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

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August 29, 2022

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QUARTERLY PROGRESS REPORT FOR THE REPORTING PERIOD OF APRIL 1, 2022, THROUGH JUNE 30, 2022, OF CALIFORNIA'S CalAIM SECTION 1115 DEMONSTRATION (11-W-00193/9)

Dear Ms. Young:

Enclosed is the Quarterly Progress Report as required by Section 87 of Special Terms and Conditions of California's Section 1115 Waiver, titled "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) (the "Demonstration"), formally known as the "Medi-Cal 2020" Demonstration, in accordance with Section 1115(a) of the Social Security Act (the Act). This is the second quarterly progress report for Demonstration Year (DY) Eighteen, which covers the reporting period of April 1, 2022, through June 30, 2022.

If you or your staff have any questions or need additional information regarding this report, please contact Amanda Font by phone at (916) 345-8580 or by email at Amanda.Font@dhcs.ca.gov.

Sincerely,

[redacted]

Jacey Cooper
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Enclosures

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

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:

Demonstration Year: Eighteen (January 1, 2022 – December 31, 2022)

Second Quarter Reporting Period: April 1, 2022 – June 30, 2022

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INTRODUCTION

CalAIM Amendment and Renewal

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

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

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

- **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 services 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.
- **CalAIM Initiatives Newly Authorized in the CalAIM Section 1115 Demonstration:**
    - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) Waiver.
    - **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 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 beneficiaries, 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, in order to provide this service in DMC-ODS and Drug Medi-Cal counties and county mental health plans (MHPs).
- **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% of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan.
    - **Dental Transformation Initiative (DTI)** authority as outlined under the Med-Cal 2020 Section 1115 demonstration transitioned into a new,

statewide dental benefit for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

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 services 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.

DHCS continues to negotiate with CMS on a number of CalAIM Section 1115 demonstration initiatives that were requested as part of the Section 1115 renewal but are not yet approved by CMS. These key initiatives include authority to provide select Medi-Cal services to individuals involved in the justice system as well as authority to provide Traditional Healers and Natural Helper services to DMC-ODS beneficiaries and the state's request for federal funding of Designated State Health Programs (DSHPs) to support the non-federal share funding for the PATH program.

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

GENERAL REPORTING REQUIREMENTS:

STCs Item 90: Monitoring Calls
CMS and DHCS mutually agreed to hold joint monthly CalAIM 1115/1915(b) Waiver monitoring calls, and the first joint call took place in DY 18-Q2 on June 13, 2022. Discussions regarding CalAIM 1115 specific-items included: Medi-Cal 2020 DY 17 Closeout Report; DY 18-Q1 Quarterly Report; draft Evaluation Design and Budget; and draft DMC-ODS SUD Monitoring Protocol.

STCs Item 91: Post Award Forum
In DY 18-Q2, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On May 12, 2022, DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting. The purpose of the SAC and BH-SAC is for stakeholders to provide DHCS with input on ongoing implementation efforts for CalAIM and the state's Section 1115 Waiver and behavioral health activities. DHCS provided updates on: SAC/BH-SAC Member Survey Results Discussion; Medi-Cal Rx Implementation; Medi-Cal Strategy to Support Health and Opportunity for Children and Families; 1915(b) Managed Care Monitoring and Oversight including Medical Loss Ratio Stakeholder Process; Enrollment in Medi-Cal for Those Ages 50 and Older Regardless of Immigration Status; CalAIM and 1115 Waiver; and Mobile Crisis Response. Past meeting materials are available on the DHCS website: 051222BHSACMeetingMaterials (ca.gov).

During this quarter, DHCS Consumer-Focused Stakeholder Working groups (CFSW) also took place on April 1, 2022, May 6, 2022, and June 3, 2022. The meeting included discussion on a wide range of DHCS programmatic implementation updates such as the Older Adult Expansion; COVID-19 Public Health Emergency Unwinding; Asset Limits Increase; Medi-Cal Rx, COVID-19 Uninsured Group Program; and American Rescue Plan Act (ARPA) postpartum care extension. The Compact of Free Association (COFA) and Hearing Aid Coverage for Children Program (HACCP) were discussed in multiple meetings this quarter. The purpose of the CFSW was 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 3, 2022. DHCS discussed the following topics: updates on Encounter Data Trends; Vaccinations; Preventative Care Outreach Project; Asian Disparities Focused Study; Managed Care Project; Ombudsman Report; Network Certification 2020; and CalAIM. 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 and advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

The aforementioned 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 beneficiary 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 18-Q2, as required in STC 87c and STC 109 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 evaluation 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

COMMUNITY-BASED ADULT SERVICES (CBAS)

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 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 CalAIM 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 Community-Based Adult Services (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 beneficiaries 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 beneficiaries place of residence and the CBAS Center when needed.

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

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

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

The state must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[1]. 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 CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model, (available in 14 counties), Geographic Managed Care Plans (available in two counties), and the final COHS County (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to

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

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 component parts of CBAS delivered outside of centers with a similar objective of supporting participants, and allowing them to remain in the community. Unbundled services include local senior centers to engage members in social and recreational activities, coordination with home delivered meals programs, group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care, and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist participants with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL)). If the participant is residing in a Coordinated Care Initiative (CCI) County and is enrolled in managed care, the MCP will be responsible for facilitating the appropriate services on the members’ behalf.

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

However, in accordance with Executive Order N-11-22 issued June 17, 2022, and the California Department of Public Health (CDPH) All Facility Letter (AFL) 20-34.7, issued on June 30, 2022, all licensed ADHCs are required to be open and providing all basic services in the center as of September 30, 2022. CDA issued All Center Letter (ACL) 22-02 notifying all CBAS providers that CBAS TAS flexibilities in effect during the COVID-19 pandemic will end on September 30, 2022. DHCS submitted an updated 1115 Waiver Attachment K on July 8, 2022, requesting to end the TAS flexibility effective October 1, 2022, prior to the previously approved flexibility period of six-months post the end of the federal PHE. In ending the CBAS TAS flexibility, the state is not altering or reducing the eligibility criteria, available services, or rate of payment for the CBAS benefit. All services included in the CBAS TAS flexibility 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. More information about the ending of CBAS TAS and the transition to full in-center services is provided in subsequent sections of this report.

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

Performance Metrics:

CDA and DHCS internal partners are meeting and working towards the development of the performance measures identified in STC 26. In addition, per STC 27, “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.”

Enrollment and Assessment Information:

Per STC 24(a), CBAS enrollment data for both MCP and FFS participants per county is shown in Figure 1 below. The CBAS Center’s licensed capacity by county is also incorporated into the same figure.

CBAS enrollment data is self-reported quarterly by the MCPs, which sometimes results in data lags. As such, DHCS will report CBAS MCP data for DY 18-Q2 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

Figure 1: Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS

County	DY16 - Q4 Apr – Jun 2021		DY17 - Q1 July – Sept 2021		DY17 - Q2 Oct - Dec 2021		DY18 – Q1 Jan – March 2022	
	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	451	72%	454	72%	464	74%	462	74%
Butte	31	31%	28	28%	24	24%	22	22%
Contra Costa	155	42%	140	38%	134	36%	131	35%
Fresno	903	47%	856	45%	867	39%	880	40%
Humboldt	84	14%	84	14%	90	15%	96	16%
Imperial	284	47%	276	46%	270	45%	267	44%
Kern	162	16%	187	18%	171	17%	217	21%
Los Angeles	24,169	59%	25,029	61%	24,545	59%	25,048	58%
Merced	120	57%	125	60%	111	53%	113	54%
Monterey	101	54%	112	60%	100	54%	77	41%
Orange	2,503	55%	2,545	56%	2,672	61%	2,748	62%
Riverside	534	34%	526	33%	523	30%	513	30%
Sacramento	512	44%	498	43%	525	46%	508	44%
San Bernardino	668	67%	663	66%	690	69%	734	73%
San Diego	2,619	81%	2,006	66%	1,842	57%	1,869	58%
San Francisco	901	57%	857	55%	841	54%	854	54%
San Joaquin	56	24%	38	16%	25	11%	36	15%
San Mateo	63	62%	68	67%	68	67%	67	66%
Santa Barbara	*	*	*	*	*	*	8	5%
Santa Clara	628	48%	607	46%	585	44%	1,001	72%
Santa Cruz	79	52%	75	49%	75	49%	98	64%
Shasta	*	*	*	*	*	*	1	1%
Stanislaus	*	*	*	*	*	*	8	1%
Ventura	924	62%	921	61%	819	55%	809	54%
Yolo	245	65%	241	64%	235	62%	232	61%
Marin, Napa, Solano	70	14%	83	17%	79	16%	82	16%
Total	**36,319**	**57%**	**36,432**	**57%**	**35,766**	**55%**	**36,881**	**55%**
								FFS and MCP Enrollment Data 03/2022

***Note: Information is not available for DY 18-Q2 due to a delay in the availability of data and will be presented in the next quarterly report.*

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

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

The data provided in the previous figure demonstrates a relatively consistent increase in enrollment for the previous 12 months, with the exception being DY 17-Q2. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Monterey, Santa Clara, and Santa Cruz County experienced an increased capacity utilization from DY 17-Q2 to DY 18-Q1 of greater than five percent. The increase in percentages of utilization are all within normal fluctuations, except for Santa Clara where DHCS believes there may be an error in data reporting and have initiated a follow-up to address the potential error. The next report will address Santa Clara's data reporting in greater detail.

A majority of counties maintained consistent enrollment and capacity utilization that did not experience fluctuations greater than five percent. Stanislaus County has been added to the figure above as there is a new center that opened in the county. No counties experienced a greater than five percent negative change related to capacity utilization during DY 18-Q1.

Overall, the capacity utilization remained static at 55 percent statewide as many counties throughout California demonstrated consistent enrollment in unduplicated participants throughout the previous 12 months, with a slight dip in participants in DY 17-Q2. DHCS will report CBAS Enrollment data for DY 18-Q2 in the next quarterly report.

Assessments for MCPs and FFS Participants

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

Figure 2 on the next page lists the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the figure is reported by DHCS.

Figure 2: CBAS Assessments Data for MCPs and FFS

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY17-Q1 (Jul-Sept 2021)	2,534	2,481 (97.9%)	53 (2.1%)	1	1 (100%)	0 (0%)
DY17-Q2 (Oct-Dec 2021)	2,779	2,688 (96.7%)	91 (3.3%)	0	0 (0%)	0 (0%)
DY18-Q1 (Jan-Mar 2022)	2,760	2,680 (97.1%)	80 (2.9%)	0	0 (0%)	0 (0%)
DY18-Q2 (Apr-Jun 2022)	*	*	*	5	4 (80%)	1 (20%)
5% Negative change between last Quarter		No	No		No	No

*Note: *MCP assessment information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous figure, for DY 18-Q1, 2,760 assessments were completed by the MCPs, of which 2,680 were determined to be eligible, and 80 were determined to be ineligible. For DHCS, five assessments were performed for CBAS benefits under FFS. As indicated in the previous figure, the number of CBAS FFS participants have maintained its decline due to the transition of CBAS into managed care, although there are occasional requests for CBAS FFS. DHCS will report CBAS MCP Assessment data for DY 18-Q2 in the next quarterly report.

CBAS Provider-Reported Data (STC 24.b)

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases licensed and enrollment capacity while conversely new CBAS Center openings increase licensed and enrollment capacity. CDPH licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Figure 3 identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY 18-Q1. As of DY 18-Q1, the number of counties with CBAS Centers and the ADA of each center are listed below in Figure 3. On average, the ADA at the 276 operating CBAS Centers is approximately 34,802 participants, which corresponds to 87.4 percent of total capacity. Provider-reported data identified in the figure below, reflects data through March 2022.

Figure 3: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	28
Total CA Counties	58
Number of CBAS Centers	276
Non-Profit Centers	48
For-Profit Centers	228
ADA @ 276 Centers	34,802
Total Licensed Capacity	39,813
Statewide ADA per Center	87.4%
CDA - MSSR Data 03/2022	

*Note: *CDA CBAS Provider Self-Reported information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Outreach Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, managed care plans (MCPs), the California Association for Adult Day Services (CAADS), the Alliance for Education and Leadership (ALE), and other interested stakeholders via multiple communication strategies such as the *CBAS Updates* newsletter, CBAS All Center Letters (ACLs), CBAS News Alerts, CBAS webinars, CAADS conferences, CAADS/ALE/CDA webinar presentations, CAADS/ALE Vision Team Meetings (includes CBAS providers), CAADS/ALE MCP meetings, CDA triannual meetings with MCPs that contract with CBAS Centers, and CDA triannual meetings with the CBAS Quality Advisory Committee. In addition, CDA responds to ongoing written and telephone inquiries from CBAS providers, MCPs and other interested stakeholders.

The following are CDA's outreach activities during DY 18-Q2: CBAS ACLs (2); CBAS News Alerts (10); CBAS Updates Webinars (one); CAADS/ALE Vision Team meetings (10); CDA MCP meetings (two); CAADS/ALE MCP meetings (three); CAADS/ALE/CDA webinar (one); CBAS Quality Advisory Committee meetings (one), and Responses to CBAS Mailbox Inquiries (143).

These outreach and educational/training activities focus on various topics including but not limited to the following: (1) CBAS program operations and public health guidance during the COVID-19 pandemic and PHE, (2) CBAS TAS, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) CBAS planning activities and policy guidance to support CBAS providers and participants for a safe transition to CBAS in-center congregate services according to public health guidance in

preparation for when CBAS TAS end, (4) CBAS reporting requirements such as the Monthly Statistical Summary Report (MSSR) and Participant Characteristics Report (PCR) to ensure accurate and timely reporting, (5) Education and training opportunities to promote quality of care and to comply with CBAS program requirements and public health guidance, (6) Guidance on ordering Personal Protective Equipment (PPE) and COVID-19 testing supplies to support CBAS provider compliance with public health guidance and state testing requirements, and (7) Policy guidance and reporting requirements including Electronic Visit Verification (EVV) for the implementation of CBAS ERS as of October 1, 2022.

CBAS Updates Webinars

This quarter, CDA presented one webinar on June 23, 2022, to provide updates on the following: (1) CDPH public health guidance for ADHC facilities, (2) CDA ACL policy directives and existing flexibilities for remote services as needed by participants through September 30, 2022 such as transitioning participants to in-center services if they choose and are able, and identifying and informing CDA which participants will not return to in-center attendance by September 30, 2022, when CBAS TAS ends, (3) Pending CDPH AFL notifying ADHC licensees of the September 30, 2022, end date of specified ADHC regulatory licensing flexibilities in effect during the COVID-19 pandemic, requiring all CBAS providers to be staffed and providing basic services in their centers effective July 1, 2022, per specified licensing requirements, and (4) CBAS ERS policy development and reporting requirements for implementation as of October 1, 2022. All CBAS Updates webinar recordings and slides are posted on the CDA website.

In addition, CDA participated in a CAADS/ALE webinar on May 24, 2022, to provide updates on the status of CDPH licensing flexibilities, CBAS TAS flexibilities, Emergency Services, and updated CDPH public health guidance impacting ADHC/CBAS Centers.

CAADS/ALE Vision Team Meetings

CDA continues to collaborate weekly with the CAADS/ALE Vision Team (which includes CBAS providers) in the development of policy guidance and the planning of webinars provided by CDA and CAADS for CBAS providers to which MCPs and other interested stakeholders are invited. These webinars have focused on CBAS Center best practices in the implementation of CBAS TAS requirements, strategies to transition CBAS participants to full in-center services in preparation for when CBAS licensing and TAS flexibilities end on September 30, 2022, public health practices/requirements to mitigate the risks of COVID-19 infection, policy guidance to implement ERS on October 1, 2022, and other issues that affect the health and wellbeing of CBAS participants, their families, and CBAS staff. During this past quarter, CBAS providers have discussed the impact of an increase in participant and staff COVID-19 infections which has resulted in the pausing of in-center services to limit the spread of infection and the inability to comply with staffing requirements for the provision of in-center services. During the

pausing of in-center services, CBAS providers have been providing remote services.

MCP Meetings

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

During this quarter, CDA convened two meetings: (1) April 7, 2022, to review initial certifications/new center applications, the transition of participants to full in-center services in preparation for the end of TAS flexibilities, and the implementation of ERS on October 1, 2022, and (2) April 18, 2022, to facilitate an in-depth discussion of the ERS policy draft and the CBAS ERS Initiation Form (CEIF) to be completed by CBAS providers and submitted to MCPs for approval when an emergency occurs. The next meeting with MCPs convened by CDA will be in September 2022.

In addition, CDA participated in three meetings with MCPs on April 6, 2022, May 4, 2022, and June 1, 2022, convened by CAADS and ALE for collaborative discussions about the transitioning of CBAS participants to full in-center services in preparation for when state ADHC licensing flexibilities and TAS flexibilities end, and to provide updates on planning for the implementation of ERS. CAADS and ALE convene ongoing monthly meetings with MCPs in which CDA participates.

CBAS Quality Strategy Advisory Committee Meetings

CDA convenes triannual meetings with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, MCPs, DHCS staff, and representatives from CAADS and ALE to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. During this quarter, CDA convened a meeting with the CBAS Quality Advisory Committee on April 28, 2022. Additional details about the CBAS Quality and Improvement Strategy and the CBAS Quality Advisory Committee are provided in the “Quality Control/Assurance Activity” section of this report.

CBAS Mailbox Inquiries

During this quarter, CDA responded to 143 CBAS mailbox inquiries which included questions about CBAS program operations during TAS, public health guidance including testing, vaccinations/boosters, masking, and six-foot distancing requirements; provision of CBAS TAS and staffing requirements; staffing shortages; transition to full in-center operations; the end of CBAS remote services; and CDA reporting requirements.

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

CDA, in collaboration with DHCS, continues to implement the activities and commitments to CMS for compliance of CBAS Centers with the federal Home and Community-Based (HCB) settings requirements by March 17, 2023, and thereafter on an ongoing basis. CDA determines CBAS Center compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS' directive in the CBAS sections of the 1115 Waiver, CDA developed the CBAS HCB Settings Transition Plan which is an attachment to California's Statewide Transition Plan (STP*)*. On February 23, 2018, CMS granted initial approval of California's STP and the CBAS Transition Plan based on the state's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions of the STP and CBAS Transition Plan before granting final approval.

California is tentatively planning to submit the STP to CMS for final approval in September or October 2022 after a preliminary review by CMS prior to posting for public comment. The state continues to implement the activities and commitments identified in the *Milestones and Timelines* in the STP and CBAS Transition Plan to comply with the federal HCB Settings requirements. CDA continues to evaluate each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Due to the COVID-19 pandemic and implementation of CBAS TAS requirements, CDA continued to conduct telephonic certification/recertification surveys during DY 18-Q2 instead of onsite surveys which includes determining compliance with the federal Home and Community-Based (HCB) Settings requirements. All existing CBAS compliance determination processes for the HCB Settings requirements are continuing during the provision of CBAS TAS, including the completion and validation of CBAS Provider Self-Assessment (PSA) and CBAS participant surveys via telephonic/virtual methods that comply with public health guidance.

Operational Updates:

COVID-19 Pandemic and Public Health Emergency

In response to the COVID-19 pandemic and subsequent PHE declaration, DHCS and CDA developed a new CBAS service delivery model, known as TAS, beginning in March 2020. Under this model, CBAS Centers provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants. To authorize this CBAS TAS model, DHCS requested flexibility under a section 1135 Waiver on March 19, 2020, and a Section 1115 Waiver on April 3, 2020. On October 9, 2020, CMS sent a letter to DHCS approving CBAS program modifications effective from March 13, 2020, through March 12, 2021 and on June 9, 2021, CMS approved California's request to extend the duration of the previously approved Emergency

Preparedness and Response Attachment K, which is an attachment to California's section 1115(a) demonstration titled, "Medi-Cal 2020" (Project No. 11-W-00193/9), to respond to the COVID-19 PHE. The Attachment K flexibilities are effective, and available to be applied by the state, from March 13, 2021, through six months after the PHE ends.

CDA continues to require CBAS providers to staff their centers with the full CBAS multidisciplinary team, conduct participant evaluations and assessments to determine a participant's willingness and ability to return to in-center congregate services, and to develop an IPCs every six months (or more frequently if the participant's needs/conditions change) that are person-centered, address participants' needs via remote and/or in-center services, and support the transition to in-center services based on conditions in their individual communities and their centers while adhering to public health guidance and risk mitigation requirements.

As a result of the fluctuations in COVID-19 infections and hospitalizations in the state, the Governor issued multiple Executive Orders between February 8, 2022, and June 30, 2022, which resulted in the CDPH issuing All Facility Letters (AFLs) extending the temporary waiver of specified regulatory ADHC licensing requirements as follows: (1) AFL 20-34.5 (issued February 8, 2022) extended ADHC licensing flexibilities to March 31, 2022, (2) AFL 20-34.6 (issued March 16, 2022) extended ADHC licensing flexibilities to June 30, 2022, and (3) AFL 20-34.7 (issued June 30, 2022) extended ADHC licensing flexibilities to September 30, 2022.

These are some of the challenges and uncertainties that CDA in collaboration with providers, their staff, participants/families, and MCPs have been navigating while preparing for the end of ADHC licensing flexibilities and the unwinding of CBAS TAS. The planned ending of ADHC licensing flexibilities on September 30, 2022, requiring the return of participants to full in-center services by October 1, 2022, may result in the discharge of some participants who may not feel ready to return to full in-center services. The anticipated number of discharges is unknown at this time. CDA has requested CBAS providers submit a Discharge Projections Report to CDA to begin the process of identifying participants who will not be returning to in-center services by October 1, 2022. This projected discharge information will be shared with CBAS participants' MCPs. Between now and October 1, 2022, many decisions will need to be made by providers and participants in collaboration with MCPs. CDA will continue to issue policy guidance and provide CBAS webinars to assist providers and participants with these decisions.

Consumer Issues and Interventions:

<u>CBAS Beneficiary/Provider Call Center Complaints (FFS/MCP) (STC24.e.iv)</u>
DHCS continues to respond to issues and questions from CBAS participants, CBAS

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

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Managed Care Plan Partner. See below Figures 4 and 5 for complaint data received by CDA and MCPs from CBAS beneficiaries and providers. DHCS will report CBAS MCP complaint data for DY 18-Q2 in the next quarterly report.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q4 (Apr - Jun 2021)	0	0	0
DY17-Q1 (Jul - Sep 2021)	0	0	0
DY17-Q2 (Oct – Dec 2021)	0	0	0
DY18-Q1 (Jan – Mar 2022)	0	0	0
CDA Data – Complaints 12/2021			

Note: CDA information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.

For complaints received by MCPs, Figure 5 illustrates there were 18 beneficiary complaints and one provider complaint submitted between DY 16-Q4 and DY 18-Q1. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports. DHCS will report CBAS MCP data for DY 18-Q2 in the next quarterly report.

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY16-Q4 (Apr - Jun 2021)	9	1	10
DY17-Q1 (Jul - Sept 2021)	0	0	0
Demonstration Year and Quarter	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**
DY17-Q2 (Oct – Dec 2021)	0	0	0
DY18-Q1 (Jan - Mar 2022)	9	0	9
			Phone Data – Phone Center Complaints 03/2022

*Note: *MCP assessment information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.*

CBAS Grievances/Appeals (FFS/MCP) (STC 24.e.iii)

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Figure 6 on the next page a total of ten grievances were filed with MCPs during DY18-Q1. Two of the grievances were solely regarding CBAS providers. One grievance was related to contractor assessment or reassessment. One grievance was related to excessive travel time to access CBAS services. Six grievances were designated as “other”. Overall, total grievances decreased by one from the prior quarter. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports. DHCS will report CBAS MCP grievance data for DY 18-Q2 in the next quarterly report.

Figure 6: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY16-Q4 (Apr - Jun 2021)	6	0	0	4	10
DY17-Q1 (Jul - Sept 2021)	6	0	0	4	10
DY17-Q2 (Oct – Dec 2021)	6	0	0	5	11
DY18-Q1 (Jan – Mar 2022)	2	1	1	6	10
MCP Data - Grievances 03/2022					

Note: CDA assessment information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.

Figure 7: 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
DY16 – Q4 (Apr – Jun 2021)	3	1	0	1	5
DY17 – Q1 (Jul – Sept 2021)	2	0	0	0	2
DY17 – Q2 (Oct – Dec 2021)	3	0	1	0	4
DY18 – Q1 (Jan – Mar 2022)	1	0	0	0	1
		MCP Data - Grievances 03/2022			

Note: MCP appeals information is not available for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.

During DY18-Q1, Figure 7 shows there was one CBAS appeal filed with a MCP. The figure illustrates the appeal was related to “denial of services or limited services”. DHCS

will report CBAS MCP appeals data for DY18-Q2 in the next quarterly report.

The California Department of Social Services (CDSS) continues to facilitate the State fair hearings/appeals processes, with Administrative Law Judges hearing all cases filed. CDSS reports the fair hearings/appeals data to DHCS. For DY 18-Q2, there were no requests for hearings related to CBAS services which are pending.

Quality Control/Assurance Activity:

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. The Quality Strategy has two overarching goals: 1) to assure CBAS provider compliance with program requirements through improved state oversight, monitoring, and transparency activities, and 2) to improve service delivery by promoting CBAS best practices, including person-centered and evidence-based care, which continue to guide CBAS program planning and operations.

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

CDA continues to convene triannual meetings with the CBAS Quality Strategy Advisory Committee. During the January 20, 2022 meeting, the CBAS Quality Advisory Committee recommended collecting and posting the following additional information on CDA's website: 1) CBAS participant characteristic data from the CBAS IPC to improve our understanding, such as who is receiving CBAS services, the complexity of their needs, and what IPC data would best identify this complexity; 2) CBAS center characteristic information to help individuals/families and MCPs find centers to meet beneficiaries' needs; and 3) demographic data that can be used to evaluate equity, access and inclusion.

During the April 18, 2022 meeting, the CBAS Quality Advisory Committee continued the discussion about the collection of participant characteristic data from the IPC including diagnoses. CDA will convene a separate work group on July 22, 2022, with members of the Quality Advisory Committee to discuss what diagnoses should be collected in addition to the ones currently collected that may correlate with a greater risk of hospitalization/adverse events.

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under CalAIM. Figure 8 indicates the number of each county's licensed capacity since the CBAS program was approved as a waiver benefit in April 2012. The figure below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 16-Q4 through DY 18-Q1.

Figure 8: CBAS Centers Licensed Capacity

County	CBAS Centers Licensed Capacity					
	DY16-Q4 Apr-Jun 2021	DY17-Q1 Jul-Sept 2021	DY17-Q2 Oct-Dec 2021	DY18-Q1 Jan-Mar 2022	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	**370**	0.0%	74%
Butte	60	60	60	**60**	0.0%	22%
Contra Costa	220	220	220	**220**	0.0%	35%
Fresno	1,132	1,132	1,297	**1,297**	0.0%	40%
Humboldt	349	349	349	**349**	0.0%	16%
Imperial	355	355	355	**355**	0.0%	44%
Kern	610	610	610	**610**	0.0%	21%
Los Angeles	24,211	24,371	24,371	**25,531**	**+4.7%**	58%
Merced	124	124	124	**124**	0.0%	54%
Monterey	110	110	110	**110**	0.0%	41%
Orange	2,678	2,678	2,603	**2,603**	0.0%	62%
Riverside	935	935	1025	**1,025**	0.0%	30%
Sacramento	680	680	680	**680**	0.0%	44%
San Bernardino	590	590	590	**590**	0.0%	73%
San Diego	1,903	1,903	1,903	**1,903**	0.0%	58%
San Francisco	926	926	926	**926**	0.0%	54%
San Joaquin	140	140	140	**140**	0.0%	15%
San Mateo	60	60	60	**60**	0.0%	66%
Santa Barbara	100	100	100	**100**	0.0%	5%
Santa Clara	780	780	780	**820**	**+5.1%**	72%
Santa Cruz	90	90	90	**90**	0.0%	64%
Shasta	85	85	85	**85**	0.0%	1%

County	DY16-Q4 Apr-Jun 2021	DY17-Q1 Jul-Sept 2021	DY17-Q2 Oct-Dec 2021	DY18-Q1 Jan-Mar 2022	Percent Change Between Last Two Quarters	Capacity Used ***
Stanislaus				**360**	**+360.0%**	1%
Ventura	886	886	886	**886**	0.0%	54%
Yolo	224	224	224	**224**	0.0%	61%
Marin, Napa, Solano	295	295	295	**295**	0.0%	16%
SUM	**37,913**	**38,073**	**38,253**	**39,813**	**+.4%**	55%

***Capacity used information is not available for DY 18-Q2 due to the delay in the availability of the data.*

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

Figure 8 reflects that the average licensed capacity used by CBAS participants is 55 percent statewide. Overall, most CBAS Centers have not operated at full or near-to-full capacity with the exception of Alameda, Santa Clara and San Bernardino. These counties operated between 72 and 74 percent capacity. Licensing capacity allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 24(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter-to-quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. There were no negative changes greater than five percent during DY 18-Q1. Los Angeles County experienced five centers opening, as well as a new center opening in Stanislaus County, which previously did not have a CBAS Center. Santa Clara County experienced a slight increase in capacity due to fluctuations in capacity.

No other significant increases or decreases were noted over the last quarter. In 2021, the total licensed capacity increased slightly and steadily statewide. DHCS will report CBAS licensing capacity data for DY 18-Q2 in the next quarterly report.

Access Monitoring (STC 24.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Figure 1, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. Data for DY 18-Q2 is not reflected in those figures due to a lack of availability but will be presented in the next quarterly report.

Unbundled Services (STC19.b.iii.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review and monitor any possible impact on participants due to CBAS Center closures. For counties that do not have a CBAS Center, the MCPs will work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA 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 are able to choose an alternate CBAS Center within their local area. Three beneficiaries received CBAS services unbundled in DY 18-Q1.

CBAS Center Utilization (Newly Opened/Closed Centers)

DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 18-Q2, CDA had 276 CBAS Center providers operating in California. According to Figure 9, no CBAS Centers closed and six centers opened in DY 18-Q1. DY 18-Q2 will be presented in the next quarterly report due to a delay in the availability of the data.

Figure 9: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
March 2022	274	0	2	2	276
February 2022	272	0	2	2	274
January 2022	270	0	2	2	272
December 2021	270	0	0	0	270
November 2021	270	0	0	0	270
October 2021	270	1	1	0	270
September 2021	270	0	0	0	270
August 2021	270	0	0	0	270
July 2021	269	0	1	1	270

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
June 2021	269	0	0	0	269
May 2021	269	1	1	0	269
April 2021	269	2	2	0	269

*Note: *CDA assessment information is not reported for DY 18-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Figure 9 shows there was no negative change of more than five percent in DY 18-Q1, so no analysis is needed to address such variances.

Budget Neutrality and Financial Updates:

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

The CalAIM Section 1115 Demonstration Waiver, approved by CMS on December 29, 2021, will have no effect on budget neutrality as it is currently a pass-through, meaning that the cost of CBAS remains the same with the waiver as it would be without the waiver. As such, the program cannot quantify savings and the extension of the program will have no effect on overall waiver budget neutrality.

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

The DMC-ODS is a program for the organized delivery of SUD services to Medi-Cal-eligible individuals with SUD that reside in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS beneficiaries). 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 beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan.

Originally authorized by the Medi-Cal 2020 demonstration, most of the components of DMC-ODS are authorized under California's Section 1115 CalAIM Demonstration approved through December 31, 2026 (for expenditure authority for services provided to DMC-ODS beneficiaries receiving short-term SUD treatment in Institutions for Mental Diseases (IMD); for expenditure authority for contingency management), California's Section 1915(b) CalAIM Waiver (for service delivery within a regional managed care environment), and California's Medicaid State Plan (for benefits coverage), as of January 1, 2022. This CalAIM demonstration will continue to provide the state with authority to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS beneficiaries who are short-term residents in residential and inpatient treatment settings that qualify as an IMD. Critical elements of the DMC-ODS Program continue to include providing a continuum of care, patient assessment, and placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria.

In fall 2022, DHCS will implement a new contingency management (CM) benefit for eligible DMC-ODS beneficiaries with a SUD in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilots will allow California to evaluate and assess the effectiveness of a CM benefit before determining whether it should be available statewide. Under the pilot, the CM benefit will be available in participating DMC-ODS counties that opt and are approved by DHCS to provide this benefit, to qualified beneficiaries who meet the eligibility requirements described below and receive services from a non-residential DMC-ODS provider.

Contingency Management Updates:

In DY 18-Q2, DHCS completed the application process for DMC-ODS counties choosing to opt into the CM pilot. CM will initially be offered in 24 counties comprising over 120 treatment provider sites and agencies.

In January 2022, DHCS released a draft policy design in partnership with nationally recognized experts from the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs and key stakeholders. This document incorporates the

thoughtful feedback received from stakeholders on aspects of the program design. This policy design document was revised in March 2022. Upon receiving stakeholder input, DHCS has begun efforts to formalize policy guidance which should be completed in the second half of 2022.

The CM training and technical assistance opportunities for participating counties and providers launched on March 23, 2022. In May 2022, DHCS provided participating counties with startup funding to assist in hiring essential staff and establishing CM program infrastructure. In addition, DHCS started providing participating counties and treatment providers with comprehensive trainings and ongoing technical assistance.

The pilot was originally scheduled to begin July 1, 2022; however, due to unforeseen circumstances involving the Department's procurement process, the Department's implementation of CM has been delayed to the fall of 2022.

Performance Metrics:

Prior quarters have been updated based on new claims data. For DY 18-Q1 and DY 18-Q2, only partial data is available at this time since counties have up to six months to submit claims after the month of service.

Figure 10: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY18-Q1	7,755	2,280	10,035
DY18-Q2	4,501	1,659	6,160

**Affordable Care Act*

Figure 11: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	11,417	11,477	11,533	DY18-Q1	11,920
	6,330	6,303	6,293	DY18-Q2	6,528
Non-ACA	4,494	4,470	4,411	DY18-Q1	5,060
	2,221	2,223	2,210	DY18-Q2	2,505

Figure 12: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY18-Q1					
ACA	337,424	$ 46,982,232.45	$ 41,753,024.43	$ 4,533,675.56	$ 695,532.46
Non-ACA	118,168	$ 15,388,576.66	$ 8,649,297.24	$ 5,404,547.92	$ 1,334,731.50
DY18-Q2					
ACA	130,793	$ 19,945,219.99	$ 17,624,843.05	$ 2,039,987.74	$ 280,389.20
Non-ACA	46,933	$ 6,801,248.84	$ 3,821,516.85	$ 2,371,580.27	$ 608,151.72

The performance metrics included (above) consist of preliminary data: Counties have six months to submit claims, which can lead to lower reported numbers when data is pulled prior to the claiming deadline. Accurate enrollment numbers are updated and provided in subsequent quarterly report cycles.

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 and reports.
- DHCS hosted All County Behavioral Health monthly meetings with counties and stakeholders to address various upcoming and published Behavioral Health Informational Notices. Additional assistance and guidance is provided during these meetings.
- DHCS issues weekly Behavioral Health Stakeholder Updates and Information Notices communication via email to stakeholders. The information provided includes announcements of finalized and draft Behavioral Health Information Notices (BHINs), and upcoming webinars.

Recent activities including CalAIM Demonstration guidance are listed below:

- April 20, 2022 – All County Behavioral Health Monthly Meeting
- May 26, 2022 – CalAIM BH Documentation Requirements Informational Webinar
- June 5, 2022 – All County Behavioral Health Monthly Meeting

Operational Updates:

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, implementation of standardized statewide screening and transition tools, behavioral health payment reform, streamlining and standardizing clinical documentation requirements, and documentation reform. DMC-ODS counties are utilizing policy guidance that were released from December

2021 through June 2022 related to these items to update and implement policies and procedures.

In addition, DMC-ODS counties continue to experience the challenges of acquiring and retaining behavioral health workforce. DHCS continues to work closely with DMC-ODS counties by providing technical assistance and monitoring to ensure compliance and implementation of new requirements.

Consumer Issues and Interventions:

In the current quarter, no beneficiary issues, complaints, or grievances related to the CalAIM Demonstration have been reported by DMC-ODS counties that are delivering DMC-ODS services.

Quality Control/Assurance Activity:

On June 3, 2022, DHCS imposed a Corrective Action Plan (CAP) on Sacramento County after Sacramento County Behavioral Health Services notified DHCS that it has a waitlist, of adult beneficiaries, to receive residential SUD treatment, including residential SUD withdrawal management services. The CAP requires Sacramento County to make specified improvements to its DMC-ODS, with associated deadlines, to address the identified deficiencies and to provide detailed reports to DHCS. The improvements include: rapidly expanding its network of residential treatment and withdrawal management providers; conducting outreach to connect beneficiaries waiting for residential treatment services with other medically necessary SUD services; and executing out-of-network contracts with providers of residential SUD services for beneficiaries on the waitlist. DHCS is holding weekly meetings with Sacramento County to provide oversight and technical assistance to address the progress of the CAP. In addition, DHCS receives weekly and monthly reports from Sacramento County, which include status updates for each beneficiary on the waitlist, including the DMC-ODS services they are currently receiving, evidence that they are providing the required Notice of Adverse Benefit Determination (NOABD) to impacted beneficiaries, and the steps the county is taking to eliminate the waitlist and ensure compliance in the future.

DHCS conducts annual monitoring reviews of counties participating in the DMC-ODS. The below reviews occurred April through June 2022.

Figure 13: DY 18-Q2 Monitoring Reviews

County	Dates
Los Angeles	04/19/2022
Nevada	04/05/2022

County	Dates
Orange	04/19/2022
Riverside	04/21/2022
Sacramento	04/20/2022
San Bernardino	04/12/2022
San Luis Obispo	04/11/2022
Ventura	04/13/2022
Alameda	05/24/2022
El Dorado	05/04/2022
Monterey	05/12/2022
Fresno	06/15/2022
Humboldt	06/06/2022
Kern	06/07/2022
Lassen	06/06/2022
Mendocino	06/06/2022
Modoc	06/06/2022
Santa Barbara	06/14/2022
Santa Cruz	06/07/2022
Shasta	06/06/2022
Siskiyou	06/06/2022
Solano	06/06/2022
Tulare	06/02/2022
Yolo	06/29/2022

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Within this reporting period, the independent evaluator for the DMC-ODS program (UCLA) created two evaluation designs for DHCS and CMS review – one for the DMC-ODS program with CMS guidance regarding section 1115 demonstration evaluation design requirements and one for the contingency management pilot specifically (Recovery Incentives). DHCS provided feedback from multiple reviewers, and UCLA addressed all suggestions and comments on the following dates:

Recovery Incentives Evaluation Design
April 18, 2022 – Submitted draft to DHCS

April 29, 2022 – Revised following DHCS review
May 20, 2022 – Revised following DHCS review
June 7, 2022 – Revised following DHCS review
June 27, 2022 – Submitted to CMS

DMC-ODS Evaluation Design
May 31, 2022 – Submitted draft to DHCS
June 10, 2022 – Revised following DHCS review
June 27, 2022 – Submitted to CMS

UCLA has begun planning data collection strategies to address the hypothesis and research questions posed in both Evaluation designs. These include county administrator surveys, provider surveys, as well as provider and consumer interviews. At this time, UCLA is working with DHCS to complete a contract amendment that will guide continued data collection efforts and deliverables.

UCLA also continued efforts to finalize and make publicly available the ASAM Criteria Assessment Interview Guide, found here. In collaboration with ASAM, the Interview Guide was released in February 2022, after which UCLA began to prepare dissemination instructions (via recorded webinar) to assist counties to use this paper-based guide. UCLA presented the Interview Guide and instructions at a California County Behavioral Health Directors Association meeting on July 14, 2022 in Sacramento.

GLOBAL PAYMENT PROGRAM (GPP)

The GPP assists public health care systems (PHCS) that provide health care for the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support 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 will incorporate services that are otherwise available to the state's Medi-Cal beneficiaries 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 will add services that aim to address health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries.

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:

The Health Equity Monitoring Metrics Protocol is being developed by the state and CMS. After the Protocol is developed and finalized, California will report performance metrics.

Outreach Activities:

Nothing to report.

Operational Updates:

The Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA-increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the PHE. During DY 18-Q2, the Secretary of Health and Human Services extended the COVID-19 PHE effective April 12, 2022. National public health emergencies are effective for 90 days unless extended or terminated.

On April 22, 2022, CMS authorized a 24 percent reduction of GPP system thresholds for GPP PY 7, calendar year 2021. The threshold reduction provides some relief to GPP Hospitals that were impacted by low service utilization in 2021.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Figure 14: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 3 Final DSH (Round 6)	($3,202,665.00)	($3,202,665.00)	DY 13	($6,405,330.00)
PY 7 (formerly 6B)-Q4	$246,184,193.93	$191,865,937.20	DY 17	$438,050,167.13
PY 7 (formerly 6B)-Q4B (Threshold Reduction Payment)	$238,241,892.40	$185,676,065.60	DY 17	$423,917,958.00
PY 8 (formerly 7)-Q1 (January 1, 2022 – March 31, 2022)	$368,091,161.24	$286,875,317.84	DY 18	$654,966,479.08
Total	**$849,314,582.57**	**$661,214,655.64**		**$1,510,529,274.21**

DY 18-Q2 GPP reporting activity includes recoupments for PY 3 Final DSH (Round 6), which occurred in April 2022. Activity also included payments made in April and May, 2022. Payments made in this time period were for PY 7 (formerly 6B)-Q4, PY 7 (formerly 6B)-Q4B (Threshold Reduction Payment), and PY 8 (formerly 7)-Q1.

In the PY 3 Final DSH (Round 6), GPP recouped $6,405,330.00 in federal-funded and Intergovernmental Transfers (IGT).

In the GPP PY 7 (formerly 6B)-Q4, the PHCS received $246,184,193.93 in federal-funded payments and $191,865,937.20 in IGT-funded payments.

In the GPP PY 7 (formerly 6B)-Q4B (Threshold Reduction Payment), the PHCS received $238,241,892.40 in federal-funded payments and $185,676,065.60 in IGT-funded payments.

In the GPP PY 8 (formerly 7)-Q1, the PHCS received $368,091,161.24 in federal-funded payments and $286,875,317.84 in IGT-funded payments.

Evaluation Activities and Interim Findings:

Nothing to report.

PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH) SUPPORTS

California's Section 1115 Waiver renewal includes expenditure authority for the “Providing Access and Transforming Health" (PATH) initiative to maintain, build, and scale services, capacity, and infrastructure necessary to ensure successful implementation of the CalAIM initiative. PATH funding aims to support community level service delivery networks by ensuring access to health care services and improving health outcomes, with particular attention to communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors. PATH funding is available for various entities such as providers, counties, former WPC Lead Entities (LEs), community-based organizations, tribes, and others.

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 justice involved initiatives in 2023, and
- Support for Implementation of ECM and Community Supports (previously known as In Lieu of Services (ILOS)), which are vital elements of CalAIM on the community level, and support for the expansion of access to services that will enable the transition from Medi-Cal 2020 to CalAIM.

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

1. WPC Services and Transition to Managed Care Mitigation Initiative – 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 MCPs under CalAIM on or before January 1, 2024.
2. Technical Assistance (TA) Initiative – PATH funding is available for the provision of TA for qualified applicants that intend to provide ECM and/or Community Supports. DHCS will engage a Third-Party Administrator (TPA) to launch and administer the TA Marketplace.
3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH TPA to establish collaborative planning and implementation efforts that support the CalAIM launch.
4. Capacity and Infrastructure Transition, Expansion and Development Initiative (CITED) – PATH funding will enable transition, expansion and development of ECM and Community Supports capacity and infrastructure. The TPA will administer and facilitate this initiative.

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

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

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

PATH Initiatives	2022				2023				2024				2025				2026			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
WPC Services and Transition																				
TA Initiative																				
Collaborative Planning and Implementation																				
CITED																				
JI Planning and Capacity Building																				

Performance Metrics:

During this quarter, DHCS approved ten registration forms out of the initial twelve counties eligible for PATH WPC Services and Transition and Mitigation funds. Two of the former WPC LEs that were eligible to apply for PATH funding under this initiative declined to apply. DHCS released invoice and utilization templates to all approved applicants and expects to receive utilization data back by DY 18-Q3. The first payment for this initiative will be processed by DY 18-Q4.

DHCS has released Round One of the JI Planning and Capacity Building application in June 2022. DHCS continues to review submissions for approval as the application period ends July 31, 2022. The Round One total application received, reviewed, and awarded funding amount will be reported in DY 18-Q3.

TPA Procurement Activity:

During this quarter, DHCS released the Invitation for Proposals (IFP) to solicit proposals from firms to serve as the PATH TPA to administer the different initiatives under PATH. DHCS received two formal proposals and conducted evaluations and interviews with both candidate organizations. After extensive reviews, follow-up questions, and negotiations, DHCS awarded the contract to PCG and the contract is fully executed as of July 1, 2022. PCG will serve as the TPA to administer, market, facilitate, develop support tools, and implement the following PATH initiatives:

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

The TPA will also serve as an intermediary between PATH funding recipients and DHCS.

DHCS has begun the TPA onboarding process for DY 18-Q3 to assist in the initial technical and logistical set-up.

Stakeholder Engagement:

DHCS hosted monthly JI Advisory Group meetings to solicit stakeholder input on policy and implementation. Advisory Group leaders and representatives are diverse, which includes counties, prisons, jails, providers, consumers, health plans, and policy organizers. Slides from past meetings are posted on the CalAIM JI Initiative webpage.

Entities interested in participating in the TA Marketplace, as a TA vendor or a potential recipient of TA (i.e., Community Based Organizations [CBO]), have been contacting DHCS to participate in PATH initiatives. DHCS has been conducting inventory of potential entities that may serve as PATH vendors or recipients, so that DHCS can conduct outreach to them once the PATH TPA is selected, on boarded, and the TA Marketplace, CITED, and Collaborative Planning and Implementation initiatives are launched.

During this quarter, DHCS drafted additional protocols in response to the comments received from the CMS on the 1115 Wavier Demonstration STCs for PATH. The additional documents include Attachment N, which outlines the Funding and Mechanics Protocol, and Attachment O, which outlines the Operational and Monitoring. DHCS has met with stakeholder and associations to gather feedback and comments. DHCS submitted the operational protocols for the PATH program to CMS at the end of April 2022.
DHCS continued development of PATH initiative work plans and design elements of each PATH initiative and drafted responses to questions from various stakeholders.

DHCS incorporates feedback from stakeholders and provides guidance on the different methods to apply the PATH initiative across each initiative. A few of the webinars and meetings hosted by DHCS for this quarter included the following:

- On May 26, 2022, DHCS hosted a CalAIM JI Advisory Group meeting to discuss ECM, auto-assignment into MCPs, and proposed pre- and post-release JI care management models.
- On June 29, 2022, DHCS hosted a public webinar to provide updated details on the PATH Program Design. The presentation included updates on the revised timelines for the TA Marketplace, Collaborative Planning and Implementation Initiative, and CITED initiative. DHCS detailed the potential application windows of the CITED initiative application process, and provided details on the allocation methodology. DHCS has announced it is soliciting and reviewing applications for collaborative planning facilitators, and leveraging existing collaborative planning efforts and flexibilities for county/regions to request to work with preferred facilitators. DHCS reviewed the TA Marketplace registration process and funding distribution.

DHCS released a preliminary draft of the PATH Collaborative Planning and Implementation Initiative guidance and sought stakeholder feedback on the existing collaborative planning efforts, existing collaborative facilitators, and geographical design for future collaborative planning groups. DHCS has also released the PATH Collaborative Planning and Implementation Initiative Facilitator applications to stakeholders seeking interested facilitators to participate.

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.

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 services, previously known as ILOS. MCPs are able to cover alternative services or settings that are "in-lieu" of services covered under the Medicaid State Plan to more effectively and efficiently address their members' physical, behavioral, developmental, long-term care (LTC), oral health, and health-related social needs.

Community Supports are optional for MCPs to offer and for members to utilize. MCPs cannot require members to use a Community Support service instead of a service or setting listed in the Medicaid State Plan.

Pursuant to 42 Code of Federal Regulations (CFR) 438.3, MCPs may not provide Community Supports without first applying to the state and obtaining state approval to offer the Community Support and demonstrating all of 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 website as a state-approved Community Support.

Community Supports services include, but are not limited to, providing nutritional assistance with medically tailored meals, personal care and homemaker services in the home, and transitioning from nursing home care to the community to improve health and lower health care costs. These services benefit Medi-Cal enrollees with complex health needs and unmet social needs who are at high risk of hospitalization, institutionalization, and other higher cost services. Several Community Supports, such as Short-Term Post-Hospitalization Housing, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services have a built-in Housing First approach, recognizing that people experiencing homelessness have higher rates of diabetes, hypertension, HIV, and mortality resulting in longer hospital stays and higher readmission rates than the general public. Community Supports are authorized through the CalAIM Demonstration in a manner that assures consistent implementation.

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

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

The evaluation of the Recuperative Care and Short-Term Post-Hospitalization housing Community Supports will focus on studying the impact on beneficiary 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 Support services, as required.

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

Performance Metrics:

To monitor ECM and Community Supports implementation, DHCS developed the Quarterly Implementation Monitoring Report, which MCPs are required to report to DHCS across multiple domains. For Community Supports specifically, MCPs must report Community Supports services that were requested, approved, and denied, as well as provider capacity. The data from this report is designed to provide DHCS with information to monitor the initial rollout of ECM and Community Supports and inform the implementation of MCP performance incentives.

DHCS is working with MCPs to better understand the initial data submission and is targeting to make the Quarter 1 2022 data publicly available by Quarter 3 2022.

Outreach Activities:

During this reporting period, DHCS held 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.

As part of the Quarterly Implementation Monitoring Report, DHCS requires MCPs report on identifying eligible members and outreach attempts. DHCS will make Quarterly 1 2022 data publicly available by Quarter 3 2022.

During this reporting period, DHCS hosted monthly TA and guidance webinars geared towards health plan executives and personnel, who have a significant role in the implementation of ECM and Community Supports. Details on the content of these meetings are included in the section below.

Operational Updates:

During this reporting period, DHCS continued to develop and evolve Community Supports initiative work plans and respond to stakeholder questions. DHCS continues to accept stakeholder feedback and intends on continuing to provide guidance on this unique set of services. A few of the webinars and meetings hosted by DHCS for this quarter included:

- Bi-weekly CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through 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 the WPC and HHP transition to ECM and Community Supports
        - Progress of contracting between MCPs and providers
        - Referrals and authorization of members into Community Supports
- On April 26, 2022, DHCS hosted its first CalAIM Monthly ECM and Community Supports Managed Care Plan Meeting of the quarter. During this meeting, DHCS provided TA on the ECM and Community Supports Quarterly Implementation Monitoring Report and the one-time WPC/HHP Transition Report. Specifically, DHCS provided an overview of the submission process and required reporting elements, in preparation for the first submission, which was due on May 15, 2022.

- On May 18, 2022, DHCS virtually hosted the first public webinar on the CalAIM Community Supports Spotlight series. The goal of the series is to review and reinforce policy guidance on individual Community Supports, identify and amplify best practices and lessons learned from community providers, WPC pilots, and MCPs, and to answer emerging questions from the field. Agenda items for this webinar included an explanation of CalAIM Community Supports, information about Medically Tailored Meals, including cost-effectiveness, eligibility requirements, and program impact, as well as best practices from the field.
- On May 31, 2022, DHCS hosted its second CalAIM Monthly ECM and Community Supports Managed Care Plan Meeting of the quarter. DHCS shared and walked through several updated guidance documents for ECM and Community Supports, including a revised ECM Policy Guide, ECM and Community Supports Frequently Asked Questions (FAQs), and an updated MOC template.
- On June 14, 2022, DHCS hosted the ECM and Community Supports in Rural California TA webinar. This TA webinar was tailored for providers and CBOs in rural California, that are either currently interested or have a future interest in providing ECM and/or Community Supports. DHCS was joined by Hill Country Community Clinic, from Shasta County, who shared their experiences with providing ECM.
- On June 28, 2022, DHCS hosted its third CalAIM Monthly ECM and Community Supports Managed Care Plan Meeting of the quarter. Agenda topics included highlighting promising practices for ECM and Community Supports authorizations and focusing on the upcoming July 2022 implementation phase.

On April 15, DHCS received final updated Models of Care (MOCs) from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections were posted on the DHCS website in mid-June, once DHCS approved all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually at a minimum.

Over the course of the reporting period, DHCS met with MCPs to reconcile differences found in their authorization policies for new Community Supports services. These calls were brief in duration, yet effective in reducing variation between policies across plans/counties.

In June 2022, DHCS accepted and approved revisions to MCPs' previously approved ECM and Community Supports MOCs to incorporate new Community Supports services and ECM populations of focus planned for implementation beginning July 1, 2022. DHCS additionally updated its Community Supports Policy Guide and All Plan Letter language to accommodate minor adjustments necessary to highlight additional provider types eligible to provide the Respite Services Community Support and to reconcile

reporting timelines.

DHCS regularly updates its ECM and Community Supports webpage with updated guidance materials and program documents, in timely response to stakeholder and consumer feedback. DHCS also maintains a regularly updated FAQ document on its ECM and Community Supports webpage. The document highlights a number of FAQs from MCPs, providers, and stakeholders and include answers provided by DHCS.

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 Managed Care Health Plans have elected to offer, up-to-date as of July 2022.

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 beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage (MA) plan. Beneficiaries 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 beneficiary's Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. In the counties where the state is authorizing the exclusively aligned enrollment (EAE) Dual-Eligible Special Needs Plan (D-SNP) model, DHCS is committed to implementing integration through integrated beneficiary member materials, integrated appeals and grievances, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care.

DHCS has implemented the waiver authority provisions to keep a beneficiary in an affiliated Medicaid plan once they have selected a MA plan, known as the matching plan policy, in twelve counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, Sacramento, San Diego, San Francisco, Santa Clara, and Stanislaus. On January 1, 2023, beneficiaries of the federal financial alignment initiative known as Cal MediConnect will transition into EAE D-SNPs and matching MCPs, in the seven Coordinated Care Initiative counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under EAE D-SNPs, beneficiaries can enroll in a D-SNP for Medicare benefits and will be enrolled in an MCP for Medi-Cal benefits, both operated by the same parent organization for better care coordination and integration. In addition, effective January 1, 2023, all dually eligible beneficiaries statewide will be mandatorily enrolled in Medi-Cal managed care, with the exception of those with a Share of Cost who are not in a LTC facility. All dually eligible beneficiaries residing in LTC facilities will be mandatorily enrolled in Medi-Cal managed care. This policy is intended to help meet the statewide goals of improving care integration and person centered care for dually eligible beneficiaries, under both CalAIM and the California Master Plan for Aging.

DHCS is developing beneficiary notices for all of these transitions, in coordination with CMS and stakeholders.

Additionally, DHCS conducts various stakeholder meetings to discuss all aspects of these transitions related to beneficiary communication, TA impacts on any system changes, continuity of care, and more.

Performance Metrics:

DHCS will be reporting annually on the matching plan policy and on the number of beneficiaries enrolled in MA plans that request to change MCPs and are referred to the MA plan in the matching plan counties.

Outreach Activities:

There are a variety of stakeholder and workgroup meetings that are occurring to engage with stakeholders about the current matching plan policy ahead of the 2023 transitions. Examples of these stakeholder meetings include but are not limited to the following: EAE CMC Transition and EAE Technical Call Meetings and MLTSS & Duals Stakeholder Workgroup. There are a variety of workgroup meetings that are formed as needs arise to discuss various D-SNP transition policy decisions needing to be made.

Operational Updates:

DHCS has implemented the waiver authority provisions to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a MA plan, in the twelve counties identified above. Operational details are currently being developed as DHCS works toward the January 2023 transition date.

Consumer Issues and Interventions:

There are no reported consumer issues at this time. DHCS is working with CMS on beneficiary testing of the D-SNP transition notices.

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:

Nothing to report.