initiative awarded 10 facilitators to oversee 26 collaborative planning groups, including a new Tribal-focused group launched in fall of 2023, with a total of $11,505,077 funding in 2023. Some facilitators oversee multiple collaborative groups across different counties/regions.

- Between CITED Round 1A and Round 1B, 139 organizations were awarded over $203 million. Awardees indicate the awarded funds will support capacity to provide ECM to over 9,500 new members aged 21 and older, to over 460 new children and youth members, as well as capacity to provide Community Supports to over 7,500 total members throughout the state.

- In CITED Round 2 there were 146 organizations awarded approximately $144 million. Over 55 percent of organizations awarded were CBOs and 87 percent of all awardees were non-profit organizations.

- The TA Marketplace was launched in 2023. A total of 213 potential TA recipients applied for eligibility to the TA Marketplace in 2023. There were 255 TA Project Eligibility Applications submitted in 2023, including 87 Hands-On projects and 168 Off-the-Shelf projects. A total of 118 projects, funded at $6,600,183, were executed by the end of the DY 19.

- JI Initiative awarded 97 entities for Round 2 and 117 entities for Round 3. Awardees were comprised of County Sheriff's Offices to support county jails, county probation offices to support youth correctional facilities, the California Department of Corrections and Rehabilitation (CDCR) to support state prisons, and county behavior health agencies to support behavioral health linkages. Round 2 awarded $64,528,922 while Round 3 awarded $328,518,594 for a total award amount of $393,047,516 in DY 19.

Figure 27 below provides a summary of the total PATH awards finalized in DY 19.

Figure 27: PATH Awards Finalized in DY 19

PATH Initiative	Awarded	Total Funding Awarded
Collaborative **	10 Facilitators	$14,750,000
CITED	291 Entities	$348,033,391
TA Marketplace	118 Projects	6,600,182.80
JI	214 Entities	$393,047,516

The first two CPI Best Practice Webinars resulted in high rates of participant satisfaction. Following the first webinar, 92 percent of participants that completed the post-webinar survey agreed content was relevant, useful, engaging and satisfying. Following the second webinar, 96 percent of participants that completed the post-webinar survey agreed content was relevant, useful, engaging and satisfying.

Payments and Expenditures:

For DY 19, DHCS processed a total of $176,862,191 in payments across multiple PATH initiatives and to the TPA.

The Mitigation Initiative payment is made through an Intergovernmental Transfer (IGT) process. Once an invoice has been approved, the LE sends the non-federal share of its approved invoice amount to DHCS. Then DHCS provides the matching federal funds and the full amount is sent back to the LE. Additional payments in the amount of $423,021 for 2022 midyear invoices processed in DY 18 were made in January 2023. During DY 19, LEs submitted their annual invoices for expenditures from July 1, 2022, to

December 31, 2022. A total annual invoice payment of $9,889,281 was made in June 2023. LEs also submitted midyear invoices for expenditures from January 1, 2023, to June 30, 2023. Payments are targeted to be processed in Q1 2024. Expenditures for July 1, 2023 – December 31, 2023, will be reported on the annual invoice due 90 days after December 31 of the PY.

While the Mitigation Initiative IGTs and PATH JI Round 1 was paid directly by DHCS, the remaining PATH JI funding rounds, and all other PATH initiatives are paid through a pass-through invoices process with the TPA. The TPA is the fiscal administrator for all of PATH funding rounds. Once a PATH award has been approved by DHCS, the TPA will invoice DHCS for payment. Payment is made of the pass-through payment process whereby funds are transferred from DHCS to the TPA and the TPA administers distribution of funds. In DY 19, the TPA processed a total of $73,144,766 to PATH JI Capacity Building awardees, $68,685,476 to CITED awardees, $569,777 to TA Vendors for TA Marketplace projects, and $10,972,538 to CPI Facilitators to oversee collaboratives.

Figure 28: DY 19 Total PATH Payments

PATH Initiative	DY 19 Jan – Dec 2023
Mitigation	$10,312,302
TA Marketplace	$569,777
Collaborative Planning	$10,972,538
CITED	$68,685,476
JI	$73,144,766
Third Party Administrator	
PCG LLC	$13,177,332
Total	**$176,862,191**

Figure 29: DY 19 Total PATH Payments by Quarter

PATH Initiative	DY 19 Q 1 Jan – March 2023	DY 19 Q 2 Apr – June 2023	DY 19 Q 3 Jul – Sep 2023	DY 19 Q 4 Oct– Dec 2023
Mitigation	$423,021	$9,889,281	$0	$0
TA Marketplace	$0	$0	$0	$569,777
Collaborative Planning	$2,610,000	$2,610,000	$2,610,000	$3,142,538
CITED	$0	$11,706,065	$15,737,566	$41,241,845
JI	$0	$1,570,701	$16,354,614	$55,219,451
Third Party Administrator				
PCG LLC	$4,492,970	$3,658,018	$2,673,066	$2,353,278
Total	**$7,525,991**	**$29,434,065**	**$37,375,247**	**$102,526,889**

Service Utilization:

The Mitigation initiative is the only PATH initiative that captures member utilization data. LEs provide mitigation services directly to Medi-Cal members until MCPs initiate coverage on these services as ECM and Community Supports implementation ramp up. The data reported in Figure 30 reflects the mitigation services provided from DY 19 Q1 through DY 19 Q3. The data is extracted from the LE's self-reported quarterly utilization reports. Utilization counts were updated during each reporting period to reflect retroactive changes and, as a result, may not match prior reports. The utilization data is reported as of December 31, 2023.

Figure 30: Mitigation Services Provided by DY 19 Q1-Q4

Lead Entity	DY 19 Q 1 Jan – March 2023	DY 19 Q 2 Apr – June 2023	DY 19 Q 3 July – Sept 2023	DY 19 Q 4 Oct – Dec 2023
Alameda	968	1,179	N/A*	N/A*
Contra Costa	N/A**	N/A**	N/A**	N/A**
Kern	N/A**	N/A**	N/A**	N/A**
Los Angeles	1,337	1,605	586	N/A*
Orange	N/A**	N/A**	N/A**	N/A**
Placer	N/A**	N/A**	N/A**	N/A**
Riverside	N/A**	N/A**	N/A**	N/A**
San Francisco	17,025	17,663	24,036	N/A*
Santa Clara	N/A**	N/A**	N/A**	N/A**
Shasta	N/A**	N/A**	N/A**	N/A**
Total*	**4,206**	**20,447**	**24,622**	

**Due to delay in the availability of data, DY 19 Q4 data, and DY 19 Q3 data for Alameda, will be reported in the next quarterly report.*

*** Indicates LEs no longer providing mitigation services since the service has started to be provided under the MCP.*

Policy/Administrative Issues and Challenges:

DHCS received over 200 applications totaling approximately $526 million in Round 1 of the PATH CITED Initiative, approaching the $580 million of funding originally allocated to the entire CITED initiative over the course of the demonstration. DHCS received an additional 301 applications totaling approximately $615 million in Round 2. The processing of these applications was timely and complex.

The TA Marketplace launched in January 2023. DHCS received initial feedback from prospective TA recipients that the marketplace shop was complicated to navigate and that there were barriers to identifying what services they may need, and which vendors were the best fit for their organization. Throughout DY 19, DHCS and the TPA met with various stakeholders to identify areas for improvement. Updates were made to the TA Marketplace initiative page to provide descriptions and examples of various marketplace terminology, as well as clarify the different application processes for TA vendors and TA recipients. In DY 19 Q4, two documents were also added to the marketplace highlighting all TA vendors and projects filtered by categories, including TA needs, ECM population of focus, Community Support, and provider type. These categories were incorporated as part of additional marketplace enhancements launching in January 2024. Recipients shopping the marketplace will be able to apply multiple filters, including by project type, to assist with determining the project and vendor most appropriate to provide the services needed.

The JI Initiative Round 2 applications were temporarily made unavailable mid-December 2022 for DHCS to update the operational criteria to align with the requirements set forth in All County Welfare Directors Letter No. 22-27 (ACWDL) in implementing a pre-release Medi-Cal application process. On January 30, 2023, DHCS reopened the PATH JI Round 2 application window. The deadline for submissions was extended to March 31, 2023, to allow additional Round 2 applications to be completed and submitted to DHCS. The JI Initiative Round 3 application window opened on May 1, 2023, within proximity to the closure of Round 2 application window and during the Round 2 review and awards process. While the formal application window closed on July 31, 2023, entities eligible for Round 3 expressed various barriers they were facing with completing applications. In DY 19 Q2, DHCS hosted webinars for prospective applicants highlighting the programmatic differences between CITED and JI initiative funding. Throughout DY 19, the TPA hosted ongoing weekly office hours to assist eligible entities with the application process and provide technical assistance to awardees on completing required reporting to meet milestones for payment. Eligible organizations were also encouraged to participate in local Collaborative Planning and Implementation groups to develop connections with local CBOs for support of re-entry services.

COMMUNITY SUPPORTS: RECUPERATIVE CARE & SHORT-TERM POST HOSPITALIZATION

One component of CalAIM is a new menu of state-approved Community Supports, originally referred to as "In Lieu of Services" or "ILOS," available for MCPs to implement through their managed care contracts with DHCS. MCPs can cover alternative services or settings that are *in lieu of* services, covered under the state plan to address their enrollees' health-related social needs more effectively and efficiently. Examples of Community Supports include assistance with medically tailored meals, transitioning from nursing home care to the community to improve health and lower health care costs, and assistance with housing navigation and tenancy support.

Pursuant to 42 Code of Federal Regulations (CFR) 438.3, MCPs must obtain state approval by demonstrating compliance with all requirements before offering Community Supports. MCPs may voluntarily agree to provide any service to a member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining the MCP rates. Once approved by DHCS, the Community Support is added to the MCP's contract and posted on the DHCS website as a state-approved Community Support offered by that MCP.

The full list of Community Supports includes:

1. **Housing Transition Navigation Services** - Assistance and support for individuals 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-Hospitalization Housing*** - Provision of temporary housing for individuals who require it after a hospitalization.
5. **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 (ARF).

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** - 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.

These services benefit Medi-Cal members with complex health needs and unmet social needs, who are at high risk of hospitalization, institutionalization, and other higher cost services. Several Community Supports, such as Short-Term Post-Hospitalization Housing, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services have a built-in "Housing First" approach, recognizing that people experiencing homelessness have higher rates of diabetes, hypertension, human immunodeficiency virus, and mortality, resulting in longer hospital stays and higher readmission rates than the general public. Community Supports are authorized through the CalAIM demonstration in a manner that assures consistent implementation.

Community Supports are a high priority and offer a significant change for DHCS. DHCS recognizes the work California MCPs and communities are undertaking to operationalize these new initiatives and to smoothly transition services provided under the WPC Pilots and the Health Homes Program.

In conjunction with the authority to provide the state-approved Community Supports under 42 CFR 438.3(e)(2), the demonstration provides separate authority for Short-Term Post-Hospitalization Housing and Recuperative Care services delivered by MCPs consistent with the other Community Supports. These two services both play an important role in California's care continuum to provide cost-effective and medically appropriate alternatives to hospitalization or institutionalization for individuals who otherwise would not have a safe or stable place to receive treatment. These alternative settings can provide appropriate medical and behavioral health supports following an

inpatient or institutional stay for electing individuals who are homeless or at risk of homelessness and who may otherwise require additional inpatient care in the absence of recuperative care.

Demonstration monitoring covers reporting of performance metrics data related to the state's Recuperative Care and Short-Term Post-Hospitalization housing services, and, where possible, informs the progress in addressing access needs of communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, urbanity, and other factors.

The evaluation of the Recuperative Care and Short-Term Post-Hospitalization Housing Community Supports will focus on studying the impact on member health outcomes and will include an assessment of whether the services lead to an avoidance of emergency department use and reductions in inpatient and long-term care. The state will also conduct a thorough cost-effectiveness analysis of these Community Supports services, as required. Information and status updates regarding evaluation progress will be included in future reports.

Monitoring and evaluation efforts will accommodate data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing disparities in access, health outcomes, and how these two Community Supports services might support bridging any such inequities.

Successes/Accomplishments

Following its established semi-annual processes, DHCS actively tracks, monitors, and reviews Model of Care (MOC) updates submitted by MCPs, which can be updated by each MCP twice each year. DHCS ensures all submitted policies and procedures are in alignment with department guidance and that prospective members are not subject to experience any gaps in care. DHCS monitors for trends in MOC reviews and reaches out to MCPs for clarification and to request additional information when necessary and as appropriate. When trends are identified, DHCS develops and issues additional TA and occasionally relay surveys for MCP response.

DHCS ensures all MOC submissions align with each MCP's approaches to increase delivery service infrastructure, Community Supports provider capacity, and uptake of Community Supports as described in the MCP's Incentive Payment Program (IPP) submissions. DHCS continues to evaluate the MCPs' implementation progress based on their IPP submissions and holds MCPs accountable for meeting all program benchmarks.

DHCS is also leveraging existing encounter data reporting mechanisms in accordance with the MCP contract for MCPs to report on Community Supports. DHCS released Billing and Invoicing Guidance and Community Supports Coding Guidance to provide further instructions for MCP reporting. In December 2022, DHCS released new Community Supports Data Sharing Guidance for stakeholder comment, which clarifies requirements and allowances in the Budget Trailer Bill, Welfare and Institutions Code, and Penal Code. DHCS continues to develop and disseminate Community Supports guidance to MCPs and Providers.

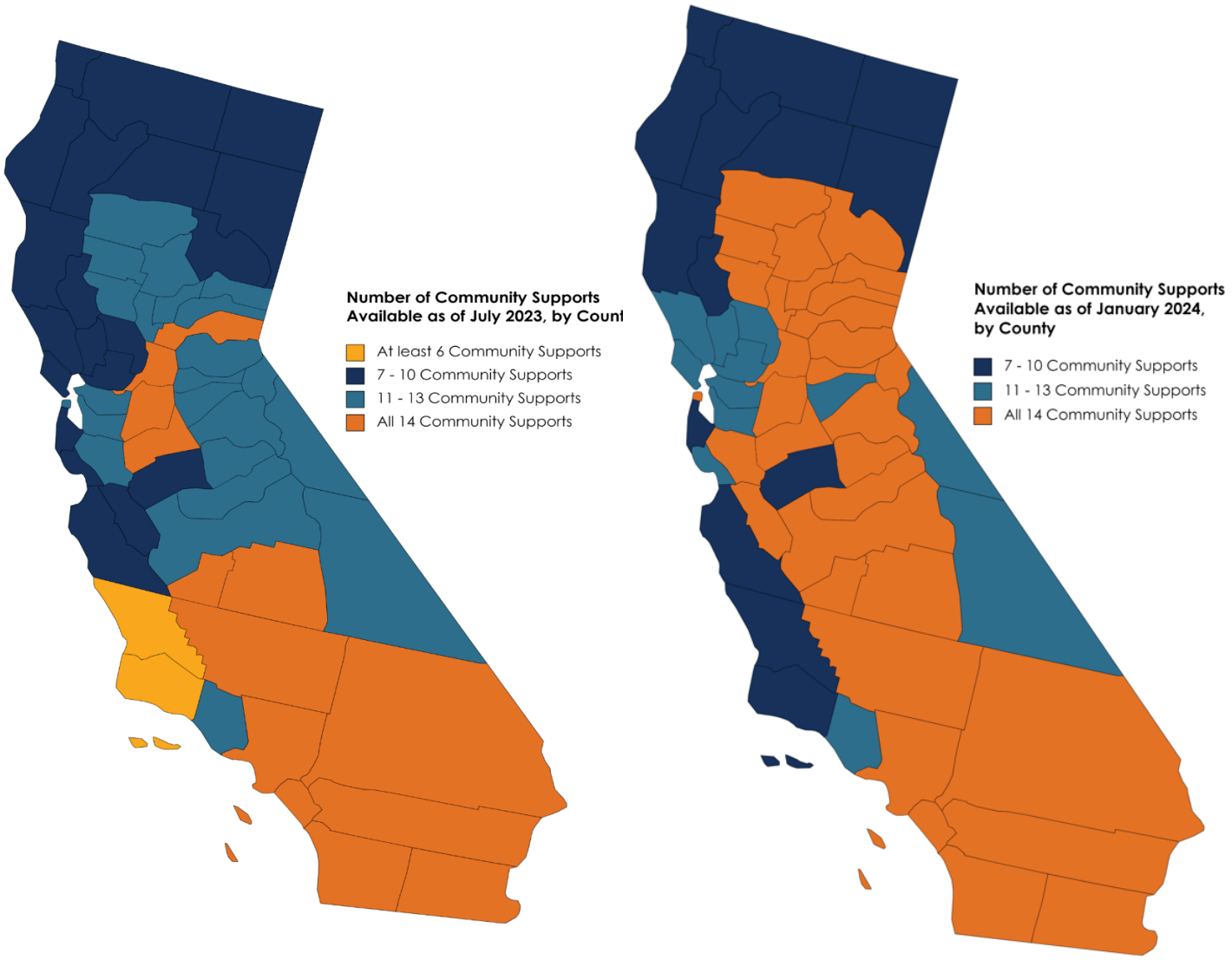
Figure 31: Number of Pre-Approved Community Supports Live as of January 2024 by County and Implementation Date

County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Total CS Live (out of 14)
Alameda	8	2	2	0	1	13
Alpine	4	4	2	2	2	14
Amador	8	2	2	1	1	14
Butte	6	2	2	0	-2	8
Calaveras	4	4	2	1	1	12
Colusa	6	3	2	0	-3	8
Contra Costa	7	4	2	0	0	13
Del Norte	0	6	2	0	0	8
El Dorado	7	2	2	0	3	14
Fresno	7	3	2	0	2	14
Glenn	6	3	2	0	-3	8
Humboldt	0	6	2	0	0	8
Imperial	4	5	5	-	-	14
Inyo	4	4	2	1	2	13
Kern	7	1	6	-	-	14

County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Total CS Live (out of 14)
Kings	9	2	3	-	-	14
Lake	0	6	2	0	0	8
Lassen	0	6	2	0	0	8
Los Angeles	9	2	3	-	-	14
Madera	8	2	3	0	1	14
Marin	6	0	2	0	3	11
Mariposa	6	2	2	0	1	11
Mendocino	6	0	2	0	0	8
Merced	1	6	1	2	0	10
Modoc	0	6	2	0	0	8
Mono	4	4	2	1	1	12
Monterey	5	2	1	2	0	10
Napa	6	0	2	0	3	11
Nevada	8	2	2	0	-4	8
Orange	4	5	5	-	-	14
Placer	9	2	3	-	-	14
Plumas	6	2	2	0	-2	8
Riverside	12	2	0	-	-	14
Sacramento	14	0	0	-	-	14
San Benito	6	2	2	0	4	14
San Bernardino	11	2	1	-	-	14
San Diego	14	0	0	-	-	14
San Francisco	8	3	2	0	1	14

County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Total CS Live (out of 14)
San Joaquin	8	1	5	-	-	14
San Luis Obispo	0	2	4	0	4	10
San Mateo	9	0	0	0	0	9
Santa Barbara	0	2	4	0	4	10
Santa Clara	9	4	0	0	1	14
Santa Cruz	4	2	1	2	2	11
Shasta	6	0	2	0	0	8
Sierra	6	2	2	0	-2	8
Siskiyou	0	6	2	0	0	8
Solano	0	6	2	0	3	11
Sonoma	6	0	2	0	3	11
Stanislaus	4	5	5	-	-	14
Sutter	6	2	4	0	-1	11
Tehama	6	2	2	0	-2	10
Trinity	0	6	2	0	0	8
Tulare	8	3	3	-	-	14
Tuolumne	4	4	2	1	3	14
Ventura	5	1	5	1	0	12
Yolo	0	6	2	0	3	11
Yuba	6	2	4	0	2	14

Due to the 2024 MCP Transition (effective January 1, 2024), Members in several rural counties temporarily lost access to a few services that had been available under Previous MCPs no longer operating within those counties. DHCS is working with the entering MCPs to retain delivery infrastructure and restore access to these services as soon as possible.



Program Highlights:

DHCS continues to strategize with leadership to discuss the development of Community Supports initiative work plans and drafted responses to questions submitted by various stakeholders. DHCS continues to accept stakeholder feedback and intends on continuing to provide guidance on this unique set of services. Webinars and meetings hosted by DHCS this year included:

- Bi-weekly CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the

rollout of newly launched benefits. In addition, this group helps DHCS identify and work through implementation challenges, provides critical review of decisions and documents before DHCS releases them more broadly, provides input on infrastructure needs to be supported by new performance incentives and PATH funding opportunities, and advises on TA needs in the market.

Topics of discussion include:

- Experience with implementation
- Member experience of ECM and Community Supports
- Progress of contracting between MCPs and providers
- Referrals and authorization of members into Community Supports

- Monthly MCP TA and Guidance webinars geared towards health plan executives and personnel who have a significant role in the implementation of Community Supports.

- Weekly meetings with the Local Health Plans of California (LHPC) and the California Association of Health Plans (CAHP) to provide TA and receive regular updates on the implementation of ECM and Community Supports.

In the first half of the year, DHCS also met with several MCPs to reconcile differences found in their authorization policies for new Community Supports. These calls helped in reducing variation between policies across plans/counties.

On March 14, 2023, DHCS staff visited Wellspace Health at their Gregory Bunker Recuperative Care Facility located in Sacramento. Founded in 1953, Wellspace Health is an integrated, non-profit 501(c)(3) Federally Qualified Health Center serving over 125,000 patients in over 30 locations in Sacramento, Placer, and Amador counties. Staff had candid discussions and learned more about potential best practices and the obstacles providers continue to manage in the field, all of which will help inform future policy revisions, guidance considerations, and overall contribute to enhancing the program's design.

On April 14, 2022, DHCS provided an Overview of CalAIM's ECM and Community Supports webinar for California Regional Centers, Directors, and Executive Staff to attend and learn more about these new CalAIM initiatives. DHCS reviewed ECM, the Population Health Care Management Continuum, and Community Supports, providing

details on the roles and responsibilities of managed care plans and providers, reviewing eligibility criteria, and discussing how members can access the two programs. The presentation included details on how Regional Centers could apply to become ECM and/or Community Supports providers.

On June 9, 2023, DHCS hosted MCP staff for an in-person ECM and Community Supports One-Day Summit. The Summit convened key staff responsible for overseeing the implementation of ECM, Community Supports, and the Justice-Involved Initiative to discuss policy refinements and key design areas for the second year of implementation and beyond. Additional sessions throughout the day focused on rate setting, the Justice-Involved initiative, and a provider panel discussion.

On June 14, 2023, DHCS released its updated January 2024 Model of Care to MCPs via email and on the ECM and Community Supports website. A redline copy of the Community Supports MOC in PDF format was made available upon request. The purpose of the minor updates made to the Community Support MOC template were to bring the MOC questions into alignment with subsequent updates that had been made to the Community Supports Policy Guide.

On July 12, 2023, DHCS shared the recent updates made to the ECM and Community Supports Policy Guides, which are aimed at supporting greater uptake and delivery of ECM and Community Supports to eligible members while reducing administrative burden and duplication. These updates reflect the policy refinements discussed at the June 9 Summit, and cover key areas including eligibility, referrals and authorizations, provider networks, payment, market awareness, and data exchange. All updated areas are indicated in red font (i.e., Updated July 2023 or Added July 2023) throughout both policy guides.

On July 28, 2023, DHCS joined the County Health Executives Association of California's (CHEAC) CalAIM Forum to provide technical assistance and clarification on the recently released Community Supports Member Information Sharing Guidance. DHCS fielded questions from CHEAC staff on the Community Supports Provider Transmission File (billing), Community Supports closed loop referrals processes, ensuring non-duplication of services, reason for Community Supports discontinuation provider documentation, and member homeless indicator MCP lists.

On August 18, 2023, DHCS hosted a virtual webinar for all stakeholders to provide an overview of the progress of Community Supports implementation and to discuss important policy refinements and areas of reinforcement. The webinar covered a range

of topics, including eligibility, referrals and authorizations, provider networks, payment, market awareness, and data exchange. Key insights from the ECM and Community Supports CY 2022 implementation report were also unveiled.

On August 22, 2023, DHCS issued an email communication to MCPs requiring that they submit a corresponding attestation of their progress toward implementation of new and reinforced policies, following the release of the updated ECM and Community Supports Policy Guide in July 2023. This requirement was discussed at the June 9 MCP Summit and during subsequent virtual meetings. By submitting attestation forms, each MCP will confirm that it has made, or is in the process of making, all necessary changes to its policies and procedures and has taken proactive measures to implement the updated/reinforced policies into its operations.

On August 24, 2023, DHCS hosted its August ECM & Community Supports Implementation Advisory Group meeting series, using the time to discuss proposed updates to DHCS' ECM and Community Supports Coding Guidance document. In late 2022, DHCS administered a survey to MCPs and ECM and Community Supports providers about their first year of CalAIM implementation, including their experience using the HCPCS codes contained in this document. DHCS received over 200 responses. Based on feedback from the survey and other stakeholder sessions, DHCS is updating certain ECM and Community Supports billing codes, which are labeled throughout the document and summarized in a new Appendix. An embargoed copy of the updated draft guidance was attached for participants' review ahead of the meeting and to reference when providing feedback.

On September 14, 2023, DHCS participated in the quarterly Managed Care Advisory Group meeting and provided a presentation and overview of Community Supports, including a review of available services, implementation progress update, and a preview of upcoming future planned activities and policy updates.

On September 21, 2023, DHCS hosted its September ECM & Community Supports Implementation Advisory Group. This meeting focused on collecting feedback and discussing potential refinements to the Community Supports service definitions for the "Housing Trio" (i.e., Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services). The effort reflects part of DHCS' commitment to increase the standardization of both ECM and Community Supports.

On October 16, 2023, DHCS traveled to, and presented at the Asthma Mitigation Project's (AMP) Final Convening at the Sierra Health Foundation in Sacramento. DHCS'

presentation included information on the Asthma Preventive Services (APS) benefit, which provides asthma education and in-home trigger assessments, as well as the Asthma Remediation Community Support. The discussion focused on the complementary nature of these two services and how they fit into DHCS' broader efforts to provide whole-person care and improve the healthcare delivery system.

On October 24, 2023, DHCS held its monthly call with MCPs where updates were provided on the Justice-Involved Initiative, the PHM Transitional Care Services Policy, the PHM Key Performance Indicator (KPI) Data Submissions, the Medi-Cal Enrollment Pathway for Assisted Living Community Providers offering Community Supports, the Incentive Payment Program Submission 4, and 2024 Incoming MCPs Needs Assessments & Gap Filling Plans.

On November 8, 2023, DHCS hosted its PATH CPI Facilitator Onsite convening, where the Department shared key background on DHCS' priorities for ECM and Community Supports implementation in 2023-2024. Topics included an ECM and Community Supports implementation update, DHCS' approach to continuous improvement, DHCS' policy "Action Plan," and Data Transparency. DHCS additionally provided enhanced technical assistance to its facilitators while onsite.

On November 15, 2023, DHCS provided a briefing to the California state legislature on ECM and Community Supports under CalAIM. Details on the CalAIM initiative, including ECM, Community Supports, and PATH, were provided and DHCS discussed how each initiative is innovating and transforming the Medi-Cal delivery system by moving Medi-Cal towards a population health approach that prioritizes prevention and WPC, and extends supports and services beyond hospitals and health care settings directly into California communities.

On November 28, 2023, DHCS held its monthly call with MCPs and provided updates on the Housing and Homelessness Incentive Program (HHIP) Submission 2 Deliverables, the Transition to JavaScript Object Notation (JSON) for QIMR Reporting, DHCS' Continuity of Care Policy for Members enrolled in Non-EAE D-SNPs receiving ECM, PATH Updates on Collaborative Planning Implementation (CPI), ECM and Community Supports Public Data Releases, and Population Needs Assessments.

On December 7, 2023, DHCS hosted a statewide webinar entitled "Relationship Building with Organizations in the CalAIM Environment." The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing ECM and Community Supports, increasing providers' successful participation in CalAIM, and

improving collaboration with MCPs, state and local government agencies, and others to build and deliver quality support services to Medi-Cal members.

On December 18, 2023, DHCS held a webinar to discuss the release of updates to the ECM and Community Supports HCPCS Guidance. These updates were informed by feedback DHCS received from the field to streamline coding data exchange to reduce administrative burden and minimize instances of delayed or non-payment due to coding issues for ECM and Community Supports.

Qualitative Findings

Community Supports Policy Guide

Over the course of DY 19, DHCS and its stakeholders identified several key areas of the Community Supports Policy Guide for which additional TA, guidance, and/or further clarification were requested. DHCS refreshes its Community Supports Policy Guide when necessary to incorporate new language and/or developments in policy, including on:

- Prime/Subcontractor Authorization Policy
- Homelessness Determinations
- Eligibility for Services
- Member Handbooks and Website Update Requirements
- Provider Network Allowances
- Continuum of Care Requirements
- Other technical corrections

DHCS updated its Community Supports Policy Guide in July 2023 to provide several key program updates, detailed below.

Development of Additional Guidance

DHCS has always envisioned modifying the Community Supports program over time and is committed to continuous improvement based on data and stakeholder feedback. DHCS has rolled out several policy changes and/or clarifications and provides TA to MCPs, including through the TA Marketplace. The TA Marketplace allows funding for the provision of TA for entities that intend to provide ECM and/or Community Supports. Entities may register for hands-on technical assistance support from vendors and access off-the-shelf TA resources in pre-defined TA domains.

In the Spring, DHCS updated the following core data guidance documents which were originally published in 2021:

- **ECM and Community Supports Billing and Invoicing Guidance**: Standard, "minimum necessary" data elements MCPs will need to collect from ECM or Community Supports Providers unable to submit ANSI ASC X12N 837P claims to MCPs.

- **Quarterly Implementation Monitoring Report (QIMR) Guidance**: Quarterly MCP reporting requirements and Excel template related to ECM and Community Supports implementation across multiple domains; the QIMR fulfills AB 133 reporting requirements.

- **Community Supports Member Information Sharing Guidance**: Standards for the exchange of Member information between MCPs and Community Supports Providers to initiate, support, and track the delivery of Community Supports

- **ECM & Community Supports Coding Options Guidance**: Contains the DHCS-established HCPCS codes and associated modifiers for ECM and Community Supports services.

DHCS identified the following priority areas and has implemented several key program design refinements, discussed in further detail below, to increase the total number of Members served:

- Standardizing Eligibility
- Streamlining and Standardizing Referral/Authorization Processes
- Expanding Provider Networks and Streamlining Payment
- Strengthening Market Awareness
- Improving Data Exchange

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

Standardizing Eligibility

Towards increasing standardization, DHCS has required that MCPs remove any previously approved restrictions or limitations and adhere with the full Community Supports service definitions by January 1, 2024. MCPs will no longer have the option to narrow the eligibility criteria or impose additional limitations on the service definitions

(which include eligibility criteria), geographic or otherwise. DHCS is working on refining the Community Supports service definitions in response to market and stakeholder feedback and looks forward to continued work with its stakeholders to provide these needed inputs.

DHCS has clarified that any previously approved modifications and/or restrictions to service definitions must be included in Member Handbooks and on the MCPs website for as long as they were in effect. Now that MCPs must come into alignment with the full DHCS Community Supports service definitions, any language about approved modifications and/or restrictions must be removed from their websites and handbooks.

In response to some MCPs having narrowed Community Supports eligibility criteria relative to the DHCS service definitions, partly due to the perception that the plan is responsible for determining cost-effectiveness, DHCS has informed MCPs that they do not need to actively assess or report on cost-effectiveness for Community Supports at the MCP or individual level for the purposes of rate setting or compliance with federal requirements. The Department will be conducting statewide aggregate analyses of the cost-effectiveness of each approved Community Supports service. Nothing prohibits MCPs from using utilization management techniques as applicable and as permitted by federal managed care regulations.

Streamlining and Standardizing Referral/Authorization Processes

In response to disparate timeframes seen for initial Community Supports authorization and reauthorization decisions within and across services, which were creating administrative burden for providers who are contracted with more than one plan and a lack of parity in the delivery of similar services for Members across the state, DHCS is working on standardizing Community Supports authorization and reauthorization periods for implementation in 2024.

Another issue raised by stakeholders that the Department is reacting to relates to presumptive authorization. DHCS knows that presumptive authorization arrangements with trusted providers can help streamline access, but it has not yet seen MCPs widely adopting such arrangements thus far. As such, DHCS is strongly encouraging its contracted MCPs to implement presumptive authorization policies, especially for the Recuperative Care and Short-Term Post-Hospitalization Housing services, including from inpatient settings, emergency departments, and skilled nursing facilities.

DHCS is also looking to begin developing statewide referral standards in 2024 due to

the number of disparate inputs, forms, and processes for referrals and authorizations witnessed across MCPs that is creating a high administrative burden for providers. DHCS expects MCPs to source most Community Supports referrals from the community, and that the use of internal data to identify potentially eligible Members should be balanced with active community-based outreach and engagement. To help mitigate these concerns, DHCS will begin developing statewide standards containing the information needed to evaluate authorizations for some Community Supports. The Department will engage directly with MCPs and Community Supports providers in the design work, with the anticipation of rolling out the referral standards for statewide adoption in the second half of 2024.

Expanding Provider Networks and Streamlining Payment

Through the Model of Care submission and review process as well as a careful look at the data received through the QIMR, DHCS recognizes that MCPs may be missing opportunities to contract Community Supports providers that have special skills or expertise, and who know the members best. As a result, DHCS has implemented new policies requiring partnerships with specific provider types that have experience serving individuals with specialized needs in each region. MCPs must contract with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., supportive housing providers, skilled nursing facilities).

DHCS is also still working on updating and refining its ECM and Community Supports HCPCS Coding Options guidance and reinforcing standardized application of codes at the provider level. This is in response to feedback received that the original HCPCS code set is being applied differently by different MCPs leading to increased administrative burden for providers. DHCS Intends on re-issuing the HCPCS Coding Guidance with clarification that MCPs must use the HCPCS coding options for Community Supports, as defined by DHCS, without additional codes or modifiers.

Finally in this area, DHCS will be reinforcing existing timely provider payment requirements with its MCPs implementing Community Supports after receiving widespread reports of non-payment or delayed invoice payments by MCPs, especially to CBOs new to billing Medi-Cal. As a reminder, Community Supports services are subject to the standard reimbursement timelines for other Medi-Cal services as specified in both its managed care boilerplate contract (“MCPs must pay 90 percent of all clean claims within 30 days of the date of receipt and 99 percent of all clean claims within 90 days”)

and California Health and Safety Code Section 13711 ("MCPs must reimburse claims or any portion of any claim, as soon as practicable, but no later than 30 working days after receipt of the claim and are subject to interest payments if failing to meet the standards"). These requirements pertain to both claims and invoices. MCPs are required to train their contracted network of Community Supports providers on how to submit clean claims, and furthermore must have personnel available to troubleshoot issues. Additionally, in July 2023, DHCS issued APL 23-020 offering clarifying guidance to MCPs about timely payment of claims.

Strengthening Market Awareness

In the first year of program implementation, DHCS noticed there was relatively low awareness among contracted providers and MCP internal staff about Community Supports and how to access them. In response, DHCS is reinforcing existing guidance and working to ensure that MCPs are proactively ensuring their contracted networks of providers are aware of Community Supports services, what the eligibility criteria are, and are encouraging or clarifying the pathway for providers to submit referrals to the MCP. MCPs must also continue to train their call centers about how to take referrals for Community Supports.

DHCS has also generally noticed low awareness in the community about Community Supports services and how to access them. DHCS has reminded MCPs that they must continue to ensure their public-facing websites, Member Handbooks, and Provider Directories include the most up-to-date information about the Community Supports they offer and how members can access them. DHCS has begun monitoring websites, member handbooks, and following up with MCPs whenever gaps are identified. The DHCS Community Supports website also contains fact sheets and other language that MCPs may use. DHCS always welcomes and encourages additional and creative ways of distributing information and continues to work with its stakeholders, MCPs, and Community Supports providers on these efforts.

Finally, in this area, DHCS noticed that some MCPs were delivering services to address Members' health-related social needs that were funded through other mechanisms outside of Community Supports, such as through value-added services. Moving forward, DHCS is requiring MCPs that are delivering such services to evaluate and determine the feasibility of transitioning them into the Community Supports program. Doing so will increase the awareness of Community Supports across the communities where other similar services are currently being provided and will drive enrollment into Community

Supports. This strategy also allows MCPs to take advantage of the funding DHCS has allocated for Community Supports. Evaluating the feasibility of transitioning existing services to Community Supports may involve modifying current eligibility criteria and confirming existing providers can meet the requirements to continue to serve as Community Supports providers. DHCS stands ready to assist MCP partners with focused technical assistance in this area.

Improving Data Exchange

For the first year of CalAIM implementation, DHCS issued data standards for information exchange between MCPs and ECM providers, but not between MCPs and Community Supports providers. In April 2023, DHCS released the new Community Supports Member Information Sharing Guidance to standardize Community Supports member information exchange. MCPs and Community Supports Providers were required to implement all standards incorporated by this guidance by September 1, 2023. All MCPs submitted attestations confirming their compliance with these new program requirements.

Also, in April 2023, DHCS updated its ECM and Community Supports Billing and Invoicing Guidance and its Quarterly Implementation Monitoring Report Guidance to accommodate these program changes and policy updates. The HCPCS Coding Guidance for ECM and Community Supports is planned for release in early Q4 2023.

Further details about these policy refinements can be found in the Community Supports Policy Guide[5] on the DHCS ECM and Community Supports webpage. DHCS has also published a "Cheat Sheet"[6] to help providers and other stakeholders navigate the ECM and Community Supports policy updates that summarizes the key policies, as well as the distinction between state-standardized policies and where there is flexibility for MCPs to define their own policies and procedures.

Quantitative Findings

To monitor ECM and Community Supports implementation, DHCS developed the Quarterly Implementation Monitoring Report, which MCPs are required to report to DHCS across multiple domains. For Community Supports specifically, MCPs must report Community Supports services that were requested, approved, and denied, as well as

[5] DHCS Community Supports Policy Guide (ca.gov)

[6] Enhanced Care Management/Community Supports: A Policy "Cheat Sheet"

provider capacity. The data from this report is designed to provide DHCS with information to monitor the initial rollout of ECM and Community Supports and inform the implementation of MCP performance incentives.

DHCS is working to produce program data and make it publicly available at the earliest opportunity, while always factoring in privacy concerns. It takes DHCS, on average, approximately eight weeks to validate and fully process the quarterly data it receives, then visualize it through Microsoft Power Business Intelligence (BI). Dashboards in Power BI are developed and being continuously refined to better help accurately visualize data for the program and capture all metrics necessary to ensure quality monitoring.

Examples of how the data are visualized are included in Figure 32 and Figure 33.

Figure 32: Program History for Members Receiving Community Support Services as of September 2023: Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:

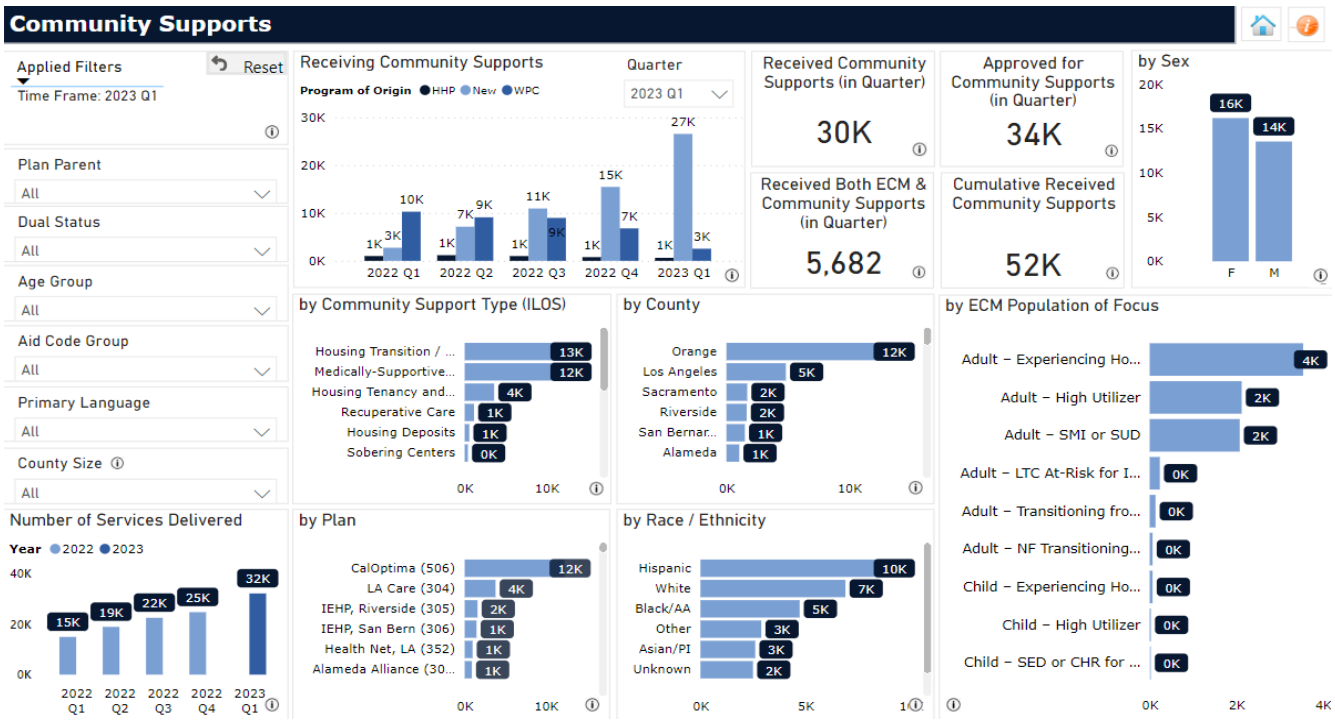
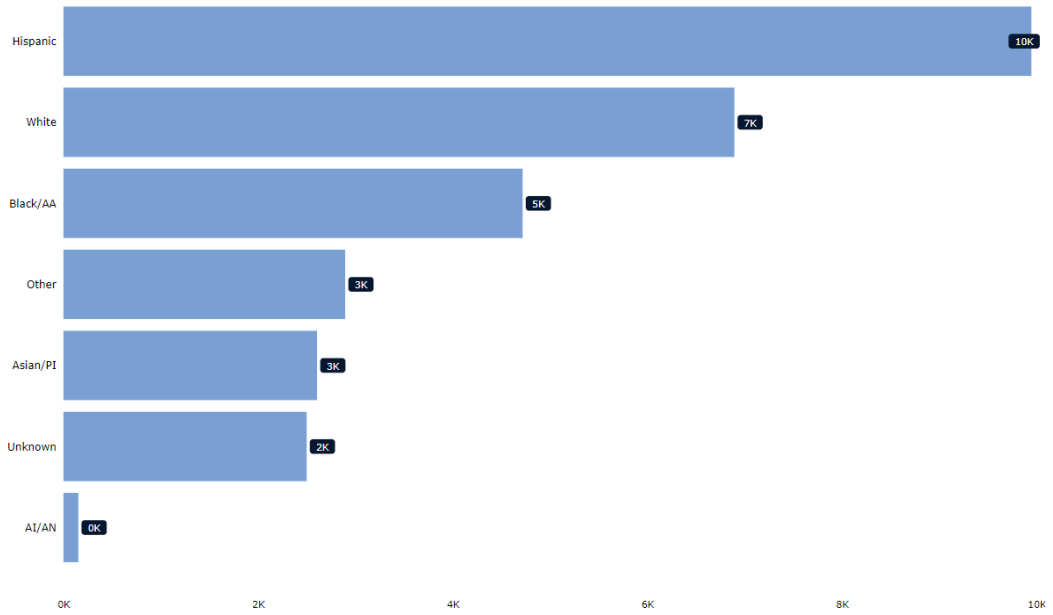


Figure 33: Demographics of Members Receiving Community Support Services as of September 2023. Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:



DHCS continues towards working to ensure a high level of data quality covering the first two years of Community Supports implementation and recognizes the gaps that exist in new providers' reporting capabilities, which MCPs must address. DHCS currently has six quarters of data available for Community Supports, but MCPs have 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.

Several of the available Community Supports offer MCPs the opportunity to better address critical health-related social needs for their members, and the services most widely offered by MCPs have included Housing Transition/Navigation, Housing Deposits, Housing Tenancy and Sustaining Services, Medically Tailored Meals, and Recuperative Care (Medical Respite).

Currently available data, as of September 2023, indicates the following number of providers, members, and counties throughout California for the following available Community Supports:

Figure 34: Number of Providers and Number of Counties offering the Recuperative Care and Short-Term Post-Hospitalization Housing Community Supports Services

Community Supports	Number of Provider Contracts	Number of Counties Offering CS
Recuperative Care	150	57
Short-Term Post-Hospitalization Housing	102	53

MCPs in nearly all California's 58 counties have elected to offer Recuperative Care and Short-term Post-Hospitalization Housing within the first few years of the program.

Current available data indicates the following number of members served across the first three quarters of 2023 for DHCS' available Recuperative Care and Short-term Post-Hospitalization Housing Community Supports:

Figure 35: Number of Unique Individuals served across Community Supports

Community Supports	2023 Q1	2023 Q2	2023 Q3
Recuperative Care	1,143	1,424	1,721
Short-Term Post-Hospitalization Housing	232	277	422

DHCS will continue to submit timely, accurate, and validated encounter data to Transformed Medicaid Statistical Information System (T-MSIS), in accordance with STC 8.12ii,

DHCS acknowledges outstanding challenges with timely and accurate data collection remain. Community Supports are a significant addition to Medi-Cal and, given the novelty of the program, require continued work with a broad range of community-based providers and various provider types. DHCS recognizes the work California MCPs and local communities statewide are undertaking to operationalize these new services and provides technical assistance and training where possible, including through webinar series such as the Community Supports Spotlight Series of eight webinar trainings held over the course of CY 2022 (DY 18). These forums allow DHCS to review and reinforce policy guidance on individual Community Supports, identify and amplify best practices or lessons learned from

community providers and MCPs, and respond to emerging questions from the field.

JavaScript Object Notation (JSON) Transition

DHCS plans to improve data availability by the end of 2023 by (1) beginning to leverage claims and encounter data in addition to QIMR data, and (2) improving cycle time of implementation data by transitioning data collection to JSON electronic file types.

The transition to JSON begins in January 2024, when DHCS will officially begin transitioning the quarterly reporting performed via the Quarterly Implementation Monitoring Report (QIMR) Excel Reports by requiring additional monthly JSON file submissions. JSON 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-six months; the transition to JSON is expected to significantly reduce lag on data collection.

The introduction of JSON monthly reporting will not remove Excel-based reporting requirements. MCPs must continue reporting as normal through the Quarterly Implementation Monitoring Report process within 45 days of the end of each quarter. MCPs must adopt the JSON monthly process as it is implemented and continue reporting via both JSON and QIMR Excel for at least 12-18 months, or until DHCS determines the data is robust enough to support the discontinuation of the QIMR in favor of receiving all program reporting via the monthly JSON file.

The transition from the QIMR to JSON is occurring across several phases:

- **Phase 1 (January 2024):** Limited data elements specific to Enhanced Care Management (ECM) and Complex Care Management (CCM) enrollment status.

- **Phase 2 (July 2024):** ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.

- **Phase 3 (January 2025):** All remaining QIMR data elements specific to Community Supports, including member-level details, utilization, authorizations, and provider networks.

DHCS has produced accompanying Technical Documentation through an available Technical Assistance Companion Guide, containing all the 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.

As stated above, MCPs are required to continue reporting as normal through the QIMR process within 45 days of the end of each quarter.

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 all of the 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 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 Special Terms and Conditions, 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 Community Supports providers in their provider directories as follows:
    - MCPs are to list all 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.

In late 2022, DHCS began conducting 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, inclusive of any DHCS approved approach to modify or restrict the Community Supports service definitions (including eligibility). Beginning on January 1, 2024, the MCP must come into alignment with the DHCS Community Supports service definitions and must remove any language about approved modifications and/or restrictions from its website.

In September 2023, DHCS issued a Community Supports Monitoring Request for Information (RFI) to select MCPs based on their Community Supports implementation for CY 2022. In August, DHCS published ECM and Community Supports implementation data for CY 2022, including statewide, county-level, and MCP-level data. Using this data, DHCS examined the degree of MCPs' implementation of Community Supports based on the utilization of Community Supports services. MCPs received this RFI if they provided zero Community Supports services in CY 2022 for a Community Support service that they elected to offer in a county where they had an average of 10,000 or more Medi-Cal MCP members and where they will continue to operate in CY 2024.

The purpose of the Monitoring RFI was to better understand specific service uptake issues and solutions the MCP has implemented, or plans to implement, to address low uptake. After reviewing RFI submissions, DHCS scheduled follow-up meetings with

MCPs, as needed, to further discuss uptake issues and the approach for addressing these issues. MCPs were required to submit responses for each Community Support service flagged in an email they received from DHCS and were encouraged to highlight county-specific uptake issues or strategies in their RFI responses.

With the end of the second full year 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, & Analysis
- Model of Care 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)

Public Reporting

On August 3, 2023, DHCS published its first ECM and Community Supports Year One (CY 2022) Implementation Report[7] along with the following message:

California has embarked on a multi-year journey to transform Medi-Cal and provide members with more coordinated, person-centered, and equitable care.

In 2022, two cornerstones of this journey -- ECM and Community Supports -- launched statewide and reached more than 125,000 managed care plan (MCP) members in the first 12 months of implementation. This Medi-Cal ECM and Community Supports Calendar Year (CY) 2022 Implementation Report provides a comprehensive overview of ECM and Community Supports implementation in the programs' first year. It includes data at the

[7] Report available at: https://storymaps.arcgis.com/collections/53cc039bc1d54e2e9fc0ac92f5b6511a

state, county, and plan levels on total members served, utilization, and provider networks. The Report is structured to provide the following detail on MCPs' progress towards implementing Community Supports over Year One (2022):

- *Total services offered / launch timeline for 2022*
- *Cumulative Members Receiving ECM in 2022*
    - *Total services offered / launch timeline*
    - *Total members served*
    - *Total services*
    - *CS by service*
    - *Total members served stratified by race/ethnicity, gender, language, HPI*
- *Quarter-Over-Quarter Trends for CS*
    - *Total number of members served in each CS by quarter*
    - *Total number of services in each CS by quarter*
- *Cumulative Provider Network*
    - *By Community Support*
    - *By Provider Type*

On January 29, 2024, DHCS publicly released its Enhanced Care Management (ECM) and Community Supports Quarterly Implementation Report for Q2 2023[8] along with the following message:

This report summarizes ECM and Community Supports implementation trends and data for the first 18 months of the programs, spanning January 2022 through June 2023. Similar to the 2022 Year One Implementation Report released in August 2023, this report provides insight into state-, county-, and managed care plan-level data.

In the first 18 months, 140,886 Medi-Cal MCP members across the state received the ECM benefit and 75,834 members received 167,960 Community Supports services. As California continues advancing its Medi-Cal transformation, ECM and Community Supports play a critical role in supporting whole-person care for Medi-Cal members with complex medical and health-related social needs. DHCS expects to see more enrollment growth across both programs in the coming months and years, including as additional Populations of Focus become eligible for ECM and additional Community Supports services are offered in counties across the state. DHCS remains committed to supporting and sustaining this growth through

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

program monitoring, design improvements, and standardization. Please note that the report is published via ArcGIS StoryMaps, a data visualization tool, and is best viewed on a desktop or laptop computer.

Policy/Administrative Issues and Challenges:

Nothing to report.

Opportunities for Improvement:

DHCS tracks stakeholder feedback and indicators in the marketplace, including comments received from providers and members of the public, to effectively gauge the amount and severity of any challenges presented. Starting in 2022, DHCS began creating reliable provider feedback loops and kicked off a Statewide Listening Tour.

DHCS continues to monitor data quality and has begun analyzing the differences between the plan-submitted data on the Quarterly Implementation Monitoring Reports and the Encounters/Claims to start visualizing how accurate the data received via the Quarterly Implementation Monitoring Report process relative to Post Adjudicated Claims & Encounters Systems. The Transition to JSON, as it is phased in through 2024 and 2025, will help facilitate enhanced analysis and promote data integrity across reporting mechanisms.

DHCS continues to invest in Community Supports Provider Education, expanding opportunities to connect with prospective Community Supports providers and utilizing the experience of current Community Supports providers to knowledge-share and orient non-traditional Providers to Medi-Cal and Community Supports.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

Providing Access and Transforming Health (PATH) Supports, Global Payment Program (GPP), Dually Eligible Enrollees in Medi-Cal Managed Care, and Reentry Demonstration and Pre-Release Services

Prior to DY 19, DHCS submitted a draft evaluation design for the PATH, GPP, and alignment and integration for dually eligible members' portions of the CalAIM 1115 waiver demonstration to CMS on June 27, 2022. In October 2022, CMS provided their initial feedback, which included suggestions and recommendations to onboard a potential contractor to assist with the evaluation design, along with expanding certain data methodologies for PATH and combining this effort with the evaluation of the Justice-Involved Initiative and the revisions to PATH evaluation design (approved by CMS in January 2023). DHCS agreed with CMS' suggestions. A revised evaluation design was submitted in November 2022 for CMS' review.

In DY 19, on December 20, 2023, DHCS entered into a contract with the Regents of the University of California on behalf of its Los Angeles campus (UCLA) and RAND Corporation, the main subcontractor for these evaluations.

UCLA-RAND will conduct the evaluation of the Providing Access and Transforming Health (PATH), Global Payment Program (GPP), Dually Eligible Member Satisfaction in the Medi-Cal Matching Process, and the newly approved Reentry Demonstration Initiative. UCLA-RAND and DHCS evaluation teams actively engaged to revise the Evaluation Design. UCLA worked with DHCS to revise the designs as requested. DHCS planned to submit a revised, expanded Evaluation Design to CMS, including a newly drafted evaluation design for the JI initiative, in early 2024. UCLA-RAND will evaluate all aspects of the PATH program, including the following components:

a. Support for Implementation of Enhanced Care Management and Community Supports
    i. WPC and Transition to Managed Care Mitigation Initiative
    ii. Technical Assistance Initiative
    iii. Collaborative Planning and Implementation Initiative
    iv. Capacity and Infrastructure Transition, Expansion, and Development (CITED)
b. JI Capacity Building Program

i. Collaborative Planning

ii. Capacity and Infrastructure

Community Supports

DHCS plans to enter into a contract for a program evaluation of Community Supports after receiving a final CMS decision on the timing and number of evaluation reports for the 12 Community Supports authorized via 1915(b) waiver authority, and alignment with the evaluation requirements that apply to the two Community Supports authorized via the 1115 waiver. In addition, DHCS will provide ongoing monitoring updates to CMS within the Annual Report on ILOS as required under the 1915(b)-waiver authority.

Community Based Adult Services (CBAS)

In summary, DY19 proved to be a historically successful year for the CBAS program. Seventeen new CBAS centers completed the initial certification process adding operations to 7 Counties, a six percent increase in new centers since 2017. All new CBAS Centers receive ongoing technical assistance, support, and training.

Emergency Remote Services (ERS) data monitoring has been consistent throughout DY19, which aligns with the one-year ERS implementation date (October 2022 – October 2023). Trends in ERS usage are assessed and analyzed for any needed actionable items, such as participants length of time on ERS, needs for higher levels of care, care coordination with the MCPs, and the revision of ERS policies and procedures to ensure greater understanding by CBAS providers, and compliance with all regulatory program requirements.

CDA reconvened the Quality Strategy Advisory Committee in Q4 of DY 19 which included members of the CDA Executive team, CBAS staff, DHCS, MCPs, and other stakeholders. The committee plans to meet monthly, and this meeting forum will be utilized to develop performance measures required in STC 5.8. Webinars and trainings were provided on the Electronic Visit Verification (EVV) onboarding and registration process, ensuring providers had the technical support needed to launch and maintain the use of the EVV platform.

Regularly scheduled meetings, trainings, collaborations, and process improvements occurred with various stakeholders throughout DY 19 to ensure the continued success and support of the CBAS program.

DMC-ODS and Contingency Management

Status of Activities/Milestones

Evaluation Design: The University of California Los Angeles (UCLA) evaluation team continued active engagement with DHCS in the planning and writing of the evaluation designs for the Recovery Incentives Program (which included the Contingency Management (CM) benefit) and the broader DMC-ODS system. In Q4 of 2022, CMS requested to combine these two evaluation designs (originally submitted separately in Spring 2022) into a single unified evaluation design. This revision was submitted to CMS on February 23, 2023, and was again re-submitted on June 26, 2023, to incorporate an evaluation of CY 2021. On July 28, 2023, CMS approved the design, formally initiating activities for the Evaluation and adding it to the demonstration STCs as a new attachment (Attachment T). Information about the Evaluation Design can be found here, and the approved Evaluation Design can be found here.

Regulatory Approvals: UCLA received Institutional Review Board (IRB) Research Exempt determinations from both State IRB (June 2022) and UCLA IRBs (Oct 2023) and was issued a Certificate of Confidentiality (Oct 2023) through The National Institutes of Health (NIH), protecting the identity of research participants in this project.

Early Implementation Lessons: From February-June 2023, UCLA observed pre-implementation trainings, readiness assessment interviews, and monthly coaching calls as part of the Recovery Incentives Program. These observations were used to inform the first report deliverable (submitted July 31, 2023), which described the initial implementation of the CA Recovery Incentives Program, California's CM benefit. The report, found here, summarizes early implementation successes while identifying themes of perceived challenges and areas for improvement.

Survey Data Collection: In June 2023, utilizing findings from the initial CM report, UCLA developed a Provider Survey to obtain perceptions and feedback from the CM Supervisors, CM Coordinators and Counselors on implementation successes and challenges. The survey launched in September, surveying programs after a minimum of five months delivering CM services as part of the Recovery Incentives Program. Data collection will continue until all programs have launched or saturation is reached.

In addition, UCLA began development of the Client Survey effort, developing both longitudinal and cross-sectional approaches. Both strategies will be utilized in the evaluation, but for the purposes of obtaining a wide range of client perceptions, UCLA

will initiate the cross-sectional approach first (scheduled to launch in Q1 of 2024). Findings will be reported in the Mid-Point Assessment Evaluation Report in June 2024.

Finally, UCLA is preparing for the annual County Administrator Survey implementation in Spring 2024, aimed to continue measuring impact of the DMC-ODS waiver on SUD service delivery as well as addressing priority areas addressed under CalAIM (e.g., health equity/racial disparities, CM, peers, harm reduction efforts, etc.).

Qualitative Interviews: In November 2023, UCLA developed Interview Guides for Provider and Client Interviews to occur following survey data collection (planned for Spring 2024).

Administrative Data Analysis: UCLA continues to receive administrative datasets including CalOMS files, SDMC Claims, MMEF, and ASAM data. DHCS is in possession of 2023 Incentive Manager data and plans to share this data with UCLA in the near future.

ASAM Assessment and Screening: In April 2023, UCLA launched the ASAM Criteria Assessment Interview Guide resource website, found here. The Interview Guide is the first publicly available standardized version of the ASAM Criteria assessment. In the latter half of CY 2023, UCLA worked to establish an agreement with ASAM defining the terms of our collaboration to update the ASAM Assessment Interview Guide to map accordingly to the recently released 4th Edition.

Additionally, UCLA continues to support the utilization of the Brief Questionnaire for Initial Placement (BQuIP), accessible here for resource support.

Statewide Perception Surveys: UCLA continues to collect and analyze the annual Mental Health Consumer Perception Survey (CPS) (May 2023) and SUD Treatment Perceptions Survey (TPS) (October 2023). Information can be found here and here.

Challenges encountered and how they are being addressed

In this CY, UCLA adapted preliminary timelines and some strategies to obtain data in response to the delayed roll out of the Recovery Incentives Program, in particular the Provider and Client surveys. The delay is not believed to affect UCLA's ability to complete the DMC-ODS/CM evaluation as planned, as these adjustments will facilitate meeting deliverable deadlines. However, UCLA has encountered some minor issues related to CM client and provider survey distribution, including sites' concerns about the difficulty of contacting clients for follow-up surveys and site staff declining to complete

surveys because they do not self-identify as "CM providers." UCLA has identified solutions such as incorporating initial cross-sectional data collection for client surveys while pilot-testing a longitudinal approach and will also procure low-cost electronic tablets for clients to complete surveys while they are on-site. UCLA has also educated sites on who is considered a "provider" and initial survey results indicate a good response rate from all intended provider respondents. Finally, timely access to administrative datasets continues to be challenging but DHCS continues to work with UCLA to coordinate these efforts.

Description of Interim Findings or Reports

In August 2023, DHCS approved UCLA's first report deliverable entitled "Short Report: The Recovery Incentives Program's Contingency Management Benefit: Early Implementation Lessons Learned, February – June 2023," found here.

In summary, UCLA identified perceived challenges and areas for potential improvement, voiced by providers and staff who will be responsible for implementing the Recovery Incentives Program. The six major themes that emerged in these discussions were related to: (1) eligibility requirements; (2) UDT testing procedures; (3) use of UDT results outside of the Recovery Incentives Program; (4) concerns about incentives; (5) incentive manager software; and (6) logistical challenges.

It should be noted that all the perceived challenges and areas for potential improvement are ones that were mentioned by providers who will be delivering Recovery Incentives services, but are not necessarily actual barriers to program implementation, since DHCS has policies and procedures in place to address these issues and the UCLA Training and Implementation Support team has communicated appropriate policies to providers as needed. Moreover, since program implementation just began, it is too early in the Recovery Incentives Program to determine if any of these issues have impeded the program or require any shifts in policy and practice — they are only being mentioned here as perceived challenges and areas for possible improvement to potentially inform guidance that DHCS and the UCLA Training and Implementation Support team may provide for sites later in the Recovery Incentives Program. UCLA is scheduled to deliver the Mid-Point Interim Report for Contingency Management to DHCS in June 2024 and the overall ODS 1115 Evaluation Mid-Point Assessment Report, consistent with STC 6.6, to DHCS in December 2024.

Out-Of-State Former Foster Youth

No evaluation updates for DY 19.

Additional Evaluation Updates

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Final Summative Evaluation Report was conducted by the University of California Los Angeles (UCLA) Center for Health Policy Research to evaluate the goals of PRIME using a conceptual framework adapted from the Triple Aim: enhanced infrastructure, better care, better health, and lower costs. The report covers the PRIME implementation period from January 2016 through June 2020. Fifty hospitals participated in the PRIME initiative, and they implemented a total of 18 projects. The report found that the hospitals under the PRIME initiative made notable progress in achieving the goals of increasing provision of patient-centered, data-driven, team-based care; improving provision of point of care services, complex care management, population health management, and culturally competent care; improving population health and patient experience in Medi-Cal; integrating physical and behavioral health; coordinating care for vulnerable populations; and transitioning public hospitals to value-based care. The PRIME Final Summative Evaluation Report was approved by CMS on March 15, 2023.

Managed Care Risk Mitigation COVID-19

The Managed Care Risk Mitigation COVID-19 Evaluation Design was approved on April 21, 2023, and the final report is due to CMS on June 30, 2028.

Managed Care Plan Transition

The Managed Care Plan transition was added to the CalAIM 1115 STCs on August 23, 2023. The STCs require DHCS to evaluate the effects of the managed care amendment on members, providers, and plans, particularly regarding achieving equitable member access to and quality of care, in alignment with the Section 1915(b) waiver reporting requirements. On October 16, 2023, DHCS executed a contract with Mathematica to conduct Section 1915(b) waiver reporting work, including the identification of access to care measures that can be aligned with the evaluation of the Managed Care Plan Transition.

Next Steps/Upcoming Evaluation Deliverables

In 2024, DHCS plans to engage in the following evaluation activities and reporting:

- Submit a revised evaluation design for the PATH, GPP, and Duals Matching Plan Policy, along with a new evaluation design for the Reentry Initiative (submitted February 7, 2024). As the independent evaluator, UCLA-RAND will begin data collection and analysis in preparation for the interim evaluation, which will be due to CMS by December 29, 2025. UCLA-RAND will submit quarterly reports to DHCS on its progress toward this goal.

- As the independent evaluator for the unified evaluation of DMC-ODS and Contingency Management, UCLA-ISAP will conduct data analysis and begin fielding surveys of county administrators, CM providers, and CM clients. UCLA-ISAP will report on its progress via two Bi-Annual Progress Reports to DHCS, the first of which was submitted to DHCS on February 8, 2024.

- UCLA-ISAP will also submit a Contingency Management Mid-Point Assessment to DHCS by June 30, 2024. This Assessment – not required by CMS – will provide early evidence on the Contingency Management pilot.

- UCLA-ISAP will submit a draft DMC-ODS Mid-Point Assessment to DHCS during 2024. The Mid-Point Assessment is due to CMS by March 1, 2025.

- DHCS will contract with an external evaluator and submit an evaluation design for Community Supports and the Managed Care Plan Transition. Currently, DHCS is awaiting final guidance from CMS on due dates and reporting requirements in relation to the In Lieu of Services evaluation.

Community-Based Adult Services (CBAS) Attachment
Annual Monitoring Report Attachment
Demonstration Year 19

STC#5.7 (HCBS Electronic Visit Verification System (EVVS)): *In the absence of an annual or quarterly reporting requirement for this HCBS item, CMS recommends that CA provide EVVS information in the annual monitoring report.*

CA Response: The State of California implemented the California Electronic Visit Verification (CalEVV) system for Personal Care Services (PCS) on January 1, 2022, and Home Health Care Services (HHCS) on January 1, 2023, in accordance with the federally mandated requirements of the 21st Century Cures Act.) system for Personal Care Services (PCS) on January 1, 2022, and Home Health Care Services (HHCS) on January 1, 2023, in accordance with the federally mandated requirements of the 21st Century Cures Act.

The CalAIM 1115 Waiver requires the state to demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for the provision of in-home PCS and HHCS to CBAS beneficiaries utilizing the CBAS Emergency Remote Services (ERS) benefit. Effective March 23, 2023, the CalEVV system began supporting the California Department of Aging (CDA) CBAS and CBAS providers to ensure compliance with CBAS ERS EVV requirements. An EVV onboarding and registration webinar was held on March 9, 2023, to introduce EVV to CBAS providers, demonstrate best practices, and explain how to accurately register for EVV. The webinar also demonstrated the submission of complete EVV data for specified ERS provided in the home which are subject to EVV.

STC#5.8 (Quality Improvement (QI) Strategy for 1915c/i approval HCBS services): *Per STC#5.8, CA "will report on the initial series [of performance measures] within one year of finalization and from that point will report annually."*

CA Response: As previously noted, the California Department of Aging (CDA) created a CBAS Quality Advisory Committee to develop a quality assurance and improvement strategy for CBAS that includes metrics for tracking and improving participant outcomes and the quality of care delivered by CBAS providers. At the end of 2023, CDA developed the initial draft of Performance Measures (PMs) and gathered stakeholder feedback via the CBAS Quality Advisory Committee. CDA hosted CBAS Quality Advisory Committee meetings in January and February 2024 to discuss the draft PMs, additional PMs identified per stakeholder input, and develop a clear outline of roles and responsibilities, tracking method & data (numerator/denominator), and a realistic timeline for capturing

the details. CDA will continue to host monthly meetings to refine and finalize the draft PMs through spring 2024 and the State plans to have the initial measures ready for CMS to review in mid-2024.

STC#5.8(f), (Financial Accountability): CA *"must demonstrate it has implemented an adequate system for ensuring financial accountability of the HCBS program…and demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438." This should be reported annually in the same way that all relevant HCBS quality assurances are reported for the 1115 demonstration.*

CA Response:

Financial Accountability

Regarding the financial accountability of HCBS as it pertains to managed care, each Managed Care Plan (MCP) is contracted with the state and required to meet specific financial viability requirements which are spelled out in Exhibit A, Attachment III, Section 1.2, of their existing contract. To monitor MCPs' compliance to the contractual solvency obligations, MCPs are required to submit monthly (if applicable), quarterly, and annual financial reports. These financial reports consist of items such as balance sheets, income statements, cash flow statements, claims schedules, and other schedules as needed, inclusive of revenue and cost data for HCBS. The state analyzes the reported data to ensure financial viability requirements are being met and the following metrics below assist in making that determination.

1. Administrative Cost Ratio (ACR)
2. Working Capital Ratio (WCR)
3. Tangible Net Equity (TNE)
4. Medical Loss Ratio (MLR)

Actuarial Soundness

The state demonstrates actuarial soundness through its annual rate submission to the Centers for Medicare and Medicaid Services (CMS). This rate submission includes various exhibits, one of which is the rate certification report that describes the rate development and provides the certification of actuarial soundness required by 42 CFR §438.4. HCBS, as applicable, would be a subset of the covered services for which actuarially sound capitation rates are developed and submitted to CMS.

Figure XX: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY19-Q1	**9,098**	**3,446**	**12,544**
DY19-Q2	**9,172**	**3,415**	**12,587**
DY19-Q3	**3,885**	**1,398**	**5,283**
DY19-Q4	**722**	**221**	**943**

Figure XX: Member Enrollment

Population	Quarter	Month 1	Month 2	Month 3	Current Enrollees (to date)
ACA	DY19-Q1	**12,555**	**12,677**	**12,890**	**13,087**
	DY19-Q2	**12,990**	**13,087**	**13,148**	**13,381**
	DY19-Q3	**13,142**	**13,102**	**12,979**	**13,412**
	DY19-Q4	**12,894**	**12,777**	**12,696**	**13,134**
Non-ACA	DY19-Q1	**5,352**	**5,327**	**5,213**	**5,621**
	DY19-Q2	**5,177**	**5,094**	**5,049**	**5,404**
	DY19-Q3	**5,012**	**4,995**	**5,055**	**5,383**
	DY19-Q4	**5,093**	**5,138**	**5,141**	**5,460**

Figure XX: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY19-Q1					
ACA	**328,474**	**$ 56,087,376.30**	**$ 49,613,322.26**	**$ 5,643,078.03**	**$ 830,976.01**
Non ACA	**124,238**	**$ 19,798,599.32**	**$ 11,136,209.45**	**$ 7,237,461.16**	**$ 1,424,928.71**
DY19-Q2					
ACA	**310,159**	**$ 52,017,216.60**	**$ 46,108,312.02**	**$ 5,138,696.92**	**$ 770,207.66**
Non ACA	**118,741**	**$ 18,008,310.58**	**$ 9,915,751.48**	**$ 6,689,544.15**	**$ 1,403,014.95**
DY19-Q3					
ACA	**102,909**	**$ 25,503,938.28**	**$ 22,457,347.93**	**$ 2,729,607.37**	**$ 316,982.98**
Non ACA	**35,144**	**$ 8,574,464.53**	**$ 4,531,513.04**	**$ 3,549,901.87**	**$ 493,049.62**
DY19-Q4					
ACA	**15,584**	**$ 3,746,007.57**	**$ 3,305,204.43**	**$ 401,768.36**	**$ 39,034.78**
Non ACA	**4,009**	**$ 999,108.09**	**$ 525,721.98**	**$ 404,900.77**	**$ 68,485.34**

ACA Expenditures by Level of Care for DY19-Q1					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	181,626	$ 28,268,139.30	$ 25,060,655.70	$ 2,999,935.30	$ 207,548.30
3.3 Residential	2,854	$ 539,558.70	$ 485,599.88	$ 53,156.24	$ 802.58
3.5 Residential	117,193	$ 22,768,938.74	$ 20,082,772.98	$ 2,577,843.44	$ 108,322.32
RES 3.2-WM	26,801	$ 4,510,739.56	$ 3,984,293.70	$ 12,143.05	$ 514,302.81

ACA Expenditures by Level of Care for DY19-Q2					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	166,434	$ 26,063,599.21	$ 23,118,246.25	$ 2,783,329.33	$ 162,023.63
3.3 Residential	1,562	$ 391,658.81	$ 352,490.61	$ 39,000.88	$ 167.32
3.5 Residential	114,357	$ 20,869,511.74	$ 18,479,169.92	$ 2,301,883.35	$ 88,458.47
RES 3.2-WM	27,806	$ 4,692,446.84	$ 4,158,405.24	$ 14,483.36	$ 519,558.24

ACA Expenditures by Level of Care for DY19-Q3					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	66,995	$ 15,664,573.38	$ 13,787,169.02	$ 1,859,540.44	$ 17,863.92
3.3 Residential	127	$ 52,438.38	$ 47,194.47	$ 5,243.91	$ -
3.5 Residential	26,536	$ 7,251,471.02	$ 6,397,907.88	$ 849,591.10	$ 3,972.04
RES 3.2-WM	9,251	$ 2,535,455.50	$ 2,225,076.56	$ 15,231.92	$ 295,147.02

ACA Expenditures by Level of Care for DY19-Q4					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	11,018	$ 2,512,932.05	$ 2,234,408.85	$ 275,697.12	$ 2,826.08
3.5 Residential	3,372	$ 908,836.32	$ 786,809.63	$ 121,206.15	$ 820.54
RES 3.2-WM	1,194	$ 324,239.20	$ 283,985.95	$ 4,865.09	$ 35,388.16

Non-ACA Expenditures by Level of Care for DY19-Q1					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	63,485	$ 8,945,166.53	$ 5,029,413.36	$ 3,402,343.63	$ 513,409.54
3.3 Residential	809	$ 197,109.02	$ 110,776.43	$ 83,785.85	$ 2,546.74
3.5 Residential	51,734	$ 9,278,535.34	$ 5,220,275.19	$ 3,740,261.60	$ 317,998.55
RES 3.2-WM	8,210	$ 1,377,788.43	$ 775,744.47	$ 11,070.08	$ 590,973.88

Non-ACA Expenditures by Level of Care for DY19-Q2					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	55,901	$ 7,871,998.83	$ 4,332,969.96	$ 3,120,440.77	$ 418,588.10
3.3 Residential	545	$ 130,166.27	$ 71,591.58	$ 57,374.98	$ 1,199.71
3.5 Residential	53,500	$ 8,495,362.94	$ 4,681,249.88	$ 3,499,338.74	$ 314,774.32
RES 3.2-WM	8,795	$ 1,510,782.54	$ 829,940.06	$ 12,389.66	$ 668,452.82

Non-ACA Expenditures by Level of Care for DY19-Q3					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	21,765	$ 4,999,334.45	$ 2,644,231.71	$ 2,255,974.62	$ 99,128.12
3.3 Residential	112	$ 39,191.82	$ 20,575.43	$ 18,616.39	$ -
3.5 Residential	10,514	$ 2,787,268.14	$ 1,472,295.36	$ 1,261,797.71	$ 53,175.07
RES 3.2-WM	2,753	$ 748,670.12	$ 394,410.54	$ 13,513.15	$ 340,746.43

Non-ACA Expenditures by Level of Care for DY19-Q4					
Level of Care	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
3.1 Residential	2,406	$ 578,022.85	$ 299,255.51	$ 262,436.93	$ 16,330.41
3.5 Residential	1,283	$ 340,101.00	$ 184,759.23	$ 139,742.87	$ 15,598.90
RES 3.2-WM	320	$ 80,984.24	$ 41,707.24	$ 2,720.97	$ 36,556.03

Due to CalAIM initiatives, county reporting of DMC-ODS services may be further delayed as compared to prior years, thus affecting reported values.

* Figure XX: Demonstration Quarterly Report Beneficiaries with FFP Funding was determined by unique beneficiaries with DMC-ODS residential claims from Short-Doyle billing system.
** Figure XX: Member Enrollment was determined by Medi-Cal monthly membership based on the presence of a claim at any time of the reporting period. However, the membership is credited not only for the month of the claim but for any months of eligibility during the reporting period, the rationale being that one does enroll Medi-Cal for a month, receive some DMC service, drop out of Medi-Cal for a month or two, then enroll again to receive a service, etc., but is enrolled for the full reporting period of eligibility. Thus the numbers for this chart represent enrollment months and the same bene be a member in multiple months of the report based on eligibility records, not claims alone.