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

SECTION 1115(A) WAIVER QUARTERLY REPORT

DEMONSTRATION/QUARTER REPORTING PERIODS:

DEMONSTRATION YEAR: TWENTY (JANUARY 1, 2024 - DECEMBER 31, 2024)

SECOND QUARTER REPORTING PERIOD: APRIL 1, 2024 – JUNE 30, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

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

On December 29, 2021, CMS approved California's 1115(a) "CalAIM" demonstration, effective through December 31, 2026. The approval is 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; and (3) Current CalAIM Section 1115 demonstration initiatives.

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**
  - **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authorities** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
  - **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to 109 to 138 percent of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan. The sunset date for this authority was on

December 31, 2021.

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

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

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

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

- **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; 12 other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
- **Dually Eligible Enrollees in Medi-Cal Managed Care** expenditure authority allows

the state to keep a member in an affiliated Medicaid plan once the member has selected a Medicare Advantage plan unless and until the member changes Medicare Advantage plans or selects Original Medicare. As part of CalAIM, DHCS is implementing policies to promote integrated care for members dually eligible for Medicare and Medi-Cal.

- **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and (2) support justice-involved (JI) pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
- **Contingency Management** to offer Medi-Cal members, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
- **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, to provide this service in DMC-ODS and Drug Medi-Cal (DMC) counties and county mental health plans (MHPs).
- **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.

Since the initial approval of the CalAIM Section 1115 demonstration, CMS has approved several amendments which can be viewed on DHCS' website. During DY 20-Q2, CMS and DHCS continued to negotiate on additional approvals for CalAIM Section 1115 demonstration amendments, including expenditure authority for transitional rent services for Medi-Cal members during critical transitions or who meet high-risk criteria, and authority for traditional healers and natural helper services. Further, DHCS continues to finalize with CMS on protocols and attachments related to CalAIM Section 1115 demonstration initiatives that were approved as part of the Section 1115 renewal.

GENERAL REPORTING REQUIREMENTS

Special Terms and Conditions (STCs) Item 15.8: Monitoring Calls

During September of 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 spring quarterly monitoring call during DY 20-Q2 took place on May 13, 2024. DHCS and CMS discussed Contingency Management (CM) and PATH – Justice Involved (JI) Initiative/Stakeholder Engagement updates. As needed, separate CalAIM 1115 deliverable-specific calls also took place during the quarter.

STCs Item 15.9: Post Award Forum

In DY 20-Q2, a meeting was held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting on May 29, 2024. The purpose of the SAC and BH-SAC is for stakeholders to provide DHCS with input on ongoing implementation efforts for CalAIM, the state's Section 1115 waiver, and behavioral health activities. DHCS provided updates on: Governor's 2024-2025 Budget Revision; Medi-Cal Redeterminations; Data Sharing and the Data Exchange Framework; Children and Youth Behavioral Health Initiative; Health Equity Roadmap Initiative; Behavioral Health Transformation/Proposition 1; and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). To view past meeting agendas, visit DHCS' website at DHCS Behavioral Health Stakeholder Advisory Committee Past Meeting Archive or DHCS Stakeholder Advisory Committee Past Meeting Archive.

During this quarter, DHCS Consumer-Focused Stakeholder Workgroup (CFSW) meetings also took place on April 5, 2024, May 3, 2024, and June 7, 2024. The meetings included discussion of DHCS programmatic implementation updates, such as: Continuous Coverage Unwinding; Accelerated Enrollment; Get Covered Webpage – Income Levels Update; Ages 26-49 Expansion/Older Adult Expansion; Medi-Cal Billing Problem; Electronic Signature; CMS Final Rule – Application and Enrollment; Asset Limits Elimination; SSApp Update (AB 1163); Reinstatement of Performance Standards in Medi-Cal Eligibility Determination (MEDIL 24-12); 250% Working Disabled Program; and Hospital Presumptive Eligibility. The purpose of the CFSW meetings is to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on June 13, 2024. DHCS discussed the following topics: Doulas; Transitional Care Services (TCS); Transitional Rent (TR); Tribal Liaisons in Medi-Cal Managed Care; Managed Care Accountability Sets (MCAS); Enhanced Care Management (ECM); Justice Involved (JI) ECM Population of Focus; and Collaborative Planning and Implementation (CPI) Initiative – Providing Access and Transforming Health (PATH). The purpose of the MCAG is to facilitate active communication between the managed care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders, advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

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

PROGRAM UPDATES

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 20-Q2, as required in item 15.5[1] of the CalAIM 1115 demonstration STCs. For each program area, this section describes program highlights, performance metrics, outreach activities, operational updates, consumer issues and interventions, quality control/assurance activity, budget neutrality and financial updates, and progress on evaluations with interim findings. Key program areas described in this section include:

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

[1] The Department of Health Care Services, CalAIM 1115 Demonstration & 1915(b) Waiver, March 6, 2024, CalAIM Provider Rate Approval.

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" 1115 demonstration waiver (BTR waiver) to include CBAS, which was approved by the CMS on March 30, 2012. CBAS was operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

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

CBAS was a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver. With the delayed implementation of the CalAIM initiative due to the COVID-19 public health emergency (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 included the CBAS benefit. The following information was included in the CMS approval letter: "Under the 1115 demonstration, the state will also continue the CBAS program to eligible older adults and adults with disabilities in an outpatient facility-based setting while now also allowing flexibility for the provision and reimbursement of remote services under specified emergency situations, i.e., Emergency Remote Services (ERS). This flexibility will allow beneficiaries to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization."

Program Requirements

CBAS is an outpatient, facility-based program, licensed by the California Department of Public Health (CDPH) and certified by CDA to participate in the Medi-Cal program. The CBAS benefit is provided to eligible Medi-Cal members who meet CBAS criteria and includes the following services: professional/skilled nursing care, personal care, social services including family/caregiver training and support, therapeutic activities, therapies such as occupational therapy, physical therapy, speech therapy, behavioral health

services, dietary/nutrition services including a meal, and transportation to and from the CBAS members' place of residence and the CBAS center when needed. CBAS participants have chronic medical, cognitive, mental health, and/or intellectual developmental disabilities and are at risk of needing institutional care. The overarching goals of the CBAS program are to support community living, promote health and well-being, and prevent hospitalization and institutionalization.

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

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

The state must maintain CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[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 CBAS as a benefit. The final transition of the CBAS benefit to managed care took place beginning October 1, 2012, into the Two-Plan Model, (available in 14 counties), Geographic Managed Care Plans (available in two counties), and the final COHS County (Ventura) at that time. As of December 1, 2014, Medi-Cal FFS only provided CBAS

[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.

coverage for CBAS-eligible participants who had an approved medical exemption from enrolling in managed care. The four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

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

Beginning in March 2020, in response to the COVID-19 PHE, DHCS and CDA worked with stakeholders including the California Association for Adult Day Services (CAADS), CBAS providers, and the MCPs, to develop and implement CBAS Temporary Alternative Services (TAS). On October 9, 2020, CMS approved DHCS' disaster 1115 amendment, which allowed flexibilities pertaining to the delivery of CBAS TAS and permitted CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (with proper safety precautions implemented). These flexibilities are described in greater detail below. 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 are taken, and if no other option for providing services was 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 were required to be open and provide 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 will end on September 30, 2022. DHCS submitted an updated 1115 waiver Attachment H 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 did not alter or reduce the eligibility criteria, available services, or rate of payment for the CBAS benefit. All services included in the CBAS TAS flexibility are 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 approved California's request to revise the end date of the CalAIM demonstration authorities in the state's Attachment H 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 H and supersedes the June 9, 2021, Attachment H, which previously allowed TAS and virtual assessment activities up to six months after the end of the public health emergency. The authorizations the State requested in the Attachment H 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 (HCBS) through the demonstration. CBAS TAS ended on September 30, 2022, and CBAS ERS were implemented as of October 1, 2022.

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

Performance Metrics

CDA continued to facilitate the Quality Strategy Advisory Committee meetings in DY 20-Q2, which included members of the CDA Executive Team, CBAS staff, CDA providers, DHCS, MCPs, and other stakeholders. The committee meets monthly to develop performance measures required in STC 5.8. In addition, per STC 5.9, "The state will work on establishing the performance measures with CMS to ensure there is no duplication of

effort and will report on the initial series within one year of finalization and from that point will report annually."

In DY 20-Q2, the committee furthered their efforts to develop performance measures. The CBAS Quality Advisory Committee members received the drafted performance measures for review, discussion, and to solicit feedback. On April 23, 2024, the Advisory Committee met and discussed the draft eligibility performance measures and reached a consensus to move four measures forward for prioritization and implementation. The four measures were sent to DHCS and CMS in draft form for review. The next category, qualified providers, was also discussed during the April 23, 2024, meeting. The qualified providers' performance measure tracks the number of providers who fulfill the CDA baseline requirements for recertification. The committee also discussed the financial accountability performance measures, which will serve as indicators of financial accountability and actuarial soundness. The May and June meetings were a continuation of April topics in an effort to move measures toward finalization. CDA will continue this process on a rolling basis as the performance measures are developed within each waiver category. Future updates and established performance measures will be forthcoming and communicated in future reports.

Enrollment and Assessment Information

Per STC 5.6(a), Figure 1 demonstrates the number of CBAS FFS and managed care beneficiaries, as well as the capacity of each county.

Each quarter, the MCPs self-report enrollment data, which results in data lags. In addition, some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

See the next pages for Figure 1.

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

County	DY 19-Q2		DY 19–Q3		DY 19–Q4		DY 20-Q1	
	Apr – Jun 2023		Jul – Sept 2023		Oct – Dec 2023		Jan – Mar 2024	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	436	70%	417	67%	405	65%	382	66%
Butte	20	20%	20	20%	25	25%	21	35%
Contra Costa	81	37%	78	35%	80	36%	77	44%
Fresno	962	44%	1,062	48%	965	44%	1,092	66%
Humboldt	101	17%	112	19%	110	19%	94	18%
Imperial	298	50%	285	47%	122	20%	262	56%
Kern	231	22%	236	23%	225	17%	392	39%
Los Angeles	17,008	38%	20,099	45%	19,504	41%	25,662	67%
Merced	137	65%	119	57%	126	60%	115	64%
Monterey	89	48%	93	50%	110	59%	95	59%
Orange	2,578	46%	2,834	50%	2,992	53%	3,061	65%
Riverside	648	37%	653	38%	646	37%	589	40%
Sacramento	403	46%	460	52%	427	48%	390	57%
San Bernardino	926	60%	917	37%	997	41%	893	42%
San Diego	2,193	59%	2,055	51%	2,398	60%	1,916	49%

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

County	DY 19-Q2		DY 19–Q3		DY 19–Q4		DY 20-Q1	
	Apr – Jun 2023		Jul – Sept 2023		Oct – Dec 2023		Jan – Mar 2024	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
San Francisco	922	59%	950	61%	886	56%	730	62%
San Joaquin	**	**	**	**	**	**	**	**
San Mateo	121	119%	126	124%	133	32%	39	15%
Santa Barbara	11	6%	16	5%	13	4%	69	30%
Santa Clara	486	35%	462	33%	458	33%	632	50%
Santa Cruz	74	49%	77	51%	117	58%	92	51%
Shasta	47	33%	45	31%	50	35%	55	41%
Stanislaus	**	**	**	**	**	**	**	**
Ventura	840	56%	859	57%	840	56%	593	39%
Yolo	246	65%	246	65%	239	63%	261	75%
Marin, Napa, Solano	50	13%	54	14%	63	17%	130	39%
Total	**28,917**	**41%**	**32,288**	**45%**	**31,905**	**43%**	**37,657**	**61%**
CBAS capacity data by County – FFS and MCP Enrollment Data								

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 1 data will be submitted one quarter in the rear due to the reporting delays*

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

Figure 1 depicts fluctuations in the data for DY 20-Q1 as both increases and decreases greater than five percent in capacity are presented. Of note, the differences in the data are solely based on a change in the calculation methodology from previous quarterly reports. Specifically, DHCS has access to Monthly Statistical Summary Reports (MSSR) which provide a more accurate assessment of county capacity. Moreover, Figure 1 presents several data points to review. For instance, new centers opened in several counties between DY 19-Q4 and DY 20-Q1 (e.g., Los Angeles, Orange, Stanislaus, and Ventura). Additionally, Stanislaus County's enrollment remains low from DY 19-Q4 to DY 20-Q1 due to increased capacity for the county.

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

Demonstration Year and Quarter	Number of CBAS Participants	Enrolled in Enhanced Care Management (ECM)	Enrolled in Community Supports (CS)	Enrolled in Enhanced Care Management (ECM) & Community Supports (CS)
DY 19-Q2 (Apr – June 2023)	34,183	993	959	54
		2.90%	2.81%	0.16%
DY 19-Q3 (July – Sept 2023)	35,945	1,514	1,396	219
		4.21%	3.88%	0.61%
DY 19-Q4 (Oct – Dec 2023)	38,571	1,810	2,082	390
		4.69%	5.40%	1.01%
DY 20-Q1 (Jan – Mar 2024)	39,776	2,482	2,224	613
		6.24%	5.59%	1.54%
				DHCS Data 03/2024

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 2 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 2 displays the number of CBAS participants who also receive ECM and Community Supports through their Medi-Cal managed care plans. ECM and Community Supports are a new statewide Medi-Cal benefit as 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 managed care plans 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 20-Q1, there were a total of 39,776 CBAS participants – 2,482 received ECM, 2,224 received Community Supports and 613 received both benefits. In addition, Figure 2 demonstrates no reported negative change greater than five percent from quarter to quarter and presents an increase in participants receiving benefits.

Figure 3: CBAS Assessments Data for MCPs and FFS

Demonstration Year and Quarter	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 19-Q2 (Apr – June 2023)	3,225	3,155	70	2	0	2
		97.8%	2.2%		0%	100%
DY 19-Q3 (July – Sept 2023)	3,238	3,184	54	0	0	0
		98.4%	1.6%		0%	0%
DY 19-Q4 (Oct – Dec 2023)	3,352	3,285	67	0	0	0
		98%	2%		0%	0%

Demonstration Year and Quarter	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 20-Q1 (Jan – Mar 2024)	3,098	3,042	56	0	0	0
		98%	2%		0%	0%
5% Negative change between last Quarter	No	No	No	No	No	No

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 3 data will be submitted one quarter in the rear due to the reporting delays.*

Assessments for MCPs and FFS Participants

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

Per STC 5.6(a), Figure 3 presents quarterly data for the total determined eligible and ineligible beneficiaries per county, with the addition of DY 20-Q1 data. Upon review of the CBAS assessments data for MCPs, the data collection for DY 19-Q3 has been corrected with new assessments displaying the value 3,238; eligible assessments corrected to 3,184, and ineligible assessments corrected to the value 54 as reflected on the DY 19 annual report. DHCS FFS members in DY 20-Q1 present zero assessments performed for CBAS benefits, with zero being eligible and zero being ineligible. DY 19-Q2 displays the latest request for FFS. MCP members in DY 20-Q1 demonstrate a total of 3,098 assessments performed and 3,042 or 98 percent, being eligible, reflecting identical percentages as DY 19-Q4. In addition, Figure 3 demonstrates no reported negative change greater than five percent from quarter to quarter. The number of CBAS FFS participants has been consistently low for the last three quarters, as a significant quantity of participants are in a managed care plan.

See the next page for Figure 4.

Figure 4: CDA and CBAS Provider Self-Reported Data

DY 19-Q3

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	290
Non-Profit Centers	46
For-Profit Centers	244
ADA at 290 Centers	25,240
Total Licensed Capacity	43,447
Statewide ADA per Center	87
CDA – Monthly Statistical Summary Report (MSSR) Data 10/2023	

DY 19-Q4

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

DY 20-Q1

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

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 4 data will be submitted one quarter in the rear due to the reporting delays.*

The opening or closing of a CBAS center affects the CBAS enrollment and average daily attendance (ADA). CBAS center closures decrease enrollment and ADA, while new CBAS center openings increase ADA and enrollment capacity. The CDPH licenses CBAS centers, and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers.

Figure 4 identifies the number of counties with CBAS centers and the ADA for the past three quarters: DY 19-Q3, DY 19-Q4, and DY 20-Q1. The tables above reflect a change in methodology. The old methodology was the sum of the average daily attendance of all CBAS centers divided by the sum of licensed center capacity of all centers. To more accurately reflect the data requested in Figure 4 on the previous page, the new methodology represents the sum of the average daily attendance of all centers divided by the number of centers. The Statewide ADA per center reflects how many participants, on average, were served on any given day at an individual CBAS center. For instance, DY 19-Q3 ADA at the 290 operating CBAS centers was approximately 25,240 participants, indicating that, on average, 87 participants were served on any given day. For DY 19-Q4, ADA at the 294 operating CBAS centers was approximately 26,097 participants, indicating that, on average, 89 participants were being served on any given day. Moreover, for DY 20-Q1, ADA at 296 active centers was approximately 27,169 participants, indicating that, on average, 92 participants were served on any given day. The Provider self-reported data identified in Figure 4 for the previous three quarters reflect data through March 2024.

The differences between DY 19-Q4 and DY 20-Q1 are: (1) the increase in the number of CBAS Centers from 294 to 296 and (2) the increase by one in for-profit centers. Additionally, in DY 20-Q1 the total ADA at 296 centers increased by 1,072 compared to DY 19-Q4, increasing the ADA percentage by two percent. Lastly, the total licensed capacity increased by 611.

Outreach Activities

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

- CBAS Updates
- CBAS ACLs and CBAS News Alerts
- CBAS webinars
- CAADS conferences
- CDA meetings with MCPs that contract with CBAS centers

- CDA meetings with the CBAS Quality Advisory Committee
- CAADS Education Committee Meetings

The following are CDA's outreach activities during DY 20-Q1:

- CBAS News Alerts **(6)**
- CBAS Webinars **(0)**
- CAADS Education Committee Meetings **(3)**
- CDA-MCP meetings **(2)**
- CBAS Quality Advisory Committee Workgroup Meetings **(3)**
- CDA DHCS meetings **(3)**
- CDA CDPH quarterly meetings **(3)**
- Responses to CBAS Mailbox Inquiries **(514)**

In addition to the outreach activities mentioned above, CDA also responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders. Outreach, education, and training activities focused on the following topics: (1) notification of CAADS Spring Conference 2024; (2) reminders related to personal protective equipment supply requests; (3) an Aging Resource Guide; (4) a summer heat advisory for the CBAS centers with recommendations for safety and well-being; (5) California Electronic Visit Verification (CalEVV) summer training opportunities; and (6) CalEVV self-registration instructions.

CBAS Webinar Updates

CDA did not facilitate any webinars in DY 20-Q2.

CAADS Education Committee Meetings

In DY 20-Q2, CDA attended three monthly CAADS Education Committee meetings to discuss and assist with planning the CAADS Fall Conference 2024 schedule overview, CDA sessions, peer-to-peer sessions, advocacy keynote focus exhibitors/sponsors, pricing, and legislative updates. This meeting forum is also used to collaborate and plan future webinars. Also, in DY 20-Q2, CDA collaborated with CAADS on the content and delivery of a June 13, 2024, webinar titled CalGrows Webinar – Person-Centered Care.

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 CBAS provider issues that require CDA assistance.

During DY 20-Q2 CDA convened two meetings with the MCPs. The purpose of the meetings was to plan and discuss CBAS program challenges with the MCPs, placing focus on overall CBAS operations, coordination, and information sharing. This included discussion around the 2024 CAADS Spring conference taking place in Sacramento on April 15-16, 2024. This session was extended through April 17, 2024, for CAADS members-only day at the Capitol (legislative visits). Further, CDA/MCPs also discussed and vetted the draft performance measures and solicited input and feedback on prioritization and implementation strategies. In addition, the group identified common data that are collected by the represented MCPs towards operationalizing the draft performance measures discussed. Finally, CDA provided the MCPs with a high-level overview of the CMS Final Access Rule and the upcoming provision of required data.

CBAS Quality Strategy Advisory Committee Meetings

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

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

Throughout DY 20-Q2, stakeholders provided input and feedback on the draft key performance measures with a focus on prioritization and implementation as well as measures that will demonstrate financial accountability and actuarial soundness. Ongoing and formal discussions and recommendations from the Quality Advisory Committee on prioritization and implementation of performance measures are to comply with the 1115 Waiver requirements.

CBAS Mailbox Inquiries

During DY 20-Q2, CDA responded to 514 CBAS mailbox inquiries. Some commonly submitted inquiries included: (1) requests from our managed care plan partners to be added to our updated distribution list for important program reminders; (2) technical assistance with online faxing of incident reports at centers; (3) requests for clarification regarding the limits of roles such as Social Workers; (4) how to search for CBAS centers that cater to specific needs (i.e., individuals with dementia); and (5) if those interested in attending a center can still do so without being eligible for a managed care plan.

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

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

Program Highlights

Compliance with CBAS EVV Requirements

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.

The CalAIM 1115 Waiver directs the state to demonstrate compliance with the EVV requirements for the provision of in-home PCS and Home Health Care Services (HHCS) to CBAS participants utilizing the CBAS ERS benefit. To ensure continued compliance, EVV in-person training is underway as of the end of DY 20-Q2. This includes several office hour sessions and in-person training at locations across California. These office-hour events are available to caregivers, providers, and Jurisdictional Entities (JE). Office hours are informal Question and Answer sessions, whereby attendees can get their

individual questions addressed by state EVV staff members. In addition, the EVV Team recently launched a California "Training Road Show" which offers training and support along with tools, resources, and state guidance on provider JE compliance, roles, and responsibilities regarding EVV.

Public and Personal Emergencies ERS Experience

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. The ERS events are broken down into two categories: public emergencies and personal emergencies. In April 2024, CDA received 1,033 ERS events, 966 personal emergencies, and 67 public emergencies. The vast majority of personal emergencies were due to serious illness. Roughly half of the public emergencies were due to disease outbreaks, and the remainder were classified as "other." In May 2024, CDA received 1,609 ERS events, 932 personal emergencies, and 677 public emergencies. The significant increase in ERS events in May was due to public emergencies classified as infectious disease outbreaks. As of June 18, 2024, CDA received 1,692 ERS events, 960 personal emergencies, and 732 public emergencies. Both categories were predominantly related to personal illness or infectious disease outbreaks. CDA continues to see the successful utilization, implementation, and value that ERS brings to the CBAS providers and participants.

Policy Development/Issues

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 are ongoing 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.

One main challenge identified by CDA in DY 20-Q2 was documentation. During onsite recertification surveys, CDA identified CBAS Centers that lacked documentation or displayed inaccurate documentation practices. Documentation challenges were addressed with individual centers through adequate plans of correction.

Figure 5: Data on CBAS Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 19-Q2 (Apr – June 2023)	0	0	0
DY 19-Q3 (Jul – Sept 2023)	0	1	1
DY 19-Q4 (Oct-Dec 2023)	0	3	3
DY 20-Q1 (Jan – March 2024)	3	0	3
CDA Data – Complaints 03/2024			

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 5 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 6: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 19-Q2 (April – June 2023)	0	0	0
DY 19-Q3 (Jul – Sept 2023)	0	1	1
DY 19-Q4 (Oct-Dec 2023)	1	0	1
DY 20-Q1 (Jan – March 2024)	3	0	3
Phone Data – Phone Center Complaints 03/2024			

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 6 data will be submitted one quarter in the rear due to the reporting delays.*

Consumer Issues and Interventions

CBAS Member /Provider Call Center Complaints (FFS/MCP)

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 webpages to provide information on CBAS to stakeholders. In addition, providers and members can submit inquiries to

CBASinfo@dhcs.ca.gov for assistance from DHCS and CBASCDA@Aging.ca.gov for assistance from CDA.

The number of issues that generate CBAS complaints are minimal, and they are collected from both participants and providers. Complaints are received via telephone or email by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current managed care plan partner. Figures 5 and 6 present complaint data received by CDA and MCPs from CBAS members and providers. Figure 5 shows three member complaints and no provider complaints received in DY 20-Q1, reflecting a difference from DY 19-Q4 data that presents no member complaints and three provider complaints. Figure 6 shows that no participant or provider complaints were received in DY 20-Q1. In addition, Figure 5 reflects no significant change in total complaints between DY 19-Q4 and DY 20-Q1. DHCS continues to work with the MCPs to uncover and resolve the causes of increased complaints identified within these reports.

Figure 7: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY 19-Q2 (Apr – Jun 2024)	4	1	0	2	7
DY 19-Q3 (Jul – Sept 2023)	7	1	1	6	15
DY 19-Q4 (Oct – Dec 2023)	7	1	0	4	12
DY 20-Q1 (Jan – Mar 2024)	10	1	0	7	18
MCP Data - Grievances 03/2024					

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 7 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 8: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY 19–Q2 (Apr – Jun 2023)	4	1	0	0	5
DY 19–Q3 (Jul - Sept 2023)	4	0	0	0	4
DY 19–Q4 (Oct - Dec 2023)	7	2	0	0	9
DY 20–Q1 (Jan – Mar 2024)	7	0	0	1	8
MCP Data - Appeals 03/2024					

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 8 data will be submitted one quarter in the rear due to the reporting delays.*

CBAS Grievances/Appeals (FFS/MCP)

The MCPs provide DHCS with grievances and appeals data. Under Figure 7 for DY 20-Q1, there were a total of 18 grievances regarding CBAS services, which is an increase from 12 grievances reported in DY 19-Q4. In addition, Figure 7 shows a reported negative change of greater than five percent between DY 19-Q4 and DY 20-Q1 for MCP grievances involving quality of care and facility accessibility.

Figure 8 presents appeals data, with a total of eight appeals being reported for DY 20-Q1. This change indicates a slight decrease from DY 19-Q4. Of the eight appeals, seven were identified as denials or limited services, and one appeal was listed in the "other CBAS appeals" column, specifically noted as an approved appeal. DHCS continues to work with the MCPs to identify and resolve sources of increased grievances and appeals identified within these reports.

Figure 9: CBAS Centers Licensed Capacity

CBAS Centers Licensed Capacity						
County	**DY 19-Q2 (Apr-June 2023)**	**DY 19-Q3 (Jul-Sept 2023)**	**DY 19-Q4 (Oct-Dec 2023)**	**DY 20-Q1 (Jan-Mar 2024)**	**Percent Change Between Last Two Quarters**	***Capacity Used**
Alameda	370	370	370	370	0.0%	66%
Butte	60	60	60	60	0.0%	35%
Contra Costa	130	130	130	130	0.0%	44%
Fresno	1,297	1,297	1,297	1,297	0.0%	66%
Humboldt	349	349	349	349	0.0%	18%
Imperial	355	355	355	355	0.0%	56%
Kern	610	805	805	805	0.0%	39%
Los Angeles	26,520	27,175	27,755	28,006	+0.9%	67%
Marin	0	0	0	0	N/A	N/A
Merced	124	124	124	124	0.0%	64%
Monterey	110	110	110	110	0.0%	59%
Napa	100	100	100	100	0.0%	42%
Orange	3,321	3,321	3,321	3,501	5.4%	65%
Riverside	1,025	1,025	1,025	1,025	0.0%	40%
Sacramento	520	520	520	520	0.0%	57%
San Bernardino	911	1,446	1,446	1,446	0.0%	42%
San Diego	2,186	2,359	2,359	2,359	0.0%	49%
San Francisco	926	926	926	926	0.0%	62%
San Joaquin	0	0	0	0	0.0%	0%
San Mateo	60	60	245	245	+0%	15%
Santa Barbara	100	180	180	180	0.0%	30%

CBAS Centers Licensed Capacity						
County	**DY 19-Q2 (Apr-June 2023)**	**DY 19-Q3 (Jul-Sept 2023)**	**DY 19-Q4 (Oct-Dec 2023)**	**DY 20-Q1 (Jan-Mar 2024)**	**Percent Change Between Last Two Quarters**	***Capacity Used**
Santa Clara	820	820	820	820	0.0%	50%
Santa Cruz	90	90	120	120	+0%	51%
Shasta	85	85	85	85	0.0%	41%
Solano	120	120	120	120	0.0%	36%
Stanislaus	510	510	510	510	0.0%	2%
Ventura	886	886	886	1,066	20.3%	39%
Yolo	224	224	224	224	0.0%	75%
SUM	**41,809**	**43,447**	**44,242**	**44,853**	**1.4%**	**61%**

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 9 data will be submitted one quarter in the rear due to the reporting delays.*

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

As shown in Figure 9, in DY 20-Q1, Orange County and Ventura County had increases greater than five percent between the last two quarters. Both Orange and Ventura Counties had new centers open in DY 20-Q1 which increased their capacity beyond five percent. The newly opened center in Orange County was certified on January 3, 2024, and the new center in Ventura County became active on March 27, 2024.

Unbundled Services

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review and monitor any possible impact on participants due to CBAS Center closures. For counties that do not have a CBAS Center, the MCPs will work with the nearest available CBAS Center to provide the necessary services. This may include, but not be limited to, the MCP contracting with a non-network provider, to ensure that continuity of care continues for the participants if they are required to enroll in managed care. Members can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center.

Prior to closing, 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 which they provide services. CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties served by CBAS can choose an alternate CBAS Center within their local area.

Figure 10: CBAS Center History

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
Mar 2024	295	0	1	1	296
Feb 2024	295	0	0	0	295
Jan 2024	294	0	1	1	295
Dec 2023	293	0	1	+1	294
Nov 2023	291	0	2	+2	293
Oct 2023	290	0	1	+1	291
Sept 2023	286	0	4	+4	290
Aug 2023	284	0	2	+2	286
July 2023	283	0	1	+1	284
June 2023	283	0	0	0	283
May 2023	282	0	1	+1	283
April 2023	281	1	2	+1	282

**Information is not reported for DY 20-Q2 due to a delay in the availability of the data and will be presented in the DY 20-Q3 Report. For future reports, Figure 10 data will be submitted one quarter in the rear due to the reporting delays.*

DHCS and CDA continue to monitor the overall utilization of CBAS, including the opening and closing of CBAS centers since April 2012, when CBAS became operational. According to the data in Figure 10 above, no centers closed, and two centers opened in DY 20-Q1, one in Orange County and the other in Ventura County. Figure 10 shows there was no negative change of more than five percent in DY 20-Q1, therefore, no analysis is needed to address such variances.

Budget Neutrality and Financial Updates

The CalAIM Section 1115 Demonstration waiver, approved by CMS on December 29, 2021, will have no effect on budget neutrality as it is currently a pass-through, meaning

that the cost of CBAS remains the same with the waiver as it would be without the waiver. As such, the program cannot quantify savings, and the extension of the program will have no effect on overall waiver budget neutrality.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal eligible individuals with a SUD who 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 traditional Drug Medi-Cal (DMC) program.

Most of the components of the DMC-ODS were originally authorized by the Medi-Cal 2020 Section 1115(a) demonstration. However, as a part of CalAIM, on June 30, 2021, DHCS submitted a 1915(b) waiver renewal to CMS to consolidate Medi-Cal managed care delivery system programs currently authorized under California's Medi-Cal 2020 Section 1115(a) demonstration – Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS – with SMHS under the 1915(b) waiver in 2022. On December 29, 2021, DHCS received approval from CMS to reauthorize DMC-ODS, shifting the managed care authority to the consolidated CalAIM 1915(b) waiver and using the Medicaid State Plan to authorize the majority of DMC-ODS benefits. The authority to provide reimbursable Medi-Cal services for DMC-ODS members residing in institutions for mental disease (IMDs) remains in the Section 1115 demonstration through December 31, 2026. This CalAIM demonstration, along with all appropriate authorities, will continue to provide the state with the ability to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS members who are short-term residents in residential and inpatient treatment settings that qualify as 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.

Contingency Management Updates

On March 28, 2023, DHCS approved the first site to offer CM services as part of the Recovery Incentives Program. Since the launch of the program in April 2023, 3,255 members have received CM services.

Currently, 24 DMC-ODS counties are participating in the Recovery Incentives Program. These counties include Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Marin, Nevada, Orange, Riverside, Sacramento, San Bernadino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Tulare, Ventura, and Yolo. Among these 24 counties, 19 counties have implemented CM services. There are 86 approved sites providing CM services to 1,258 active members, as of June 30, 2024. Alameda County has one approved site, Contra Costa County has two

approved sites, Fresno County has one approved site, Imperial County has four approved sites, Kern County has four approved sites, Los Angeles County has 44 approved sites, Marin County has three approved sites, Nevada County has one approved site, Orange County has two approved sites, Riverside County has eight approved sites, San Bernardino County has one approved site, San Diego County has three approved sites, San Francisco County has four approved sites, San Mateo has one approved site, Santa Barbara County has three approved sites, Santa Clara County has one approved site, Tulare County has two approved sites, Ventura County has one approved site, and Yolo County has one approved site. Collectively, these counties cover 80 percent of Medi-Cal membership.

In addition to the 86 approved sites offering CM services, there are 19 sites 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.

CM recognizes individual positive behavioral change, as evidenced by drug tests that are negative for stimulants, and reinforces that behavior through motivational incentives. As part of the Recovery Incentives Program, urine drug tests (UDTs) are used to qualify a member for motivational incentives. The abstinence rate in Q2 2024, which factors in drug test results and absences, was 86 percent across all sites. Between April 1 and June 30, 2024, 19,030 UDTs were administered, of which 18,024 were negative for stimulants. As a result, $279,663 in gift cards (motivational incentives) were earned in DY 20-Q2 by eligible members for meeting the treatment goal of submitting a UDT 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, $254,540.50 were disbursed in Q2. When a member chooses to redeem a gift card, they can choose from a list of pre-approved vendors. The most common gift card redemptions in Q2 include Walmart (57 percent), Nike and Foot Locker (18 percent), and Marshalls (four percent). DHCS continues to process the intake of CM data, which will be used for incentive payment processing, evaluation activities, creation of reports, and dashboard metrics.

Throughout Q2 of 2024, the DHCS Recovery Incentives Program team continued weekly planning meetings with the CM training and technical assistance provider, University of California, Los Angeles (UCLA), and the Incentive Manager (IM) vendor, Q2i. DHCS shared a revised Behavioral Health Information Notice (BHIN) for stakeholder feedback on June 28, 2024, and anticipates publishing the final BHIN in August 2024. Additionally, DHCS finalized an Implementation Plan (IP) to allow the remaining DMC-ODS counties

not currently in the program to submit an IP for DHCS review, indicating they are interested in providing CM services through the Recovery Incentives Program. The IP will be published once the revised BHIN is finalized in August 2024. Oversight and monitoring activities included continued and ongoing coaching calls, which provide support to CM providers, and fidelity reviews, which began in July 2023 with sites and counties participating to discuss adherence to the CM protocol. In June 2024, DHCS shared a quarterly progress report template with stakeholders and plans to provide the finalized template to counties in Q3 of 2024 to use for tracking oversight activities. The Recovery Incentives Program team continued to respond to questions from participating counties and provider sites, supported the refinement of training materials for counties and providers, and coordinated with CDPH for expedited processing of Clinical Laboratory Improvement Amendments waivers.

Recovery Incentives: California's Contingency Management Program – Training and Technical Assistance Activities, DY 20-Q2

DY 20-Q2 (April 1, 2024 – June 30, 2024)

Statewide CM pilot training curriculum, readiness review and fidelity assessment tool development activities: Key activities accomplished during DY 20-Q2 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and then once every six months thereafter for the duration of the Recovery Incentives Program. Fidelity Monitoring Self-Study and Interview #1 are completed 2-3 months following Program launch, Fidelity Monitoring Self-Study and Interview #2 are completed 4-6 months following Program launch, and Fidelity Monitoring Self-Study and Interview #3 are completed 8-10 months after Program launch. Copies of Fidelity Monitoring Self-Study #1, # 2 and #3 are on file at DHCS. Scheduling these regularly required reviews (inclusive of both the Fidelity Monitoring Self-Study and Interviews) ensures the Recovery Incentives Program is being delivered consistently and rigorously over time, and allows the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of 14 Fidelity Monitoring #1 interviews, four Fidelity Monitoring #2 interviews, and ten Fidelity Monitoring #3 interviews were completed during the reporting period.

- **Outreach Efforts:** To increase enrollment, sites were encouraged to utilize Sample Messages as outlined in the Provider Outreach & Communications Toolkit on the Recovery Incentives website. These messages include website text, email newsletter, and social media posts. Additional outreach materials include the Recovery Incentives Program flyer, wallet cards, and a FAQ document.

- **Site-Level CLIA Waiver/State Lab Registration:** A total of 144 State Lab Registration Applications and 134 Clinical Laboratory Improvement Amendments (CLIA) Certificate Applications have been identified as completed/approved. A total of 159 Site Lab Directors has been identified.

- **Recovery Incentives Program Website:** The Recovery Incentives website was updated as materials were refined. Website updates included the Implementation Training registration links, IM Portal gift card informational document, CM Provider Outreach Toolkit, Program Manual with Appendices, and Recovery Incentives Training Flyer updating the DHCS logo.

- **CM Overview Training (On-Demand):** A total of 89 individuals completed the CM Overview Training on-demand course between April 1, 2024 – June 30, 2024.

- **Two-Part CM Implementation Training:** Thirteen Implementation Trainings were delivered (with 153 total participants) from 12 of the 24 counties.

- **Coaching Calls:** Thirty interactive Zoom Coaching Calls were conducted with a total of 385 attendees.

- **Readiness Assessment:** Ten Readiness Assessment interviews were conducted. Nine outreach calls for Readiness Assessment preparedness were conducted. The two-step Readiness Assessment process was initiated by seven sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process).

Medi-Cal Peer Support Services Updates

Medi-Cal Peer Support Services are an optional behavioral health Medi-Cal benefit that can be implemented within DMC-ODS, DMC, and/or SMHS delivery systems. As of June 30, 2024, 3,524 individuals are certified as Medi-Cal Peer Support Specialists through the California Mental Health Services Authority (CalMHSA) certification program. CalMHSA is currently the sole county-selected and DHCS-recognized certification program for Medi-Cal Peer Support Specialists (see Figure 11 for a breakdown of new applicants by application/certification status). As of June 30, 2024, 51 out of 58 California counties provide Medi-Cal Peer Support Services, including 32 DMC-ODS, 49 MHPs, and ten DMC programs. DHCS provides the opportunity for counties to opt-in to provide Medi-Cal Peer Support Services on an annual basis.

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

Applications & Certifications per Quarter[3]	Q1 (1/1/24-3/31/24)	Q2 (4/1/24-6/30/24)
New Applications submitted	854	916
New Certifications	508	520

Throughout DY 20-Q2, DHCS conducted stakeholder engagement on program implementation, addressed stakeholder questions on service delivery, billing, claiming, scholarships, supervision, and updates for Medi-Cal Peer Support Specialists in the Provider Information Management System (PIMS), and coordinated regularly with CalMHSA to ensure responsiveness to stakeholders and alignment with policy. In DY 20-Q2, DHCS also integrated stakeholder feedback into an all-inclusive Medi-Cal Peer Support Services BHIN, as well as accompanying FAQs, which are expected to be released early in DY 20-Q3.

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 late 2024.

Performance Metrics

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

Figure 12: Quarterly Count of Unduplicated Members with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY 19-Q3	9,742	3,433	13,175
DY 19-Q4	9,615	3,167	12,782
DY 20-Q1	8,546	2,666	11,212
DY 20-Q2	4,696	1,243	5,939

**Affordable Care Act (ACA)*

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

Figure 13: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees to Date
ACA	10,919	11,140	11,292	DY 19-Q3	11,492
ACA	11,407	11,378	11,332	DY 19-Q4	11,634
ACA	11,347	11,284	11,254	DY 20-Q1	11,585
ACA	11,211	11,134	11,081	DY 20-Q2	11,409
Non-ACA	4,196	4,066	3,980	DY 19-Q3	4,433
Non-ACA	3,890	3,876	3,878	DY 19-Q4	4,156
Non-ACA	3,843	3,856	3,849	DY 20-Q1	4,121
Non-ACA	3,852	3,867	3,861	DY 20-Q2	4,101

Figure 14: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	306,417	$82,922,094.11	$73,303,603.36	$8,933,860.54	$684,630.21	DY 19-Q3
Non-ACA	96,065	$25,787,282.97	$13,599,725.96	$10,888,898.11	$1,298,658.90	DY 19-Q3
ACA	315,453	$84,060,095.59	$73,991,941.75	$9,452,883.08	$615,270.76	DY 19-Q4
Non-ACA	90,841	$24,299,818.42	$12,547,457.57	$10,443,365.79	$1,308,995.06	DY 19-Q4
ACA	283,386	$72,362,740.56	$62,533,118.33	$9,158,115.30	$671,506.93	DY 20-Q1
Non-ACA	73,950	$19,304,457.12	$9,665,013.30	$8,376,805.85	$1,262,637.97	DY 20-Q1
ACA	132,389	$32,412,179.16	$27,944,089.95	$4,213,139.27	$254,949.94	DY 20-Q2
Non-ACA	29,798	$7,384,379.17	$3,701,094.51	$3,227,836.13	$455,448.53	DY 20-Q2

Performance Metrics Enclosures/Attachments

The attachment, CalAIM 1115 Waiver Progress Report DY 20-Q2_ODS-RES.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 20-Q2 as of July 29, 2024.

Outreach Activities

- DHCS held monthly calls with each participating DMC-ODS county to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including status updates on Corrective Action Plans (CAPs) and reports.
- DHCS issues weekly Behavioral Health Stakeholder Updates via email to stakeholders. The information provided includes announcements of finalized and draft BHINs, upcoming webinars, and other relevant information.
- DHCS held webinars through the monthly All County Behavioral Health Call to provide technical assistance and program updates regarding contractual and regulatory compliance. The dates of these webinars and topics presented are as follows:
  - April 17, 2024
    - Medi-Cal Mobile Crisis Data Report
    - Medi-Cal Mobile Crisis
    - Recovery Incentive Programs
    - CalAIM Behavioral Health Quality Improvement Program March 2024 Reporting Period Update
  - May 15, 2024
    - Documentation Re-Design Update FAQ
    - Drug Medi-Cal Organized Delivery System FAQ
  - June 27, 2024
    - BHIN 23-032: Interoperability Compliance Monitoring Results
    - State Work Plan for Access Improvement
    - Drug Medi-Cal Organized Delivery System FAQ

Operational Updates

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including: 1) updates to the criteria to access SMHS; 2) implementation of standardized statewide screening and transition tools; 3) behavioral health payment reform; and 4) streamlining and standardizing

clinical documentation requirements through documentation reform. DMC-ODS counties are utilizing policy guidance that was released from December 2021 through March 2024 (related to these items) to update and implement policies and procedures.

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

- 24-020 - 2024 Network Certification Requirements for County Mental Health Plans (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans
- 24-023 - Standards for Specific Behavioral Health Provider Types and Services; Amends Relevant Sections Within Title 9 and Title 22 of the California Code of Regulations (CCR)

Consumer Issues and Interventions

DHCS continues to respond to issues, complaints, or grievances related to DMC-ODS counties delivering DMC-ODS services for members. Issues that generate complaints or grievances related to DMC-ODS are minimal. DHCS did not receive any grievances during DY 20-Q2.

Quality Control/Assurance Activity

During DY 20-Q2, DHCS conducted 23 compliance reviews, which concludes the annual compliance reviews for fiscal year 2023-24. Figure 15 demonstrates when County DMC-ODS compliance reviews were conducted during DY 20-Q2.

Figure 15: DY 20-Q2 Monitoring Reviews

County	Month/Year
Marin	April 2024
San Luis Obispo	April 2024
Monterey	April 2024
Riverside	April 2024
Santa Clara	May 2024
Alameda	May 2024
Yolo	May 2024
Imperial	May 2024
Sacramento	May 2024
San Bernardino	May 2024
Nevada	May 2024

County	Month/Year
Santa Cruz	May 2024
Siskiyou	May 2024
Shasta	May 2024
Mendocino	May 2024
Humboldt	May 2024
Lassen	June 2024
Solano	June 2024
Santa Barbara	June 2024
Modoc	June 2024
Los Angeles	June 2024
San Benito	June 2024
El Dorado	June 2024

DHCS continues to provide technical assistance and support to DMC-ODS counties to resolve outstanding CAPs. There are no major activities updates to report regarding quality control/assurance during DY 20-Q2.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

UCLA continued activities on the 1115 waiver evaluation, as described below:

Survey and Interview Data Collection

CM/Recovery Incentives Evaluation Activities

- Throughout this reporting period, UCLA continued the dissemination of Provider Surveys at approved/launched programs following five months from their approval to launch. At the end of this reporting period, 182 surveys were received, with a 92 percent response rate. A sample of the respondents were followed up with for qualitative interviews for a more in-depth understanding of their experience with the delivery of the Recovery Incentives protocol. Fifteen interviews were completed in this reporting period. Preliminary findings will be summarized in the Mid-Point Assessment Evaluation Report; however a brief presentation of these data, named Recovery Incentives CPDD 06162024 Urada et al and attached to this report, was provided at the College on Problems of Drug Dependence (CPDD) conference in June 2024.

- During Q2 of 2024, UCLA continued the follow up data collection of a small longitudinal study among clients enrolled in the Recovery Incentive Program (sample size: N=47). This sample was identified as part of the cross-sectional survey conducted in Feb-March 2024 to be followed up at approximately weeks six, 14, and 26. The week six surveys started dissemination in late March and completed with a 72 percent response rate. The week 14 surveys began dissemination in late May and will continue into Q3, with week 26 surveys to follow. Lessons from this effort will inform on the most viable methods for a larger longitudinal collection effort in the future. However, data from the cross-sectional client survey (N=547) (including qualitative comments) are currently being analyzed for inclusion in the Mid-Point Assessment Evaluation Report. Preliminary findings were included in the brief presentation at the CPDD conference in June 2024.

1115 Waiver Evaluation Activities

- In this reporting period, UCLA distributed a County Administrator Survey to SUD/BH County Administrators of DMC-ODS counties. The survey aims to continue measuring the 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, contingency management, peers, harm reduction efforts, etc.). Collection was completed by the end of DY 20-Q2 with a 100 percent response rate. Findings will be reported in the Mid-Point Assessment Evaluation Report.

Administrative Data Analysis

- UCLA continued to receive administrative datasets including California Outcomes Measurement System (CalOMS) files, Short-Doyle Medi-Cal (SDMC) Claims, Monthly Medi-Cal Eligibility File (MMEF), ASAM data, and most recently in Q2 the Incentive Manager data. Analysis is underway and preliminary findings will be summarized in the Mid-Point Assessment Evaluation Report; however, a brief presentation of these data was provided at the CPDD conference in June 2024.

Statewide Perception Surveys

- Consumer Perception Surveys (CPS)/Mental Health (MHSIP) – During this reporting period, the 2024 CPS Data collection period occurred on May 20-24, 2024, as detailed in BHIN 24-009. Approximately 11,000 mental health clients completed the survey online and another approximately 25,000 completed the survey on paper. More are expected to be submitted electronically by end of July 2024. UCLA is currently processing and validating the data. Analysis occurs in Q3, and reporting occurs in Q4. The latest updates and additional information regarding the CPS can be found on the CPS website.

- Treatment Perception Survey (TPS)/Substance Use – During this reporting period, UCLA continued preparations for TPS 2024 with proposed dates as October 21-25, 2024. The latest updates and additional information regarding the TPS can be found on the TPS website.

Additional Activities/Technical Assistance

- ASAM Assessment and Screening: UCLA continues to work with ASAM to update the existing ASAM Criteria Assessment Interview Guide with the recently released 4th Edition of the ASAM Criteria. In this reporting period, the collaborative agreement was in negotiation with UCLA and ASAM. Additionally, UCLA continues to support the utilization of the Brief Questionnaire for Initial Placement (BQuIP), which is accessible on the BQuIP website for resource support.

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.

Performance Metrics

Nothing to report.

Outreach Activities

Nothing to report.

Operational Updates

On February 23, 2024, CMS published Final Rule 2024-03542, which provided clarification regarding the Consolidated Appropriations Act (CAA), 2021. Impacts of the final rule resulted in an increase to the Non-Designated Public Hospitals' FFY 2022 DSH allotment allocation, thereby reducing the GPP budgets for both FFY 2022 and FFY 2023 allotments. The adjustment calculations began in DY 20-Q2 and impacts GPP budgets for program years (PY) 7 and 8. Final adjustments will be implemented in DY 20-Q3.

Consumer Issues and Interventions

Nothing to report.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Figure 16: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 9 Quarter 4	$343,522,540.18	$343,522,540.17	DY 19	$687,045,080.35
PY 10 Quarter 1	$362,461,771.03	$362,461,771.03	DY 20	$724,923,542.06
Total	**$705,984,311.21**	**$705,984,311.20**		**$1,411,968,622.41**

DY 20-Q2 reporting activities include payments made in April 2024 for GPP PY 9-Q4 and PY 10-Q1.

In GPP PY 9-Q4, the PHCS received $343,522,540.18 in federally funded payments and $343,522,540.17 in intergovernmental transfer (IGT) funded payments. DHCS recouped $14,981,616.73 in total funds from San Francisco General Hospital and returned IGT funds in the amount of $4,898,649.58. The recoupment was due to an overpayment to San Francisco General Hospital.

Additionally, DY 20-Q2 reporting activities include payments made in April 2024, for GPP PY 10-Q1, where PHCS received $362,461,771.03 in federally funded payments and $362,461,771.03 in IGT funded payments.

Evaluation Activities and Interim Findings

Throughout DY 20-Q2, DHCS worked collaboratively with the University of California on behalf of its Los Angeles campus (UCLA-RAND) and the California Association of Public Hospitals and Health Systems (CAPH) by meeting regularly to discuss evaluation activities and reporting.

PROVIDING ACCESS AND TRANSFORMING HEALTH

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 to participate in the Medi-Cal delivery system as California widely implements ECM, Community Supports, and Justice-Involved Services under CalAIM. PATH funding is available for various entities such as providers, counties, cities, local government agencies, former WPC Lead Entities (LEs), community-based organizations (CBOs), hospitals, Medi-Cal Tribal and designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

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

PATH includes the following four initiatives:

1. WPC Services and Transition to Managed Care Mitigation Initiative – PATH funding will directly support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM on or before January 1, 2024. PATH funding will also directly support former WPC Pilot LEs to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Medi-Cal services for Justice-involved populations prior to release will launch in October 2024.
2. Technical Assistance (TA) Marketplace Initiative – PATH funding is available for the provision of TA for qualified applicants that intend to provide ECM and/or Community Supports.
3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH Third-Party Administrator (TPA) to establish collaborative planning and implementation efforts that support the CalAIM launch.
4. Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative – PATH funding will enable transition, expansion, and development of ECM and Community Supports capacity and infrastructure.

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

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

Performance Metrics

Enrollment and Utilization data was collected for the WPC Services and Transition to Managed Care Mitigation Initiative in DY 20-Q1. Through the TA Marketplace initiative, 285 TA Projects were approved through DY 20-Q2.

Operational Updates

WPC Services and Transition to Managed Care Mitigation Initiative

WPC Transition funding is available to support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM on or before January 1, 2024. Funding is also available to support LEs to pay for existing WPC services to the Justice-Involved population prior to release before those services are transitioned into managed care, which will not launch until October 2024.

During DY 20-Q2, the third payment for this initiative was processed to the three currently active grantees of the PATH WPC Services and Transition to Managed Care Mitigation Initiative. As of DY 20-Q2, two grantees submitted their annual invoices to DHCS and one grantee requested an extension for their PATH Utilization Report to DHCS for activities from July 1, 2023 to December 31, 2023, due to identified data discrepancies. DHCS reviewed and validated utilization reports as part of the payment

process for two grantees during DY 20-Q2. Data validation is required to ensure accurate reporting for services provided. For any data discrepancies, DHCS worked with LEs to ensure all reports were accurate before payment was made. There were seven LEs with services that were adopted in CalAIM earlier than originally anticipated in DY 18, and only three LEs are currently providing services not launched through managed care. These earlier adoptions of services left nine million dollars in available funding through the WPC Mitigation initiative. The next invoicing period will be for services from July 2023 to December 2023.

TA Marketplace

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

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

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

As of June 30, 2024, 448 TA Recipient registration requests have been received and 368 of those have been approved. Additionally, as of June 30, 2024, 431 projects have been approved or fully executed.

Currently, there are 116 approved vendors from four rounds of vendor procurement. In DY 20-Q2 during the fourth round of vendor procurement, new entities applied to become TA Vendors and currently contracted TA Vendors applied for an expansion to provide additional TA as defined below:

- Provide TA in additional TA domains, including Hand-On projects.

- Add new off-the-shelf TA projects in the TA domains in which they are already qualified.
- Qualify as a TA vendor that meets the cross-cutting competency for rural communities.

The seven TA domains are listed below and will be expanded and revised through the lifespan of the initiatives as needed to meet the needs of ECM and Community Supports providers. All domains have cross-cutting competencies focused on rural communities. These domains include:

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

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

As of DY 20-Q2 there are 396 approved off-the-shelf projects and 92 vendors approved to provide hands-on TA projects. The Round Four TA Marketplace Vendor application window opened April 1, 2024, and closed on April 30, 2024. In Round Four, 25 new TA Vendors were approved for offerings across all seven TA Domains. Additionally, 19 existing TA Vendors were newly approved to expand service offerings. A total of 127 new Off-the-Shelf TA Projects were added. Round Four Vendors and projects approved during DY 20-Q2 will be added to the Marketplace in July 2024.

During DY 20-Q2 DHCS and the TPA worked to procure “On-Demand Resources” to make available through the TA Marketplace: 1) “CalAIM 101” and 2) “ECM 101.” The vendor proposals submitted during the procurement period were reviewed by DHCS and the TPA. The On-Demand Resources are expected to be made available through the PATH TA Marketplace website in DY 20-Q3. Additional On-Demand Resources are planned to be procured and made available throughout DY 20.

Collaborative Planning and Implementation (CPI) Initiative

Collaborative Planning and Implementation (CPI) provides funding and support for planning efforts to drive implementation of ECM and Community Supports, including identifying needs and gaps, surfacing solutions, and sharing best practices across regions. There are 26 regional collaborative groups throughout the State, which are led by nine facilitators selected by DHCS and administered by the PATH TPA. The collaborative groups were established based on regional location, size, and with consideration to preserving existing collaboratives. The TPA and facilitators continue to meet monthly to review updates, provide outreach, discuss deliverables, address gaps in services, share ideas, and discuss challenges and successes. Facilitators hold roundtables with their collaborative groups monthly. From August 2022 through June 2024, the TPA registered a total of 1,193 organizations to participate with CPI. CPI participant registrations are accepted on a continual basis and participants are connected with selected facilitators.

In DY 20-Q2, DHCS and the TPA collected and reviewed 182 Q4 Facilitator deliverables. A DY 20-Q1 lookback analysis indicated the TPA collected and reviewed 182 Q1 deliverables, conducted 34 one-on-one coaching sessions with facilitators, and held 78 collaborative convenings across the state.

For DY 20-Q2 DHCS and the TPA hosted three CPI Monthly Facilitator Support Meetings on April 9, May 14, and June 4, 2024, for all PATH CPI Facilitators to discuss implementation challenges, solutions and best practices learned.

Capacity and Infrastructure Transition, Expansion, and Development (CITED) Initiative

The Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative provides funding to enable the transition, expansion, and development of ECM and Community Supports capacity and infrastructure. Applicants are encouraged to coordinate applications with local MCPs that they contract with or intend to contract with to provide ECM/Community Supports services. Applicants who wish to receive CITED funding must submit an application and funding request to DHCS' TPA describing how they intend to use CITED funding. The DHCS-contracted PATH TPA will support the administration and management of the CITED initiative.

CITED Round Three applications opened on January 15, 2024, and closed on February 15, 2024. A total of 421 applications were received. DHCS is in the process of reviewing Round Three applications and intends to announce Round Three awardees in DY 20-Q3. Applicants that receive CITED funding must be actively contracted with the Medi-Cal MCP to provide ECM/Community Supports or have a signed attestation from

the MCP that they intend to contract with to provide ECM/Community Supports in a timely manner. MCPs are not eligible to receive CITED funding.

The availability of WPC Transition initiative 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 programs. DHCS is repurposing unclaimed funds into a specific CITED-Intergovernmental Transfer (CITED-IGT) Round to be available for eligible entities. During DY 19-Q3, DHCS leveraged the availability of additional funding through a CITED-IGT round of funding that provides an opportunity to further support cities, counties, public hospitals, and other local government agencies in further developing and expanding infrastructure as they implement ECM and Community Supports. To be eligible for CITED-IGT, applicants must be able to contribute the non-federal share through IGT. Through CITED-IGT, there are $85 million in total computable unencumbered funds ($42.5 million from federal funding and $42.5 million non-federal share contributed by IGT eligible entities). In DY 19-Q3, DHCS awarded 15 entities via CITED-IGT funds for approximately $48.8 million. Three entities have declined their CITED-IGT award as of DY 20-Q2, and the new total awards for CITED-IGT is $46.1 million. Awardees will complete the progress report for CITED-IGT Round Two in DY 20-Q4. Another CITED-IGT Round was made available to eligible entities in Round Three and DHCS intends to announce awards in DY 20-Q3.

Justice-Involved Capacity Building Program (JI)

The application period for PATH JI Round Two closed on March 31, 2023, with $151 million allocated for the round. A total of 42 applications were received with an initial total funding request of $62.6 million. The PATH JI Round Two award notifications were released on a rolling basis. As of the end of DY 20-Q1, $65.54 million has been approved and awarded. In DY 20-Q2, DHCS began review of application amendments. PATH JI Round Two awardees submitted their Interim Progress Report on March 1, 2024. DHCS continued review of the Progress Reports in DY 20-Q2.

The application period for PATH JI Round Three closed on August 31, 2023, with $410 million allocated for the round. DHCS and PCG completed review of all applications and are pending final items for approval. DHCS is now working with stakeholders to develop implementation plans for the Round Three funding. As of the end of DY 20-Q1, DHCS and PCG have reviewed a total of 129 applications for Round Three, approving 126 with $358.8 million total funds approved. In DY 20-Q2, DHCS and PCG paused office hours while reviewing implementation plans and providing targeted TA assistance to Behavioral Health and Correctional partners.

DHCS will release an updated Policy and Operational Guide for planning and

implementing the CalAIM JI Reentry Initiative for stakeholder comment in DY 20-Q3. DHCS is reviewing additional comments and feedback on the new draft guidance. The draft guidance updates are intended to provide clarification on stakeholder feedback and comments.

TPA Support Activity

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

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

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

Stakeholder Engagement

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

- PCG published and distributed three monthly CalAIM PATH Newsletters in DY 20-Q2. The newsletters are provided to all TA vendors and recipients, CITED awardees, CPI facilitators and participants, PATH JI participants, and other subscribed stakeholders to provide a snapshot on activities and opportunities to engage through PATH.
- PCG released a quarterly MCP Toolkit to support MCPs with sharing PATH engagement opportunities with their networks.
- In DY 20-Q2, ten email blasts were sent out through DHCS' Office of Communications to DHCS' extensive stakeholder Listserv to communicate key opportunities to engage in PATH.

JI Initiative

- DHCS and the California Department of Corrections and Rehabilitation (CDCR) meet on a monthly basis to discuss the pre-release application process, policy and technical issues, concerns, and barriers to the implementation of mandatory pre-release processes.
- The JI Pre-Release Application Sub-Workgroup meets bi-weekly as of January but previously met monthly beginning in September 2022. The workgroup participants include county agencies, advocates, and stakeholders. DHCS uses this forum to provide additional guidance and technical assistance to implementation partners to support the ongoing efforts regarding the broader pre-release Medi-Cal enrollment and suspension processes mandate. The sub-workgroup participants include county agencies, county correctional agencies, advocates, and stakeholders.
- The Inmate Workgroup meets monthly and consists of county sheriffs from all 58 counties, representatives from the California Statewide Automated Welfare System, California Work Opportunity, and Responsibility to Kids Information Network (CalWIN[4]), and the Chief Probation Officers of California.
- The Data Sharing Workgroup meets with county social services departments (SSDs) throughout the state and all Medi-Cal providers to gain knowledge on issues relating to data-sharing among agencies. The feedback from these agencies is assisting in the drafting of a new data-sharing agreement in compliance and alignment with the HIPAA rules and regulations.
- DHCS and PCG paused PATH Office Hours for the months of May and June for review of PATH Round Three implementation plans and will restart office hours in July to begin discussion of PATH Round Three progress reports.
- During DY 20-Q3, DHCS will release the updated Policy and Operational Guide for Planning and Implementing the CalAIM JI Initiative Guide, which includes DHCS policy updates to Pharmacy and Readiness Assessment requirements for correctional facilities. Updates to previous versions will be reflected with highlights and strikethroughs to facilitate Pharmacy and Readiness Assessment stakeholder tracking of the changes. The Policy and Operational Guide for Planning and Implementing the CalAIM JI Initiative Guide will be updated on a quarterly basis.

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

CITED Initiative

- On June 25, 2024, DHCS and the TPA hosted a Progress Report office hour to discuss awardees' feedback and inquiries, pertaining to the Round One Q6 progress report.
- DHCS and the TPA are actively working on identifying opportunities for engagement of historically marginalized populations. DHCS and the TPA organized an outreach and engagement plan geared toward optimizing engagement efforts to tribal entities.

TA Marketplace

- The last two TA Marketplace Virtual Vendor Fairs were held on April 9 and April 25, 2024. During Virtual Vendor Fairs, approved TA vendors provided information on their organization and services to potential TA Recipients and encouraged utilization of the TA Marketplace. Vendor Fairs are open to anyone interested in learning more about TA offerings through the TA Marketplace. Approved TA Recipients and organizations currently contracted with or planning to contract with a Medi-Cal MCPs to provide ECM/Community Supports are encouraged to attend. These Vendor Fairs focused on vendors providing services in Domains Two, Five, Six, and Seven, covering Community Supports, Promoting Health Equity, Supporting Cross-Sector Partnerships, and Workforce.

CPI Initiative

- A monthly newsletter is sent out to CPI Facilitators with updates on ECM, Community Supports, and MCP guidance and reporting policies, including various PATH Initiative updates.
- DHCS and the TPA host monthly facilitator support meetings to discuss implementation challenges along with potential solutions, and facilitate communication and collaboration between DHCS, the TPA and the facilitators. In DY 20-Q2, these meetings were held on April 9, May 14, and June 4, 2024.
- On June 27, 2024, DHCS and the TPA hosted the third Best Practices Webinar titled "Tools to Better Engage Eligible Members in CalAIM." The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing ECM and Community Supports, increase providers' successful participation in CalAIM, and improve collaboration between MCPs, state and local government agencies, and others to build and deliver quality support services to Medi-Cal members. Over 1,500 individuals registered to attend this webinar.

- On June 17, 2024, the PATHways to Success web portal launched. This web portal features on-the-ground testimonials from organizations across California participating in the PATH initiative. In DY 20-Q2, PCG published three PATH success stories to the PATHways to Success web portal.

Consumer Issues and Interventions

DHCS and the TPA received stakeholder feedback on the TA Marketplace initiative's overall useability. Some recipients have expressed concerns with the process to request TA Projects, as there are multiple approval steps. The TPA is continuing to develop additional resources to assist recipients with the process. In DY 20-Q2, the TPA released example Project Eligibility Application templates to support TA Recipients and TA Vendors with preparing applications that require less rework for approval.

Following the revamp of the TA Marketplace website and the addition of TA Vendor profile cards from December 2023, a series of enhancements went live on the TA Marketplace website in January 2024. To attract applicants that have not engaged in the TA Marketplace, the webpage layout was changed, and several new features were added: advanced filtering capability, and updated Vendor Profile Cards.

The TA Marketplace On-Demand Resource Library launched in DY 20-Q2. This library contains static resources which are available directly through the CA PATH website for organizations looking to learn more about CalAIM and CA PATH. On-Demand resources are suitable for organizations at all levels of readiness for ECM and/or Community Supports. Additional material will be added to the On-Demand Resource Library on an ongoing basis.

Quality Control/Assurance Activity

The TPA conducts ongoing cross-initiative collaboration to ensure there is no duplication or inappropriate use of funds. For example, upon review of CITED applications there is a review step to track whether the applicant has applied or received funds from CITED prior. Moreover, there is a check on whether the applicant has applied for the TA Marketplace. In some instances, an applicant's request may be better suited for the TA Marketplace. Such applicants are referred to apply to the TA Marketplace. Additionally, when reviewing TA Marketplace project applications, there is a review to ensure no aspects of the project are funded through CITED.

Budget Neutrality and Financial Updates

For the WPC Mitigation Initiative, services are claimed through invoicing biannually. Out of the ten LEs, three are eligible to submit claims through the initiative. The three

entities submitted invoices for PATH WPC Services and Transition to Managed Care Mitigation for DHCS expenditures for the period of January to June 2023. Two of these payments were made during DY 20-Q2 totaling $3,315,623.92. Additionally, a payment was made for one entity for the period of January through December 2022 in the amount of $14,257,532.17. The next payment will be reported and invoiced during DY 20–Q3. DHCS is working with one entity to complete invoices through the WPC Mitigation Initiative and receive payment for services from January 2023 to June 2023.

For the CPI Initiative in DY 20, there are nine facilitators and one policy improvement coordinator contracted to oversee 26 collaborative planning groups. Some facilitators oversee multiple collaboratives across different counties/regions. During this quarter, payments totaling $5,140,266.94 were made to facilitators for meeting milestones.

The CITED Initiative awarded funds are only disbursed for completed milestones. Awarded applicants are required to submit quarterly progress reports detailing movement toward goals, purchases made, challenges encountered, and milestones accomplished. During DY 20-Q2 DHCS reviewed and approved CITED Progress Reports for Round 1A, 1B, and Round Two approved applicants. As of June 30, 2024, $94,723,353.33 has been paid out to Round One entities. As of June 30, 2024, $16,977,813.27 has been paid to Round Two entities. DHCS is currently reviewing applications for CITED Round Three and awards are expected to be announced in DY 20-Q3.

During DY 20-Q2, payments totaling $991,050.25 were made to vendors for completion of milestones of approved TA projects via the TA Marketplace Initiative. As of DY 20-Q2 there are 431 approved TA projects.

PATH JI Capacity Building efforts have awarded $4,550,952.95 across 39 counties, including CDCR, to support initial planning efforts in Round One of the initiative. In DY 20-Q2, $2,353,906.00 funds have been approved for distribution to Round Two approved applicants and $1,949,635.20 have been approved for distribution to Round Three approved applicants for completion of milestones. DHCS is also still reviewing remaining applications for JI Round Three and ongoing awards are expected to be announced in DY 20-Q3.

Figure 17: PATH Initiative Amounts

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
DY 18-Q1				
n/a	$0	$0	$0	$0
DY 18-Q2				
n/a	$0	$0	$0	$0
DY 18-Q3				
JI	$775,000	$387,500	$387,500	$0
DY 18-Q4				
JI	$3,775,952.95	$1,887,976.50	$1,887,976.48	$0
WPC Mitigation	$16,314,792.73	$8,157,321.37	$0	$8,157,321.37
Collaborative Planning	$1,450,000	$725,000	$725,000	$0
CITED	$0	$0	$0	$0
DY 19-Q1				
JI	$0	$0	$0	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$207,433,952.46	$103,716,976.23	$103,716,976.23	$0
DY 19-Q2				
JI	$2,115,577.90	$1,057,788.95	$1,057,788.95	$0

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
WPC Mitigation	$19,778,113.42	$9,889,056.71	$0	$9,889,056.71
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$5,220,000.00	$2,610,000.00	$2,610,000.00	$0
CITED	$0	$0	$0	$0
DY 19-Q3				
JI	$16,209,737.68	$8,104,868.84	$8,104,868.84	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$1,604,311.50	$802,155.75	$802,155.75	$0
DY 19-Q4				
JI	$55,219,451	$27,609,725.50	$27,609,725.50	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$569,777	$284,888.50	$284,888.50	$0
Collaborative Planning	$3,142,538.47	$1,571,269.24	$1,571,269.24	$0
CITED	$41,241,845	$20,620,922.50	$20,620,922.50	$0

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
DY 20-Q1				
JI	$10,955,296.36	$5,477,648.18	$5,477,648.18	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$1,680,501.85	$840,250.93	$840,250.93	$0
Collaborative Planning	$3,677,251.93	$1,838,625.96	$1,838,625.96	$0
CITED	$26,387,135.00	$13,193,567.50	$13,193,567.50	$0
DY 20-Q2				
JI	$4,303,541.20	$2,151,770.60	$2,151,770.60	$0
WPC Mitigation	$17,573,156.09	$9,670,545.04	$0	$7,902,611.05
TA Marketplace	$991,050.25	$495,525.13	$495,525.13	$0
Collaborative Planning	$2,043,307.21	$1,021,653.8	$1,021,653.8	$0
CITED	$16,628,555.78	$8,314,277.89	$8,314,277.89	$0

Figure 18: Total Approved Amounts by PATH Initiative, DY 20-Q2

PATH Initiative	Total Payment
JI	$4,303,541.20
WPC Mitigation	$17,573,156.09
TA Marketplace	$991,050.25
Collaborative Planning	$2,043,307.71
CITED	$16,628,555.78
TPA	
Public Consulting Group LLC	$0.00
TOTAL	**$41,539,611.03**

Evaluation Activities and Interim Findings

On June 5, 2024, DHCS received CMS feedback on the CalAIM 1115 Evaluation. DHCS is currently in the process of working with the contractor, University of California Los Angeles (UCLA)-RAND, to revise and resubmit a final approved version that includes CMS feedback, by December 5. DHCS continues to collaborate with UCLA-RAND on the evaluation components, including the PATH Initiative, via weekly, monthly, or ad-hoc meetings.

COMMUNITY SUPPORTS: RECUPERATIVE CARE AND SHORT-TERM POST HOSPITALIZATION

California's Section 1115 waiver renewal includes expenditure authority for two of the state's fourteen preapproved Community Supports. MCPs can cover alternative services or settings that are "in-lieu" of services covered under the Medicaid State Plan to address their members' physical, behavioral, developmental, long-term care (LTC), oral health, and health-related social needs more effectively and efficiently.

Community Supports are optional for MCPs to offer and for members to utilize. MCPs cannot require members to use Community Supports instead of a service or setting listed in the Medicaid State Plan. Pursuant to 42 Code of Federal Regulations (CFR) 438.3, MCPs cannot provide Community Supports without first applying to the state and obtaining state approval to offer the Community Support and demonstrating the requirements will be met. 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 will be added to the MCP's contract and posted on the DHCS ECM & Community Supports website as a state-approved Community Support.

The full list of Community Supports includes:

1. **Housing Transition Navigation Services** - Assistance and support for individuals in transitioning from homelessness to stable housing.
2. **Housing Deposits** - Financial assistance for housing deposits to help individuals secure stable housing.
3. **Housing Tenancy & Sustaining Services** - Services aimed at helping individuals maintain their housing stability, such as ongoing support for rent and tenancy-related needs.
4. **Short-Term Post-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.

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, or 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 LTC. The state will also conduct a thorough cost-effectiveness analysis of these Community Supports, as required.

Monitoring and evaluation efforts will be supported by data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing

disparities in access and potential impacts of these community support on addressing access barriers.

Performance Metrics

To monitor ECM and Community Supports implementation, DHCS developed the Quarterly Implementation Monitoring Report (QIMR), which MCPs are required to report to DHCS across multiple domains. For Community Supports specifically, MCPs must report Community Supports that were requested, approved, utilized, and/or denied, in addition to 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 continues monitoring MCPs offering and implementation of Community Supports, including as it relates to the 2024 MCP transition in certain counties.[5]

From July 2023 to January 2024, DHCS has seen a steady uptake of Community Supports offered by MCPs statewide. Figure 19 on the next page shows a substantial proliferation of counties with at least one MCP offering all 14 community supports – with 11 counties as of July 2023 and 19 counties by January 2024.

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

Figure 19: Number of Community Supports, by County, Live as of July 2023 and January 2024

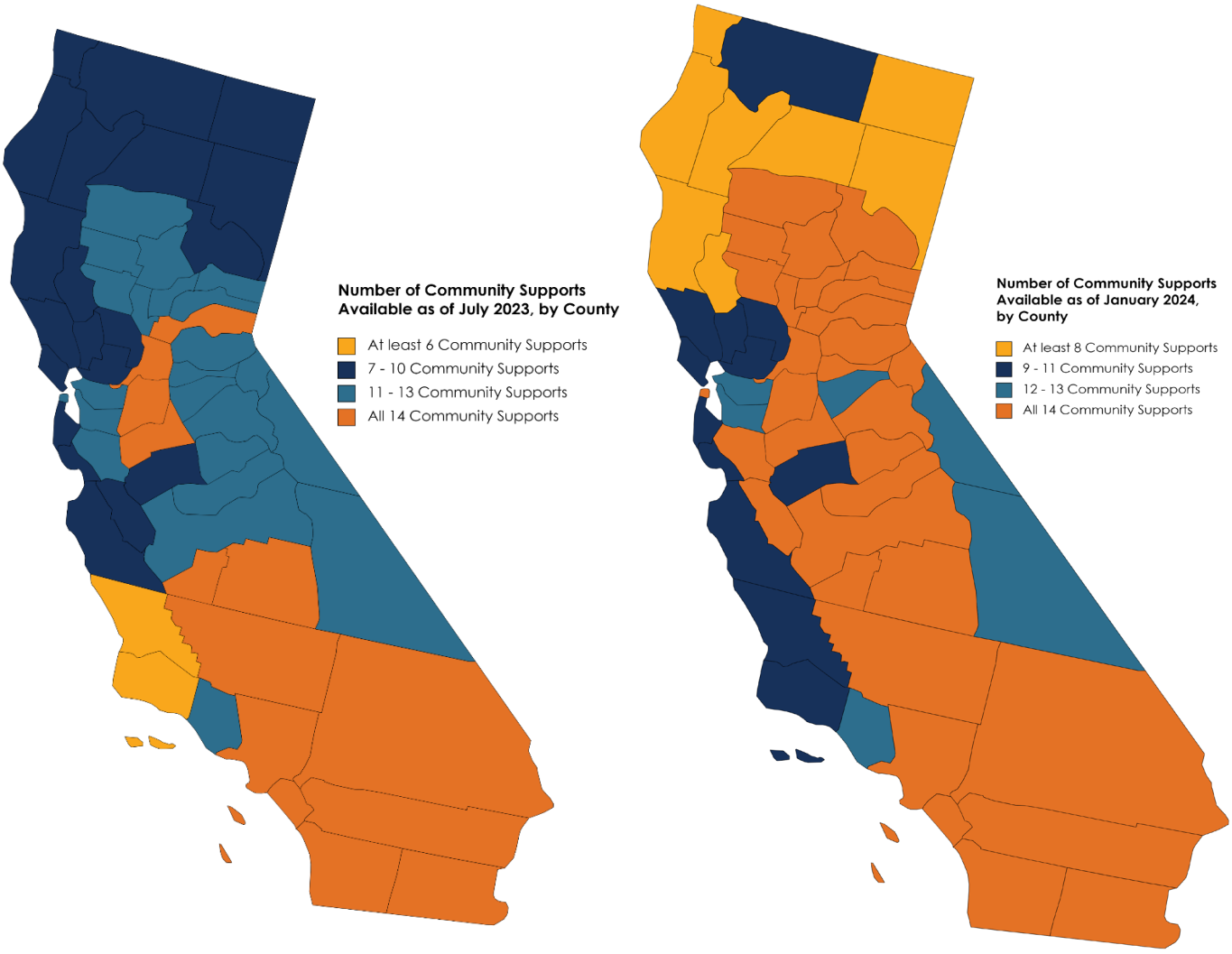
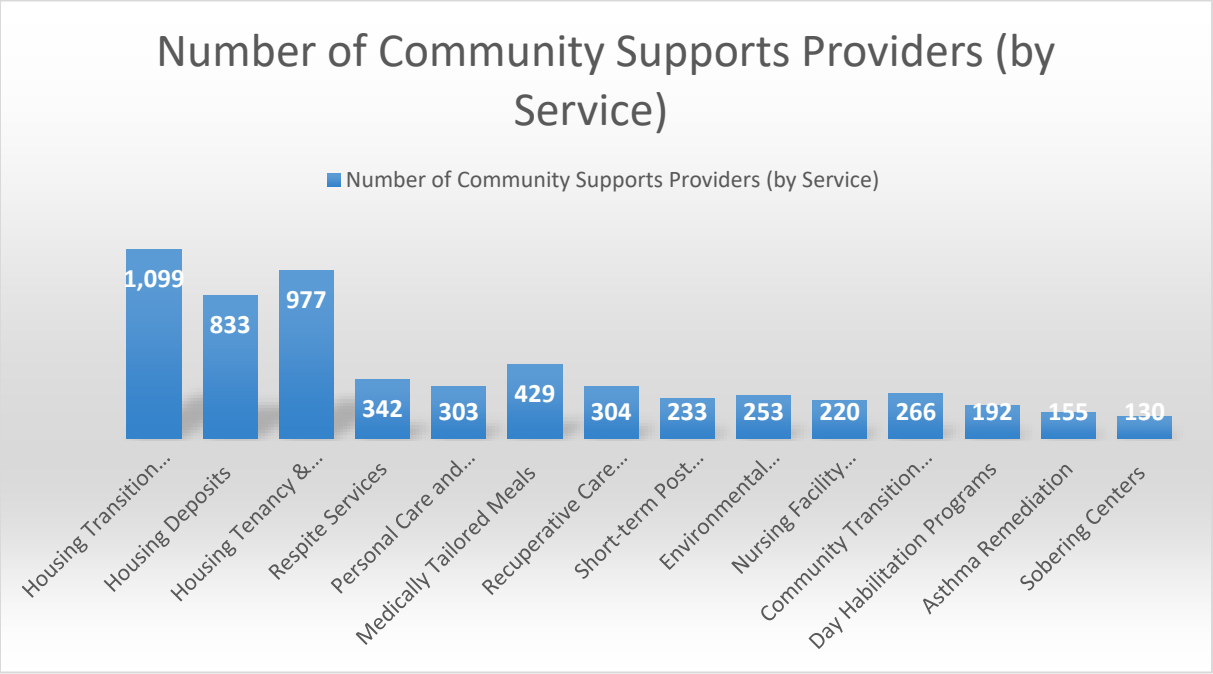


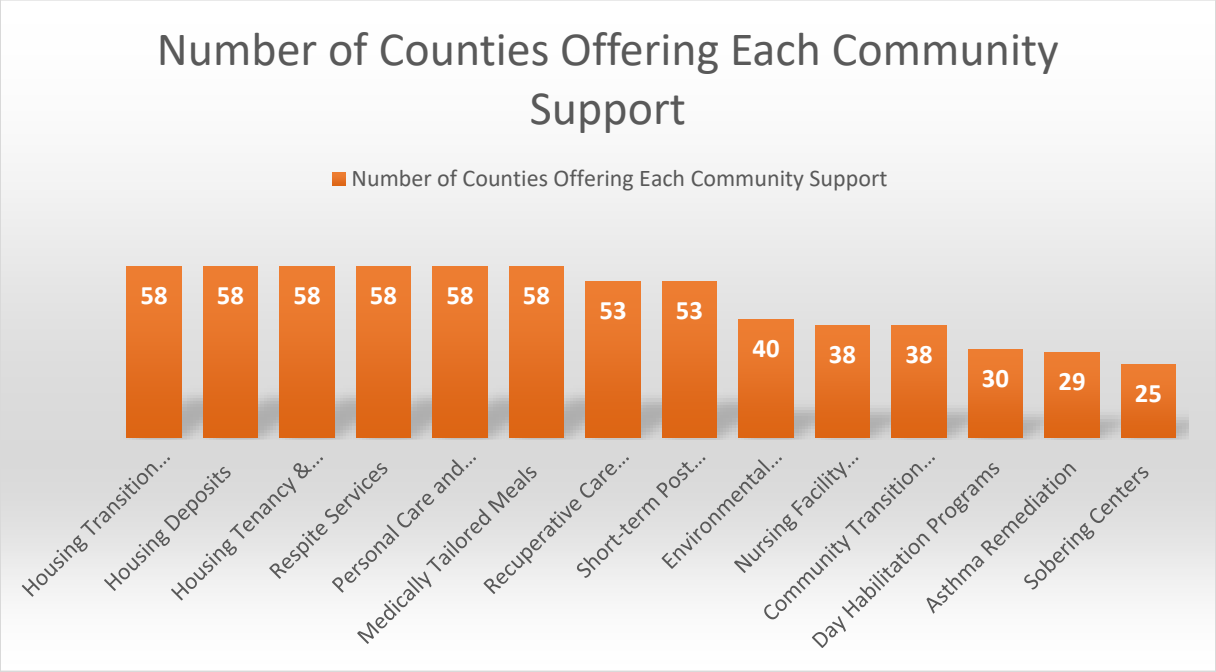
Figure 20 below displays currently available data as of June 2024, indicating the number of providers and counties where services are available throughout California for the following Community Supports:

Figure 20: Number of Providers and Counties Offering Community Supports, as of June 2024

Community Supports	Number of Providers	Number of Counties Offering the Community Support
Housing Transition Navigation Services	1,099	58

Community Supports	Number of Providers	Number of Counties Offering the Community Support
Housing Deposits	833	58
Housing Tenancy & Sustaining Services	977	58
Respite Services	342	58
Personal Care and Homemaker Services	303	58
Medically Tailored Meals	429	58
Recuperative Care (Medical Respite)	304	53
Short-term Post Hospitalization Housing	233	53
Environmental Accessibility Adaptations	253	40
Nursing Facility Transition/Diversion to Assisted Living Facilities	220	38
Community Transition Services/Nursing Facility Transition to a Home	266	38
Day Habilitation Programs	192	30
Asthma Remediation	155	29
Sobering Centers	130	25





Source: Quarterly Implementation Monitoring Report (QIMR) data submitted by Medi-Cal Managed Care Plans to DHCS for the Q1 2024 reporting period.

At least one plan in all 58 California counties has elected to offer all three of the Housing Supports, Respite Services (for caregivers), and Personal Care and Homemaker Services. Short-Term Post-Hospitalization Housing and Recuperative Care continue to expand and are now both available in 91 percent (53 out of 58) of counties.

From that data, we can see that there are robust networks for the housing trio of community support services: Housing Tenancy and Sustaining Services, Housing Transition and Navigation Services, Housing Deposits.

There has also been substantial uptake of Medically Tailored Meals/Medically Supportive Foods, another service that is now available in all 58 counties. All 58 counties now have at least eight services live, with several MCPs in 23 total counties having already adopted all 14 preapproved Community Supports.

Utilization data for Community Supports

Figure 21 below reflects current available data indicating the following number of unique individuals served across DY 19 (Q1 2023 – Q4 2023) for DHCS' available Community Supports.

Figure 21: Unique Individuals Served Across DY 19 Q1 – DY 19 Q4

Community Support	2023 Q1	2023 Q2	2023 Q3	2023 Q4
Housing Transition/ Navigation Services	15,363	18,602	20,918	23,921
Housing Deposits	587	669	1,028	1,301
Housing Tenancy and Sustaining Services	11,442	14,431	16,334	17,067
Short-Term Post-Hospitalization Housing	245	305	442	521
Recuperative Care	1,351	1,644	1,845	1,613
Respite Services	81	139	278	404
Nursing Facility (NF) Transition/Diversion to Assisted Living Facility	188	245	377	370
Community Transition Services/Nursing Facility Transition to a Home	161	128	150	172
Personal Care and Homemaker Services	214	443	806	1,287
Day Habilitation Programs	238	301	474	535
Environmental Accessibility Adaptations	19	39	135	665
Medically Tailored Meals/ Medically Supportive Food	12,586	21,027	29,713	42,924
Sobering Centers	502	620	818	952
Asthma Remediation	325	937	615	758
Grand Total of Unique Members	**40,347**	**55,887**	**68,442**	**85,995**

Source: Quarterly Implementation Monitoring Report (QIMR) data submitted by Medi-Cal Managed Care Plans to DHCS for the Q1 2023 to Q4 2023 reporting periods.

As indicated by Figure 21, there has been steady increase in the unique number of members who have used community supports each quarter indicating that the services have expanded significantly over the course of the year. Notable increases include:

- Medically Tailored Meals/Medically-Supportive Food, which had a 241 percent increase in member use from Q1 to Q4 of 2023.
- Personal and Homemaker Services, which had a 501 percent increase in member use from Q1 to Q4 of 2023.
- Environmental Accessibility Adaptations also increased by 34 times from Q1 to Q4 of 2023, with the most dramatic increase (393 percent) from Q3 to Q4.

Medically Tailored Meals/Medically-Supportive Food showed the most substantial growth in both absolute numbers and percentage increases over 2023, highlighting a significant rise in demand and availability of the service. Utilization numbers consistently trended upwards and presented a significant increase of 241 percent from Q1 to Q4. Factors explaining this trend may include increased demand, accelerating awareness, program expansion, operational improvements, and even seasonal factors such as an increased need during colder months or holiday-related demands. It also highlights a significant expansion of the service and response to needs or opportunities. The increased utilization of this service suggests that the program is meeting its goals and adapting to changing demands, setting precedent for future growth and sustainability.

Some of the rapid increases in Personal Care and Homemaker Services and Environmental Accessibility Adaptions may be attributable to the go live of ECM for populations of focus for nursing home transitions in January 2023, for which these specific Community Supports services were well-positioned to provide enhanced support. These increases also may indicate a heightened emphasis on delivering these services and broader awareness within communities.

The Housing Trio also continues to have steady increases with housing deposits increasing most substantially during this period. These services have shown consistent growth throughout the year, suggesting steady demand and ongoing program expansion. This growth and expansion can be attributed to counties further building out and enhancing their social service networks and as treating providers and members become more aware of available service options.

Both Recuperative Care and Asthma Remediation showed notable changes throughout 2023, reflecting possible variations in service demand and/or availability. For both services, the data indicates periods of high demand followed by a slight decrease, which could be influenced by external factors or variations in community needs. This sequence

of fluctuations underscore the importance of MCPs' ability to adjust and respond to potential changes in demand.

DHCS is conducting further analysis on certain identified trends to assess whether external factors or changes in policy that might have influenced these trends, especially the sharp increases in certain services. Increased focus is being paid to high-growth areas such as Medically Tailored Meals/Medically-Supportive Food and Environmental Accessibility Adaptations. DHCS continues to monitor and analyze trends to identify opportunities to adjust and enhance the focus of future technical assistance or guidance as appropriate.

Outreach Activities

During this reporting period, DHCS continued to strategize and discuss the implementation of Community Supports and drafted responses to questions pertaining to the suite of benefits, which were submitted by various stakeholders. DHCS continues to accept stakeholder feedback and intends on continuing to refine guidance on this unique set of services. A few of the webinars and meetings hosted by DHCS for this quarter included:

- 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 transition 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.

Over the course of the reporting period, DHCS also met with several MCPs to reconcile

differences found in their member noticing policies for Community Supports. These calls helped in reducing variation between policies across plans/counties and ensuring eligible members can easily access Community Supports.

On April 4, 2024, DHCS hosted its fourth monthly ECM & Community Supports Implementation Advisory Group (IAG) meeting of the year. The April IAG meeting featured a discussion on proposed refinements to the Housing Deposits Community Supports service definition. DHCS encouraged attendance from all MCP organizational staff who directly work with and/or oversee the housing related Community Supports services to attend the session to encourage a robust discussion.

On April 4, 2024 DHCS also met with Community Supports staff at two MCPs: Community Health Group and Positive Healthcare (also known as AIDS HealthCare Foundation) to review and discuss low utilization over time for several of their elected services: Housing Tenancy and Sustaining Services, Short-Term Post Hospitalization Housing, Day Habilitation Programs, Sobering Centers for Community Health Group; and Housing Tenancy and Sustaining Services for AIDS HealthCare Foundation.

On April 8, 2024, DHCS met with staff at CalViva Health Plan to review and discuss low utilization over time for their Environmental Accessibility Adaptions, Recuperative Care, and Sobering Centers elected services.

On April 11, 2024, DHCS met with staff at the Health Plan of San Joaquin to review and discuss low utilization over time for their Environmental Accessibility Adaptations, Sobering Centers, and Short-Term Post-Hospitalization Housing elected services.

On April 12, 2024, DHCS met with staff at the Inland Empire Health Plan to review and discuss low utilization over time for their Asthma Remediation and Sobering Centers elected services.

On April 15, 2024, DHCS met with staff at Blue Shield Promise (BSP) as well as Santa Clara Family Health Plan (SCFHP) to review and discuss low utilization over time for several of their elected services: Day Habilitation Programs and Sobering Centers for BSP, and Recuperative Care and Sobering Centers for SCFHP.

On April 18, 2024, DHCS met with staff at L.A. Care Health Plan to discuss low utilization over time for their Sobering Centers elected service.

On April 23, 2024, DHCS hosted its fourth monthly ECM & Community Supports MCP TA call of the year. The purpose of this meeting is to collaborate with Medi-Cal MCPs to discuss upcoming projects and program transitions, including updates on Community Supports implementation. Topics for the meeting included: a look at ECM & Community

Supports data through Q3 2023, discussion on streamlining ECM referrals and authorizations, a review of the updated ECM/CS webpage design, a note on updated Community Supports Elections, discussion on expanding networks and streamlining payments through the CPI group, and a detailed look at how to engage MCPs in PATH Outreach, Engagement, and Marketing (OEM) efforts.

On May 2, 2024, DHCS hosted its first of two May IAG monthly webinars, which featured a discussion on ECM referrals and authorizations, and requested feedback from the IAG on streamlining access to ECM via ECM referral and authorization standards.

On May 15, 2024, DHCS confirmed having received all final QIMR submissions for the reporting period of Q1 2024 (January 1 – March 31, 2024).

On May 21, 2024, DHCS hosted its fifth monthly ECM & Community Supports MCP TA call of the year. The main topic for this meeting was hosting a discussion and providing further information on Phase Two of the JSON Transition process, including the due dates across the planned testing/staging periods and for the Phase Two production files.

On May 30, 2024, DHCS hosted its second of two May IAG monthly webinars (originally scheduled for June 2024). This IAG meeting featured a discussion on proposed refinements to the Medically Tailored Meals/Medically-Supportive Food (MTM/MSF) Community Supports service definition. DHCS encouraged attendance from individuals at MCP organizations, who directly work with and oversee the MTM/MSF Community Supports service, and hosted a robust discussion with all attendees.

On May 31, 2024, DHCS hosted an all-comers webinar on ECM and Community Supports for individuals and families experiencing homelessness. In this webinar, DHCS leaders were joined by panelists from providers and managed care plans delivering ECM and key housing-related Community Supports. The following items were discussed:

- Ways in which ECM and Community Supports aim to address members' clinical and non-clinical needs
- Perspectives from providers on connecting members to key housing-related Community Supports and braiding ECM and Community Supports services for individuals and families experiencing homelessness
- Guidance provided to community partners and providers on referring individuals to ECM and Community Supports and engaging members experiencing homelessness in CalAIM.

On June 5, 2024, DHCS hosted PCG and PATH CPI Facilitators in Sacramento for an in-person meeting. The CPI initiative provides funding to support regional collaborative

planning efforts among MCPs, providers, community-based organizations, county agencies, public hospitals, tribes, and others to support implementation of ECM and Community Supports. Stakeholders in a region form collaborative planning groups that work together to identify, discuss, and resolve implementation issues as well as identify how PATH and other CalAIM funding initiatives may be used to address gaps identified in MCP Needs Assessments and Gap Filling Plans. One objective of the meeting was to promote bi-directional communication and inputs across the facilitators and DHCS through sharing insights from "the field" in alignment with the ECM and Community Supports Action Plan[6], including identification of challenges and potential solutions regarding CalAIM implementation. A second objective was for facilitators, PCG, and DHCS to discuss and come to consensus on goal-setting opportunities for the CPI initiative from June 24 – December 24 and beyond.

On June 18, 2024, DHCS met with representatives from Fullwell, a Food as Medicine collaborative, to discuss their feedback and concerns regarding some of the current service definition language. DHCS was informed that different components of the service, including eligibility criteria, have been interpreted differently by various MCPs since service inception. The robust discussion held with this group has helped inform the ongoing service definition refinements DHCS is currently working towards.

On June 25, 2024, DHCS hosted its sixth monthly ECM & Community Supports TA Call of the year to present updates on several key policy areas, including its work towards updating and refining five service definitions: Housing Deposits, Community Transitions Home, Nursing Facility Transition/Diversion to Assisted Living Facilities, Medically Tailored Meals/Medically-Supportive Food, and Asthma Remediation. These services were chosen due to the significant volume of stakeholder feedback received on each, where stakeholders and organizational partners highlighted substantial opportunities to clarify and address certain ambiguities implicit in the current existing service definition language. DHCS additionally shared further information on the July 1 Model of Care (MOC) expectations and process: a minor Healthcare Common Procedure Coding System (HCPCS) Coding Guidance refresh to provide further clarity around several included footnotes, and an additional Community Supports Elections Chart refresh that was made to align with final MCP elections planned for implementation on July 1, 2024.

On June 26, 2024, DHCS connected with Community Supports staff at L.A. Care Health Plan to discuss their interpretation of the Nursing Facility Transition/Diversion to Assisted Living Facilities Community Support. The meeting afforded DHCS and L.A. Care

[6] The ECM and Community Supports Action Plan is available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Community-Supports-Action-Plan-03192024.pdf

to discuss variances interpreting the service definition language and is helping to inform current, ongoing efforts to refresh and update five service definitions. The updates are meant to provide further clarity on all included components of each service to promote statewide standardization and stimulate quality improvements.

On June 27, 2024, DHCS hosted a statewide webinar titled "Tools to Better Engage Eligible Members in California Advancing and Innovating Medi-Cal (CalAIM)." The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing ECM and Community Supports, increase providers' successful participation in CalAIM, and improve collaboration with MCPs, state and local government agencies, and others to build and deliver quality support services to Medi-Cal members.

2024 MCP Transition

DHCS' expectation as it pertains to the MCP transition, effective January 1, 2024, was that transitioning members actively receiving Community Supports would not face disruption. Receiving MCPs were to honor existing authorizations and maintain continuity of care for Community Support services. The Receiving MCP must maintain all authorizations for no less than the length of time originally authorized by the Previous MCP; however, the Receiving MCP is not required to maintain the authorization for more than 12 months beyond January 1, 2024, unless it chooses to do so. These, and related expectations were outlined in Section V, Continuity of Care of the Transition Policy Guide[7]. In some instances, the Transition Policy for Community Supports offered enhanced protections beyond those for other services.

DHCS closely monitored MCP adherence to this Transition Policy for Community Supports to prevent disruptions in Community Supports authorizations, provider relationships, and/or services in affected counties. As of the end of Q2 2024, all MCPs have fulfilled their obligations under this policy and have confirmed automatically authorizing services for eligible members and contracting with all eligible out-of-network (OON) providers who had already previously been providing the same services within the county under a previous MCP.

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

Network Overlap and Continuity of Care (CoC) for Community Supports Providers

DHCS expected that transitioning members who had been actively receiving Community Supports would continue with their existing Community Supports Provider.

When MCPs' Community Supports Aligned: If the Previous MCP and the Receiving MCP offered the same Community Supports, even if there were variances in amount, duration, or scope, DHCS required mandatory overlap of the Previous MCP's and Receiving MCP's Community Supports providers to the maximum extent possible to ensure CoC and maintain delivery system capacity. DHCS has other initiatives that facilitate contracting between Community Supports Providers and MCPs. The Incentive Payment Program (IPP) rewards MCPs for contracting with Community Supports providers as part of the transition and PATH CITED grants encourage awardees to enter into Community Supports contracts with Receiving MCPs. Receiving MCPs were required to proactively contact all eligible OON Community Supports providers with whom transitioning members had pre-existing relationships and contract with them as Community Supports providers in advance of the transition on January 1, 2024.

If a Previous MCP's Community Supports provider did not wish to enter into a contract with the Receiving MCP's network, or if both parties were unable to reach an agreement, the Receiving MCP was required to offer a CoC for Provider agreement with the Community Supports provider for up to 12 months. If the Receiving MCP's efforts did not result in an agreement with the Community Supports provider, the Receiving MCP had to explain in writing to DHCS why the provider and the MCP could not execute a contract or CoC for Provider agreement.

When MCPs' Community Supports Did Not Align: Nothing in the policy required the Receiving MCP to offer Community Supports, as it is considered voluntary for each MCP. Therefore, if the Receiving MCP did not offer a Community Support which had been offered by the Previous MCP, the Receiving MCP was not required to build a contracted network for delivery of the specific Community Support. However, the Receiving MCP was strongly encouraged to offer a CoC for Provider agreement with the Community Supports provider for up to 12 months. If the Receiving MCP's efforts did not result in an agreement with the Community Supports provider, and as a result there was no Community Supports provider in the Receiving MCP's Network to deliver the Community Support, the Receiving MCP was strongly encouraged to arrange for an OON provider.

DHCS' Approach to Connecting Transitioning Members with Community Supports Providers for Continuity of Care

If the Receiving MCP confirmed the member's former Community Supports provider was part of its network, agreed to join its network, or participates under a CoC for Provider agreement, the Receiving MCP was required to connect the member with their existing Community Supports provider to ensure that relationship was not disrupted. The Receiving MCP received data necessary to effectuate this policy in November 2023 from both DHCS as well as Previous MCPs in an effort to achieve both comprehensiveness and timeliness.

If the Receiving MCP did not bring the Community Supports provider into its network or establish an agreement with the Community Supports provider, the Receiving MCP was required to transition the member to an in-network Community Supports provider. If a member wanted to change their Community Supports provider, they could contact and notify the Receiving MCP (their new MCP) to do so.

Quarterly Implementation Monitoring Report

DHCS works to produce program data and make it publicly available at the earliest opportunity, while factoring in member privacy concerns. It takes the Department, on average, approximately six months to validate, fully process the quarterly data it receives, visualize it through Microsoft Power Business Intelligence (BI), an enterprise business performance management solution, as well as develop and review materials for public reporting.

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

DHCS continues working to ensure a high level of data quality covering the first two years of implementation and recognizes the gaps that continue to exist in new providers' reporting capabilities, which MCPs are helping to address. DHCS currently has eight quarters of data available for Community Supports and is still processing and validating Q1 2024 data, but MCPs have consistently communicated caution due to the significant data lag they are experiencing with their providers, many of whom are brand new to Medi-Cal and/or the managed care delivery system.

DHCS is improving data availability 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.

JavaScript Object Notation (JSON) Transition

The transition to JSON began in January 2024, when DHCS officially began transitioning the quarterly reporting performed via the QIMR Excel Reports by requiring additional monthly JSON file submissions. JSON, or JavaScript Object Notation, is an open standard file format that streamlines the collection and transmission of implementation data and is utilized by the Department for other mandatory reporting purposes. Currently, QIMR data lags real-time implementation by approximately four (4) to six (6) months; the transition to JSON is expected to significantly reduce lag on data collection.

The introduction of JSON monthly reporting does not remove Excel-based reporting requirements. MCPs must continue reporting as normal through the QIMR 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 next QIMR, which will include data through DY 20-Q2, is due to DHCS by August 14, 2024.

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

- Phase One (January 2024): Limited data elements specific to ECM and Complex Care Management (CCM) enrollment status.
    - Phase One was successfully adopted in January 2024 and all MCPs have been producing and submitting monthly JSON files beginning on February 10th (for the reported month of January). DHCS has worked with MCPs to identify and address technical issues and continues to provide additional technical assistance.
- Phase Two (July 2024): ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
- Phase Three (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 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.

Operational Updates

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

On July 1, 2024, DHCS received final updated Models of Care (MOCs) and final January 2025 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections are posted on the DHCS website once DHCS issues its final approval for all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually. Technical assistance and guidance webinars are recorded and hosted on the DHCS website and are updated regularly. DHCS also maintains a regularly updated FAQs document on its ECM and Community Supports webpage, which highlights several FAQs from MCPs, providers, and stakeholders. The FAQs document also includes answers and policy clarifications provided by DHCS.

Moving forward, DHCS is publishing Quarterly Implementation Reports on a quarterly cadence to relay data publicly on Community Supports, including member characteristics, service utilization metrics, and network development. On April 4, 2024, DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q3 2023[8] along with the following message and press release:

Medi-Cal Transformation Continues
New Enhanced Care Management and Community Supports Report Shows Progress

SACRAMENTO - The Department of Health Care Services (DHCS) today released the latest Enhanced Care Management (ECM) and Community Supports Quarterly Implementation Report that includes data from January 2022 through September 2023. This data release adds third quarter 2023 utilization data at the state, county, and Medi-Cal managed care plan (MCP) levels and demographics, including ethnicity, primary language spoken, age, and sex.

WHAT THE DATA SHOWS: *The data report demonstrates the uptick in both the availability and use of Community Supports, showing significant growth in the number of*

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

counties offering these services. As of January 2024, 23 counties across California offered all 14 Community Supports, and all counties offered at least seven Community Supports. This marks a significant increase from the end of 2022, when only three counties offered all 14 Community Supports. Overall, approximately 103,000 unique Medi-Cal members used Community Supports in the first 21 months of the program, with more than 186,000 total services delivered. There is significant quarter-over-quarter growth in utilization; approximately 62,000 members utilized Community Supports in Q3 2023 alone, up 170% from Q4 2022.

ECM and Community Supports aim to improve Medi-Cal members' overall health and well-being by addressing both medical and social factors that can impact a person's health, including housing assistance, medically tailored meals to support short term recovery, homemakers and personal services to create a high-touch, person-centered approach to care.

WHAT THEY'RE SAYING: *"Every day, more Medi-Cal members are benefitting from personalized care that goes beyond the traditional doctor's office or hospital setting," said* ***DHCS Director Michelle Baass****. "Enhanced Care Management and Community Supports are two key pillars of Medi-Cal transformation, and we're seeing a great response. But there is still room to help even more people."*

"CalAIM is a nation-leading effort that requires the support of all individuals, organizations, and health plans trusted with delivering care to members," said ***State Medicaid Director Tyler Sadwith.*** *"We are working closely with stakeholders, providers, and Medi-Cal managed care plans to ensure members and their caregivers know they can readily access these transformative services."*

WHY THIS MATTERS: *The latest ECM and Community Supports Quarterly Implementation Report update shows a sustained increase in utilization as additional Populations of Focus (POF) become eligible for ECM and additional Community Supports services are offered in counties across the state. DHCS expects to see more enrollment growth across ECM and Community Supports in the coming months and years. As California continues transforming Medi-Cal, 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 remains committed to supporting and sustaining this growth through program monitoring, design improvements, standardization, and direct technical assistance.*

"At Pacific Clinics, everything we do helps the people we serve to achieve their wellness *goals and advance health equity. Medi-Cal transformation is essential to this work," said* ***Vice President of Emerging and Statewide Services Jacquelyn H. Torres****. "Through Community Supports, we provide crucial pathways to affordable housing for individuals*

and families. Additionally, Enhanced Care Management ensures access to comprehensive services tailored to meet complex health needs with life-affirming services and care.

DHCS is additionally finalizing further policy to clarify several ongoing, planned, and future activities specific to updating Community Supports policy and facilitating a higher degree of standardization of services and service delivery between counties. Over the last nine months, DHCS has undertaken a broad effort to increase standardization across the ECM & Community Supports programs, with the aim of reducing administrative burden, increasing uptake, and ensuring consistency for the delivery of services.

On May 7, 2024, DHCS notified MCPs of its preparations to publish the Q4 2023 update to the ECM and Community Supports Quarterly Implementation Report. DHCS notified MCPs that the Q4 2023 update will reflect QIMR data submitted to DHCS through Tuesday, May 21, 2024, and that any resubmissions made after that date will not be reflected in the public report when it is updated with Q4 2023 data in July.

DHCS encouraged MCPs to proactively resubmit QIMR data to DHCS upon discovery of incompleteness or inaccuracies and asked MCPs that identified data issues with their earlier 2023 QIMR submissions to resubmit updated data to DHCS no later than May 21, 2024. In addition to public reporting, DHCS is using QIMR data submitted through May 21, 2024, to determine any monitoring and enforcement actions for 2023.

The next ECM and Community Supports Quarterly Implementation Report for Q4 2023 is currently being processed and is scheduled for release by the end of July 2024.

Other Monitoring Activities

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

- **Community Supports**: As required in A.B. 133 14184/206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021), up-to-date information about Community Supports services being offered by the MCP, including, at minimum:
  - A short description of each available service that is consistent with the service definitions listed in the Community Supports Policy Guide (terminology should not differ from DHCS' terminology).
  - The eligible population(s) for each service

- 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.

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

» Up-to-date member and provider facing information about Community Supports and how to request access to Community Supports.

» Up-to-date information about all Community Supports being offered by the MCP, including, at minimum: A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS' terminology.

» The eligible population(s) for each service. Beginning on January 1, 2024, MCPs were required to fully align with the DHCS Community Supports service definitions and had to remove any language about previously approved modifications and/or restrictions from its website.

In March 2024, DHCS issued a Community Supports Monitoring Request for Information (RFI) to select MCPs based on their Community Supports implementation for CY 2023. In April 2024, DHCS published ECM and Community Supports implementation data for Q3 2023, 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, or relatively few, Community Supports services 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 continue to operate in CY 2024.

The purpose of this Monitoring RFI is to understand specific service uptake issues and solutions the MCP has implemented, or plans to implement, in order to address low uptake. DHCS schedules follow-up meetings with each MCP, as needed, to further discuss uptake issues and the approach for addressing these issues. MCPs are 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.

Over the ten full quarters of Community Supports implementation, the number of Community Supports elected by MCPs across California's 58 counties has significantly increased. Now that MCPs have had sufficient time to ramp up their processes, DHCS' primary focus is increased monitoring in addition to the following regular activities:

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

DHCS and its MCP partners are working to expand access, use and utilization of Community Supports in 2024 and beyond. This work will include:

- Refining program operations and policies to eliminate barriers to provider contracting and service use through an ECM and Community Supports "Action Plan," which includes streamlining authorizations and referral processes, expanding provider networks, and improving data exchange.
- Hosting regular listening sessions, including PATH CPI Initiative workgroups for providers and community members across the state, welcoming feedback on the implementation of Community Supports from diverse stakeholder groups.
- Expanding and utilizing a variety of methods as required in MCP contracts to identify members who may benefit from Community Supports. This also includes proactively ensuring contracted networks of providers are aware of Community Supports

services, what the eligibility criteria are, and encourage and make clear the pathway for submitting referrals to MCPs.

- Ensuring MCP public-facing websites, Member Handbooks, and Provider Directories include the most up-to-date information about Community Supports offered and how to access them.

Opportunities for Improvement and Implementation of the Action Plan

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

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

To address these concerns, DHCS has developed an ECM and Community Supports Action Plan[9] that addresses the following key areas:

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

The goal of all these efforts is to increase the availability and uptake of Community

[9] Available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Community-Supports-Action-Plan-03192024.pdf

Supports for Medi-Cal Members who need them.

Examples of activities that align to the Action Plan include:

- Promote ongoing education of staff, Community Supports providers, community partners, and provide outreach efforts. MCPs are actively working on creating robust training and educational platforms to help identify eligible members and refer them to Community Supports. DHCS maintains a resource library of all Community Supports webinars on our public website.
- Directing CBOs and Providers who may be eligible for PATH Technical Assistance, engagement through Collaborative and/or for CITED funding to those resources.
- Direct MCPs to engage members with flyers, notices, open forums, and other methods to enhance member awareness.
- From January 2022 to December 2024, the CalAIM IPP provided payments to MCPS totaling $1.5 billion, to expand capacity and infrastructure to support CalAIM implementation.
- Direct engagement with contracted Community Supports providers on ways to improve utilization of Community Supports services among members. For example, DHCS has developed guidance to streamline authorization processes for time sensitive Community Supports (i.e., medical respite) by promoting best practices for presumptive authorizations. These refinements to guidance were made based on input from providers as well as MCPs to reduce barriers to care.
- Exploring methods by which to further integrate Community Supports into the overall continuum of care for members in each county.

DHCS continues to track 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. DHCS has also created reliable provider feedback loops and conducted a Statewide Listening Tour which helped to inform much of its work over 2023 and continues to inform ongoing work in 2024.

DHCS continues to monitor data quality and has begun analyzing the differences between the plan-submitted data on the QIMRs and the Encounters/Claims to start visualizing how accurate the data received via the QIMR process is relative to Post Adjudicated Claims & Encounters Systems. The transition to JSON will further accelerate this reconciliation process and enable better overall data quality and integrity for the program.

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. The Department frequently fields requests for provider TA and provides additional guidance to both its contracted MCPs and Community Supports providers.

DHCS continues to work with MCPs and community-based organizations/providers to spread awareness of Community Supports and understand any barriers to increasing access for services. Feedback from MCPs and CBOs will continue to inform further development and enhancement of DHCS guidance, in order to further define expectations and requirements and clarify Community Supports service definitions.

Consumer Issues and Interventions

Nothing to report.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

Nothing to report.

Enclosures/Attachments

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

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

DUALLY-ELIGIBLE ENROLLEES IN MEDI-CAL MANAGED CARE

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

Members impacted by this expenditure authority will be able to change Medicaid plans by picking a new MA plan or Original Medicare once a quarter. A dually eligible members' Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. This policy is known as the Medi-Cal Matching Plan policy. For 2022 and 2023, DHCS has implemented the waiver authority provisions for this policy in twelve counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, Sacramento, San Diego, San Francisco, Santa Clara, and Stanislaus. Starting January 1, 2024, DHCS expanded the Medi-Cal matching plan policy to also apply in Kings, Madera, Orange, San Mateo, and Tulare counties, to align with changes in Medi-Medi plans described below.

In 2022, DHCS developed a webpage to provide stakeholders with more detailed information about the Medi-Cal matching plan policy. In addition, DHCS updated the member notice regarding this policy, to explain the policy more clearly, effective January 1, 2023.

In a separate but related policy, on January 1, 2023, members of the federal financial alignment initiative known as Cal MediConnect (CMC) transitioned into Exclusively Aligned Enrollment (EAE) Dual-Eligible Special Needs Plans (D-SNPs) 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, (known as Medi-Medi plans in California), members can enroll in a D-SNP for Medicare benefits and will be enrolled in an MCP for Medi-Cal benefits, both operated by the same parent organization for better care coordination and integration. For these plans, DHCS is committed to implementing integration through integrated member materials, integrated appeals and grievances, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care. For contract year 2024, beginning January 1, 2024, DHCS expanded the availability of Medi-Medi plans to five additional counties: Fresno, Kings, Madera, Sacramento, and Tulare.

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

eligible members residing in LTC facilities, including those with a SOC, were required to enroll in Medi-Cal managed care. As of 2022, most dually eligible members in COHS counties and the seven CCI counties were already enrolled in Medi-Cal managed care plans. This policy for the remaining 31 counties is intended to help meet the statewide goals of improving care integration and person-centered care for dually eligible members, under both CalAIM and the California Master Plan for Aging.

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

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

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

Performance Metrics

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

Outreach Activities

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

Operational Updates

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

identified above.

Consumer Issues and Interventions

With the mandatory Medi-Cal managed care enrollment of all dual eligible members effective January 1, 2023, several Medicare providers mistakenly thought that they could no longer get reimbursed for those patients if the provider was not enrolled in the Medi-Cal plan's network. As a result, some Medicare providers initially stopped seeing their dually eligible patients, and several dual eligible members requested an exemption to enrollment in Medi-Cal managed care, and an exemption to the Medi-Cal matching plan policy. DHCS has conducted extensive provider and member outreach for providers and members from September 2022 through the present, to address these concerns and to educate providers and members.

Quality Control/Assurance Activity

Nothing to report.

Budget Neutrality and Financial Updates

Nothing to report.

Evaluation Activities and Interim Findings

Nothing to report.