DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 28, 2023

Jacey Cooper
State Medicaid Director
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Director Cooper:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Evaluation Design[1], which is required by the Special Terms and Conditions (STCs), specifically, STC #15.3, of the section 1115 demonstration, "California Advancing and Innovating Medi-Cal (CalAIM) Demonstration" (Project No: 11-W-00193/9), effective through December 31, 2026. CMS has determined that the Evaluation Design, which was submitted on June 27, 2022 and June 26, 2023, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's DMC-ODS Evaluation Design.

CMS has added the approved DMC-ODS Evaluation Design to the demonstration's STCs as Attachment T. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

[1] The DMC-ODS Evaluation Design is inclusive of the state's substance use disorder and contingency management programs.

We appreciate our continued partnership with California on the CalAIM section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Paula M. Kazi -S Digitally signed by Paula M. Kazi -S
Date: 2023.07.28 00:13:42 -04'00'

Paula M. Kazi
Acting Director
Division of Demonstration Monitoring and Evaluation

cc: Cheryl Young, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX and XXI plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter, or as otherwise indicated herein or in the Special Terms and Conditions (STCs), through December 31, 2026.

The following expenditure authorities shall enable California to implement the CalAIM Demonstration. All Medicaid requirements apply to expenditure authority 3, 4, 5, 7, 8, 9, 10, 11 and 13 (except as inconsistent with those authorities or except as provided herein or as set forth in the STCs).

1. **Global Payments Program for Public Health Care Systems**. Expenditures for payments to eligible Public Health Care Systems, subject to the annual expenditure limits set forth in the STCs, to support participating Public Health Care systems providers that incur costs for uninsured care under the value-based global budget structure set forth in the STCs.

2. **Chiropractic Services Provided by Indian Health Service (IHS) and Tribal Facilities.** Expenditures for chiropractic services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by IHS/tribal providers to individuals enrolled in the Medi-Cal program.

3. **Expenditures Related to Community Based Adult Services (CBAS).** Expenditures for CBAS services furnished to individuals who meet the level of care or other qualifying criteria.

4. **Expenditures Related to Low Income Pregnant Women.** Expenditures to provide post-partum benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the Federal Poverty Level (FPL), that includes all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL. This authority will sunset on December 31, 2021.

5. **Expenditures Related to the Drug Medi-Cal Organized Delivery System (DMC- ODS) for Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered Medicaid services furnished to qualified DMC-ODS beneficiaries who are primarily receiving treatment and withdrawal management services for

substance use disorder as short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

6. **Expenditures Related to Providing Access and Transforming Health (PATH).** Expenditures for payments to Qualified Applicants approved under one or more PATH initiatives. Such expenditures may include payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of an approved PATH program.

7. **Expenditures Related to Contingency Management.** Expenditures for Contingency Management services provided to qualifying DMC-ODS beneficiaries who reside in a DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit, beginning July 1, 2022 through December 31, 2026.

8. **Expenditures Related to Health-Related Social Needs (HRSN) Services Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.** Expenditures for HRSN services, specifically recuperative care and short-term post hospitalization housing services, as detailed in the service description in the STCs, for Medi-Cal managed care enrollees who meet the eligibility criteria specified in the STCs and any related requirements.

9. **Expenditures Related to Dually Eligible Enrollees in Medi-Cal Managed Care.** Expenditures under contracts with Medicaid plans that do not meet the requirements under section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4)(A)(ii)(I) of the Act and 42 CFR 438.56(c)(2)(i) to the extent necessary to allow the state to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage plan unless and until the beneficiary changes Medicare Advantage plans or selects Original Medicare. Beneficiaries impacted by this expenditure authority will be able to change Medicaid plans by picking a new Medicare Advantage Plan or Original Medicare once a quarter between January through September pursuant to 42 CFR 423.38(c)(4)(i) and following the annual coordination election period from October through December pursuant to 42 CFR 423.38(b)(3). A dually eligible beneficiary's Medicaid plan will be aligned with the new Medicare Advantage Plan, to the extent the Medicare Advantage Plan has an affiliated Medicaid plan. Pursuant to 438.56(e)(1) which requires a state to approve disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment, the state will be allowed to align approval of disenrollment from a Medicaid plan with disenrollment from a Medicare Advantage plan.

10. **Expenditures Related to Out-of-State Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date.

11. **Expenditures for Deemed SSI Populations.** Expenditures to extend eligibility for individuals in the following Deemed SSI populations who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members as of July 1, 2022, and (2) no longer applying the asset test as of January 1, 2024:

    i. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
    ii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
    iii. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

12. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, identified in these STCs, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs.

13. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible for the Children's Health Insurance Program (CHIP) if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

Title XXI Expenditure Authority:

1. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

1. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

2. **Amount, Duration, and Scope of Services and Comparability**
Section 1902(a)(10)(B) and 1902(a)(17)

To enable the state to provide only a limited set of pre-release services, as specified in these

STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

4. **Requirements for Providers under the State Plan**
Section 1902(a)(27) and 1902(a)(78)

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above

1. **Requirements for Providers under the State Plan** **Section 2107(e)(1)(D)**

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the approval date, through December 31, 2026, unless otherwise specified.

Under the authority of section 1115(a) (1) of the Social Security Act (the Act), the following waivers shall enable California to implement the CalAIM Demonstration.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care. These authorities sunset on December 31, 2021.

To enable the State to require that individuals who elect to receive Health Home Program (HHP) services (under the state plan) are restricted to the Medi-Cal Managed Care Plan offered by the HHP provider to receive covered services other than family planning services. These authorities sunset on December 31, 2021.

No waiver of freedom of choice is authorized for family planning providers.

2. **Disproportionate Share Hospital (DSH) requirements**
Section 1902(a)(13)(A) (insofar as it incorporates Section 1923)

To exempt the State from making DSH payments, in accordance with Section 1923, to a hospital which qualifies as a disproportionate share hospital during any year for which the Public Health Care System with which the disproportionate share hospital is affiliated receives payment pursuant to the Global Payment Program.

3. **Statewideness** **Section 1902(a)(1)**

To enable the State to operate the demonstration on a county-by-county basis.

To enable the State to provide CBAS services on a geographically limited basis.

To enable the State to provide DMC-ODS services to short-term residents on a geographically limited basis.

To enable the state to provide contingency management services to qualifying DMC-ODS beneficiaries only in participating DMC-ODS counties that elect and are approved by DHCS to provide contingency management.

To enable the State to authorize sustaining services under PATH to individuals on a geographically limited basis.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide recuperative care and short-term post-hospitalization housing services only in certain geographic areas where Medi-Cal managed care plans elect to offer these services.

4. **Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)**

To enable the State to provide different benefits for low-income pregnant women between 109 percent up to and including 138 percent of the Federal Poverty Level, as compared to other pregnant women in the same eligibility group. This authority will sunset on December 31, 2021.

To enable the State to provide DMC-ODS treatment and withdrawal management services for substance use disorder, for short term residents, in facilities that meet the definition of an Institution for Mental Diseases (IMD) that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide contingency management in approved DMC-ODS counties, to eligible individuals with substance use disorders under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide sustaining services under PATH that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide health-related social needs services, specifically recuperative care and short-term post hospitalization housing services, that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide CBAS services that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to (1) apply targeted resource disregards of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members as of July 1, 2022 and (2) effective January 1, 2024 no longer apply income and resource financial methodologies to the following populations, which is in a manner that is not applied consistently to all eligibility groups in the state:

ii. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
iii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
iv. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for California's CalAIM, formerly Medi-Cal 2020, section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

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

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

The STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through December 31, 2026.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Historical Context
3. General Program Requirements
4. State Plan and Demonstration Populations Affected by the Demonstration
5. Demonstration Programs
    a. Community Based Adult Services
    b. PATH
    c. Duals
6. Drug Medi-Cal Organized Delivery System
7. Contingency Management
8. Community Supports

9. Reentry Demonstration Initiative
10. Designated State Health Programs
11. Provider Payment Rate Increase Requirement
12. Negative Balance
13. Global Payment Program
14. General Reporting Requirements
15. Evaluation of the Demonstration
16. General Financial Requirements
17. Monitoring Budget Neutrality for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Global Payment Program Participating Public Health Care Systems
Attachment D: Funding and Reimbursement Protocol for IHS
Attachment E: SUD Health IT Plan
Attachment F: Accounting Procedures
Attachment G: Demonstration and Program Years
Attachment H: Community-Based Adult Services (CBAS) Provider Standards of Participation
Attachment I: Drug Medi-Cal Organized Delivery System (DMC-ODS) County Certified Public Expenditures (CPE) Protocol
Attachment J: SUD Monitoring Protocol (Reserved)
Attachment K: Global Payment Program Funding and Mechanics Protocol
Attachment L: Global Payment Program Valuation Methodology Protocol
Attachment M: Global Payment Program Health Equity Monitoring Metrics Protocol (Reserved)
Attachment N: Providing Access and Transforming Health (PATH) Funding and Mechanics Protocol
Attachment O: Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol
Attachment P: Historical Information-Budget Neutrality Test (Reserved)
Attachment Q: DSH Coordination Methodology
Attachment R: Negative Balance Payment Schedule (Reserved)
Attachment S: CBAS Program Integrity
Attachment T: Evaluation Design (Reserved)
Attachment U: Community Supports Appendix
Attachment V: Contingency Management Procedures and Protocols
Attachment W: Reentry Demonstration Initiative Qualifying Conditions and Services
Attachment X: Health-Related Social Needs (HRSN) Community Supports Protocol (Reserved)
Attachment Y: Approved Designated State Health Program (DSHP) List (Reserved)
Attachment Z: Designated State Health Program (DSHP) Claiming Protocol (Reserved)
Attachment AA: Designated State Health Program (DSHP) Sustainability Plan (Reserved)
Attachment BB: Designated State Health Program (DSHP) Related Provider Payment

Increase Assessment Attestation Table (Reserved)
Attachment CC: Reentry Demonstration Initiative Implementation Plan (Reserved)
Attachment DD: Monitoring Protocol (Reserved)
Attachment EE: Reentry Demonstration Initiative Reinvestment Plan (Reserved)
Attachment FF: Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment'
Attachment GG: Attachment K – Emergency Preparedness and Response; Lump Sum Incentive Payments

2. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

In November 2010, the Federal government approved California's five-year Medicaid section 1115 Bridge to Reform demonstration, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The Bridge to Reform demonstration achieved the goals of simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system, and reinforcing California's safety net to meet the needs of the uninsured.

In December 2015, the Federal government approved the Medi-Cal 2020 demonstration embodying the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. Bridge to Reform waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) were continued in Medi-Cal 2020, and with the foundation of the successes of the Bridge to Reform Demonstration, Medi-Cal 2020 initiatives continued to improve the quality and value of care provided to California's Medi-Cal beneficiaries.

Medi-Cal 2020 initiatives included:

1. A Public Hospital Redesign and Incentives in Medi-Cal program (PRIME), which aimed to improve the quality and value of care provided by California's safety net hospitals and hospital systems;

2. A Global Payment Program (GPP) that aimed to streamline funding sources for care for California's remaining uninsured population and create a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services;

3. A Whole Person Care (WPC) Pilot program that aimed to support local and regional efforts to integrate the systems and improve the care provided to Medi-Cal's most high-risk beneficiaries; and

4. A Dental Transformation Initiative (DTI) aimed to improve access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.

On June 15, 2016, California submitted an amendment to the Demonstration to expand the definition of a WPC Pilot lead entity to include federally recognized tribes and tribal health programs operated under a Public Law 93-638 contract with the Federal Indian Health Services.

CMS approved this amendment on December 8, 2016.

On August 15, 2016, the state submitted an amendment to the demonstration to revise the methodology for determining the baseline metrics for purposes of receiving incentive payments for new and existing dental service office locations under the DTI. California also sought authority to provide incentive payments for specified dental services delivered at provider service office locations at two levels: a 37.5 percent above the state's Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet at least a 1 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children served in the previous year with a preventive dental service; and a 75 percent above the state's SMA incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children receiving a preventive dental service in the previous year. CMS approved this amendment on January 6, 2017.

On August 17, 2017, CMS approved the state's request to amend the demonstration to provide coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they "aged out" of foster at age 18 (or a higher age as elected by the state) and were enrolled at Medi-Cal at the time.

California submitted an amendment on November 10, 2016, as a companion to the Health Homes Program (HHP) State Plan Amendment (SPA) 16-007, to request a waiver of freedom of choice in the non- county organized health system (COHS) counties in order to provide the HHP services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Managed care plans (MCPs) will be responsible for the overall administration of the HHP, which will be structured as a HHP network with members functioning as a team to provide care coordination. Fee-For-Service (FFS) members who meet the eligibility criteria for HHP may choose to voluntarily enroll in a MCP to receive HHP services along with other state plan services provided through MCPs. HHP services will not be provided through a FFS delivery system; therefore, beneficiaries in FFS in non-COHS counties will have to enroll in a MCP to receive HHP services. CMS approved this request on December 19, 2017.

On August 3, 2020, California received CMS approval to permit the GPP to continue from July 1, 2020 to December 31, 2020 and to permit eligible Medi-Cal beneficiaries in Orange County to elect to disenroll from CalOptima (a COHS including CalOptima Program of All-Inclusive Care for the Elderly (PACE)), to be enrolled in a PACE organization not affiliated with CalOptima.

On December 30, 2020, CMS approved a temporary extension of the state's section 1115 demonstration, in order to allow the state and CMS to continue working together on approval of a longer-term renewal of this demonstration by December 31, 2021. This temporary extension continued most elements of the Medi-Cal 2020 Section 1115 demonstration unchanged pending a full renewal and included an additional authorization for the GPP program. The extension included the removal of the authority for the State's Designated State Health Programs (DSHP).

On December 29, 2021, CMS approved the California Advancing & Innovating Medi-Cal (CalAIM) demonstration. This demonstration authorized a five-year renewal of components of the Medi-Cal 2020 section 1115 demonstration, including new authorities, to continue advancing the state's goal of improving health outcomes and reducing health disparities for Medicaid and

other low-income populations in the State. Building on the successes of the Medi-Cal 2020 demonstration, California has moved to implement whole person care strategies statewide through the State's CalAIM 1915(b) managed care delivery system and is moving other aspects of the Medi-Cal 2020 demonstration into the Medi-Cal State Plan. The CalAIM section 1115 demonstration initiatives include:

- Renewing the GPP to streamline funding sources for care for California's remaining uninsured population with a renewed focus on addressing social needs and responding to the impacts of systemic racism and inequities on the uninsured populations served by California's public hospitals.
- Authorizing Community Supports services: recuperative care and short-term post-hospitalization housing.
- Authorizing the Providing Access and Transforming Health (PATH) Supports expenditure authority to (1) sustain, transition, and expand the successful WPC Pilot and HHP services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports, and (2) sustain reentry pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.
- Continuing short-term residential treatment services to eligible individuals with a substance use disorder (SUD) in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Authorizing Contingency Management as a DMC-ODS benefit, to offer Medi-Cal beneficiaries this evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.

On June 29, 2022, CMS approved an amendment to the demonstration to provide parity with the asset disregard policy for populations covered under SPA 21-0053. This amendment increases the asset limit and subsequently eliminates the asset test for the populations not able to be covered under state plan authority. The resources disregard will be $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members. This disregard is effective as of July 1, 2022. The elimination of the asset test for the populations covered under the demonstration will be effective January 1, 2024.

On January 26, 2023, CMS approved an amendment to the CalAIM demonstration to allow the state to provide a targeted set of pre-release services to individuals who are Medicaid eligible or individuals who would be eligible for CHIP except for their incarceration status and who are incarcerated in state prisons, county jails, or youth correctional facilities. This set of services would be provided for up to 90 days immediately prior to the expected date of release to improve transitions (in particular, transitions of health coverage and care) back to the community and for other purposes, including to reduce emergency department visits and inpatient hospital admissions; reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death; and lead to improved health outcomes in general. CMS also is approving the authority for Designated State Health Programs (DSHP), which California will use to support portions of the PATH program that was approved in the December 29, 2021 extension of CalAIM. CMS is approving additional PATH funding for planning and implementation of the reentry demonstration initiative. Lastly, in this amendment CMS is approving an adjustment to the budget neutrality methodology for two previously approved community supports, short-term post-hospitalization services and recuperative care, that address Health-Related Social Needs

(HRSN), consistent with current CMS policy. Since these services are considered HRSN, CMS is adjusting the state's budget neutrality calculations to conform to current CMS policy for demonstrations that address HRSN, and will be treating these two services as "capped hypothetical expenditures."

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Laws**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

3.2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived in the waiver document (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. Nothing in this demonstration absolves California from being subject to future guidance on contingency management and the state would otherwise need to come into compliance with such guidance. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.6. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to discuss the language changes necessary to ensure compliance with Law, Regulation, and Policy. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

3.4. **Coordination with the Medicare Program.** The state must have processes in place to coordinate with the Medicare program for Medicare-Medicaid beneficiaries, including:

a. The state must provide contact information to Medicare-Medicaid beneficiaries on how they can obtain assistance with their Medicare coverage at any point of enrollment or disenrollment from Medi-Cal managed care or upon request by the beneficiary.

b. The state must provide accurate reports to CMS of the eligibility and enrollment of Medicare-Medicaid beneficiaries in the demonstration.

c. The state must comply with requirements for Medicaid payment of Medicare cost-sharing for Medicare-Medicaid enrollees, including ensuring any organization delegated with that responsibility adheres with the requirements.

d. The state must provide CMS with requested financial information and other demonstration aspects that have a specific impact on the Medicare-Medicaid population. Requests for information will include a reasonable timeframe for responses as agreed to by CMS and the state.

3.5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 3.8 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.6. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

3.7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 3.8, except as provided in STC 3.3.

3.8. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the

state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary; and

e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.9. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 3.10.

3.10. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or

expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued services or benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.8 or extension, are proposed by the state.

3.14. **Federal Financial Participation.** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Federal Financial Participation (FFP) for Indian Health Services.** Supplemental payments to participating Indian Health Services and tribal facilities are limited to the costs incurred by the certifying entity in providing chiropractic services.

3.16. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated demonstration functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study,

evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5)

4. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

4.1. **Eligibility.** Certain state plan eligibles are affected by the Demonstration, as described below.

State plan eligibles derive their eligibility through the Medicaid or CHIP state plans and are subject to all applicable Medicaid and CHIP laws and regulations in accordance with the Medicaid or CHIP state plans, except as expressly waived or made inapplicable and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

The following population groups are affected by the Demonstration:

a. Out-of-State Former Foster Care Youth, defined as youth under age 26, who were in foster care under the responsibility of a state other than California or a tribe in such other state when they turned age 18 or such higher age as the state elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid at that time; and are now applying for Medicaid in California. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory Title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

b. Community Based Adult Services (CBAS) Populations are persons who are age 18 or older and meet CBAS eligibility under STC 5.1(a) and (d).

c. DMC-ODS populations are persons receiving residential services pursuant to DMC-ODS, regardless of the length of stay, as described in STC 6.1 and individuals receiving contingency management services, as described in STC 7.1.

d. Deemed SSI Populations.

i. The resource disregard described in section (ii) below, will be applied in determining eligibility for the following groups, subject to section (iii) below:

1. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;

2. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and

3. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

ii. The resource disregard to be applied to individuals described in section (i) above will be as follows:

1. Effective July 1, 2022, the resource disregard will be $130,000 for each individual and an additional $65,000 for each additional household member of the individual, up to a maximum of 10 household members; and
2. Effective January 1, 2024, all resources will be disregarded for each individual.

iii. The resource disregard described in section (ii) above, will not apply to the following individuals who are otherwise eligible under the state plan in:

1. A categorically needy eligibility group to which there is available:

a. The minimum mandatory medical assistance described in section 1902(a)(10)(A) of the Act, as implemented at 42 CFR § 441.210; or

b. Benchmark benefits described in section 1937 of the Act, as implemented at 42 CFR § 440.300 et seq; or

2. A medically needy group covered under the state plan without a spenddown.

e. Reentry Demonstration Initiative Populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarcerated status, and who are incarcerated in a state prison, county jail, or youth correctional facility and who meet the eligibility criteria under STC 9.2.

5. DEMONSTRATION PROGRAMS

A. Community-Based Adult Services (CBAS) for Medi-Cal State Plan Populations

5.1. **CBAS Eligibility and Delivery System.** CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

a. CBAS Recipients are those persons who:

i. Are age 18 years and older;

ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare;

iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care; and

iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 5.1(b), or are

determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 5.1(d) and STC 5.1(e).

b. Delivery System.

i. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 5.1(a) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. A Medi-Cal managed care plan shall ensure that every CBAS provider within their service area, that has been approved by the California Department of Aging as a CBAS provider, is included in the plan's network, to the extent that the CBAS provider remains licensed as an Adult Day Health Care Center, certified and enrolled as a Medi-Cal provider, and is willing to enter into a network provider agreement with the plan on mutually agreeable terms and meets the plan's credentialing and quality standards.

ii. CBAS shall be available as a Medi-Cal fee-for-service benefit delivered through licensed Adult Day Health Care Centers approved by the California Department of Aging as a CBAS provider, that are certified and enrolled as a Medi-Cal provider, for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS is provided.

iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the Department of Health Care Services must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:

i. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the Medi-Cal managed care plan will authorize unbundled services and facilitate utilization through care coordination.

ii. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:

a. DHCS will work with the local CBAS Center network and beneficiary's physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS benefits that are medically necessary for the beneficiary.

b. DHCS will work with the beneficiary's physician to arrange for needed nursing services, or referral to, or reassessment of, In-Home Supportive Services (IHSS) as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).

c. If the beneficiary needs therapeutic services, DHCS will work with the beneficiary's physician to coordinate the authorization of needed services.

d. If the beneficiary needs mental health and/or substance use disorder services, DHCS will work with the beneficiary's physician to refer the beneficiary to the local behavioral health services department or appropriate behavioral health professionals or services.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 5.1(a) and 5.1(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state engaged in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the section 1115 demonstration, to ensure complete compliance with HCBS settings by March 17, 2023.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 5.1(a) and for whom CBAS is available based on STC 5.1(b) who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v) below:

i. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations; OR

ii. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior

Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (e) Schizophrenia and Other Psychiatric Disorders, (f) Mood Disorders, (g) Anxiety Disorders, (h) Somatoform Disorders, (i) Factitious Disorders, (j) Dissociative Disorders, (k) Paraphilia, (l) Eating Disorders, (m) Impulse Control Disorders Not Elsewhere Classified, (n) Adjustment Disorders, (o) Personality Disorders, or (p) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:

i. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

ii. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; or

iii. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease; or

iv. Have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

v. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

e. CBAS Eligibility Determination. Eligibility determinations for the CBAS benefit will be performed as follows:

i. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by the Department of Health Care Services unless criteria under STC 5.1(e)(ii) are met. The eligibility determination shall be performed by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care.

ii. An initial face-to-face review is not required when a managed care plan or the Department of Health Care Services or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses.

iii. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

f. Grievances and Appeals

i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.

ii. A CBAS participant may file a grievance with their Medi-Cal managed care plan as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Medi-Cal managed care plan at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the plan.

5.2. **CBAS Benefit and Individual Plan of Care (IPC).**

a. Core Services: Professional nursing care, personal care and/ or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows. CBAS benefits include the following:

i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.

ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.

iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities. The CBAS physical therapy and occupational therapy maintenance programs are considered part of Therapeutic Activities.

v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed and as specified on the person's IPC:

i. Restorative physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the Health and Safety Code (H&S Code), physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

ii. Restorative occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the H&S Code, occupational therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

iii. Speech therapy provided by a licensed, certified, or recognized speech therapist or speech therapy assistant within their scope of practice to restore function when there is an expectation that the participant's condition will improve significantly in a reasonable period of time as determined by the multidisciplinary assessment team.

iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.

v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.

vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).

The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The planning process and the development and review of the IPC will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the Department of Health Care Services.

Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports.

Person- Centered Planning includes consideration of the current and unique bio-psycho-social- cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

i. Medical diagnoses

ii. Prescribed medications.

iii. Scheduled days at the CBAS center.

iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.

v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).

vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.

vii. Participation in specific group activities.

viii. Transportation needs, provided or arranged, to and from CBAS participants' place of residence and the CBAS center, when needed, including special transportation.

ix. Special diet requirements, dietary counseling and education, if needed.

x. A plan for any other necessary services that the CBAS center will coordinate.

xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

5.3. **Remote CBAS Services- Emergency Remote Services (ERS).** Under certain unique circumstances, CBAS ERS may be provided in response to the individual's person-centered needs. CBAS ERS (i.e., professional nursing care; personal care services; social services; behavioral health services; speech therapy; therapeutic activities; registered dietician-nutrition counseling; physical therapy; occupational therapy; meals) shall be provided in alternative service locations (e.g., community setting or participant's home) and/or, as appropriate, telephonically, via telehealth, live virtual video conferencing, as clinically appropriate.

a. These unique circumstances are limited to the following:

i. Qualified emergencies - state or local disasters such as wildfires and power outages (to allow for services prior to the official declaration of a formal public health emergency (PHE)) as determined by the Department of Health Care Services or its contractor(s)); and,

ii. Personal emergencies - time-limited illness/injury, crises, or care transitions that temporarily, on a time-limited basis, prevent or restrict enrolled CBAS participants from receiving services, in-person, at the CBAS center (subject to approval by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care).

b. These special circumstances are time-limited and vary based on the unique circumstances and identified needs of the participant as documented in the participant's individual care plan. Participants will be assessed at least every three months as part of the reauthorization of the individual's care plan and a review for a continued need for remote/telehealth delivery of CBAS services.

5.4. **CBAS Provider Specifications.** CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The Department of Health Care Services maintains Standards of Participation for all CBAS providers which are found in Attachment H to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

d. CBAS providers approved for provision of CBAS Emergency Remote Services must:

    i. Maintain regular communication with the participant via phone, email, other electronic device, or in-person visits in order to assess need related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

    ii. Maintain phone and email access for participant and family support, to be staffed a minimum of six hours daily, during provider-defined hours of services, Monday through Friday.

    iii. Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

    iv. Respond to needs and outcomes through targeted interventions and evaluate outcomes.

    v. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.

    vi. CBAS providers will work with individual participants to ensure they have the proper support they need in the event of equipment/technology failure including, but not limited to, arranging for alternative tools/equipment, evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.

    vii. The CBAS provider will be required to identify back-up telehealth modality service delivery options or in-person/in-home visits in the instance that equipment/technology failure prevents the provision of services through telehealth.

    viii. Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed. Note: Meals are limited to no more than two meals per day.

e. Medi-Cal certification requires that a CBAS provider adhere to federal and state laws and regulations regarding the confidentiality, security, and unauthorized disclosure of protected health information. The role of the provider in remote service delivery is to:

i. Explain privacy requirements and appropriately document in the individual's clinical records that the individual and/or the legal representative, when appropriate, has consented to receive CBAS services via telehealth.

ii. Confirm that the provider and the individual will use two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that the equipment is adequately suited for the individual's needs in order for remote service delivery.

5.5. **Responsibilities of Managed Care Plans for CBAS Benefits.** The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and with these STCs and shall include that plans do the following.

a. Contract Requirements for Managed Care Plans:

i. Contract with sufficient available CBAS providers in the managed care plans covered geographic service areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in STC 5.1(d). Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.

ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on or after April 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012:

iii. Plans must ensure that telehealth delivery of the service will meet HIPAA requirements and the methodology is accepted by the HIPAA compliance officer.

iv. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic service area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.

v. Confirm that every contracted CBAS provider is licensed, certified, enrolled in Medi-Cal, operating, and meets the managed care plan's credentialing and quality standards, including required Medi-Cal enrollment of staff.

i. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing, Medi-Cal enrollment, or quality standards, is terminated pursuant to the terms of

the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.

ii. The managed care plan shall provide the Department of Health Care Services a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 5.1, the processes and timelines in State law, and all of the following:

i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.

ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than 30 calendar days from the initial eligibility inquiry request.

iii. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the member in writing of his/her CBAS eligibility determination within two business days of the decision.

iv. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

i. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.

ii. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.

iii. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with STC 5.1(f).

v. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility

whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

vi. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.

vii. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.

viii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.

c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:

i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.

ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant, and significant changes in participant condition are conducted in a timely manner and facilitate care coordination.

iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.

iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

5.6. **CBAS Center Provider Oversight, Monitoring, and Reporting.** The state shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section XI, General Reporting Requirements and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

a. Enrollment Information: to include the number of CBAS FFS and managed care beneficiaries in each county, the capacity of each county, total determined eligible and ineligible beneficiaries per county quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.

b. The quarterly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.

c. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 5.9, inclusive of all amendments.

e. CBAS FFS and Managed Care Access Monitoring. The Department of Health Care Services will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.

   i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

   ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

   iii. Review of FFS and managed care grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or managed care plan staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

   iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the managed care plans.

   v. CMS requires the state to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

   vi. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the

negative change as well as an analysis that addresses such variances. Evidence of sufficient access monitoring and a corrective action plan must be provided to the regional office annually and at any other time a significant impact to the Medi-Cal managed care plan's operations are administered.

vii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

5.7. **HCBS Electronic Visit Verification System**. For any in-home services provided to CBAS beneficiaries under the CBAS Emergency Remote Services, the state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

5.8. **Quality Improvement Strategy for 1915(c) or 1915(i) Approvable HCBS Services:** For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS State plan, the state's Quality Assessment and Performance Improvement Plan must encompass long-term services and supports (LTSS) specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302. The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually. The performance measures shall include the following components:

a. Administrative Authority: A performance measure should be developed and tracked for any authority that the Department of Healthcare Services delegates to another agency, unless already captured in another performance measure.

b. Level of Care or Eligibility based on 1115 Requirements: Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility, and the processes for determining level of care or eligibility for HCBS are followed as documented. While a performance measure for annual levels of care/eligibility is not required to be reported, the state is expected to be sure that annual levels of care/eligibility are determined.

c. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.

d. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered

in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

e. Health and Welfare: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

f. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.

5.9. **Monitoring and Reporting of HCBS Quality Assurance:** The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers as an attachment to its Annual Monitoring Report described in STC 14.5.

The state must report, as an attachment to its Annual Monitoring Reports (refer to STC 14.5) identified issues and gaps found during the oversight and monitoring of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. 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.

5.10. **Beneficiary Protections**:

a. Person-centered planning. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.301(c)(3) or 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

b. Conflict of Interest. The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options (for use in MLTSS programs with self-direction).

d. The state, either directly or through its managed care plan contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

5.11. **CBAS Provider Reimbursement**.

a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are not enrolled in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.

b. Managed care plans shall reimburse contracted CBAS providers pursuant to a reimbursement structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Per Welfare and Institutions Code section 14184.201(d)(4), managed care plans shall reimburse contracted CBAS providers at the rate the CBAS provider would have been paid by DHCS for CBAS services under the fee-for-service delivery system (described in 19(b)(iii) above), unless the plan and contracted CBAS provider mutually agree to a different reimbursement amount. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their reimbursement structure in paying CBAS providers.

5.12. **CBAS Program Integrity.**

a. Following a determination that a credible allegation of fraud exists involving a CBAS provider, the state shall notify managed care plans promptly of the finding. The state must require managed care plans to report, in a timeframe and manner as specified by the state, but no less frequently than quarterly, to the state all payments made to the applicable CBAS provider for CBAS services provided after the date of notification; the state must disclose this information to CMS beginning with payments made on or after April 1, 2016.

b. If the credible allegation of fraud is proven:

i. For purposes of claiming FFP, the state must adjust its claiming associated with payments to a managed care plan to account for an amount equal to what the managed care plan has paid to an applicable CBAS provider for dates of

services occurring after the state has notified the managed care plan that the CBAS provider has been referred for investigation. The state shall refund the federal share associated with such payments in accordance with Attachment S.

ii. The state may recoup from its payment to a managed care plan an amount equal to what the managed care plan has paid to the applicable CBAS provider for dates of service after the state has notified the managed care plan that the CBAS provider has been referred for investigation.

iii. Additional specifications pertaining to these requirements including information about how payments and claiming will be adjusted and MCPs will be notified are set forth in Attachment S in accordance with the Medicaid Managed Care rule at 80 FR 31097 or the finalized 42 CFR 438

B. Providing Access and Transforming Health

5.13. **Providing Access and Transforming Health (PATH) Overview.** The state is authorized up to $1.85 billion (total computable) in expenditure authority for PATH, subject to the provisions in STC 5.16. PATH is one-time transitional funding that will support the state's efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the CalAIM initiative. PATH funding will ensure Medi-Cal beneficiaries have continuous access to benefits and services previously covered by WPC Pilots as these activities are integrated into Medi-Cal managed care plans (MCPs). It will also support planning and information technology (IT) investments for pre-release services and reentry activities. Examples of pre-release services and reentry activities include pre-release application and suspension/unsuspension processes, assessment of qualification for reentry demonstration initiative services, the provision of pre-release services for up to 90 days immediately prior to the expected date of release, and care coordination to support reentry planning. Unless otherwise specified, this expenditure authority is authorized over the five years of the demonstration from January 1, 2022 through December 31, 2026. This funding will be administered by DHCS or a Third Party Administrator (TPA). All of PATH funding, except for sustaining services below, will be considered an administrative cost and will be paid at the 50 percent regular administrative expenditure matching rate. Funding for Sustaining Services Through the Transition to Managed Care will be matched at the medical assistance payment (MAP) matching rate.

a. The state shall select Qualified Applicants, described in STC 5.19, to receive payments under PATH, as outlined in STC 5.13(d) below, to support counties, providers, and MCPs as they sustain, transition, and expand WPC and Health Home Pilot services and interventions initially authorized under the Medi-Cal 2020 demonstration to statewide services available through the Medi-Cal managed care delivery system. PATH funding will support the development of capacity, transitional non-service expenditures, infrastructure, and systems across the state, including in those counties that did not participate in WPC.

b. The state and Qualified Applicants as defined in STC 5.19 will be subject to requirements around eligibility for funding, program integrity, and evaluation, as

outlined in the PATH STCs, PATH Monitoring Protocol, CalAIM demonstration reporting, and the CalAIM demonstration evaluation approach in STC 15.4.

c. A former "WPC Lead Entity" refers to the cities, county agencies, designated public hospitals, district municipal public hospitals, or federally recognized tribes and tribal health programs that participated in the Whole Person Care Pilots as authorized and defined under the Medi-Cal 2020 demonstration.

d. For applicable initiatives, Qualified Applicants must provide DHCS or the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System and Innovation Program to promote appropriate distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example, enrollment, access/affordability and other indicators.

e. PATH funding must not supplant funding provided by other Federal, state or local funding sources. The PATH payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or replace provider payments from MCPs. The PATH funding must not supplant funding provided for the state's Department of Corrections (DOC) for the purchase of technology for state prisons, county jails, and youth correction facilities.

5.14. **PATH Programs Description**. Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program, which is comprised of five initiatives:

a. **Support for Sustaining Services Through the Transition to Managed Care.** PATH funding is available for the Support for Sustaining Services Through the Transition to Managed Care Initiative for former WPC Pilot Lead Entities to sustain existing WPC Pilot services that will continue under CalAIM as Community Supports, as defined in Section VIII and the 1915(b) waiver. This funding is intended to ensure continuity of services for individuals when a Community Support is not adopted by the MCP on January 1, 2022, but there is a commitment from the MCP that it will elect to offer the Community Support before January 1, 2024. Funding for services will be matched at MAP for these specific services under PATH expenditures. Allowable Services may assist in the continuity of access to WPC services that are transitioning to CalAIM and may not be covered on "day one." For example:

i. Housing transition navigation services, housing tenancy and sustaining services, or asthma remediation;

ii. Sobering center services;

iii. Recuperative care services.

b. **The funding may not be used to initiate new services.** WPC services and infrastructure that will not continue under CalAIM (i.e., where there is no

corresponding CalAIM Community Support) would not be eligible for this funding. Funding may not be used to fund WPC services indefinitely and may only be used to continue services until the services are picked up by MCPs no later than January 1, 2024. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

c. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care.** PATH will make funding available to former WPC Pilot Lead Entities to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Direct funding is available for WPC Pilot Lead Entities, as well as ECM / Community Supports providers which work with jails, prisons, and youth correctional facilities to sustain existing WPC Pilot pre-release and reentry services that map to required ECM and MCP-offered Community Supports. Funding may be used only to pay former WPC Lead Entities for services provided. Some WPC services will not be covered by MCPs until mid-2022 or 2023; this funding may be used to sustain these services until they are transitioned to and paid for by MCPs. This funding will be matched at ADM for these specific PATH expenditures. The funding may not be used to initiate new services, sustain services that were provided in WPC but are not transitioning to CalAIM, or sustain services indefinitely without a plan to transition them to the consolidated CalAIM Section 1915(b) waiver delivery system and other related authorities.

d. **Technical Assistance Marketplace.** PATH will make funding available for the provision of technical assistance (TA) to Qualified Applicants that are contracted with or that intend to contract with one or more MCPs as an ECM or Community Supports provider. This funding will be matched at ADM for these specific PATH expenditures. Qualified Applicants, as described in STC 5.19, can apply to the TPA for TA support. Allowable expenditures include, but are not limited to, the following, and once finalized will be included as an Operational Protocol at Attachment O within the STCs:

    i. Workforce training to support expansion of services to newly eligible populations or vulnerable populations (e.g., individuals who are experiencing homeless);

    ii. Technical assistance (e.g., through trainings, one-on-one consultations) mining EHR data to identify individuals newly eligible for ECM/Community Support (ILOS) services;

    iii. Developing and distributing in-depth guidance for implementing data sharing processes between providers and housing services organizations to connect members to housing community support services;

    iv. Providing specific training to support the development, coordination, and implementation for regional learning collaboratives/learning networks; and

    v. Detailed training on how to connect justice-involved individuals to housing services.

e. **Collaborative Planning and Implementation for ECM and Community Supports.** Expenditure authority will make funding available to establish and facilitate regional collaborative planning efforts to support readiness for CalAIM implementation. Regional collaborative planning efforts will be organized and facilitated by a TPA or Vendor, and should include at a minimum: MCPs, city, county, and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and Designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. As the implementers of ECM and Community Supports, MCPs will not be eligible to receive funding through this initiative but are expected to participate in Collaborative Planning and Implementation initiatives ongoing in their service areas. This funding will be matched at ADM for these specific PATH expenditures. Allowable expenditures include, but are not limited to, the following, and once finalized, will be included as an Operational Protocol at Attachment O in the STCs.

   i. Support collaborative planning between MCPs and local stakeholders to identify and address gaps that may hinder implementation of ECM / Community Support services;

   ii. Development of implementation plans to operationalize CalAIM and address ECM/Community Support service gaps using PATH funding;

   iii. Identify and resolve ongoing ECM/Community Supports service delivery challenges through regular meetings and collaboration throughout the five-year CalAIM demonstration period; and

   iv. Support development, coordination and implementation of virtual or in-person meetings to support ECM/Community Supports quality improvement efforts to ensure the delivery of high-quality services.

f. **Support for Expanding Access to Services.** Expenditure authority will make funding available to enable the transition, expansion and development of capacity and infrastructure necessary for city, county, and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. Allowable expenditures include, but are not limited to:

   i. Hiring staff that will have a direct role in the execution and expansion of ECM/Community Supports services to boost capacity to assure access to these services;

   ii. Supporting implementation of a closed-loop referral system to ensure individuals referred to needed services were able to access those services;

   iii. Purchasing billing systems for newly available services; and

   iv. Providing up front funding needed by providers/community-based organizations to deliver ECM/Community Supports services (e.g., purchasing infrastructure that refrigerates fresh food).

g. Eligible entities include, at a minimum, city, county and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs.

a. Qualified Applicants must provide the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH Program to promote equitable distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example: MCP revenue, enrollment, access/affordability and other indicators.

5.15. **The PATH Reentry Demonstration Initiative Planning and Implementation Program** will provide expenditure authority to fund supports needed for Medi-Cal pre-release application and suspension/unsuspension planning and purchase of certified electronic health record technology to support Medi-Cal pre-release applications. PATH reentry demonstration initiative planning and implementation funds will also provide funding over the remaining four years of the demonstration (beginning January 26, 2023) to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning between DHCS, carceral facilities participating in the reentry demonstration initiative (e.g., state prisons, county jails, youth correctional facilities), county behavioral health agencies, community-based providers, probation offices, community health workers, managed care plans, sheriff's offices, local county social services departments, and others. The specific use of this funding will be proposed by the Qualified Applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the carceral facility) and must be properly cost-allocated to Medicaid or CHIP, as necessary, and once finalized will be included in the PATH Operational and Monitoring Protocol at Attachment O within the STCs. These allowable expenditures may include the following:

a. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status) and coordinating pre-release and post-release services for enrollees. This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social services departments, county behavioral health agencies, and others, such as managed care plans and community-based providers, in order to support the provision of pre-release

services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

b. **Hiring of Staff and Training.** Expenditures for Qualified Applicants to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medi-Cal enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

c. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

d. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

e. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medi-Cal enrollment process and suspension/unsuspension process for eligible individuals and coordination of a period for up to 90 days immediately prior to the expected date of release and reentry planning services for individuals qualifying for reentry demonstration initiative services.

f. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration between California's correctional institutions (county jails, youth correctional facilities, and state prisons), correctional agencies (e.g., California Department of Corrections and Rehabilitation, Sheriff's Offices, Probation Offices, etc.), local county social services departments, county behavioral health agencies, managed care plans, community-based providers and others involved in supporting and planning for the reentry demonstration initiative. This may include conferences and meetings convened with the agencies, organizations, and stakeholders involved in the initiative.

g. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying uninsured who are potentially eligible for Medi-Cal; (2) assisting with the completion of an application; (3) submitting an application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

h. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry.

5.16. **PATH Funding Amounts.** PATH will be funded at the amounts described in the table below for each of the five (5) years of the CalAIM demonstration renewal, with funding phasing down over time as the CalAIM delivery system matures, totaling a maximum of $1.85 billion over five years. To the extent any of the funds associated with PATH are not fully expended or fully allocated in a given demonstration year, PATH funds may be reallocated across other PATH initiatives or years, subject to overall PATH expenditure limits. DHCS will detail within quarterly and annual reports when it reallocates PATH funding to a future DY and/or from one PATH initiative to another.

Table 1. Annual Total Computable PATH Funding by Initiative (Amounts in Millions)

Program	**PY 1 (2022)**	**PY 2 (2023)**	**PY 3 (2024)**	**PY 4 (2025)**	**PY 5 (2026)**	**Total**
Ensuring Access to Services During Transition and Delivery System Transformation and Innovation	$554	$430	$230	$70	$5	$1,289
Reentry Demonstration Initiative Planning and Implementation	$10	$350	$201	$0	$0	$561
Total	**$564**	**$780**	**$431**	**$70**	**$5**	**$1,850**

5.17. **PATH Funding Administration.** Subject to the funding limits in Table 1, DHCS will review, approve, and make payments for PATH funding in accordance with the requirements in these PATH STCs. DHCS will make payments directly to awarded Qualified Applicants or via the TPA to Qualified Applicants. DHCS will monitor payments to ensure compliance with PATH program requirements, applicable statutory and regulatory requirements, and to prevent fraud, waste and abuse. DHCS will ensure that it has appropriate mechanisms and methodologies in place to ensure the appropriate amount of FFP is claimed for each PATH program and initiative.

5.18. **Payment to Qualified Applicants and the TPA is limited to the overall PATH funding limit stipulated in Table 1.** Qualified Applicants and the TPA must attest to DHCS that they have appropriate funds controls between PATH funding and billing for Medi-Cal applicable state plan covered services.

a. DHCS will approve applicants, and administer and monitor funds for the Support for Sustaining Services Through the Transition to Managed Care, and Support for Sustaining Reentry Services Through the Transition to Managed Care initiatives. A TPA may administer and oversee funding for the other PATH initiatives, including the Reentry Demonstration Initiative Planning and Implementation Program.

b. For the Technical Assistance Marketplace, Collaborative Planning and Implementation of ECM and Community Supports, and Support for Expanding Access to Services initiatives, the TPA will be responsible for monitoring PATH payments to identify duplicate funding received by Qualified Applicants for covered Medi-Cal services or other payment programs, such as incentives. The TPA may also administer the Reentry Demonstration Initiative Planning and Implementation Program.

c. To the extent that the intensity of needs shift, PATH funds may be reallocated across PATH initiatives or future demonstration years, subject to overall PATH expenditure limits.

5.19. **Qualified Applicants.** Criteria for Qualified Applicants will vary by PATH initiative.

a. Qualified Applicants for the PATH Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program will also vary by initiative.

i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020 demonstration, will be eligible to become a Qualified Applicant to receive Support for Sustaining Services Through the Transition to Managed Care Initiative funding. Qualified Applicants may use funding from this initiative to sustain allowable WPC services until they transition to CalAIM.

ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020 demonstration that have previously offered pre-release services as part of the WPC Pilots will be eligible to become a Qualified Applicant. Qualified Applicants may use funding from this initiative to sustain previously offered pre-release services until they transition to CalAIM.

iii. For the Technical Assistance Marketplace Initiative, Collaborative Planning and Implementation of ECM and Community Supports Initiative and Support for Expanding Access to Services, the following entities, at a minimum, will be eligible to become a Qualified Applicant to receive TA support: city, county, and other government agencies; county and community-based providers including but not limited to public hospitals, CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers; and other entities as approved by DHCS or the TPA.

b. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include correctional institutions (county jails, youth correctional facilities, and state prisons), the California Department of Corrections and Rehabilitation, Probation Offices, Sheriff's Offices, county behavioral health agencies, county departments of social services, county departments of public health, and other entities as relevant to the needs of justice-involved individuals as approved by DHCS.

5.20. **Invoice and Application Process for Qualified Applicants**. Qualified Applicants will be required to submit invoices and/or applications, to be processed and evaluated by DHCS or the TPA, in order to receive PATH dollars. Funding will vary by initiative and by Qualified Applicant. If a selected applicant fails to substantially comply with any of the terms of the approved application, DHCS will take corrective action and may terminate agreement and redirect applicable funds to other selected applicants who qualify for additional PATH funds or to other Qualified Applicants whose programs were not previously selected for funding, in that same demonstration year or a future demonstration year, as applicable.

a. The invoice and/or application process for Qualified Applicants under the PATH "Ensuring Access to Services During Transition and Delivery System Transformation and Innovation" program will vary by initiative.

i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

iii. For the Technical Assistance Marketplace Initiative, Qualified Applicants must submit a standardized application to the TPA that outlines the request for TA or supporting resources, and other relevant information to be determined by DHCS.

iv. For the Collaborative Planning and Implementation Initiative, Qualified Applicants must submit a standardized application to the TPA outlining their interest and intent to establish and support local collaborative planning in the region and in collaboration with other entities, along with other relevant information to be determined by DHCS.

v. For the Support for Expanding Access to Services Initiative, the Qualified Applicant must submit a standardized application to the TPA outlining the intended purpose of the PATH funds, along with other relevant information to be determined by DHCS.

b. For the Reentry Demonstration Initiative Planning and Implementation Program, Qualified Applicants must submit a standardized application for participation and/or invoices in the format specified by DHCS for spending on permissible activities.

5.21. **Treatment of PATH Funds.** PATH payments are available to Qualified Applicants. PATH Payments shall not be considered direct reimbursement for expenditures or payments for new services. PATH payments are intended to support transitional non-service expenditures, interventions and non-Medicaid covered transitional services that support the transition from WPC Pilots and Health Home Program to CalAIM, expand access to needed services, and enable community-based providers to provide Community Supports.

PATH payments are not direct reimbursement for expenditures incurred by participating entities. PATH payments shall not be considered payments for services otherwise reimbursable under the Medi-Cal program, and therefore providers may continue to bill Medi-Cal and/or the Medi-Cal managed care plan for all applicable state plan covered services. PATH payments are not reimbursement for health care services that are recognized under these STCs or under the state plan. PATH payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, disproportionate share hospital payments or administrative activities as defined under these STCs and/or under the state plan. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

5.22. **PATH Progress Reports.** Qualified Applicants and the TPA receiving PATH funding shall submit progress reports in a manner and frequency specified by DHCS. Progress reports will include reporting on performance metrics that are standardized by PATH program and initiative. The state will work with the TPA to develop such performance metrics across PATH programs and initiatives. Qualified Applicants will also be responsible for determining entity-specific milestones related to their need for and use of PATH funding. These proposed milestones may be reviewed and approved by the state or the TPA, as appropriate, as a condition of funding receipt. In these cases, the Qualified Applicant will be expected to provide narrative reports in a frequency and manner established by the state and the TPA. Ongoing funding may be based on progress towards or achievement of those milestones and performance metrics, as determined by the state. Failure to adequately meet or report on milestones and performance metrics may preclude a Qualified Applicant from receiving future PATH funding.

Wherever possible, with respect to the two Support for Sustaining Services Initiatives, progress reports will seek to collect information that may be used to understand race, ethnicity, geographic location, and other characteristics of individuals who receive services associated with these two initiatives. For other PATH initiatives, the state will work to prioritize support for Qualified Applicants that have been historically underutilized and/or under-resourced, and/or that serve the diverse needs of the state's population.

5.23. **PATH Funding and Mechanics Protocol.** Within one hundred and twenty (120) days of CMS approval of the terms and conditions for the CalAIM renewal, CMS and the state will develop and finalize a PATH Funding and Mechanics Protocol that will outline additional detail on the milestones and award criteria for the Qualified Applicants. As needed, the PATH Funding and Mechanics Protocol will be updated within 180 days following approval of the reentry demonstration and DSHP initiatives to address these components outlined in these STCs.

5.24. **PATH Program Integrity.** DHCS will ensure that all PATH payments are made consistent with these STCs. Within one hundred and twenty (120) days of CMS approval of the STCs for the CalAIM renewal, CMS and the state will develop and finalize a PATH Operational and Monitoring Protocol that will outline DHCS' approach to PATH program integrity, oversight, monitoring, and performance metrics, including any required reporting to CMS. As needed, the PATH Operational and Monitoring Protocol will be updated within 180 days following approval of the reentry and DSHP initiatives to address these components outlined in these STCs. The

state will ensure that PATH funding is subject to program integrity standards. Program integrity activities will include, at a minimum:

a. **Completing progress reporting on PATH-funded activities.** All PATH funding recipients will be expected to submit progress reports that document PATH-funded activities. Recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state or its contracted TPA will monitor for funding irregularities and potential duplication across all PATH programs and initiatives.

b. **Participating in audit processes.** The state or its contracted TPA will conduct spot-audits to ensure that PATH funds are being spent on permissible uses and are being documented and reported on appropriately.

c. **Ensuring action is taken to address noncompliance.** The state or its contracted TPA will ensure that action is taken to address any identified non-compliance with PATH funding parameters. If the state determines that a funding recipient has failed to demonstrate appropriate performance, DHCS may impose corrective actions which may include caps on funding, recoupment of funding, or discontinuation of PATH funding. The state may also impose corrective actions for a Qualified Applicant if it is determined that it is out of compliance with requirements as set forth in the STCs and attachments, the agreement between the Qualified Applicant and the state, and/or policy letters or guidance set forth by the state. Prior to initiating any corrective action on Qualified Applicants, the state shall provide the Qualified Applicants notice and an opportunity to comment regarding the identified area of non-compliance. CMS reserves the right to require DHCS to return FFP associated with recoupment of funding for Qualified Applicant and TPA noncompliance.

5.25. **Sources of Non-Federal Share Funding for PATH Expenditures.** The state must have permissible sources for the non-federal share of all PATH expenditures, which may include, as applicable to a specific PATH initiative or program, permissible intergovernmental transfers (IGTs) from qualifying governmental entities, or state funds. Sources of non-federal share funding shall not include impermissible provider taxes or non-bona fide provider-related donations under Section 1903(w), impermissible IGTs from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal law to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

For PATH expenditures derived from IGTs, the qualified funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433, subpart B, and not derived from the impermissible sources listed above.

C. Dually Eligible Enrollees in Medi-Cal Managed Care

5.26. Under the expenditure authority for the Duals Eligible Program, the state will align a dually eligible beneficiary's Medicaid plan with their Medicare Advantage (MA) Plan choice, to the extent the Medicare Advantage plan has an affiliated Medicaid plan. In counties where the state is authorizing exclusively aligned enrollment Dual Eligible Special Needs Plans (D-SNPs), the state will limit enrollment into D-SNPs without Medicaid managed care plans, further simplifying the health plan market for dually eligible individuals. The state is committed to implementing valuable aspects of integration, including integrated appeals and grievances, continuation of Medicare benefits pending appeal, integrated member materials, and care coordination that extends across Medicare and Medicaid benefits in counties where the state is authorizing the exclusively aligned enrollment D-SNP model. Aligned Medicare/Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care. This will include:

a. The state will develop a process by which the enrollment broker can directly facilitate immediate Medicaid plan disenrollment should the beneficiary need be urgent/medically necessary, particularly during the last quarter of the calendar year. In addition, the Cal MediConnect Ombudsman, and any successor program, can make a warm handoff to the enrollment broker to facilitate immediate Medicaid plan disenrollment in the circumstances described above.

b. With the consultation of stakeholders through the Duals & LTSS Workgroup, the state will implement continuity of care requirements to support beneficiary access to prior providers until, at a minimum, the beneficiary has the opportunity to change Medicaid plans.

c. The state will ensure that beneficiary communications from the state and from plans in counties with exclusively aligned enrollment D-SNPs explain the benefits of enrollment in integrated care, and in all counties with Medicaid plan and MA alignment the beneficiary communications explain the opportunities, process, and timing for changing Medicaid plans. Beneficiary communications will include contact information for Health Insurance Counseling and Advisory Program (HICAP) and ombudsman services.

d. DHCS will develop and implement the necessary system changes to effectuate exclusively aligned enrollment for D-SNPs aligned with the Medicaid managed care plans. The state will work collaboratively with advocates, health plans, and CMS to develop and implement a long-term system.

6. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

6.1. **Drug Medi-Cal and Organized Delivery System.** The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD 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 components of DMC-ODS are authorized under California's Section 1915(b) 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. The CalAIM demonstration will continue to test whether this authority will increase access to evidence-based treatment services and improve overall health and long-term outcomes for those with SUD when a full continuum of care is provided. Critical elements of the DMC-ODS Program continue to include providing a continuum of care and patient assessment and placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria.

During the demonstration period, the state seeks to continue achieving the following goals:

a. Increased rates of identification, initiation, and engagement in treatment;

b. Increased adherence to and retention in treatment;

c. Reductions in overdose deaths, particularly those due to opioids;

d. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

e. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and

f. Improved access to care for physical health conditions among beneficiaries.

DMC-ODS Program. Under this demonstration, DMC-ODS beneficiaries will continue to have access to high-quality, evidence-based SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under section 1903 of the Act in the absence of the expenditure authority granted herein. The state will continue to be eligible to receive FFP for DMC-ODS beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. California will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 6.5 below. The ASAM Criteria assessment shall continue to be used for all DMC-ODS beneficiaries to determine placement into the appropriate level of care.

In counties that do not opt into the DMC-ODS Program, beneficiaries receive only the "Substance Use Disorder Treatment Services" covered under California's Medicaid State Plan, they are not eligible to receive the "Expanded SUD Treatment Services" covered under the State Plan which are limited to beneficiaries residing in DMC-ODS counties.

Beneficiaries under the age of 21 are eligible to receive coverable Medicaid services pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) of the Act. Nothing in the DMC-ODS overrides any EPSDT requirements. Counties remain responsible for the provision of medically necessary DMC-ODS services pursuant to the EPSDT mandate.

As outlined in Table 2 below, DMC-ODS benefits reflect a continuum of care that ensures that beneficiaries can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The ASAM Criteria Assessment shall be used for all beneficiaries to determine placement into the appropriate level of care. DMC-ODS counties must provide independent review for residential services within 24 hours of the submission of the request by the provider. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System

Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) and Early Intervention	State plan (individual services covered) SABIRT is delivered through fee-for-service (FFS) and Managed Care Plan (MCPs) delivery systems for beneficiaries aged 11 years and older Early intervention services (excluding to SABIRT) are available in DMC-ODS and Drug Medi-Cal for beneficiaries under age 21	Required • Coordination with SABIRT delivered through FFS/MCPs • Additional early intervention services for beneficiaries under age 21
Outpatient services (also known as Outpatient Drug Free)	State plan (individual services covered)	Required
Intensive outpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Partial hospitalization services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Residential/inpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • At least one ASAM level of care initially • ASAM Levels 3.5 available within two years • ASAM Levels 3.1 and 3.3 available within three years • Coordination with ASAM Levels 3.7 and 4.0 delivered through FFS/MCPs Optional • ASAM Levels 3.7 and 4.0
Withdrawal management services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • Coordination with ASAM Levels 3.7-WM and 4.0-WM delivered through FFS/MCPs • At least one level of withdrawal management (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, or 4-WM) Optional • Additional levels of withdrawal management

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Narcotic Treatment Program services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Medications for Addiction Treatment for Alcohol Use Disorders and Other Non-Opioid Substance Use Disorders	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Medications for Addiction Treatment for Opioid Use Disorders	State plan (individual services covered) 1115 expenditure authorityfor services provided to individuals in IMDs	Required
Recovery Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Peer Support Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Contingency management services	1115 expenditure authority (individual services covered)	Optional
Care Coordination services	State plan 1115 expenditure authority for services provided to individuals in IMDs	Required

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Clinician consultation services	State plan (reimbursable activity; not a distinct service) 1115 expenditure authority for services provided to individuals in IMDs	Required

6.2. **DMC-ODS County Requirements.** The following requirements apply to counties that participated in DMC-ODS as part of the Medi-Cal 2020 demonstration and new DMC-ODS counties as outlined in their approved County Implementation Plan and managed care contract.

a. **Access to Critical Levels of Care.** DMC-ODS counties are required to cover all mandatory DMC-ODS benefits and optional DMC-ODS it has elected to provide, as outlined in Table 2 above.

b. **Use of Evidence-based SUD-specific Patient Placement Criteria.** DMC-ODS counties are required to ensure the ASAM Criteria is used for all beneficiaries to determine placement into the appropriate level of care.

c. **Patient Placement.** DMC-ODS counties are required to implement a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** DMC-ODS counties are required to contract with residential SUD treatment providers that are licensed by DHCS, the California Department of Social Services (CDSS), or the California Department of Public Health (CDPH), as applicable. Residential providers licensed by DHCS offering ASAM levels 3.1, 3.3, 3.5, and 3.2-WM must also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates that the program is capable of delivering care consistent with the ASAM criteria. Residential providers are issued licenses and a DHCS LOC Designation for a two-year period that may be extended for subsequent two-year periods. During the licensure and designation period, DHCS shall conduct at least one onsite program visit for compliance and may conduct announced or unannounced site visits throughout the period. Residential providers must furnish MAT directly or facilitate access to MAT offsite. Residential providers licensed by CDPH or CDSS offering ASAM Levels of Care 3.1, 3.3, or 3.5 without a DHCS Level of Care Designation will be required to obtain an ASAM LOC Certification by January 1, 2024.

e. **Sufficient Provider Capacity.** DMC-ODS counties are required to maintain and monitor a network of contracted, DMC-certified providers and that is sufficient to provide adequate access to all covered DMC-ODS services. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, each DMC-ODS county must consider the following:

i. Require its providers to meet State Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

ii. The anticipated number of Medi-Cal eligible beneficiaries.

iii. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.

iv. The expected number and types of providers in terms of training and experience needed to meet expected utilization.

v. The number of network providers who are not accepting new beneficiaries.

vi. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for beneficiaries with disabilities

f. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** To the extent applicable, DMC-ODS counties are required to comply with opioid prescribing guidelines, overdose prevention initiative, and other interventions to prevent prescription drug misuse and coverage of and access to naloxone for overdose reversal, including but not limited to those developed by DHCS and CDPH.

g. **Improved Care Coordination and Transitions Between Levels of Care.** DMC-ODS counties are required to implement a care coordination plan to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, DMC-ODS counties will describe how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

h. **SUD Health IT Plan.** Implementation of the milestones and Metrics as detailed in STC 6.3 or Attachment E.

6.3. **SUD Health Information Technology Plan ("Health IT Plan").** The Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to

CMS the applicable Health IT Plan, to be included as Attachment E to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type.

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of health IT ecosystem improvement. The plan must include implementation milestones and projected dates for achieving them (see Attachment E), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

a. The state must include in its Monitoring Protocol an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

b. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report.

c. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

d. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

f. Components of the Health IT Plan include:

    i. The Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).

    ii. The Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders. · This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

iii. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

iv. The Health IT Plan will describe how the activities described in (i), (ii) and (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.

v. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

vi. In developing the Health IT Plan, states should use the following resources:

    i. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

    ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

    iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.4. **DMC-ODS Financing.** For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide the state with financial data on an annual basis in a form and manner

specified by the State. This data is to be collected for the purpose of setting the rates for NTP services. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

a. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment I) must explain the process the state will use to determine costs incurred by the counties under this demonstration.

b. Only state plan DMC services will be provided prior to the DHCS approval of the State/County intergovernmental agreement (managed care contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC- ODS services.

c. SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.

d. Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

e. This STC will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology. The state will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based

payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

6.5. **SUD Monitoring Protocol.** The state must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment J. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in these STCs;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section XII of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

6.6. **SUD Mid-Point Assessment.** The state must conduct an independent Mid-Point Assessment by December 31, 2024. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of program data during the CalAIM approval period, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state will require that the independent assessor consult with key stakeholders including, but not limited to: representatives of DMC-ODS counties, SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risks, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the Mid-Point Assessment Report to CMS no later than sixty (60) days after December 31, 2024 and the state must brief CMS on the report, if requested. The state must submit a revised Mid-Point Assessment Report within sixty (60) calendar days after receipt of CMS's comments, if any.

Elements of the Mid-Point Assessment Report include:

a. A brief overview of how the state met each milestone outlined in the State Medicaid Director letter, SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, dated November 1, 2017, through the implementation of California's DMC-ODC program under the Medi-Cal 2020 demonstration approval period, including any lessons learned for best practices and challenges in achieving the milestones. In addition, the Assessment must include an examination of progress toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected progress in achieving desired targets and goals in performance measures, to date;

c. A determination of factors likely to affect future performance on measure targets not yet met and an assessment about the risk of possibly missing those performance targets;

a. For measure targets at medium to high risk of not being met, recommendations for adjustments to the state's DMC-ODS implementation and operational approaches or to pertinent factors that the state can influence that will help ameliorate those risks and support improvement; and

d. An assessment of whether the state is on track to meet the budget neutrality requirements.

6.7. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Performance Measure Targets and Failure to Report Measurement Data.** Up to $5,000,000 in FFP for DMC-ODS services in IMDs may be deferred if the state is not making adequate progress in the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

7. CONTINGENCY MANAGEMENT SERVICES

7.1. Contingency Management Overview

a. Beginning no earlier than July 1, 2022, DHCS will implement a new contingency management benefit for eligible DMC-ODS beneficiaries with a substance use disorder 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 contingency management benefit before determining whether it should be available statewide.

b. Under the pilot, the contingency management 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.

7.2. **Eligibility.** To qualify for the contingency management benefit, a Medi-Cal beneficiary must meet the following conditions:

a. Be enrolled in a comprehensive treatment program that offers other services (e.g., group or individual therapy) delivered in person or via telehealth;

b. Be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional

substance use disorders and/or diagnoses does not disqualify an individual from receiving the contingency management benefit;

c. Reside in a participating DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit;

a. Not be enrolled in another contingency management program for substance use disorder;

d. Receive services from a non-residential DMC-ODS provider that offers the contingency management benefit in accordance with DHCS policies and procedures; and

e. Contingency management should never be used in place of medication treatment for addiction treatment (e.g., for opioid use disorder or alcohol use).

7.3. **Service Description**

a. The contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a substance use disorder and as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

b. The contingency management benefit utilizes an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or treatment/medication adherence. The contingency management benefit provides motivational incentives for treatment/medication adherence or non-use of substances as evidenced by, for example, negative drug tests.

c. Contingency management is offered along with other therapeutic interventions, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d).

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified, recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries that meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in in the Procedures and

Protocols in Attachment V, which will be submitted to CMS for review and approval before the program can be implemented.

i. To qualify for a contingency management motivational incentive, a beneficiary must demonstrate treatment/medication adherence or non-use of substances.

ii. The size, nature and distribution of all contingency management motivational incentives shall be determined in strict accordance with DHCS procedures and protocols, listed in Attachment V. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

i. Providers have no discretion to determine the size or distribution of motivational incentives which will be determined by DHCS.

ii. Motivational incentives may be managed and disbursed through a mobile or web-based incentive management software program that includes strict safeguards against fraud and abuse that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

iii. To calculate and generate the motivational incentives in accordance with the schedule in Attachment V, providers shall enter the evidence of the Medi-Cal beneficiary receiving the contingency management benefit into a mobile or web-based incentive management software program.

7.4. **DMC-ODS County Participation.** To participate in the contingency management pilot, a county must participate in DMC-ODS, submit an application, and be selected by DHCS.

a. The application process shall identify counties that meet at least the following standards:

i. Participating counties shall establish a network of providers that can provide contingency management in accordance with DHCS requirements.

ii. Participating counties shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and work with DHCS to identify and support providers requiring further training or technical assistance in accordance with DHCS set standards, to be outlined in DHCS guidance.

b. DHCS will provide training, technical assistance and monitoring to counties throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by DHCS, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

c. Participating counties and providers shall comply with any billing and data reporting requirements established by DHCS to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

7.5. Eligible Contingency Management Providers

a. The contingency management benefit will be delivered by DMC-ODS providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with DHCS standards that will be outlined in DHCS guidance included in Attachment V and shall meet the following requirements:

   i. Must serve beneficiaries residing in DMC-ODS counties that have been approved by DHCS for participation in the contingency management pilot;

   ii. Must be enrolled in Medi-Cal, and certified to provide Medi-Cal and DMC-ODS services, and offer outpatient, intensive outpatient, narcotic treatment program, and/or partial hospitalization services;

   iii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training developed and offered by a qualified contractor designated by DHCS;

   iv. Undergo a readiness review by DHCS and a qualified contractor designated by DHCS to ensure that they are capable to offer the contingency management benefit in accordance with DHCS standards that will be detailed in DHCS guidance; and

   v. Participate in ongoing training and technical assistance as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.

c. The following practitioners delivering care at qualified DMC-ODS providers can deliver the contingency management benefit through activities, such as administering point-of-care urine drug tests, informing beneficiaries of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

   i. Licensed Practitioner of the Healing Arts (LPHAs);

   ii. SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;

iii. Certified peer support specialists; and

iv. Other trained staff under supervision of an LPHA.

d. SUD providers will be required to offer accompanying DMC-ODS SUD treatment services and evidence-based practices for a substance use disorder and any other co-occurring substance use disorder in addition to contingency management services. These services may include individual, group and/or family counseling using a range of applicable evidence-based modalities and techniques, including but not limited to cognitive behavioral therapy, community reinforcement, motivational interviewing, care coordination, peer support services, medications for addiction treatment, recovery supports, withdrawal management, medication services, and patient education.

e. Pilot Evaluation. In alignment with the CalAIM demonstration evaluation requirements outlined in Section XII of these STCs, CA will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost-effectiveness of these services, and its effects on beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder and other types of SUD.

8. COMMUNITY SUPPORTS

8.1. Community Supports Overview.

The state is authorized to use expenditure authority to provide Health-Related Social Needs (HRSN) services, specifically recuperative care and short-term post-hospitalization housing, through electing Medi-Cal managed care plans as part of an array of evidence-based, cost-effective, health-related "Community Supports" under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, and must comply with the requirements of STC 8.6. Under the section 1115 demonstration, recuperative care and short-term post-hospitalization housing will be referred to as "Community Supports." The remaining other twelve (12) Community Supports are authorized, subject to the conditions enumerated in the 1915(b) waiver, via the Medi-Cal managed care plan contracts as in lieu of services (ILOS) pursuant to 42 CFR 438.3(e)(2) as part of CMS's review and consideration for approval of the managed care plan contracts for federal financial participation. By authorizing recuperative care and short-term post-hospitalization housing under the CalAIM demonstration, the state will be subject to the requirements detailed in the 1115 demonstration, outlined below, and will include such requirements in contracts between the state and managed care plans, as the operational construct for these two services. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible.

Recuperative care and short-term post-hospitalization housing authorized under the CalAIM demonstration must be administered in a manner that is: (1) cost effective and medically appropriate; (2) voluntary for the Medi-Cal managed care plans to offer and the

beneficiary to use; and (3) offered exclusively through managed care plans and incorporated into the development of capitation rates for electing managed care plans. These services will be consistent with STC 8.6 and STC 8.8 as demonstration-authorized services regarded as qualifying for Title XIX matching funds for populations who meet the eligibility criteria described in STC 8.5 and Attachment U.

8.2. **Service Delivery.** Consistent with the Medi-Cal managed care contract and DHCS guidance applicable to all Community Supports:

a. Recuperative care and short-term post-hospitalization services authorized under the CalAIM demonstration will only be available from electing Medi-Cal managed care plans.

b. Medi-Cal managed care plans have the option to provide one or both Community Supports authorized under this demonstration on a voluntary basis through contracted network providers, as further described in STC 8.3.

c. Medi-Cal managed care plans that elect to offer these demonstration-based Community Supports do not need to offer the services or settings statewide or in all counties in which the Medi-Cal managed care plan operates.

d. The state must require that each Medi-Cal managed care plan must report to DHCS the counties in which it intends to offer the Community Supports and any sub-county limitations on the availability of the service. Managed care plans must receive state approval and provide public notice of any such limitations on each Community Support, including specifying such limitations in the enrollee handbook.

e. Medi-Cal managed care plans will have the option to newly offer these services or change their election to offer these services every six (6) months.

f. Medi-Cal managed care plans may discontinue offering Community Supports annually with notice to DHCS and beneficiaries, as described in the Medi-Cal managed care plan contract.

8.3. **Contracted Providers.** Consistent with the Medi-Cal managed care contract and DHCS guidance and applicable to all Community Supports:

a. Electing Medi-Cal plans will contract with Community Supports providers ("Contracted Providers") to deliver the elected Community Supports authorized under the demonstration.

b. Electing Medi-Cal plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the Community Supports being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

c. The Medi-Cal managed care plan and Contracted Provider must agree to a rate for the provision of applicable Community Supports, consistent with DHCS guidance for these services, and in compliance with all related federal requirements.

d. Eligible settings for recuperative care and short-term post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

8.4. **Provider Network Capacity.** Electing Medi-Cal managed care plans must ensure the two Community Supports authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the Community Supports, in accordance with the Medi-Cal managed care plan contracts and other DHCS guidance.

8.5. **Eligibility Criteria for Community Supports.** In accordance with the Medi-Cal managed care plan contracts and DHCS guidance, these Community Supports services are available to people experiencing homelessness or who are at risk of homelessness, and who have been determined by a provider (at the plan or network level) to have medical needs significant enough to result in emergency department visits, hospital admissions or other institutional care.

a. For this purpose, California is using the U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization, and (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the HUD definition to thirty (30) days. Additional detail on eligibility for these services are outlined in Attachment U.

b. An electing Medi-Cal managed care plan will identify enrollees who may benefit from the Community Supports authorized under the demonstration, who meet these eligibility criteria, and for whom the Community Supports services will be medically appropriate as determined by a provider (at the plan or network level) and allow an individual to avoid institutionalization.

c. Medi-Cal managed care plans must accept requests and referrals for the Community Supports from enrollees and on behalf of enrollees from providers and organizations that serve them, including community-based organizations.

d. Community Supports shall supplement and not supplant services received by the Medi-Cal enrollee through other state, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

8.6. **Allowable HRSN Services and Definitions.** Recuperative care and short-term post-hospitalization housing settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level), to receive treatment on a short-term basis. Eligible settings for recuperative care and short-term post hospitalization housing must have clinicians who can provide appropriate medical and/or behavioral health care. Short-term post-hospitalization housing settings must also offer transitional supports to help enrollees secure stable housing and avoid future readmissions. Recuperative care may be offered for up to ninety (90) days in duration, and short-term post-hospitalization housing may be offered once during the demonstration period for no more than six (6) months in duration. Electing Medi-Cal managed care plans will implement recuperative care and short-term post-hospitalization housing in accordance with the detailed service definitions, standards and requirements in Attachment U.

Requirements and limitations:

a. Recuperative care and short-term post-hospitalization services must be medically appropriate and cost-effective such that the aggregate cost of providing the service does not exceed the aggregate cost of institutional care in a nursing or inpatient facility.

b. Provision of these services will be optional both for the MCP to offer and the individual to receive the service.

c. Provision of either service does not make an enrollee ineligible for allowable services under the state plan, including institutional care.

8.7. **Excluded HRSN Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (including building modification and building rehabilitation);

b. Capital investments;

c. Room and board, except as described in STC 8.6 and Attachment U;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School-based programs for children that supplant Medicaid state plan programs;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

8.8. **General Guardrails and Reporting Requirements for Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.** While recuperative care and short-term post-hospitalization services are not ILOS authorized under the 1915(b) waiver authority, to reduce administrative burden, the state may coordinate reporting, monitoring, and evaluation efforts of the HRSN services, recuperative care and short-term post hospitalization services, in alignment with corresponding expectations stipulated in California's 1915(b)(1)/(4) CalAIM waiver, while also recognizing that there are additional expectations for monitoring and evaluation for recuperative care and short-term post hospitalization services as provided in these STCs that must also be met. To the extent appropriate, the state and CMS will work collaboratively to assure there is no redundancy in reporting efforts under the section 1115 and 1915(b) authorities.

8.9. **Compliance with Federal Requirements.** The state shall ensure recuperative care and short-term post-hospitalization housing Community Supports are delivered in accordance with all applicable federal statute, regulation or guidance.

8.10. **HRSN Community Supports Protocol.** The state must submit, for CMS review and approval, the HRSN Community Supports Protocol covering the HRSN services authorized in this demonstration. Once approved, the Protocol will be affixed as Attachment X to these STCs. The state may stagger the submission of this Protocol, with the Maintenance of Effort (MOE; see STC 8.14) information submitted no later than 90 days after the inclusion of this STC in the demonstration approval. The remaining content of the Protocol must be submitted to CMS no later than nine months after this STC is effective.

a. A description of the process for identifying beneficiaries with HRSN, including outlining beneficiary qualification criteria for services.

b. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment and based on clinical and social risk factors, as applicable, may deem the service to be medically appropriate.

c. A description of the process for developing care plans based on assessment of need that is also culturally responsive and trauma informed.

d. A plan for establishing and/or improving information technology (IT) infrastructure, data sharing and partnerships with an array of health system and social services

stakeholders, to the extent those entities are vital, to provide needed administrative and HRSN-related data on beneficiary characteristics, eligibility, screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

e. A plan for tracking and improving the share of Medicaid beneficiaries who are eligible for the Supplemental Nutrition Assistance Program (SNAP) who are enrolled in that program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries, including establishing a timeline for reporting.

f. Information as required per STC 8.14 (MOE).

g. Information as required per STC 8.15 (Partnerships with State and Local Entities).

8.11. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state's conflict of interest policies.

8.12. **CMS Approval of Managed Care Contracts.**

a. As part of the state's submission of associated Medicaid managed care plan contracts to implement CalAIM, the state must provide documentation including, but not limited to:

i. Beneficiary and plan protections, including but not limited to:

i. Recuperative Care and Short-Term Post Hospitalization Housing Community Supports must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.

ii. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if Recuperative Care and Short-Term Post Hospitalization Housing Community Supports were not an option.

iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances if they request Recuperative Care and Short-Term Post Hospitalization Housing Community Supports offered by their Medicaid managed care plan, but were not authorized to receive the requested Recuperative Care and Short-Term Post Hospitalization Housing Community Supports services because of a determination that it was not medically appropriate or cost effective.

iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving Recuperative Care and Short-Term Post Hospitalization Housing Community Supports or have received these services in the past.

v. Managed care plans are prohibited from requiring a beneficiary to utilize Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

vi. Managed care plans must timely submit any related data requested by the state or CMS, including, but not limited to:

a. Data to evaluate the utilization and effectiveness of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

b. Any data necessary to monitor health outcomes and quality metrics at the local and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities.

c. Any data necessary to monitor appeals and grievances for beneficiaries.

i. Documentation to ensure appropriate clinical support for the medical appropriateness of Recuperative Care and Short-Term Post Hospitalization Housing Community Supports, including but not limited to:

1. A documented process to authorize Recuperative Care and Short-Term Post Hospitalization Housing Community Supports for beneficiaries for whom there is an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgment has determined it to be medically appropriate for the specific beneficiary as provision of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts.

2. Any data determined necessary by the state or CMS to monitor and oversee the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

ii. All data and related documentation necessary to monitor and evaluate cost effectiveness, including but not limited to:

1. The managed care plans must submit timely and accurate encounter data to the state on Recuperative Care and Short-Term Post Hospitalization Housing Community Supports

provided to members. The state must seek CMS approval on what is considered and appropriate and reasonable timeframe for plan submission of encounter data. This encounter data must include data necessary for the state to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.

2. Any additional information requested by CMS, the state or oversight body to aid in on-going evaluation of the cost effectiveness of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports or any independent assessment or analysis conducted by the state, CMS, or an independent entity.

iii. Any additional information determined reasonable, appropriate and necessary by CMS.

8.13. **Rate Methodologies.** All new or modified payment rates, methodologies and/or associated data for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval following the normal managed care rate setting process, including via standard managed care rate certifications and, when applicable, through the state directed payments submission process and in accordance with 42 CFR 438.6(c).

8.14. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding, which the state will submit to CMS for CMS approval, for ongoing social services related to housing transition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of the approval of the demonstration amendment to integrate the community supports in the HRSN framework, as part of the HRSN Community Supports Protocol, the state will submit a plan to CMS for CMS approval that specifies how the state will determine baseline spending on these services. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.

8.15. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the HRSN Community Supports Protocol that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing upon conclusion of temporary Medicaid payment, as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring Reports described in STC 14.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's

plan is fully implemented, the state may conclude its status updates in the Quarterly and Annual Monitoring Reports.

9. REENTRY DEMONSTRATION INITIATIVE

9.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medi-Cal beneficiaries and demonstration beneficiaries who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county jails, or youth correctional facilities, as specified by the implementation timeline in STC 9.8 and the implementation plan in STC 9.9. The objective of this component of the demonstration is to facilitate beneficiaries' access to certain healthcare services and case management, provided by Medicaid participating providers, CHIP participating providers, or by carceral providers who are not participating in Medicaid or CHIP, while beneficiaries are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to communities. This bridge to coverage begins prior to release and is expected to promote continuity of care and improve health outcomes for justice-involved individuals. Further, coverage beyond 30 days (for up to 90 days immediately before the expected date of release) is expected to provide a longer runway for enrollees to identify and begin to receive needed services, contribute to a reduction in post-release acute care utilization, and lead to a reduction in health crises, overdoses, and overdose-related deaths. The purpose of this reentry demonstration initiative is to provide short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death in the near-term post-release.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release;

e. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;

f. Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release; and

g. Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

9.2. **Qualifying Criteria for Pre-Release Services.** In order to qualify to receive services under this component of the demonstration, a beneficiary must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, county jail, or youth correctional facility as defined in STC 9.4;

b. Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and

c. Meet one of the following site-specific requirements:

i. Is an individual residing in a state prison or county jail who meets at least one of the health-related criteria described below and further defined in Attachment W. Meeting such health-related criteria may be indicated by a beneficiary, found at an initial screening conducted by the correctional facility upon intake, determined during a beneficiary's incarceration, or found during assessment in the process of pre-release planning.

a. Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria as defined in Attachment W;

b. Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

c. Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

d. Intellectual or developmental disability (I/DD), defined as a disability that begins before an individual has turned 18 years of

age and that is expected to continue indefinitely and present a substantial disability as defined in Attachment W;

e. Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment;

f. Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); or

g. Currently pregnant or within a 12-month postpartum period, as defined in Attachment W.

ii. Is an individual incarcerated in a youth correctional facility.

a. Has been identified as expected to be released in the next 90 days and identified for participation in the demonstration.

9.3. **Scope of Pre-Release Services**. The pre-release services authorized under the reentry demonstration initiative include the following services currently covered under the California Medicaid and CHIP State Plans, and further described in Attachment W. Contingent upon CMS's approval of the state's Reentry Demonstration Initiative Implementation Plan (see STC 9.9), the state may begin claiming FFP for services covered through the initiative at the time of inclusion of this STC, expected to begin April 1, 2024.

a. The pre-release services are:

i. Reentry case management services;

ii. Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

iii. Laboratory and radiology services;

iv. Medications and medication administration;

v. MAT, for all Food and Drug Administration-approved medications, including coverage for counseling; and

vi. Services provided by community health workers with lived experience.

b. In addition to the pre-release services specified in STC 9.3(a), qualifying beneficiaries will also receive covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and durable medical equipment (DME) upon release, consistent with approved state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative comprises a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the California Medicaid or CHIP State Plans, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT benefit for qualifying Medicaid beneficiaries under age 21) are not available to qualifying beneficiaries through the reentry demonstration initiative.

9.4. **Participating Facilities**. The pre-release services will be provided at state prisons, county jails, and youth correctional facilities, or outside of the correctional facility with appropriate transportation and security oversight provided by the carceral facility, subject to DHCS approval of a facility's readiness, according to the phase-in schedule described in STC 9.8.

9.5. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under California state scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional-facility based providers.

c. All participating providers and provider staff, including carceral providers, shall have necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or carceral providers who have expertise working with justice-involved individuals.

9.6. **Suspension of Coverage**. Upon entry of a Medicaid beneficiary into a participating correctional facility, DHCS must not terminate and generally shall suspend their Medicaid coverage, as described in the Reentry Demonstration Initiative Implementation Plan.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medi-Cal and with submitting an application to the county departments of social services, unless the individual declines such assistance or wants to decline enrollment.

9.7. **Coverage of Individuals Otherwise Eligible for CHIP During Incarceration.** If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status,

and they qualify to receive pre-release services per STC 9.2, pre-release services will be covered under this demonstration's expenditure authority.

9.8. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented on a phased-in approach, as described below. All participating state prisons, county jails, and youth correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying beneficiaries who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). DHCS will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medi-Cal and CHIP application and enrollment processes for individuals who are not enrolled in Medi-Cal or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine a beneficiary's qualification for pre-release services;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of the pre-release services, as listed in STC 9.3, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;

d. Coordination amongst partners with a role in furnishing health care and HRSN services to beneficiaries, including, but not limited to, social service departments, managed care plans, county behavioral health agencies, county departments of health, and community-based providers;

e. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and their managed care plan, and making referrals to care management and community supports providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan) and DME upon release, consistent with approved state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements

specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g. A data exchange process to support the care coordination and transition activities described in (d) and (e) of this subsection;

h. Reporting of requested data from DHCS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers that the correctional facilities will partner with for the provision of pre-release services.

9.9. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the state's approach to implementing the reentry demonstration initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The state must submit the draft Implementation Plan to CMS for review no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to their draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment CC, and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the reentry demonstration initiative that are not already captured in the STCs (including any other attachments). CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the reentry demonstration initiative at the time of inclusion of this STC, expected to begin April 1, 2024.

The Reentry Demonstration Initiative Implementation Plan must describe the implementation settings, the time period that pre-release services are available, and phase-in approach to implementation, as applicable. Other than providing such contextual information, the core requirement of the Implementation Plan is for the state to describe the specific processes, including timelines and programmatic content where applicable, for meeting the below milestones, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the Implementation Plan must document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that must be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the Implementation Plan must identify the main anticipated implementation challenges and the state's specific plans to address these challenges. The Implementation Plan is also required to document the state's strategies to drive positive changes in health care quality for all beneficiaries, thereby reducing disparities and improving health

equity. The state will be required to provide the following information related to, but not limited to, the following milestones and actions.

a. **Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated**. The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state, e.g., relevant state Medicaid agency website, if the individual will be moving to a different state upon release.

b. **Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.** The state must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The state must detail how the facilities will ensure that beneficiaries can access the demonstration benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the state must establish state requirements for carceral health providers who are not participating in Medicaid or CHIP that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

c. **Milestone 3: Promoting continuity of care.** The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, as well as HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or projected activities to ensure that Medicaid managed care plan and county behavioral health plan contracts include requirements and processes for transfer of relevant health

information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

d. **Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.** The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe, per the guidelines in the forthcoming SMDL. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the state must describe how they will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

e. **Milestone 5: Ensuring cross-system collaboration.** The state must describe how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication and engagement between corrections systems, community supervision entities, health care organizations, the state Medicaid agency, and supported employment and housing organizations. The state must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the state must develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.

9.10. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the reentry demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report.

The Mid-Point Assessment Report must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the reentry demonstration initiative. The report must be completed by the end of the third year of demonstration implementation. In the event that the reentry demonstration initiative is implemented at a timeline within the demonstration approval period, such as not to provide adequate implementation period to contribute toward a meaningful mid-point assessment, the report may be completed during a future extension of the demonstration, assuming it would also extend the authority for the reentry demonstration initiative. In the event that CMS and the state do not extend the reentry demonstration initiative beyond the demonstration's approval period ending in December 31, 2026, the mid-point assessment must be completed and the report submitted to CMS no later than when the demonstration's Summative Evaluation Report is due to CMS, which is 18 months after the end of the demonstration approval period (STC 15.8). If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: pre- and post-release providers participating in the state's reentry demonstration initiative, eligible and participating beneficiaries, and other key partners in carceral and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol for ameliorating these risks subject to CMS approval.

Elements of the Mid-Point Assessment Report must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment Report.

9.11. **Reentry Initiative Reinvestment Plan**. To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries prior to the individual facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as

described in the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the CalAIM demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

    iv. Improved health information technology and data sharing;

    v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

    vi. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the justice-involved population and,

    vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within one hundred and twenty (120) days of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan as part of the implementation plan referred to in STC 9.9 for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment EE.

10. DESIGNATED STATE HEALTH PROGRAMS

10.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support DSHP-funded initiatives, as described in STC 10.3. This DSHP authority will be available from DY19 - DY22.

a. The DSHP will have an established limit in the amount of $1,292,850,000 total computable expenditures, in aggregate, for DY19 - DY22.

b. The state may claim FFP for up to the annual amounts outlined in Table 3, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year. The total amount of DSHP FFP that the state may claim in DY 19 through 22 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives

Table 3. Annual Limits in Total Computable Expenditures for DSHP.

	DY19	DY20	DY21	DY22
Total Computable Expenditures	**$323,212,500**	**$323,212,500**	**$323,212,500**	**$323,212,500**

c. The state must contribute $114,075,000 in original, non-freed up DSHP funds, over the 5-year demonstration period towards its initiatives described in STC 5(b). These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the amendment approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public heath-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. The state is not eligible to claim FFP for DSHP expenditures until the list is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. The Approved DSHP List will be appended to the STCs as Attachment Y and thereafter may be changed or updated only with CMS approval.

10.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 5 percent of total provider expenditures or claims through DSHP identified as described in STC 10.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 10.1.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

    i. Bricks and mortar;

    ii. Shelters, vaccines, and medications for animals;

    iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

    iv. Revolving capital funds; and

    v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

10.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. DSHP-funded initiatives specifically

associated with transitional non-service expenditures start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. All PATH initiatives and programs described in STC 5.14 and 5.15, excluding expenditures on Support for Sustaining Services Through the Transition to Managed Care, as described in STC 5.14.a.

10.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS within 150 calendar days of the approval of this amendment, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to claim FFP for DSHP expenditures until the protocol is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. Once approved by CMS, the protocol becomes Attachment Z to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 10.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

10.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol in Attachment Z.

10.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than the end of December 31, 2024, after the approval of this authority. Upon CMS approval, the plan will become Attachment AA to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

11. Provider Rate Increase Requirement

11.1. The provider payment rate increase requirements, in California, described hereafter, are a condition for expenditure authorities as referenced in Expenditure Authority 12.

11.2. As a condition of approval and ongoing provision of FFP for DSHP and related expenditures over this demonstration period of performance, DY 19 through DY 22, the state will in accordance with these STCs increase and (at least) subsequently sustain, through DY 22, Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase for DY 20 and (at least) subsequently sustain through DY 22, network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio, as determined by STC 11.5 for a representative sample of these services for any of these three categories of services, is below 80 percent. The state will further increase the rate for these same services in service categories in the delivery systems with ratios below 80 percent. The total annual state cost for these rate increases for all categories of service combined shall be no less than $21.76 million. If the average Medicaid to Medicare provider rate ratio for a representative sample of these services under each of the state's Medicaid fee-for-service program and Medicaid managed care delivery system for any of these three categories of services is below 80 percent, the state shall only be required to increase provider payments for the delivery system for that category of service for which the ratio is below 80 percent.

11.3. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section. Additionally, the state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this section (i.e., cost-shifting).

11.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under

this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

11.5. Within 90 days of the approval of the demonstration amendment, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:

i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); and

ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 11.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019; and

iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

11.6. To establish the state's ratio for each service category identified in STC 11.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 11.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average

provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 11.5(b) using Medicaid managed care provider payment rate and utilization data.

11.7. In determining the ratios required under STC 11.5 and 11.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and may not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a), and 438.6(d).

11.8. If the state is required to increase provider payment rates for managed care plans per STC 11.2 and 11.6, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of the percentage increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

11.9. For the entirety of DY 20 through DY 22, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 19, and such rate will be in effect on the first day of DY 20. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 11.4.

11.10. If the state uses a managed care delivery system for any of the service categories defined in STC 11.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 20 through DY 22, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 19 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 11.4.

11.11. The state will provide the information to document the payment rate ratio required under STC 11.5 and 11.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

11.12. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

11.13. Within 90 days of the approval of the demonstration amendment, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 11.5 and 11.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment BB:

California DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to DSHP related provider payment increase requirements for the demonstration period of performance DY 19 thru DY 22		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system*

		for applicable covered service categories]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b); insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]*

In accordance with STCs 11.1 through 11.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and do not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment increase will be applied to all the services in each of the three categories in each of the fee-for-service or managed care delivery systems with a ratio below 80 percent if these systems apply to the state's Medicaid program listed herein. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 19 plus at least a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*], in the total amount of state expenditure of at least $21.76 million across affected delivery systems.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system and under a managed care delivery system, the state agrees to define primary care, behavioral health and obstetric care, including identify applicable service codes and providers types for each of primary care, behavioral health and obstetric care in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

The effective date of the rate increases is the first day of DY 20 and will be at least sustained, if not higher, through DY 22.

The additional payment increases required under STC 11.2 will also be made in the total amount of state expenditure of at least $21.76 million across the affected delivery systems.

California [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care. For any such payments, as necessary to comply with the DSHP STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid funding questions) as required by statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]. The state will also provide similar documentation for the additional payment increases required under STC 11.2.
California [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]. The state will also provide similar documentation for the additional payment increases required under STC 11.2.
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary, so that the Medicaid to Medicare ratio increases by two percentage points, will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans. The state will also assure that 100 percent of the additional payment increases under STC 11.2 will be paid to providers of the applicable services.
California agrees not to use DSHP funding to finance any provider payment rate increase required under Section 11. California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 11.
I, *[insert name of SMD or CFO (or equivalent position)*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____]

[Provide printed name of signatory _____]

[*Provide date_____*]

12. Negative Balance

12.1. **Repayment of Payment Management System (PMS) Negative Account Balances:** As of November 6, 2021, California has negative account balances in some of its Medicaid PMS accounts. In order to bring the accounts into balance, the state shall do the following:

a. **Issue Resolution**. CMS and the state shall work collaboratively to resolve outstanding financial issues:

i. Delayed certified public expenditure reconciliations – The state should review all approved payment methodologies that require a final reconciliation and ensure that clear time frames are incorporated within the approved methodology. For any methodology not containing a clear timeline for completion of the final reconciliation, the state must submit a proposed revised methodology no later than December 31, 2022.

ii. Open deferrals – The state must immediately submit decreasing adjustments for any remaining placeholder claims after December 31, 2021. For all other open deferrals currently beyond the regulatory 120-day response period, the state must submit a timeline for resolving the deferral. This proposed timeline needs to be submitted no later than March 31, 2022. CMS will work collaboratively with the state to resolve each outstanding issue.

b. **Repayment Process.**

i. Negative Account Balances – For any negative account balances unresolved as of June 30, 2022, CMS will issue a demand letter to the state identifying the final negative account balance amount and the state's right to appeal. The state may request a repayment schedule in Attachment R that ensures repayment of any remaining amount of the negative account balances identified through Federal Fiscal Year 2020 through regular quarterly installments, plus interest, by the end of the waiver period (12/31/2020) or in three years or less from CMS' approval of the repayment schedule. Interest will begin on the date of the demand notice and end when the debt is paid in full. Additional repayment requirements are identified in section c through h below.

ii. Deferred Claims – For any deferred claims 1) not paid by CMS by June 30, 2022, 2) for which the state has drawn FFP from its PMS account, and 3) for which the state has not returned all drawn FFP to its PMS account by June 30, 2022, CMS shall proceed by disallowance in accordance with 42 CFR 430 Subpart C. The state may request a repayment schedule in accordance with 42

CFR 430 Subpart C. This repayment is not subject to the provisions of subsection (c) through (h) below.

c. **Repayment Period Interest**. Interest will accrue on the final unresolved negative account balance amount; at the Current Value of Funds Rate (CVFR) published by the U.S. Department of Treasury, beginning on the date of the demand letter issued by CMS pursuant to STC 12.1(b)(i) until the entire principle amount is repaid in full. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

d. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

e. **Source of Repayment Funds.** The funding source of repayment cannot be derived from federal funds, including any Medicaid or CHIP funds available to the state in FY 2014 or later PMS accounts.

f. **Mechanism of Repayment.** The quarter payment amount due or payment in full may be sent via FedWire (preferred), Automated Clearing House (ACH), or check – specific instructions for FedWire or ACH may be obtained from your state's Division of Payment Management representative. The quarter payment amount due or in payment full via check should be made payable to: "The Department of Health and Human Services" and sent to the following address:

HHS Program Support Center
P.O. Box 979132
St. Louis, MO 63197

Please include your PMS account number and a brief description explaining the nature of the return. Please include a copy of this STC along with your payment.

g. **PMS Draws for Deferred FFP.** When CMS issues a deferral of claims for FFP to the state in accordance with the timelines set forth in 42 CFR 430.40, the state must immediately return the deferred FFP to the applicable PMS subaccount while the deferral is being resolved. After CMS reviews the deferred claims, CMS will determine the allowability of the claims. If CMS determines that a deferred claims are allowable under federal requirements, CMS will release the deferred funds to the appropriate PMS subaccount and will notify California that the funds are available for draw.

h. **Adjustments to Repayment Schedule.** The state may request a recalculation of the repayment schedule from CMS if the state decides to make accelerated repayment installments. CMS will work with the state to recalculate based on any existing

positive amounts that may be available in the PMS subaccount(s) and/or any positive Medicaid grant awards issued that may reduce the outstanding negative PMS subaccount(s) balances. CMS will reissue the repayment schedule to reflect adjustments, if any.

i. **Cash Management Improvement Act (CMIA) Agreement.** The Repayment of Payment Management System (PMS) Negative Account Balances section of these STCs does not preclude action by other federal agencies, including the United States Department of Treasury resulting from a violation of the CMIA agreement between the State of California and the United States Department of Treasury.

13. Global Payment Program

13.1. California will operate a global payment program (GPP) to assist public health care systems (PHCS) that provide health care for the uninsured. The GPP is meant to focus on value, rather than volume, of care provided. The purpose is to support PHCS for their key role in providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Promoting more cost-effective and higher value care means that the payment structure will reward the provision of care in more appropriate venues, rather than through the emergency department or through inpatient hospital settings. 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. The state will continue to test and assess this approach to assist PHCS, and will strengthen the GPP performance and effectiveness for potentially broader application.

13.2. Under the GPP, participating PHCS will continue receiving GPP payments that will be calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforce structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. The methodology for setting service values will incorporate measures of value for the patient in conjunction with the recognition of costs to the health care system. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness.

13.3. Payments will not exceed the limits in Attachment K (GPP Funding and Mechanics Protocol), but may be less if the thresholds are not achieved. Services will be grouped into categories that reflect where care is being provided. Within each category services will be grouped into tiers of similar service intensity. This will assist in modifying relative values of services, so that their long-term value is incorporated and no longer an externality. Service tiers across categories that aim to provide the same end result would have relative values of generally equivalent care. The intent of this framework is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that is person-centered.

13.4. The total amount of annual funding available for the GPP in PY1-12 is a combination of a portion of the state's DSH allotment that would otherwise be allocated to the PHCS and the

amount associated with the historical Safety Net Care Uncompensated Care Pool (UC Pool) that existed before the GPP.

13.5. **Entities Eligible to Receive Global Payments.** Payments under the GPP are available for PHCS that are comprised of a designated public hospital (DPH) identified in Attachment C that agrees to participate in the GPP and that DPH's affiliated and contracted providers (collectively, for purposes of the GPP only, Public Health Care System or "PHCS"). For purposes of the GPP, multiple DPHs and their affiliated and contracted providers may comprise a single PHCS in accordance with criteria established and set forth in Attachment K (GPP Funding and Mechanics Protocol). DHCS shall identify to CMS all PHCS that will participate in the GPP.

13.6. **General Overview of Global Payments**

a. Global payments shall be available based on a GPP program year ("GPP PY"). The first GPP PY is for the period July 1, 2015 through June 30, 2016. GPP PY 6 aligned with the six-month period of July 1, 2020 through December 31, 2020. GPP PY7 aligned with the period of January 1, 2021 through December 31, 2021. GPP PYs 8 through 12 will continue to align with CY periods, beginning with GPP PY 8 aligning with the CY period of January 1, 2022 through December 31, 2022.

b. An annual GPP budget for each participating PHCS shall be established in accordance with the parameters set forth in Attachment K (GPP Funding and Mechanics Protocol). For the purposes of GPP PY 6, the annual GPP budget shall be established for a six-month period; for GPP PY7 and all future PYs, the global budget shall be established for a full calendar year. The aggregate GPP budget among participating PHCS shall not exceed the total computable amount of GPP funds available in a given GPP PY, as established by the limits set forth in STC 13.10(e).

c. PHCS shall be required to provide a threshold amount of care, measured in points, to earn their entire annual GPP budget amount. Points for services will be assigned in a manner that incorporates measures of value for the patient and that achieves other programmatic goals, as set forth in Attachment L (GPP Valuation Methodology Protocol).

d. Each PHCS annual threshold point amount is determined through a baseline analysis, accounting for factors such as its historical and projected volume, cost and mix of services to the uninsured and estimated need, determined in accordance with Attachment L (GPP Valuation Methodology Protocol). These thresholds will ensure that PHCS only receive full GPP payments if the PHCS provides levels of services to the uninsured population necessary to meet its threshold that has been set based on the level of services that would otherwise have been provided to the uninsured. For purposes of the GPP, care will be considered uninsured for individuals for whom there is no source of third-party coverage for the specific service furnished by the PHCS. Furthermore, an individual will not be considered uninsured with regard to a non-traditional service (as identified in Attachment L, GPP Valuation Methodology Protocol) he or she receives from the PHCS if the individual has a source of third party

coverage for the category of service for which the non-traditional service is being used as a substitute.

e. Interim GPP payments shall be made to PHCS on a quarterly basis, calculated as 25 percent of the PHCS's annual global budget, or, with respect to GPP PY 6, 50 percent of the PHCS's annual budget. Within nine months following the end of each GPP PY, the state shall reconcile interim payments to the amount earned for services as established by the reports submitted in accordance with f. below.

f. Attachment K (GPP Funding and Mechanics Protocol) sets forth a reporting schedule by which each PHCS will report its actual services provided under the GPP and the corresponding points valuation to be used by DHCS to determine the payments due. The report shall at least include the GPP-related services furnished by the PHCS during the applicable year, reported by category, tier, and type, and shall serve as the basis for reconciling interim GPP payments with final amounts due. As payments for services under the GPP are based on point value, no cost reconciliation protocol will apply. PHCS shall not be subject to the reporting requirements of 42 C.F.R. Section 447.299.

g. The full amount of a PHCS global budget shall be payable to the PHCS if it meets or exceeds its designated threshold for a given GPP PY. In the event a PHCS does not achieve or exceed its threshold for a given GPP PY, the PHCS's GPP payment shall equal its global budget as reduced by the proportion by which it fell short of its threshold.

h. The state, in accordance with procedures set forth in Attachment K (GPP Funding and Mechanics Protocol), shall redistribute unearned GPP funds that were available in a given GPP PY amongst other PHCS that have exceeded their respective threshold for that year.

i. The non-federal federal share of GPP payments will be provided by PHCS through intergovernmental transfers (IGT), subject to the requirements of STC 16.10 (Sources of Non-Federal Share) below. Upon receipt of the IGTs, DHCS will draw the federal funding and pay both the non-federal and federal shares of the applicable GPP payments in accordance with the requirements and schedules described herein and in Attachment K (GPP Funding and Mechanics Protocol). In the event GPP payments are recouped upon reconciliation, DHCS will repay the corresponding federal share to CMS in accordance with federal regulations at 42 CFR 430.30, et seq.

j. GPP payments determined annually for each eligible PHCS, after accounting for finalization of the applicable DSH allotment and subparagraphs (g) and (h) as applicable, represent the final amounts available for that GPP PY.

13.7. **Valuation of Service**

a. Services under the GPP shall be valued in accordance with the methodology set forth in Attachment L (GPP Valuation Methodology Protocol). The valuation methodology allows for the continuation of services provided by Public Health Care Systems that

were reimbursed under the DSH and SNCP structure that existed for PHCS prior to the GPP, while encouraging more cost-effective and innovative care where appropriate. Point values shall also be developed for those innovative or alternative services where there is currently little to no reimbursement. The valuation methodology reflects the following programmatic goals:

i. Facilitate a shift away from the previous cost-based payment that was restricted to mostly hospital settings and subject to prolonged periods of cost reconciliation;

ii. Broaden the settings in which Public Health Care Systems receive payment for services furnished to the uninsured, and encourages Public Health Care Systems to provide greater primary and preventive services, as well as to create access to alternative modalities such as telehealth, group visits and health coaching;

iii. Emphasize coordinated care and alternative modalities by recognizing the higher value of access to primary care, ambulatory care, and other core components of care management, as compared to the higher cost of avoidable emergency room visits and acute care hospital stays;

iv. Recognize the value of services that typically are not directly or separately reimbursed by Medicaid or other payors ("non-traditional" services), and that substitute or complement services for which payment is typically available upon provision of the service ("traditional" services).

v. Make GPP a potentially equity-enhancing program through valuation of additional services otherwise available for the state's Medicaid beneficiaries such that the program can incentivize provision of such services to the uninsured population, potentially to begin addressing health inequities among populations these hospital systems serve.

b. All services eligible for points under the GPP are grouped into the four categories described below in STC 13.11:

c. Services within the categories are further stratified into tiers based on similar service intensity, activity and/or effort. Relative point values are assigned to tiers for purposes of reporting and generating payments.

d. The valuation methodology incorporates a phased approach in which traditional services, over the course of the demonstration approval period, reflect reduced point values. High intensity services will continue to be recognized for their value and importance, including recognition in the point system that emergency room visits and inpatient stays may be necessary and appropriate.

e. Relative point values will be initially set based on cost and then adjusted to a limited degree based on other measures of value, in order to assist in maintaining accountability for the amount of services provided compared to the funding PHCS receive. Higher relative value points may be assigned to services, including non-

traditional services that help promote one or more of the objectives from the list below; however, the relative point value of services, except for those services for which cost information is not readily available, such as non- traditional services, may not vary from their initial cost-based amounts by more than 40 percent at any time during the GPP.

i. Timeliness and convenience of service to patient;

ii. Increased access to care;

iii. Earlier intervention;

iv. Appropriate resource use for a given outcome;

v. Health and wellness services that result in improved patient; decisions and overall health status;

vi. Potential to mitigate future costs;

vii. Preventative services;

viii. Likelihood of bringing a patient into an organized system of care; and

ix. Additional criteria, to be designed by the state.

f. In GPP PYs in which point revaluation has occurred, point revaluation must be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if its utilization and the mix of services provided remained the same as in the baseline period used to determine the designated threshold. When DHCS develops for approval point values for additional services intended to increase health equity, this subparagraph shall not be interpreted to necessarily require revaluation of other existing services' values. However, the state must provide valuation for any additional services, as further described.

g. The exact methodology for assigning points to the services is reflected in Attachment L (GPP Valuation Methodology Protocol), as approved by CMS on March 21, 2016. This Protocol remains in effect until the state introduces additional services to the GPP. Any updates to Attachment L, including introduction of additional services, and any modifications to the valuation methodology, will be subject to CMS approval, and will require CMS approval before it can be implemented. If the state proposes to change point valuations or add new services, it must obtain CMS approval before they may be implemented in the program.

h. PHCS are not required to provide every service identified on Attachment LFF (GPP Valuation Methodology Protocol), but are allowed the flexibility to provide any combination of services, through their global payments budgets and service-related point thresholds, to address local needs.

13.8. **Global Payment Program Funding and Mechanics Protocol and Global Payment Program Service Valuation Methodology Protocol.** The GPP Funding and Mechanics Protocol

(Attachment K) and the GPP Valuation Methodology Protocol (Attachment L) set forth in detail the parameters and procedures related to the operation of the GPP.

a. **Global Payment Program Valuation Methodology Protocol** includes the following:

   i. The master list of services and activities for which points apply under the GPP and their associated point values, including the placement of services within the categories and tiers and how point values will change over the course of the demonstration.

   ii. Methodology for calculating and modifying the PHCS thresholds.

b. **The Global Payment Program Funding and Mechanics Protocol specifies the following:**

   i. How PHCS may be defined, including criteria for when multiple DPHs may comprise a single Public Health Care System.

   ii. Methodology for establishing and modifying annual global budgets for each PHCS.

   iii. Technical guidance on how eligible services to the uninsured are defined, accounted for and reported.

   iv. Reporting schedule for PHCS to report services provided under the GPP.

   v. IGT, interim payment and final payment reconciliation mechanics and schedules.

   vi. Methods for redistributing unused portions of annual global budgets among PHCS that exceeded their point threshold.

Within 90 calendar days of CMS approval of the CalAIM demonstration, the state will submit an updated version of the GPP Funding and Mechanics Protocol (Attachment K) and the GPP Valuation Methodology Protocol (Attachment L). Updates to both protocols must accommodate, among other things, inclusion of additional services available to Medi-Cal beneficiaries that the state will introduce in the GPP services with the aim of supporting health equity considerations in the state. For both the deliverables, the state must submit a revised Protocol within sixty (60) calendar days after receipt of CMS's comments, if any. Once the updated Protocols are finalized and approved, these will replace any previous CMS-approved versions, and the updated versions will be incorporated into the STCs as Attachments K and L, respectively.

13.9. **Global Payment Program Health Equity Monitoring Metrics Protocol:** No later than ninety (90) calendar days after the approval of the CalAIM demonstration extension, the state will submit to CMS a GPP Health Equity Monitoring Metrics Protocol outlining a set of metrics focused on access to, utilization of, and quality of health care and/or health outcomes that the state will systematically calculate and report for understanding existing health inequities among the state's uninsured population who receive GPP services, and thereafter, for tracking progress in bridging any such inequities. The metrics will, to the extent possible, leverage the national

established quality measures, including but not limited to, Medicaid Adult, Child, and Maternity Core Sets, and will in general be reported annually once available. The state can also propose other nationally recognized measures or appropriate metrics that are aligned with its demonstration goals pertinent to the GPP, the uncompensated care pool, and its health equity considerations.

The state will work collaboratively with CMS through iterations of the Protocol to finalize an approvable set of health equity metrics and prioritize collection of data on race, ethnicity, language, disability status and other factors to the extent feasible, and using the data to identify disparities in access, health outcomes and quality and experiences of care. The Health Equity Monitoring Metrics Protocol will outline for each of the selected metrics the reporting timeline, which might be impacted by the state's data systems readiness, the baseline reporting period, and the reporting frequency. The state will report the progress and metrics data through its Quarterly and/or Annual Monitoring Reports, per the reporting schedule that will be established in the Protocol. To the extent the state will require ramp-up time to set up data systems to be able to begin reporting the various metrics data overall or for any of the key subpopulations of interest, the state should provide regular updates to CMS on progress with data systems readiness via the Monitoring Reports.

Once approved, the Health Equity Monitoring Metrics Protocol will be appended to these STCs as Attachment M.

13.10. **Funding and Annual Limits.**

a. Under the GPP, a portion of the state's DSH funding and funding from the UC Pool are combined to make payments to participating PHCS that incur costs for services to the remaining uninsured. During each GPP PY, FFP will be available for such GPP payment expenditures up to the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, adjusted as described in subparagraphs of this STC b and c below ("Adjusted DSH"), combined with the additional Demonstration UC funding amounts as set forth in subparagraph d below. For the purposes of GPP PY 6, only the Adjusted DSH shall be reduced by 50 percent. In order to align federal fiscal year DSH allotment amounts with the conversion to calendar year GPP PYs, GPP PYs 7 through 12 will be funded 50 percent of the Adjusted DSH for the FFY beginning prior to the first GPP PY, and 50 percent of the Adjusted DSH for the FFY beginning during the GPP PY.

b. A portion of California's DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP. The amount set aside shall be identified in Attachment Q DSH Coordination Methodology.

c. In any year to which reductions to California's DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to GPP in a given GPP PY shall be reduced consistent with CMS guidelines.

d. The total computable amount available for the UC component shall equal $472 million in GPP PY1. For GPP PYs two through five, the UC component was determined by

CMS based upon the information contained in the Independent Report on Uncompensated Care. As approved by CMS on July 14, 2016, the total computable amounts available for the UC component shall equal $472 million for each of GPP PYs two through five. For GPP PY 6 the total computable amount available for the UC component shall equal $236 million. For GPP PY 7 through 12, the total computable amount available for the UC component shall equal $472 million annually.

e. Taken together, the total computable annual limits for GPP payments will not exceed the limits set forth below:

GPP PY 1 (SFY 15-16) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 2 (SFY 16-17) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 3 (SFY 17-18) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 4 (SFY 18-19) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 5 (SFY 19-20) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 6 (July 1, 2020 – December 31, 2020) – Adjusted DSH at 50% + $236 million = approximately $1.45 billion
GPP PY 7 (CY 2021)- Adjusted DSH + $472 million= approximately $2.9 billion
GPP PY 8 (CY 2022) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 9 (CY 2023) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 10 (CY 2024) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 11 (CY 2025) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 12 (CY 2026) – Adjusted DSH + $472 million = approximately $2.9 billion

f. The non-federal share of payments under the GPP shall be funded by voluntary intergovernmental transfers made by PHCS, or governmental agencies affiliated with PHCS. The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non- bona fide provider-related donations. The State must have permissible sources for the non-federal share of GPP expenditures, which may include permissible IGTs from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid or Medicare (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

g. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

13.11. **Categories.** Each service will be assigned into a category by the state that best reflects its characteristics of intensity and area delivered. These categories will assist in determining the point values of individual services. The categories listed below are intended to provide a broad overview of the categories and services. In addition to the categories below, the state will create a new category to include those services intended to address health equity; this new category will be in effect beginning in PY9. The full description of categories are included in Attachment M and shall be updated to reflect any additional services intended to address health equity.

a. **Category 1:** Traditional Outpatient – This category includes traditional outpatient services provided by a public hospital system facility:

i. Non-physician practitioner;

ii. Traditional, provider-based primary care or specialty care visit;

iii. Mental health visit;

iv. Dental;

v. Public health visit;

vi. Post-hospital discharge;

vii. Emergency room/Urgent Care; and

viii. Outpatient procedures/surgery, provider performed diagnostic procedures.

b. **Category 2:** Non-Traditional Outpatient – This category includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings

i. Community health worker encounters;

ii. Health coach encounters;

iii. Care navigation; and

iv. Health education & community wellness encounters.

c. **Category 3:** Technology-Based Outpatient – This category includes technology- based outpatient encounters that rely mainly on technology to provide care:

i. Call line encounters;

ii. Texting;

iii. Telephone and email consultations between provider and patient;

iv. Provider-to-provider eConsults for specialty care; and

v. Telemedicine;

d. **Category 4:** Inpatient and Facility Stays – This category includes traditional inpatient and facility stays by patients:

i. Recuperative/respite care days;

ii. Sober center days;

iii. Sub-acute care days; and

iv. Skilled nursing facility days;

13.12. **Service Threshold.** The threshold amounts for each PHCS will initially be constructed using the volume and cost of services occurring in participating providers, and will use the most recent complete state fiscal year data (Base SFY). Point values for each service will be consistent across all providers. The threshold amounts shall be determined in accordance with the methodology set forth in Attachment K (GPP Funding and Mechanics Protocol), which takes into account the following requirements and factors:

a. Historic point values for each service category on a per unit of service basis across all Public Health Care Systems, taking into account at a minimum, the varying methods for identifying units and categories of services, cost per unit, cost trends and service mix;

b. Base SFY utilization for each Public Health Care System; and

c. Adjustments to account for changes in uninsured service needs since Base SFY, including the coverage expansions resulting from ACA implementation; and,

d. Adjustments to account for public health emergencies or other state of emergency situations that impact the delivery of GPP services by a Public Health Care System.

e. This threshold will require approval by CMS before it can be finalized.

f. Thresholds for GPP PY2-PY12 will decline in proportion to reductions in annual limits.

13.13. **Coordination with DSH**

a. To maintain budget neutrality, the state will not make state plan-based DSH payments and uncompensated care payments to hospitals participating in the GPP.

b. Hospitals that meet DSH eligibility criteria and which are not participating within a PHCS may receive DSH payments under the applicable provisions of Attachment 4.19-A of the state plan, as modified pursuant to Attachment Q (DSH Coordination Methodology).

13.14. **Discontinuation of GPP**

DHCS may, in consultation with the participating PHCS, discontinue the GPP in any subsequent state fiscal year(s) for the remainder of the Demonstration and revert to financing

uncompensated care costs for Medicaid and uninsured patients under the DSH program pursuant to the state plan. DHCS shall notify CMS no later than 30 calendar days prior to the start of the initial state fiscal year for which the GPP will be discontinued. DHCS will follow the appropriate processes as is necessary to facilitate DSH payments to affected PHCS under the State plan.

13.15. **DSH Payments and FFY**

The state is not authorized to make a DSH payment under the Medicaid state plan for any hospital for any federal fiscal year (FFY) in which that hospital is eligible for a GPP payment for a GPP PY or portion thereof that is within that FFY. A DSH payment is considered to be made for a FFY if the payment would count against the DSH allotment for that FFY. In the event that the GPP is not authorized for a full PY, the state is prohibited from making duplicate GPP and DSH payments to GPP-eligible hospitals and must submit, subject to CMS approval, a method for allocating GPP and DSH payments to avoid duplication during the affected period.

14. GENERAL REPORTING REQUIREMENTS

14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in

satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

14.2. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

14.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

14.4. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment DD. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of

quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 14.5), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

For the HRSN and reentry services, authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Health Equity Measure Slate from CMS. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and develop appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the HRSN Community Supports Protocol (STC 8.10(d)).

In addition, the state must describe in the Monitoring Protocol methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (such as, services rendered, resolution of identified need, etc., as applicable), (4) social needs screening results from electronic health records, health plans, or other partner agencies, and (5) data related to carceral status Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

To the extent applicable, the state's selection and reporting of monitoring metrics for the HRSN services is expected to align with the monitoring required by the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services.

For the qualitative elements (e.g., operational updates as described in STC 14.5 below), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

14.5. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives, as applicable for all key demonstration initiatives and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the

demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of reporting metrics data on quality of care and health outcomes that are known to be important for closing key equity gaps in Medicaid and CHIP (e.g. the National Quality Forum (NQF) "disparities sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to the demonstration initiatives and populations. If needed, the State may submit an amendment to its monitoring plan no more than 150 days after receiving the final Health Equity Measure Slate from CMS to incorporate these measures.

Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

For the approved HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, in addition to reporting on the metrics described above, the state may align with monitoring required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, as may be applicable. The state must track beneficiary participation in applicable services over time, as well as narratively report annually on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and contracted providers of applicable services (e.g., managed care plan and their contracted HRSN providers). Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

The state's selection and reporting of quality of care and health outcomes metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating carceral settings. In addition, the state is expected to monitor the number

of beneficiaries served and types of services rendered under the demonstration Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

In addition, the state must demonstrate through its Annual Monitoring Reports to CMS improvements in Medicaid fee-for-service base provider payment rates and payment rates for providers enrolled in managed care to the extent required by the DSHP-related STCs. As applicable, the state must also track the number and characteristics of contracted or participating organizations, specifically under the demonstration's HRSN and reentry initiatives, and corresponding payment-related metrics.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

14.6. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

14.7. **Close-Out Report.** Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state shall include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.7 and 15.8, respectively.

c. The state must present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out report.

e. The revised Close-Out report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 14.1.

14.8. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

14.9. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

15. EVALUATION OF THE DEMONSTRATION

15.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any

federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including, as applicable and in consultation and collaboration with the state, representation from the state's independent evaluators, and organizations associated with the demonstration operations—in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.

15.2. **Independent Evaluator**. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

15.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.7 and 15.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary

modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

15.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment T to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

15.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the Evaluation Design must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must analyze outcomes, such as enrollment and enrollment continuity, and measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, hypotheses for the DMC-ODS component of the demonstration must include an assessment of the core goals of the program, to include (but are not limited to): initiation and engagement with treatment, reduction in unnecessary and inappropriate utilization of emergency department and inpatient hospitalization through expanded utilization of DMC-ODS services, and reductions in key outcomes such as deaths due to overdose. In addition, the state will also evaluate the effectiveness of the Contingency Management benefits provided to qualifying DMC-ODS beneficiaries. Further, the state will evaluate its program goals to improve alignment and integration and to enhance beneficiary experience under the expenditure authority provided in the demonstration for dually eligible beneficiaries.

Similarly, in alignment with the overarching goals of PATH and DSHP authority to support various infrastructure, transitional non-service expenditures, and capacity building efforts and the overall implementation and operationalization of CalAIM in the state, the evaluation of

these demonstration components—for example—will analyze hypotheses focused on items such as how PATH (including the DSHP funding), in conjunction with related CalAIM initiatives, promotes: access to community-based providers of ECM, reentry services, and HRSN services, specifically, the two Community Supports authorized through this demonstration, and improved access and utilization of health care services at the community-level, with particular attention to historically under-resourced or marginalized populations. The evaluation will be informed by progress reports to be submitted to DHCS by Qualified Applicants on the need for and use of PATH funding and achievement of defined milestones.

The demonstration's GPP evaluation must study hypotheses and research questions that help understand, for example, whether the program leads to improvements in care delivery in more appropriate settings and improvements in health equity via improvements in access, quality and experience of care, and health outcomes among the state's uninsured population.

Hypotheses for the HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, must focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and beneficiary physical and behavioral health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys). Given the populations of focus and the program designs of the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual and/or community level.

The state is required to examine whether and how state and local investments in housing and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services. The state is also required to include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications, related to the provision of upstream HRSN services.

Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and

efficient provision of high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination, connections between carceral and community services, access to and quality of care in carceral and community settings, preventive and routine physical and behavioral health care utilization, non-emergent emergency department visits and inpatient hospitalizations.

The state must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services.

The demonstration's evaluation efforts will be expected to include an examination of carceral provider qualifications and standards as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the state's HRSN initiative, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated care costs. As noted above, the state must also analyze the costs and cost effectiveness of the HRSN services and the budgetary effects of the reentry demonstration initiative. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the reentry demonstration initiative and the HRSN components, and beneficiary experience with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

15.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

15.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

15.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within thirty (30) calendar days.

15.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.

15.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

15.12. **Additional Publications and Presentations**. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

16. GENERAL FINANCIAL REQUIREMENTS

16.1. **Allowable Expenditures**. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

16.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting

instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid or Medicare funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

b. The state certifies that state and local monies are used as the source of non-federal share for the demonstration expenditures. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by federal law or these STCs. All sources of the non-federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations and are not derived from impermissible provider taxes or donations or federal funds (unless the other federal funding source by law allows use of federal funds for purposes of obtaining additional federal matching funds under Medicaid). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare and Medicaid. Further, these sources and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies, any sources determined to be

impermissible by CMS shall be addressed within the time frames set by CMS. For non-federal share funding using intergovernmental transfers, the funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 Subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money not permitted by law to be used as state share, impermissible taxes, and non-bona fide provider-related donations.

c. Under all circumstances, health care providers must retain 100 percent of their payments received under this demonstration. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of these demonstration payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

d. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and does not duplicate other sources of federal funds.

16.4. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with all applicable requirements for payments, including those in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

16.5. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

16.6. **State Monitoring of Non-Federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after the effective date of the demonstration amendment that added this STC. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

16.7. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

16.8. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

16.9. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table below provides a master list of MEGs defined for this demonstration.

Table 4: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CBAS	Hypo	X		X	An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.
OOS FFCY	Hypo	X		X	Expenditures for extending eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
DMC-ODS: IMD	Hypo	X		X	Expenditures for otherwise covered Medicaid services furnished to qualified beneficiaries who are primarily receiving treatment and withdrawal management services for substance use disorder as short-term residents in facilities that meet the definition of an IMD.
IHS Chiropractic Services	Hypo	X		X	Supplemental payments to support participating IHS and tribal facilities that incur costs associated with chiropractic services for which Medi-Cal coverage was eliminated hat are furnished by these providers to individuals enrolled in the Medi-Cal program.
HRSN Services	Capped Hypo		X	X	Recuperative care and Short-Term Post Hospitalization Housing
PATH Supports	Non-Hypo			X	Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH program
IP UPL PH	Non-Hypo		X		Inpatient Upper Payment Limit for Public Hospitals
GPP	Non-Hypo			X	DSH & SNCP (Safety Net Care Pool)
Contingency Management	Non-Hypo			X	Expenditures for evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Asset Test	Hypo	X		X	Expenditures to extend eligibility for individuals in the following Deemed SSI populations who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member
Reentry Demonstration Initiative	Hypo	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails, or youth correctional facilities.
PATH - Reentry Demonstration Initiative Transitional Non-Service Expenditures	Hypo		X	X	Expenditures to for planning and supporting the reentry demonstration initiative including for technology and IT services, hiring and training of staff, purchasing of necessary technology and electronic health records and billing systems, developing protocols and procedures, and other expenditures to provide support for pre-release services.
DSHP	Non-Hypo			X	Expenditures for costs of designated programs which are otherwise state-funded

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

16.10. **Reporting Expenditures and Member Months**. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00193/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy

rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 WAIVER or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months**. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. Appropriate exceptions, as applicable, must be documented in the state's Budget Neutrality Specifications Manual referenced in STC 16.6(e) The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual**. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
CBAS		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
OOS FFCY		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
DMC-ODS: IMD		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
IHS Chiropractic Services		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
HRSN Services		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service/ Date of payment	MAP	Y	1/1/2022	12/31/2026
PATH Supports		See STC 16.6	Follow CMS-64.10 or	Date of Service	ADM/ MAP	N	1/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
			CMS-64.9 Category of Service Definition					
IP UPL PH		See STC 16.6	NA	Date of Service	MAP	N	1/1/2022	12/31/2026
GPP		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	N	1/1/2022	12/31/2026
Contingency Management		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	N	7/1/2022	12/31/2026
Asset Test		See STC 16.6	Follow CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	7/1/2022	12/31/2026
Reentry Demonstration Initiative			Follow CMS-64.9 Category of Service Definition	Date of Services	MAP	Y	4/1/2024	12/31/2026
DSHP			Follow CMS-64.10	Date of Payment	ADM	N	1/26/2023	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
			Category of Service Definition					
PATH – Reentry Demonstration Initiative Transitional Non-Service Expenditures			Follow CMS-64.10 Category of Service Definition	Date of Payment	ADM	N	1/26/2023	12/31/2026
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Follow CMS-64.10 Category of Service Definition	Date of Payment	ADM	N	1/1/2022	12/31/2026

g. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 6: Demonstration Years		
Demonstration Year 18	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 19	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 20	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 21	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 22	January 1, 2026 to December 31, 2026	12 months

h. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.

i. **Claiming Period**. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

j. **Future Adjustment to Budget Neutrality**. CMS reserves the right to adjust the budget neutrality expenditure limit:

    i. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

    ii. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law, whichever is earlier

    iii. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's

knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

16.11. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 16.11c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.8. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

16.12. **Supplemental Payments to IHS and 638 Facilities.** The state shall make supplemental payments to participating Indian Health Service (IHS) and tribal 638 facilities that incur costs associated with providing chiropractic services. Supplemental payments shall be computed based on the cost for chiropractic services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing chiropractic services to non-IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment D. The annual limit for such supplemental payments shall be $1,550,000 total computable per year (DY 18-22).

16.13. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for CalAIM to ensure oversight and monitoring of demonstration claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after the renewal approval to account for changes and expansions to the waiver as described within these STCs for the CalAIM Demonstration.

17. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

17.1. **Budget Neutrality Effective Date.** All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2022. Notwithstanding this effective date, expenditures made for Uncompensated Care Pool payments under GPP during the temporary extension period of July 1, 2020 through December 31, 2021 are permitted.

17.2. **Limit on Title XIX Funding.** California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit

will consist of three parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California and disproportionate share hospital (DSH) allotments. Spending under the budget neutrality limit is authorized for all spending related to approved expenditure authorities. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the demonstration extension (January1, 2022 through December 31, 2026). Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for General Financial Requirements Under Title XIX. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

17.3. **Risk.** California will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

17.4. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

17.5. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any

amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 7: Main Budget Neutrality Test								
MEG	**PC or Agg.**	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**
Contingency Management	Agg.	WW Only	N/A	$4,866,666	$29,200,000	$31,515,350	$31,515,350	$31,515,350
IP UPL PH	Agg.	WOW Only	N/A	$863,054,000	$863,054,000	$863,054,000	$863,054,000	$863,054,000
DSHP	N/A	WW Only	N/A	The state must have savings to offset these expenditures.				
GPP-DSH	N/A	Both	N/A	The state shall calculate annually in accordance with Attachment Q.				
GPP	N/A	WW Only	N/A	$472,000,000	$472,000,000	$472,000,000	$472,000,000	$472,000,000
PATH Supports	Agg.	WW Only	N/A	The state must have savings to offset these expenditures, except for certain PATH-Reentry Demonstration Initiative Transitional Non-Service Expenditures as shown in Table 8.				

17.6. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

17.7. **Hypothetical Budget Neutrality Test 1:** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are

counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test. The following applies to hypothetical budget neutrality tests under this demonstration:

i. Actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS services (whether provided through managed care or fee-for- service) to the SPD Medicaid-only population and to dual eligible.

ii. Actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the DMC- ODS benefit to the eligible population;

iii. Actual expenditures for the Deemed SSI asset limit increase and elimination will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be actual cost of increasing and eliminating the asset limit for the Deemed SSI populations;

Table 8: Hypothetical Budget Neutrality Test 1								
Eligibility Group (EG)	**PC or Agg.**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**
CBAS	PC	Both	0 %	$6.90	$6.90	$6.90	$6.90	$6.90
OOS FFCY	PC	Both	5.2%	$371.88	$391.22	$411.56	$432.96	$455.47
DMC-ODS IMD	PC	Both	5.2%	$2,795.87	$2,941.26	$3,094.21	$3,255.11	$3,424.38
IHS Chiropractic Services	PC	Both	4.7%	$539.98	$565.36	$591.93	$619.75	$648.88
Asset Test	PC	Both	4.50%	$980.94	$1,025.08	$1,071.21	$1,119.41	$1,169.78
PATH - Reentry Demonstration Initiative	PC	Both	0%	0	0	$534.85	$604.38	$640.72
PATH- Reentry Demonstration Initiative Transitional Non-Service Expenditures	Agg.	Both	0%	0	$209,000,000	$201,000,000	$0	0

17.8. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in STC 8, CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped

Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

17.9. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 9: Capped Hypothetical Budget Neutrality Test

MEG	Agg	WOW Only, WW Only, or Both	DY 18	DY 19	DY 20	DY 21	DY 22
HRSN Services	Agg	Both	$353,702,693	$371,919,141	$391,653,626	$412,906,148	$434,158,671

17.10. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

17.11. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2022 through December 31, 2026. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward

savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (07/01/2015 to 06/30/2020). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

17.12. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 17.11, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $99,215,335,167.

17.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 10: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 19 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 20 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent
DY 21 through DY22	Cumulative budget neutrality limit plus:	0.0 percent

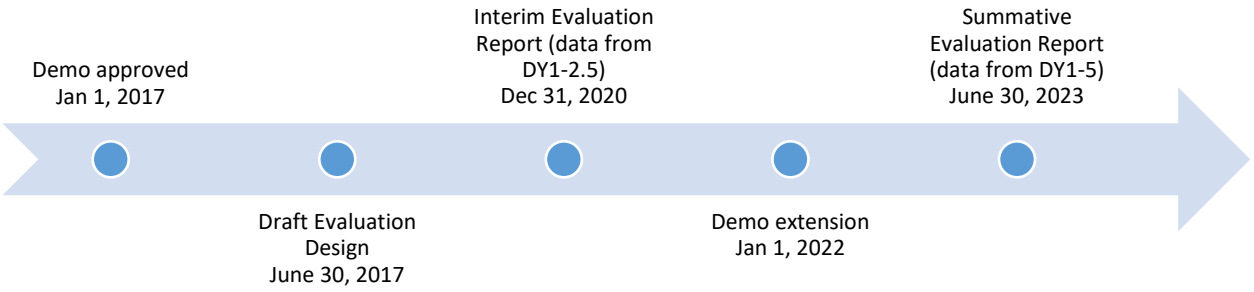
Attachment A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to

which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute

directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health

Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

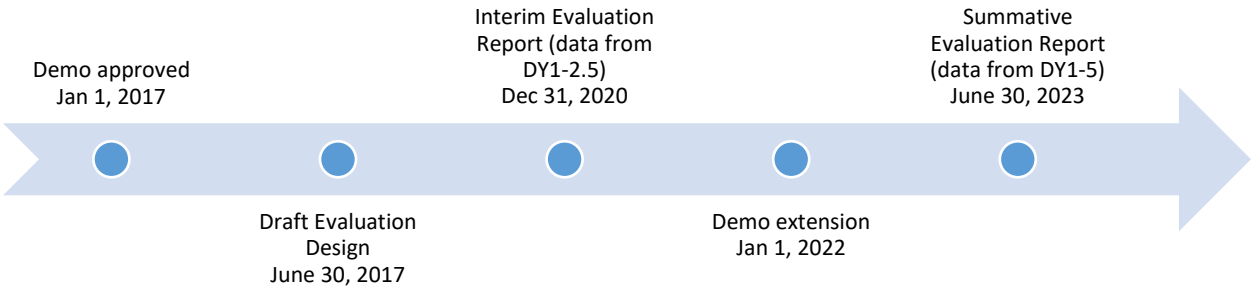
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is

appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.

3) *Evaluation Period* – Describe the time periods for which data will be collected.

4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

D. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

a. If the state did not fully achieve its intended goals, why not?
b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C
Global Payment Program Participating Public Health Care Systems

Public Health Care Systems participating in the GPP consist of the following designated public hospitals (DPHs), including any successor or differently named hospital as applicable, and their affiliated and contracted providers. The DPHs are operated by a county, a city and county, University of California, or special hospital authority described in Section 101850 or 101852, *et seq.*, of the California Health & Safety Code.

1. Los Angeles County (LA Co.) health system
    a. LA Co. Harbor/UCLA Medical Center
    b. LA Co. Olive View Medical Center
    c. LA Co. Rancho Los Amigos National Rehabilitation Center
    d. LA Co. University of Southern California Medical Center
2. Alameda Health System
    a. Highland Hospital (including the Fairmont and John George Psychiatric facilities)
    b. Alameda Hospital
    c. San Leandro Hospital
3. Arrowhead Regional Medical Center
4. Contra Costa Regional Medical Center
5. Kern Medical Center
6. Natividad Medical Center
7. Riverside University Health System -- Medical Center
8. San Francisco General Hospital
9. San Joaquin General Hospital
10. San Mateo County General Hospital
11. Santa Clara Valley Medical Center
12. Ventura County Medical Center

Attachment D - Funding and Reimbursement Protocol for IHS

Funding and Reimbursement Protocol for Claiming IHS and 638 Facilities Uncompensated Care Payment Methodology The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from November 1, 2015 through December 31, 2020 as required by STC 16.12. Using the methodology escribed below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low-Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and December 31, 2014 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal. Costs for optional dental and psychology, that were eliminated through SPA 09-001, but have been added back in through State Plan Amendments are not available for reimbursement through these supplemental payments.

A. Provider Claiming Methodology for services provided November 1, 2015 through December 31, 2020

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
    b. Whether the service was provided to an IHS eligible individual; and
    c. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third-party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a

Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third-party payments received by each facility forthe qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility foruncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

Exhibit 1.B: Aggregate Encounter Report for January 1, 2022 through October 31, 2026

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____ _____

Title Date

_____

Signature (officer of the governmental entity)

Attachment E

SUD Health IT Plan

California Progress on SUD HIT Plan

Overview

The state's Department of Justice (DOJ) manages the Controlled Substance Utilization Review and Evaluation System (CURES), the state's prescription drug monitoring program (PDMP). CURES is governed by strict statutory and regulatory requirements that limit the entities—licensed prescribers, pharmacists, regulatory agency officials, and law enforcement officials--who can access the database. CURES stores Schedule II-V controlled substance prescription information that is reported as dispensed in California. Prescribers must consult CURES to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 6 months thereafter if the substance remains part of the treatment of the patient. In accordance with CMS' request, this document details the state of CURES for each functionality included in the SUD HIT.

Prescription Drug Monitoring Program Functionalities

- **Interstate sharing:** AB 1751 (Stats 2018, Ch 478, Low) authorized the DOJ, once final regulations addressing CURES access and use have been issued, to participate in interstate sharing. The DOJ is in the process of developing functionality within CURES to support interstate data sharing and plans to use both RxCheck and sPMPi to facilitate data sharing across states. Additionally, DOJ is actively working with potential data sharing partners. Data obtained from CURES may be provided to authorized users of another state PDMP if the entity operating the interstate data sharing hub, and the PDMP of that state, have entered into an agreement with the DOJ for interstate sharing of PDMP information. Implementation of this functionality is scheduled for Spring 2022.
- **Enhanced "ease of use" for prescribers and other state and federal stakeholders**. CURES launched the Information Exchange Webservice (IEWS) an interoperability platform in 2018 that allows for integration with providers' EHRs and with HIEs where users log into the data system. Currently, 50 health IT entities, including HIEs and large health systems, whose users are authorized to access CURES, use the platform. In addition, DOJ is engaged in a CURES optimization effort to update the "look and feel" of the web-portal and dashboard to promote ease of use. Additionally, interstate searches will be available through the IEWS. Implementation of the optimized CURES is scheduled for Spring 2022.
- **Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.** *See bullet immediately above*
- **Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.** CURES presents daily patient safety alerts within the CURES dashboard to prescribers when their patient's aggregate prescription level exceeds certain thresholds, including:
  - Patient is currently prescribed more than 90 morphine milligram equivalents per day

- Patient has obtained prescriptions from 6 or more prescribers or 6 or more pharmacies during last 6 months
- Patient is currently prescribed more than 40 morphine milligram equivalents of methadone daily
- Patient is currently prescribed opioids more than 90 consecutive days
- Patient is currently prescribed both benzodiazepines and opioids

The CURES database also provides health care practitioners and pharmacists with a messaging capability that allows a message to be sent to another health care practitioner regarding a mutual patient from within the secure CURES environment.

Current and Future PDMP Query Capabilities

- **Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query).** CURES uses an algorithm to de-duplicate patient entities and that considers various elements of a patient record. It is important to note that use of this algorithm is applied only when CURES generates daily patient safety alerts and for the production of CURES de-identified datasets.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes

- **Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.** The IEWS platform allows providers easy access to CURES through their EHR as detailed above. State statute requires prescribers to review a patient's history on CURES within 24 hours or one business day before prescribing a controlled substance. In accordance with state law, approved prescribers and pharmacists will be able delegate their authority to access CURES reports. This delegate functionality will become available within the web application in Spring 2022. Delegate access through IEWS is dependent on the National Council for Prescription Drug Programs (NCPDP) to adopt an update to the NCPDP SCRIPT Standard and is therefore on a longer timeframe.
- **Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.** In addition to the CURES functionality described above and related to patient alerts, CURES includes links to resources on safe prescribing of controlled substances. For example, the CURES public website includes links to the CDC prescribing guidelines, Medical Board of California guidelines, California's Department of Public Health (CDPH) opioid overdose surveillance dashboard, as well as the CDPH Guidance Letter.

Master Patient Index / Identity Management

- **Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.** See bullet above on master patient index/patient matching.

Overall Objective for Enhancing PDMP Functionality & Interoperability

- **Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.** Key functionalities intended to help minimize the risk of inappropriate opioid

overprescribing are described above. Additionally, in accordance with state statute and regulations, a public or private entity, including a Bona Fide Researcher, is eligible to obtain data from CURES, subject to the requirements of the data request process. Accordingly, there is no specific data transmittal that occurs between CURES and Medicaid. Related other state IT efforts, DHCS data and clinical staff regularly monitor inappropriate prescribing of opioids through its routine utilization monitoring, an effort that has increased in priority due to the current opioid crisis. Onsite reviews of suspect practitioners have resulted in Drug Code Limitation, a sanction restricting pharmacies from billing for prescriptions written by sanctioned practitioners, and suspension from the Medi-Cal program when there is evidence of potential fraud and/or patient harm. Fraud investigations are conducted and cases are referred to law enforcement for criminal investigation and prosecution when warranted.

Attachment F

Accounting Procedures
(Reserved)

Attachment G

Demonstration and Program Years

CalAIM: Demonstration and Program Years

Demonstration Year (DY)	Dates
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

Global Payment Program	
Program Year (PY)	**Dates**
PY 6	July 1, 2020 through December 31, 2020
PY 7	January 1, 2021 through December 31, 2021
PY 8	January 1, 2022 through December 31, 2022
PY 9	January 1, 2023 through December 31, 2023
PY 10	January 1, 2024 through December 31, 2024
PY 11	January 1, 2025 through December 31, 2025
PY 12	January 1, 2026 through December 31, 2026

Attachment H
Community-Based Adult Services (CBAS) Provider Standards of Participation

A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

4. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
5. Adhere to these waiver Standards of Participation (SOPs);
6. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
7. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
8. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
9. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. Future reference in these SOPs will specify CDA.

B. CBAS Center Services

1. CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of services and the duration of attendance of each participant at the center.
    a. Core services: each CBAS participant shall be scheduled to receive ALL of these services on each day of attendance at the center:

i. Professional nursing.
ii. Therapeutic activities.
iii. Social services and/or personal care services.
iv. One meal offered per day.

b. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
i. Restorative physical therapy.
ii. Restorative occupational therapy.
iii. Speech therapy.
iv. Behavioral health services.
v. Registered dietitian services.

c. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

2. Requirements specified in Section B.1 of these SOPs may be suspended in the event of qualifying emergencies pursuant to the CBAS STCs for Emergency Remote Services (ERS). All requirements for CBAS ERS specified in the CBAS STCs and further defined in state-issued policy letters must be met to be eligible for reimbursement.

A. Legal Authority and Requirements

1. CBAS providers shall:
   a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s), except when CBAS ERS supports and services are delivered in accordance with these STCs and SOPs and all requirements specified in state-issued policy letters.
   b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; in Medi-Cal Provider Bulletins and CBAS All Center Letters, and as set forth in these SOPs.
   c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
   d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.

2. If there is a change in adopted laws or regulations governing the licensing of ADHC centers and/or the certification of CBAS providers, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

B. Physical Plant and Health and Safety Requirements

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
    a. Comply with state and local building requirements and codes.
    b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
    c. Have a working, listed telephone number.
    d. Have a working FAX number.
    e. Have a working email address.
    f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
    g. Have a working heating and cooling system.
    h. Have adequate lighting.
    i. Have appropriate water supply and plumbing.
2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
    a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
    b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
    c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
    d. Appropriate office area(s).
3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.
4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.
5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.
6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.
2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months, as specified in the STCs, and must continue to be supported by the participant's IPC. Reauthorization for CBAS ERS is required at least every three months, in accordance with the STCs and all requirements specified in state-issued policy letters.
3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.
2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.
3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.
4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.
5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.
6. Be approved by the participant or participant's authorized representative and documented in the signed CDA ADHC/CBAS Participation Agreement attesting to having participated in the center's care planning process to develop the IPC. Signing the CDA ADHC/CBAS Participation Agreement shall occur after the participant's assessment or reassessment process has been completed and the IPC has been developed, and prior to the delivery of CBAS services identified on the IPC.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA), including days of service provided under CBAS ERS, from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.
    a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.
2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.
    a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.
3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.
4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants.
    a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
    b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).
5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.
6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times.
    a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
    b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.
2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.
3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.
4. Financial and accounting records that fully disclose the disposition of all funds.
5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.
6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
    a. Discharge plan at time of disenrollment from the CBAS center:
        i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
    b. Incident reports:
        i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.
7. Written policies and procedures for center operations and the provision of services to CBAS participants.
8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
    a. Use of the local 911 system.
    b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
    c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.
9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.
10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).

11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).
12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs. Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.
    a. A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.
    b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).
13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
    a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).
    b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.
    c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

Attachment I
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol (Updated September 16, 2020)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by Federal law to be used for such purpose. The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers, payments made to contracted managed care plans, and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver, authorized under California's Section 1915(b) waiver, and California's Medicaid State Plan to eligible Medi-Cal beneficiaries. Services provided to beneficiaries residing in an IMD will be reported in the necessary 1115 line items within the CMS-64 report, separate and apart from all other services rendered to beneficiaries residing outside of an IMD.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers for substance use disorder services rendered. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

Each DMC ODS county that contracts with a managed care plan pays the managed care plan a county specific interim per utilizer per month (PUPM) rate for all substance use disorder services rendered by county and non-county providers to each user each month. Each county-specific PUPM rate is reviewed and approved by DHCS, and is subject to reconciliation as described below.

The county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for

inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

The county-specific interim PUPM rates are based on the following criteria.

- Total enrollment for each county multiplied by assumed prevalence rates and penetration rates by age group equals estimated utilizers for each county.
- Estimated utilizers multiplied by the percentage of utilizers in Marin County, Riverside County, and San Mateo County who used each mode of service.
- Estimated utilizers by mode of services multiplied by the average rate per mode of service paid in Marin County, Riverside County, and San Mateo County or the Fiscal Year 2015-16 county cost trended forward, if available, determined the total cost for each mode of service.
- Summed the total cost across all modes of service to determine the total cost for the estimated utilizers.
- Divided the total estimated cost by the total estimated utilizers to determine the service component of the interim PUPM rate.

As the State reviews proposed county interim rates and county interim PUPM rates, the additional information that is considered in the review includes data that illustrates the contract providers' or contract managed care plan's projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate or contract managed care interim PUPM rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process and request additional justification and/or correction to the projections. DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(9) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report. A county with an approved PUPM rate will not be required to submit a cost report for non-county-operated providers. The reconciliation of those payments will be subject to a reconciliation based on payments and actual encounters. A county with an approved PUPM rate will be required to submit a county provider cost report for county-operated providers, and payments for services rendered by county-operated providers will be reconciled to county-operated provider cost.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types. There is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS. For the purposes of determining DMC ODS county certified public expenditures for county-operated and contract providers under the 1115 waiver, each county as contractor with the State receives and aggregates the legal entity cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) legal entities (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

This attachment will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology in DMC-ODS; DHCS will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.
2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. "DHCS" means the California Department of Health Care Services.
4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. "DMC" means Drug Medi-Cal.
6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare

Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).

7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).
9. "IOT" means intensive outpatient treatment.
10. "Legal Entity" means each county alcohol and drug department or agency, each corporation and its subsidiaries, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.
11. "NTP" or "OTP" means narcotic treatment program treatment.
12. "ODF" means outpatient drug free treatment.
13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.
14. "Interim Per Utilizer Per Month(PUPM) Rate" means the approved county specific monthly interim rate paid per beneficiary who utilized at least one substance use disorder service for the month in which the service(s) is rendered.
15. "PH" means partial hospitalization.
16. "SUD" means substance use disorder.
17. "Total Utilizer Months" means the number of months during which all beneficiaries utilized at least one substance use disorder service.

SUMMARY OF STATE-DEVELOPED COST REPORT

Modifications to the Current CMS Approved SUD Cost Report Forms

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services. and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost

settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs must submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)

This worksheet collects legal entity details, including entity name, address, other contact information, and all related legal entity information under the same county contract. This worksheet is also where the legal entity representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)

This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)

This worksheet requires the legal entity to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the legal entity related to their SUD services and it must demonstrate the allocation methodologies used by the legal entity (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 - ODF: Tab I - PH: Tab 12 - IOT: Tab 16 - Residential: Tab 20 - NTPI

This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 - ODF: Tab 9 - PH: Tab 13 - IOT: Tab 17 - Residential: Tab 21 - NTP

This worksheet allows the legal entity to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 - ODF; Tab 10 - PH: Tab 14 - IOT: Tab 18 Residential: Tab 22 - NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The legal entity will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 - ODF: Tab 1l - PH: Tab 15 - IOT: Tab 19 Residential: Tab 23 - NTP)

This worksheet requires the legal entity to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

PUPM Reconciliation Report Description

The PUPM Reconciliation Report reconciles costs eligible for reimbursement with the total PUPM payments the county made to the Managed Care Plan (i.e., Certified Public Expenditures). For non-NTP services provided by non-county-operated providers, cost eligible for reimbursement are equal to the lower of the amount the managed care plan paid the contract provider or the prevailing charge for the same or similar service. For non-NTP services provided by county-operated providers, costs eligible for reimbursement are equal to county-operated provider's allowable cost. Reimbursement for non-NTP inpatient hospital services, provided either by non-county-operated providers or county-operated providers, will not exceed the provider's customary charge for the service. For NTP services provided by non-county operated providers, the cost eligible for reimbursement is equal to the lower of the USDR, or the provider's usual and customary charge for the same or similar services. For NTP services provided by county-operated providers, the cost eligible for reimbursement is equal to the lower of county-operated provider's allowable cost, the USDR, or the provider's usual and customary charge for the same or similar service. The following describes each tab in the PUPM Reconciliation Report and how it is used to calculate costs eligible for reimbursement and to compare those costs eligible for reimbursement to the county's certified public expenditures.

DMC ODS County Information Worksheet

This worksheet captures detailed contact information for the DMC ODS County and its contracted managed care plan. Contact information includes the county code; county name; managed care plan; and name, phone number, and e-mail address of the person the county wants the state to contact with questions about the PUPM Reconciliation Report.

Total Beneficiaries Served Worksheet

The DMC ODS County or contracted managed care plan must enter the total unduplicated beneficiaries served by month and aid code group based upon a report generated by DHCS. This worksheet calculates Total Utilizer Months.

Approved Units of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the total approved units of service rendered by non-county-operated providers for the reporting fiscal year

by aid code group, modality, and population (i.e., perinatal or non-perinatal) based upon a report generated by DHCS.

Cost Per Unit of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the cost of services for each DMC ODS covered service modality provided to Medi-Cal beneficiaries enrolled in the DMC ODS County for which the reconciliation report is submitted. This worksheet calculates the cost per unit of service for each service modality. This worksheet is also prepopulated with the prevailing charge for each service modality. The USDR is the prevailing charge for NTP services.

Third Party Revenue Worksheet

The managed care plan must enter any revenue it received from third parties for the units of service reported in the Approved Units of Service Worksheet.

Eligible Cost Worksheet

This worksheet calculates the managed care plan's eligible costs for each DMC ODS service modality. Eligible costs for each service modality is equal to the total units of service multiplied by the cost per unit of service minus third party revenue.

Eligible Prevailing Charges Worksheet

This worksheet calculates the total prevailing charges less third party revenue for each DMC ODS service modality. Eligible prevailing charges is equal to the total units of service multiplied by the prevailing charge per unit of service minus third party revenue.

Cost Allocation Worksheet

This worksheet calculates the proportion of eligible costs that are to be reimbursed by the federal government, state government, and county government by service modality.

Prevailing Charges For Non-County-Operated Providers Allocation Worksheet

This worksheet calculates the proportion of eligible prevailing charges that would be reimbursed by the federal government, state government, and county government by service modality.

UPL/Budget Neutrality Demonstration Worksheet

This worksheet compares the total actual cost to total prevailing charges by aid code group, selects the lower of total actual cost or prevailing charges, and calculates federal reimbursement based upon the lower of total actual cost or prevailing charges.

County Contracted MCP Reconciliation Worksheet

This worksheet reconciles contracted managed care plan's actual costs eligible for reimbursement with the County interim PUPM payments to the managed care plan. The County or the contracted managed care plan must enter actual costs eligible for reimbursement by aid code group for county-operated providers as determined in the cost report form described on page 5. The worksheet adds the actual costs eligible for reimbursement for non-county-operated providers to calculate the total costs eligible for reimbursement. The county must enter the total interim payments made to the managed care plan. The amount of total costs eligible for reimbursement

less County interim payments to the contracted managed care plan equals the amount due to or from the contracted managed care plan.

DHCS County Reconciliation Worksheet

This worksheet reconciles the DMC ODS County's final total payments to the contracted managed care plan for DMC ODS services with total interim payments made to the DMC ODS County for those services. The DMC ODS County received an overpayment when interim payments exceed the DMC ODS County's final total payments. DHCS will recoup any overpayments to the DMC ODS County and return the overpayment to the federal government. The DMC ODS County received an underpayment when its final total payments to the managed care plan exceed interim payments. DHCS will made addition interim payments to the DMC ODS County when there is an under payment. DHCS will not pay a DMC ODS county more than the amount it paid the managed care plan for DMC ODS services rendered.

County Certification

The County Auditor Controller must certify the final total payments to the managed care plan as reported in the Total Payments Worksheet.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates or county interim PUPM rate for the covered services. Annual county interim rates for each covered service will be developed by the county and approved by the State. Annual county interim PUPM rates for the covered services will also be approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51. All interim payments for services rendered by contract providers and county operated providers will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements. All interim payments for services rendered through contracts with a managed care plan will be subject to an annual reconciliation.

Proposed county interim rates must be developed for each required and (if indicated) optional service modality. The proposed county interim rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and cost settlement.

Proposed county interim PUPM rates must be developed for all required and optional service modalities. The proposed county interim PUPM rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation.

The proposed county interim rates and county interim PUPM rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be calculated for each service including both county directly

delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers and managed care plans are considered to be actual expenditures according to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.

For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

For a county that contracts with a managed care plan, the USDR rates for NTP services will serve as the upper payment limit for reconciliation purposes. The managed care plan will pay the provider the lower of the USDR or the provider's usual and customary charge for NTP services.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP. Interim payments for FFP for county contracts with county-specific rates by covered service will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Interim payments of FFP for services rendered through county contracts with managed care plans will be available through claim adjudication at the county Interim PUPM rate for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share

expenditure), and claims integrity requirements. Claims will be reimbursed at the interim PUPM rate developed by the county participating in the demonstration and approved by the State. All interim PUPM rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS – COUNTY SPECIFIC RATES

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS noninstitutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such

as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

INTERIM RECONCILIATION OF INTERIM PUPM PAYMENTS

DHCS will complete the interim reconciliation and settlement of DMC ODS counties' interim PUPM payments to managed care plans with which they contract no later than twelve months after the close of the State fiscal year. Each DMC ODS county that contracts with a managed care plan must submit a PUPM Reconciliation Report to DHCS by November 1st following the close of the fiscal year. DHCS staff will review the PUPM Reconciliation Report to validate the total beneficiaries served, total approved units of service, and rate per service modality. If the Interim Reconciliation Worksheet shows that the DMC ODS County made additional payments to the managed care plan, DHCS will make an additional payment of FFP to the DMC ODS County. If the Interim Reconciliation Worksheet shows that the DMC ODS County recouped a portion of the Interim PUPM payments already paid to the managed care plan, DHCS will recoup those funds from the DMC ODS County and return them to the federal government. Participating counties and their contracted managed care plan must maintain fiscal and statistical records for the period covered by PUPM Reconciliation report that are accurate and sufficiently detailed to substantiate the PUPM reconciliation data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.

All records of funds expended and services rendered are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final reconciliation and settlement of the cost report or PUPM reconciliation within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report or reconciliation are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State

determines that the county received an underpayment, the State makes an additional payment to the county.

COVID-19 PUBLIC HEALTH EMERGENCY

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for non-NTP services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- Each DMC ODS county may pay contracted providers at up to 100 percent above the approved county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed in this Attachment.
- For purposes of interim Medicaid payments, claims will be reimbursed at the lower of the county's billed amount or the approved annual interim rates for each covered service increased by 100 percent.
- For purposes of interim and final reconciliation, DHCS will settle interim payments for outpatient services to actual allowable cost. The limitation of customary charges is suspended.
- For inpatient hospital-based residential and withdrawal management services (including ASAM levels 3.7 and 4), DHCS will continue to settle interim payments to the lower of actual allowable cost or usual and customary charges.

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.

Attachment J
SUD Monitoring Protocol

What follows are the Planned Metrics and Reporting Schedule tabs from the SUD monitoring protocol workbook (part A). The full workbook is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Planned Metrics (Version 6.0)
State: California
Demonstration Name: CalAIM

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting cadence	Data source	Measurement method	Reporting frequency	Reporting authority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)[b]	State plans to phase in reporting? (Y/N)	SUD monitoring report in which metric will be phased in (Format: BY#/CY#, e.g., BY1/CY3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 (Do not delete or edit this row)	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metrics*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/01/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: BY2/CY4*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go-live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y	See attachment for metric 5 calculation methods.	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	consistent	N	The Department will supplement CMS-provided technical specifications for this metric with codes from CMS Core Set MY2020 OUD measure specifications related to NDCs for OUD Treatments (updated as of May 2020; available at https://www.medicaid.gov/license/form/040112#TS1). It was not feasible to embed specific NDC codes in this locked workbook.	N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y	See attachment for metric 13 calculation methods.	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims;	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y	See attachment for metric 14 calculation methods.	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
16	SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3400; Medicaid Adult Core Set; Adjusted HEDIS measure][c]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure][c]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA; NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	consistent	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2021 – 12/31/2022	consistent	consistent	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[d]	Administrative records	Quarter	Quarterly	Recommended	N								

Attachment J
SUD Monitoring Protocol

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics rationale
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[4]	Administrative records	Quarter	Quarterly	Recommended	N						
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[4]	Administrative records	Quarter	Quarterly	Recommended	N						
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	1/1/2022-12/31/2022	decrease	No more than 30 days	Y	See attachment for metric 36 calculation methods.	N
Q1	*Number of Checks*	Total number of CURES Patient Activity Reports (PAR) searched.	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase			N
Q2	*Number of Web updates*	Total number of online CURES resources information updates published during the reporting period.	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	consistent or increase			N
Q3	*Number of corrections live*	Connecting corrections systems to SUD delivery system for incarcerated individual release to community	Health IT	State-specific	Other annual metrics	Administrative records	Year	Annually	Required	Y	1/1/2022-12/31/2022	consistent	increase			N
State-specific metrics																
[Insert row(s) for any additional state-specific metrics by right-clicking on row 31 and selecting "Insert"]																

[a] There are no CMS-provided metrics related to milestone 3

[b] If the state is not reporting a required metric (i.e., column K = "N"), enter explanation in corresponding row in column P.

[c] The state should use column P to outline calculation methods for specific metrics as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations Monitoring Protocol Instructions.

[d] Rates 1 and 2 reported for Metric #17(1) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[e] Rates 1 and 2 reported for Metric #17(2) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[f] While grievances and appeals metrics are recommended for reporting, the state is required, per 42 CFR 431.428(a)5, to provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, in its annual (Q4) monitoring report.

Attachment J
SUD Monitoring Protocol

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 6.0)

State: California
Demonstration Name: CalAIM

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SUD demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SUD demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviation from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e., column H="Y"), the state should describe these deviations in column L, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviations from standard reporting schedule," to indicate the SUD measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Substance Use Disorder Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SUD demonstration year (SUD DY1)	
Start date	01/01/2022
End date	12/31/2022
Dates of first quarter of the baseline reporting period for CMS-constructed metrics	
Reporting period (SUD DY and Q)	DY7Q1
Start date	01/01/2022
End date	03/31/2022
Broader section 1115 demonstration reporting period corresponding with the first SUD reporting quarter, if applicable. If there is no broader demonstration, fill in the first SUD reporting period. (Format DY#Q#; e.g., DY3Q1)	DY18Q1
First SUD monitoring report due date (per STCs) (MM/DD/YYYY)	05/30/2022
First SUD monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs)	
Baseline period for EQMs	CY2022
SUD DY and Q associated with monitoring report	DY8Q3
SUD DY and Q start date (MM/DD/YYYY)	07/01/2023
SUD DY and Q end date (MM/DD/YYYY)	09/30/2023
Dates of last SUD reporting quarter:	
Start date	10/01/2026
End date	12/31/2026

*California first received approval for a SUD demonstration in 2015 and, as such, the first year of the state's demonstration extension beginning January 1, 2022 aligns with its SUD DY7. However, because the state will begin structured monitoring reporting using the standardized monitoring tools in CY 2022, this is considered as the state's baseline period for the purposes of monitoring reporting.

Table 2. Substance Use Disorder Demonstration Reporting Schedule

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2022	03/31/2022	05/30/2022	DY18Q1	DY7Q1	Narrative information	DY7Q1	N		
					Grievances and appeals	DY7Q1	N		
					Other monthly and quarterly metrics				
					Annual metrics that are established quality measures				
					Other annual metrics				
04/01/2022	06/30/2022	08/29/2022	DY18Q2	DY7Q2	Narrative information	DY7Q2	N		
					Grievances and appeals	DY7Q2	N		
					Other monthly and quarterly metrics	DY7Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2022	09/30/2022	11/29/2022	DY18Q3	DY7Q3	Narrative information	DY7Q3	N		
					Grievances and appeals	DY7Q3	N		
					Other monthly and quarterly metrics	DY7Q2	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
10/01/2022	12/31/2022	03/31/2023	DY18Q4	DY7Q4	Narrative information	DY7Q4	N		
					Grievances and appeals	DY7Q4	N		
					Other monthly and quarterly metrics	DY7Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2023	03/31/2023	05/30/2023	DY19Q1	DY8Q1	Narrative information	DY8Q1	N		
					Grievances and appeals	DY8Q1	N		
					Other monthly and quarterly metrics	DY7Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY7	N		
04/01/2023	06/30/2023	08/29/2023	DY19Q2	DY8Q2	Narrative information	DY8Q2	N		
					Grievances and appeals	DY8Q2	N		
					Other monthly and quarterly metrics	DY8Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2023	09/30/2023	11/29/2023	DY19Q3	DY8Q3	Narrative information	DY8Q3	N		
					Grievances and appeals	DY8Q3	N		

Attachment J
SUD Monitoring Protocol

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other monthly and quarterly metrics	DY8Q2	N		
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics				
10/01/2023	12/31/2023	03/30/2024	DY19Q4	DY8Q4	Narrative information	DY8Q4	N		
					Grievances and appeals	DY8Q4	N		
					Other monthly and quarterly metrics	DY8Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2024	03/31/2024	05/30/2024	DY20Q1	DY9Q1	Narrative information	DY9Q1	N		
					Grievances and appeals	DY9Q1	N		
					Other monthly and quarterly metrics	DY8Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY8	N		
04/01/2024	06/30/2024	08/29/2024	DY20Q2	DY9Q2	Narrative information	DY9Q2	N		
					Grievances and appeals	DY9Q2	N		
					Other monthly and quarterly metrics	DY9Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2024	09/30/2024	11/29/2024	DY20Q3	DY9Q3	Narrative information	DY9Q3	N		
					Grievances and appeals	DY9Q3	N		
					Other monthly and quarterly metrics	DY9Q2	N		
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics				
10/01/2024	12/31/2024	03/31/2025	DY20Q4	DY9Q4	Narrative information	DY9Q4	N		
					Grievances and appeals	DY9Q4	N		
					Other monthly and quarterly metrics	DY9Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2025	03/31/2025	05/30/2025	DY21Q1	DY10Q1	Narrative information	DY10Q1	N		
					Grievances and appeals	DY10Q1	N		
					Other monthly and quarterly metrics	DY9Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY9	N		
04/01/2025	06/30/2025	08/29/2025	DY21Q2	DY10Q2	Narrative information	DY10Q2	N		
					Grievances and appeals	DY10Q2	N		
					Other monthly and quarterly metrics	DY10Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2025	09/30/2025	11/29/2025	DY21Q3	DY10Q3	Narrative information	DY10Q3	N		
					Grievances and appeals	DY10Q3	N		
					Other monthly and quarterly metrics	DY10Q2	N		
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics				
10/01/2025	12/31/2025	03/31/2026	DY21Q4	DY10Q4	Narrative information	DY10Q4	N		
					Grievances and appeals	DY10Q4	N		
					Other monthly and quarterly metrics	DY10Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2026	03/31/2026	05/30/2026	DY22Q1	DY11Q1	Narrative information	DY11Q1	N		
					Grievances and appeals	DY11Q1	N		
					Other monthly and quarterly metrics	DY10Q4	N		
					Annual metrics that are established quality measures				
					Other annual metrics	DY10	N		
04/01/2026	06/30/2026	08/29/2026	DY22Q2	DY11Q2	Narrative information	DY11Q2	N		
					Grievances and appeals	DY11Q2	N		
					Other monthly and quarterly metrics	DY11Q1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2026	09/30/2026	11/29/2026	DY22Q3	DY11Q3	Narrative information	DY11Q3	N		
					Grievances and appeals	DY11Q3	N		
					Other monthly and quarterly metrics	DY11Q2	N		
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics				
10/01/2026	12/31/2026	03/31/2027	DY22Q4	DY11Q4	Narrative information	DY11Q4	N		
					Grievances and appeals	DY11Q4	N		
					Other monthly and quarterly metrics	DY11Q3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				

[Add rows for all additional demonstration reporting quarters]

[a] **SUD demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SUD reporting schedule tab" should align with the first day of a month. If a state's SUD demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SUD reporting schedule" tab. Please see Appendix A for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after monitoring protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its SUD monitoring protocol. Definitions for certain rows are provided below the table. The Performance Metrics Database and Analytics (PMDA) system will populate some rows of the table. The state should complete the rest of the table. The state can revise the demonstration goals and objectives if needed. PMDA will use this information to populate part of the title page of the state's monitoring reports.

State	California
Demonstration name	CalAIM
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 01/01/2022 *End Date:* 12/31/2026
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 01/01/2022
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 01/01/2022
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* During the demonstration period, the state seeks to achieve these goals: 1. Increased rates of identification, initiation, and engagement in treatment; 2. Increased adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. Improved access to care for physical health conditions among beneficiaries.

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook (which can be accessed via PMDA – see Monitoring Protocol Instructions for more details) and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first SUD demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

Attachment K
Global Payment Program Funding and Mechanics Protocol

A. Public Health Care Systems (PHCS)

GPP Payments are available for PHCS, which are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment C. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C.

The GPP provides support for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS will provide an assurance that, to the extent the GPP exceeds the amount that is attributable to the state's Adjusted DSH (determined pursuant to STC 78), a percentage of GPP points earned by each PHCS will be associated with care and activities that are furnished through charity care and discount payment policies for financially qualified, uninsured individuals that adhere to California state law ability-to-pay requirements. The required percentage is equal to the amount of the GPP that is in excess of the Adjusted DSH divided by the total GPP for the year. For the first year of the GPP, each PHCS is required in the aggregate to satisfy the above assurance for at least 21.4% of GPP points earned.

Each PHCS shall identify to DHCS the affiliated and contracted providers that will constitute the PHCS, and shall notify DHCS of changes.

B. Determination of GPP Annual Limits

For each GPP PY, DHCS shall work with CMS to determine the annual limit for the GPP consistent with STC 78. The annual limit shall be calculated as the sum of the Adjusted DSH allotment and the Uncompensated Care Component for PY 1-12. F. The Adjusted DSH allotment shall be determined consistent with the provisions of Attachment Q (DSH Coordination Methodology).

C. Establishment of Participating PHCS global budgets

DHCS will determine for each PHCS a global budget for each GPP PY, which is the total amount of funding each PHCS will earn if it meets or exceeds its applicable threshold. Threshold amounts for each PHCS for GPP PY1 are set forth in Attachment L, section B. Threshold amounts for subsequent GPP PYs will be calculated through adjustments in proportion to changes in the size of the aggregate GPP annual limits, except where otherwise allowed during a public health emergency or other state of emergency, as set forth in Attachment L, section B.

To determine a PHCS' global budget for a GPP year, DHCS shall calculate the PHCS' allocation percentage, which is the PHCS's point threshold for a GPP PY divided by the sum of all PHCS point thresholds for the same GPP PY. The PHCS's global budget shall equal the allocation percentage multiplied by the total computable annual limit for the GPP, as set forth in STC 78 of

the Special Terms and Conditions ("Funding and Annual Limits").

DHCS shall determine an initial total computable annual limit for a GPP PY based on the initial CA DSH allotment published by CMS for the applicable GPP PY and any uncompensated care funding allocated under the applicable waiver. DHCS shall determine initial threshold amounts and annual budgets for each PHCS based on this information and publish the information on its GPP webpage within 10 days of the determination. Threshold amounts and annual budgets may be adjusted throughout the GPP PY in coordination with funding allocation adjustments.

DHCS shall determine the final total computable annual limit for a GPP PY upon CMS notification of the final CA DSH allotment and shall publish the final amounts, and associated PHCS threshold amounts and annual budgets within 10 days of such determination.

D. Reporting Requirements

By August 15th following each GPP PY, or with respect to GPP PY 6 through 12, by February 15th following the GPP PY, each PHCS shall submit an interim year-end summary report summarizing the aggregate number of uninsured units of service provided during the GPP PY, broken out by the service categories, tiers, and types as defined in Attachment L (GPP Valuation Methodology Protocol). The summary report will also compute the number of points earned based on the corresponding point valuations for the services provided, and the payments due to the PHCS (net of any payments previously received for the GPP PY). Data contained in the interim year-end summary report will be based on the best data available through the close of the GPP PY. Revisions to the interim data will be reflected in the final reconciliation report.

By March 31st following the close of each GPP PY, or with respect to GPP PY 6 through 12, by September 30th following the GPP PY each PHCS shall submit a final year-end reconciliation summary report in the same format as the interim year-end summary report referenced above that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Starting with GPP PY 2, each PHCS shall submit encounter-level data on their uninsured services in order to provide auditable verification that the reported uninsured services were provided. For this purpose, encounter-level data may include line-level encounters or documentation of claims or other reliable methods for determining the number of contracted units of service to the uninsured by contracted providers. Such reporting shall be provided at the time of the final reconciliation summary reports. All reports shall be submitted in a manner and format as set forth by DHCS. In addition, for all GPP PYs, PHCS shall maintain documentation of services and shall make such information available to DHCS or CMS upon request.

DHCS shall review all summary reports and data submitted for accuracy and compliance with established procedures, and perform tests for reasonableness. If discrepancies or inconsistencies are identified, DHCS shall work directly with PHCS staff to promptly resolve issues and correct data and reporting. PHCS shall provide a formal response to DHCS inquiries within five (5)

business days of receipt of an inquiry or question; additional time to respond may be requested by the PHCS and approved by DHCS.

The interim year-end summary report and the final year-end reconciliation summary report shall be due at the times specified in Tables 1 and 1.1 below. If the identified date falls on a weekend or holiday, the report shall be due at the close of the following business day.

Table 1: Reporting timeline, PY 1-6

Report name	**Reporting period**	**Report due date to DHCS**	**Reporting Period**	**Report Due Date to DCHS**
Interim year-end summary report	July 1 – June 30	August 15 (following program year)	GPP PY 6 July 1 – December 31	February 15 (following program year)
Final year-end reconciliation	July 1 – June 30	March 31 (following program year)	GPP PY 6 July 1 – December 31	September 30 (following program year)

Table 1.1: Reporting timeline, PY 7-12

Report name	**Reporting period**	**Report due date to DHCS**
Interim year-end summary report	January 1 – December 31	February 15 (following program year)
Final year-end reconciliation	January 1 – December 31	September 30 (following program year)

E. Payment schedule

Interim Payments

PHCS shall receive interim quarterly GPP payments based on 25% of their annual global budget for the first three quarters of the GPP PY. DHCS will notify PHCS of the IGT due dates and

payment dates according to Tables 2 and 2B. For GPP PY 6, PHCS shall receive only two quarterly payments, each based on 50% of their annual budget. DHCS will notify PHCS of the IGT due dates and payment dates according to Table 2A. Payments will be made within 15 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Tables 2, 2A, and 2B. However, beginning in PY 7, quarter 2 payments will be made within 30 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Table 2B. For a PHCS that is comprised of more than one DPH, payments will be made to the health system under which the DPHs operate.

For the fourth quarter of each GPP PY, an interim payment shall be made to each PHCS that is sufficient to bring the PHCS' interim payments for the GPP PY to the amount earned by the PHCS based on its interim year-end summary report. The total Interim payments earned by a PHCS shall be determined by multiplying the PHCS's annual global budget by the ratio of the value of the points earned during the GPP PY to the PHCS's threshold, as reported in the interim year-end summary report; however, no PHCS may earn more than its annual global budget prorated by the number of months in the reporting period. The fourth quarter interim payment shall be calculated based on the amount earned by the PHCS for the GPP PY, net of any GPP payments previously received by the PHCS for the GPP PY. If the PHCS' interim year-end summary report reflects an annual payment that is less than 75% of its total annual budget, no additional interim payment shall be made for the fourth quarter. DHCS shall calculate the amount of the required IGTs for the fourth quarter and make GPP IGT notifications to all PHCS no later than 30 calendar days after submission of the interim year-end summary report, as shown in Tables 2 and 2B. PHCS shall submit IGTs within 7 days of receiving notification. Interim payments will be made to all PHCS no later than one month following their respective IGT notification date, if IGTs are received within the required 7 days.

Final Reconciliation and Redistribution Process

There will be a final reconciliation annually following the submission of each PHCS' final reconciliation summary report and (beginning with GPP PY 2) the required supporting encounter data. DHCS shall determine the amount earned by each PHCS based on the total number of points earned by each PHCS for the GPP PY, as reported in the final year-end reconciliation summary reports. For PHCS that exceeded their threshold for the GPP PY, the amount earned is subject to adjustment in accordance with the following redistribution process set forth below.

DHCS will identify any GPP global budget amounts that PHCS were individually unable to claim and redistribute such unclaimed amounts to the PHCS that exceeded their point thresholds for the applicable GPP PY. To determine redistribution amounts, DHCS shall first calculate a dollar amount of funding per GPP point by dividing the total GPP annual limit for the GPP PY by the aggregate threshold points for all PHCS. DHCS will then multiply this dollar amount by the amount by which each PHCS has exceeded its threshold to determine the PHCS's maximum redistribution amount. Each PHCS that has exceeded its threshold will receive its maximum redistribution amount if there are sufficient unused funds for the year from other PHCS. If there are insufficient unused funds to pay all PHCS that exceeded their thresholds their maximum redistribution amount, then each PHCS will receive an adjusted redistribution amount, prorating the amount of unused funds available by the number of points each PHCS is above its applicable

threshold. The redistributed amounts following this determination shall be added to the GPP amounts earned by the applicable PHCS for the purposes of the final reconciliation.

Based on the final reconciliation amounts determined as set forth above, DHCS shall adjust, as necessary, the interim payments previously made to the PHCS for the GPP PY. Within 90 calendar days of receiving the final reconciliation summary reports from the PHCS DHCS shall calculate the amount of the required IGTs for the reconciliation and make GPP IGT notifications to all PHCS, as shown in Tables 2, 2A and 2B.

PHCS shall submit IGTs within 14 days of receiving notification. Final payments will be made to all PHCS no later than 45 days following their respective IGT notification date, if PHCS have submitted the IGTs within the 14-day requirement. If the necessary IGTs are submitted past the 14-day requirement, final payments, as well as any other associated payments, will be made no later than 45 days following submission of the necessary IGT amounts. If, at the end of the reconciliation process, it is determined that the interim GPP funds for a GPP PY exceeded the amounts due upon final reconciliation, DHCS shall recoup the amounts from the appropriate PHCS. In the event of any recoupments, DHCS shall return the associated IGT funds to the transferring entity within 14 calendar days.

Payment Summary Report to CMS

For each GPP PY, DHCS will submit a Payment Summary Report to CMS (following the schedule in Tables 2, 2A and 2B) that summarizes all GPP transactions to date which pertain to that GPP PY and includes a list of entities that have provided IGTs during the report period and the amount of the IGTs provided.

Transactions include interim payments, final payments, and recoupments. Each transaction record will include the name of the PHCS to which the transaction pertains, whether the transaction is an interim, reconciliation, or redistribution payment, the interim year-end Summary Report or Final Reconciliation Summary Report that supports the transaction, and the Quarterly Expenditure Report on which the transaction was or will be reported. The Payment Summary Report following the Final Reconciliation Summary Report will show how the sum of all transactions for each PHCS matches the PHCS final reconciliation amount.

Table 2: Interim and Final Payment timeline, GPP PY 1-5

Payment	Payment Amount	Payment Amount & IGT Notification Date	IGT Due Date	Payment Date	Payment Summary Report to CMS
Interim Quarter 1	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	25% of Annual	December 15	December 22	January 15	February 15
Interim Quarter 3	25% of Annual	March 15	March 22	April 15	May 15

Interim Quarter 4	Final Interim based on interim year-end summary report	September 15 following the GPP PY end	September 22 following the GPP PY end	October 15 following GPP PY end	November 15 following GPP PY end
Final Reconciliation	Final reconciled amount	June 30 following the GPP PY end	July 14 after notification date	August 15 after notification date	September 15 after notification date

Table 2A: Interim and Final Payment timeline, GPP PY 6

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	50% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	50% of Annual	December 15	December 22	January 15	February 15
Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Table 2B: Interim and Final Payment timeline, GPP PY 7-12

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 2	25% of Annual	July 1	July 7	July 30	August 15
Interim Quarter 3	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 4	Final Interim based on interim year-end summary report	March 15 following the GPP PY end	March 22 following the GPP PY end	April 15 following GPP PY end	May 15 following GPP PY end
Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Attachment L
Global Payment Program Valuation

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

   Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-5) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.

   Categories 1 through 5 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically- mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services. Category 5 services are those aiming to advance health equity in the state.

   Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in- person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.

   The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

Table 1: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial Point Value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, andother non-emergent care (physicians orother licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis Stabilization	T	250
	D	High-intensity outpatientservices	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
			*Doula service (prenatal or postnatal)	NT	60
			*Peer support	NT	25
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
			Home nursing visit	NT	75

	C	Community- based face-to-face encounters	Paramedic treat and release	NT	75
			Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-providercare team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C	Store and forward telehealth	Telehealth (patient - provider) - Store & Forward	NT	*100
			Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store &Forward	NT	*100
	D	Real-time telehealth	Telephone consultation withPCP	NT	*100
			Telehealth (patient - provider) - real time	NT	*100
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services; low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient,high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community Services	Trauma	T	863
			Transplant/burn	T	1,131
**5: Equity-Enhancing Services	A	Enhanced care management	Enhanced care management	E	75 PMPM
	B	Community Supports	Asthma remediation	E	80/case
			Community transition: Nursing facility to home	E	220 PMPM
			Day habilitation	E	3/hr
			Housing deposits	E	700/ move-in
			Housing tenancy and sustaining service	E	90 PMPM

			Housing transition navigation service	E	90 PMPM
			Nursing facility transition/diversion to assisted living facility	E	12/day
			Personal care services	E	4/hr
			Short-term post-hospitalization housing	E	15/day
	C	Other Equity-Enhancing Services	Team-based street outreach and engagement	E	150/visit

Notes:
*Services and points marked with an asterisk are applicable to PY 8 and forward. Services and points prior to CalAIM are shown in Medi-Cal 2020 STCs.
**The Equity Enhancing Services Category is effective beginning in PY 9.

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as "traditional" services, will receive initial point valuations based on their cost per unit of service in the historical year SFY 2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation of non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payers, and are often provided as substitutes for or complementary to traditional services. These services are assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.

The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care team, which would both help address and treat the presenting condition, as

well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration enhances the PCPs' capacity to provide high-quality, patient-centered care, and allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. This increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services will receive fewer points over time. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible. Point revaluation will be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4, except that in GPP PY 6, an additional point value change will be made at the same average annual pace of changes from PY1 to PY5. This phase-in is illustrated in Table 2. Point values for

GPP PYs 7 through 12 will not change.

Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

Table 2: Revaluations to categories of service, by year, compared to initial point value, PYs 1-12

Category of service	Initial point value	Point value (% change) PY 1	Point value (% change), PY 2	Point value (% change), PY 3	Point value (% change) PY 4	Point value (% change) PY 5	Point value (% change) PY 6	Point value (% change), PY 7 -12
OP ER	160	160 (0%)	158 (-1%)	156 (-2.5%)	152 (-5%)	152 (-5%)	151 (-5.5%)	151 (-5.5%)
Mental health ER / crisis	250	250 (0%)	248 (-1%)	244 (-2.5%)	238 (-5%)	238 (-5%)	236 (-5.5%)	236 (-5.5%)
IP med/surg	634	634 (0%)	630 (-0.6%)	624 (-1.5%)	615 (-3%)	615 (-3%)	613 (-3.3%)	613 (-3.3%)
IP mental	341	341 (0%)	339 (-0.6%)	336 (-1.5%)	331 (-3%)	331 (-3%)	329 (-3.3%)	329 (-3.3%)

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

DHCS established GPP PY 1-point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.For GPP PY 2 through 7, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 78, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

During a period of public health emergency or other state of emergency only, thresholds may be further adjusted without modifying the applicable total GPP payments available for achieving such thresholds by a determined percentage based upon estimated impact to utilization rates. All threshold adjustment methodologies shall be approved by CMS. In response to the COVID-19 public health emergency GPP PY 5 PHCS thresholds will be reduced by 10% and PHCS threshold adjustments for GPP PY 6 will be reduced by 29%. Any additional PYs impacted by the COVID-19 public health emergency will be proposed once the extent of the impact to the delivery of GPP services due to the public health emergency is determined.

Starting in PY 8 and continuing through PY 12, DHCS will shift to the revised threshold percentages in Table 4, to reflect utilization experience in selected prior years, in order to bring budgets closer to that experience. For PY 8, the final total system threshold is

determined by dividing the final GPP budget for PY 8 by the same value per point as PY 1. The resulting PY 8 final total system threshold is then allocated to each PHCS using the recalibrated percentages in Table 4, to determine the final PY 8 system threshold for each PHCS. For GPP PY 9 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 78, compared to the final PY 8 thresholds, e.g. if total GPP funding in PY 9 is 5% less than PY 8 each PHCS threshold will be reduced by 5% so that the value for each individual point remains consistent from PY 1 through PY 12.

Table 3: GPP PY 1 PHCS Thresholds, Based on FY 2014-15 Uninsured Services

Public Health Care System	**System Threshold, GPP PY1**
Los Angeles County Health System	101,573,445
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Natividad Medical Center	2,959,964
Riverside University Health System – Medical Center	8,066,127
Zuckerberg San Francisco General	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Table 4: GPP PY 8 PHCS Thresholds

Public Health Care System	**Recalibrated System Threshold Percentage, GPP PY 8**	**Interim System Threshold, GPP PY 8, based on estimated PY 8 budget of $2,535,234,481 and same value per point as PY 1**
Los Angeles County Health System	52.40%	121,307,020
Alameda Health System	9.03%	20,893,537
Arrowhead Regional Medical Center	3.32%	7,695,510
Contra Costa Regional Medical Center	2.99%	6,919,139
Kern Medical Center	2.08%	4,817,416
Natividad Medical Center	1.69%	3,922,128

Riverside University Health System - Medical Center	4.44%	10,280,798
Zuckerberg San Francisco General	5.78%	13,387,427
San Joaquin General Hospital	1.50%	3,464,138
San Mateo County General Hospital	4.32%	9,997,269
Santa Clara Valley Medical Center	9.64%	22,316,425
Ventura County Medical Center	2.81%	6,497,487
	100.00%	231,498,294

Appendix 1

Table 5: Categories of Service and Point Values, Traditional

Category	**Tier**	**Service Name**	**Cost/unit**	**Initial point value**
1: Outpatient	B	OP Primary / Specialty (**benchmark, 100)**	587	**100**
	B	Dental	365	**62**
	B	MH Outpatient	225	**38**
	B	SU Outpatient	62	**11**
	B	SU Methadone	11	**2**
	B	Contracted Prim/Spec	110	**19**
	C	OP ER	942	**160**
	C	Contracted ER	411	**70**
	C	MH ER/Crisis Stabilization	1,470	**250**
	D	OP Surgery	4,554	**776**
4: Inpatient	A	SNF	829	**141**
	A	MH/SU Residential	138	**23**
	B	Med/surg	3,721	**634**
	B	MH Inpatient	2,000	**341**
	C	ICU/CCU	5,663	**964**
	D	Trauma	5,069	**863**
	D	Transplant/Burn	6,644	**1,131**

Appendix 2

Table 6: Categories of Service and Point Values, Non-Traditional
DHCS may update the codes and descriptions contained in this table to reflect ongoing changes made by CMS or other nationally recognized entities. Updated codes and descriptions will be reflected in reporting guidance provided by DHCS to PHCS.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
Service Category 1: Outpatient				
A	RN Visit[84, 85] (includes Wound Assessment visits)	**99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		50
A	PharmD Visit[86]	**99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided.		75
A	Complex Care Manager[87]	**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored.		75
Service Category 2: Complementary Patient Support and Care Services				
A	Wellness[88,89]	G0438 Annual wellness visit; includes a personalized prevention plan of service (PPPS),		15

[84] CMS Source: MCD Search (cms.gov), Accessed 11/14/2015
[85] Understanding When to Use 99211 | AAFP, Accessed 11/10/2015
[86] Pharmacist Services Technical Advisory Coalition, Medication Therapy Management Service Codes | Pharmacist Services Technical Advisory Coalition (pstac.org), Accessed 11/15/2015
[87] CMS Medicare Learning Network, MLN909188 – Chronic Care Management (cms.gov), Accessed 11/15/2015
88 https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINATION_CODES.pdf
[89] Publications & Multimedia | CMS

Table 7

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		Initial visit G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit **S5190** Wellness assessment, performed by non- physician **Z00.00, Z00.01** Z00.00: Encounter for general adult medical examination without abnormal findings Z00.01 Encounter for general adult medical examination with abnormal findings		
A	Patient Support Group	**Non-physician Health Care Professional CPT Code** **98961** Education And Training For Patient Self- Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients **98962** Education And Training as above; 5-8 Patients		15

A	Community Health Worker (CHW)		Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.[90]	15
A	Health Education		Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change interventions.	25
A	Nutrition Education[91,92]	**97802** Medical nutrition therapy; initial assessment and intervention, individual, face- to-face with the patient **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient		25

[90] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. Community Health Workers (bls.gov), Accessed 11/24/2015.
[91] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), NCD - Medical Nutrition Therapy (180.1) (cms.gov)
[92] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries with Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. Microsoft Word - A02_115.doc (cms.gov)

Table 8

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Case management		Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost- effective outcomes.[93] **Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[94]	25
A	Health coach		Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[95]	15
A	Panel management		Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment options.[96]	15

[93] Case Management Society of America, What Is A Case Manager | Case Management Society of America (cmsa.org), Accessed 11/15/2015
[94] Oregon APM Patient Touches, direct communication with Oregon Health Authority
[95] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.
[96] Oregon APM Patient Touches.

Table 9

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Oral Hygiene Encounters		Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists	30
A	Doula service, prenatal or postnatal		Personal support to women, including emotional and physical support, and families throughout a person's pregnancy and postpartum experience, provided by a qualified doula.	60
A	Peer support		Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.	25
B	Group medical visits	**99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting **99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions)		50
B	Integrative medical therapies	**97810-97811,97813-97814:** Acupuncture, one or more needles, with or without electrical stimulation, personal one-on-one contact with the patient		50

B	Palliative Care	**0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.	Encounters with non-provider care team members that focus on preventing and relieving suffering, and improving the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning.	50
B	Pain management		Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders	50
C	Physician Home Visit[97]	**99341 - 99345** Home visit, new patient; **99347 - 99350** Home visit, established patient		125

[97] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: Billing and Coding Guidelines L31613 PHYS-081 - Home and Domiciliary Visits (cms.gov). Accessed 11/10/2015

Table 10

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
C	Home nursing visits	**G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications.	75
C	Mobile Clinic Visits	**CPT Physician Code** **99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service **99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service **99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service **OR 99201-5; 99211-5** Use POS code 15 with the above codes to signify a services provided in a mobile setting[98]		90
C	Paramedic treat and release		Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[99]	75
Service Category 3: Technology-Based Outpatient[100]				
A	Texting		Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must	1

			not originate from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment.	

[98] Ask an AAPC expert ! AAPC

[99] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, EMS provider determinations of necessity for transport and reimbursement for EMS response, medical care, and transport: combined resource document for the National Association of EMS Physicians position statements - PubMed (nih.gov) Accessed 11/24/2015

[100] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. Policy - ATA (americantelemed.org) Accessed 10/28/2015

Table 11

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
A	Video Observed Therapy		Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[101]	10
A	Nurse advice line102,103	**98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment		10
A	RN e-Visit[104]	**98970-98972** Qualified nonphysician health care professional online digital evaluation and management service, for established patient, for up to 7 days		10

B	Email consultation with PCP[105]	**99421-99423** Online digital evaluation and management service, for established patient, for up to 7 days		30

[101] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. Tuberculosis (ca.gov), Accessed 11/24/15
[102] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. CMS Manual System, Accessed 10/20/2015
[103] American Academy of Pediatrics, Charging for Nurse Telephone Triage. Pediatric Nurse Telephone Triage: A Companion To Pediatric Telephone Protocols | AAP Books | American Academy of Pediatrics, Accessed 10/20/2015
[104] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount | Guidance Portal (hhs.gov), Accessed 10/20/2015
[105] MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET | CMS

Table 12

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
C	Telehealth (patient - provider) - Store & Forward106,107	Digital Retinal Screening **92250** (global) Fundus photography with interpretation and report		100
C	Telehealth – Store & Forward	+GQ modifier for distant site: **99241-99243** Office consultation, new or established patient **99251-99253** Initial inpatient consultation **99211-99214** Office or other outpatient visit **99231-99233** Subsequent hospital care OR **99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations	Store and Forward services that include images, such as Teleophthalmology and Teledermatology	100

C	Telehealth (provider - provider) – eConsult/ eReferral[108]	**99446-99449**, **99451 + modifier GQ** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional,		50
D	Telephone consultation with PCP109	**CPT Physician Code 99441 through 99443**. **OR 99201-99215 with modifier 93** Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options	100
D	Telehealth (patient provider) - real time[110,111]	**99201-99215** with modifier **95** "Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems"		100

[106] Ophthalmology (ophthal) (ca.gov),Accessed 10/15/2015; Page updated August 2020
[107] Communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs
[108] RTR- ECONSULT CPT CODES, UC Davis, plus communication on 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.
[109] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. CMS Manual System, Accessed 10/20/2015
[110]CMS Medicare Learning Network: Telehealth Services, Telehealth Services (cms.gov) Accessed 10/28/2015
[111] Medi-Cal: Provider Manuals, Accessed 10/28/2015

Table 13

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
D	Telehealth (provider - provider) - real time[112]		Communication between two providers for purposes of consultation, performed via interactive audio and video	90

			telecommunications systems	
Service Category 4: Inpatient				
A	Sobering Center[113]		Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[114]	50
A	Recuperative/Respite Care[115]		Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy (e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[116]	85

[112] *Ibid*
[113] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. Community Supports - San Francisco Health Plan (sfhp.org), Accessed 11/25/2015
[114] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.
[115] National Health Care *for the* Homeless Council, definition of Recuperative Care Home - National Health Care for the Homeless Council (nhchc.org), Accessed 11/24/2015.
[116] Ibid 12/23/2015 communication with Dr. Hammer.

Table 14: Categories of Service and Point Values, Equity-Enhancing Services

Category	Tier	**Service Name** (description when not in CalAIM)	Initial point value
5	**A**	Enhanced care management	75 PMPM
	B	Asthma remediation	80/case
	B	Community transition: Nursing facility to home	220 PMPM
	B	Day habilitation	3/hr
	B	Housing deposits	700/move-in
	B	Housing tenancy and sustaining service	90 PMPM
	B	Housing transition navigation service	90 PMPM
	B	Nursing facility transition/diversion to assisted living facility	12/day
	B	Personal care services	4/hr
	B	Short-term post-hospitalization housing	15/day
	C	Team-based street outreach and engagement: Service for people who have similar needs and intensity to those needing ECM but who are harder to reach, typically houseless, such as referral and transitions to shelter, mental health, substance use, physical health services, sources of income, permanent housing opportunities and/or other supportive services, building sufficient trust to help them navigate to housing and services, including eventually Medi-Cal enrollment and CalAIM services	150/visit

Note: services without descriptions above are defined in accordance with CalAIM.

Attachment M
Global Payment Program Health Equity Monitoring Metrics Protocol
(Reserved)

Attachment N
Providing Access and Transforming Health (PATH) Supports
Funding and Mechanics Protocol

In accordance with the State's section 1115 demonstration and Special Terms and Conditions (STC 5.13 – 5.25), this protocol provides additional detail on the requirements for the Providing Access and Transforming Health (PATH) initiative as specifically required by STC 5.23. Designated State Health Programs (DSHP) will be used to support portions of PATH. The State is authorized for up to $1.85 billion (total computable) in expenditure authority for PATH. PATH is one-time transitional funding that will support State efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) Pilot Program and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This protocol outlines the award criteria and milestones for Qualified Applicants to receive funding through PATH across the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program (which is comprised of five initiatives), as well as the Reentry Demonstration Initiative Planning and Implementation Program. See *Attachment O: PATH Operational and Monitoring Protocol* which outlines allowable state expenditures for activities permitted under PATH, required progress reporting and performance metrics, and the State's approach to PATH-related program integrity.

I. Award Criteria for Qualified Applicants

A. Global Award Criteria For PATH

In order to receive PATH funds through any program or initiative, Qualified Applicants must meet the following global award criteria:

i. The Qualified Applicant must meet the initiative-specific Qualified Applicant criteria outlined in *Section B: Initiative-Specific Award Criteria* of this protocol.
ii. The Qualified Applicant must complete all components required in the application and submit all necessary supporting documentation, as required.
iii. The Qualified Applicant's application must be reviewed and approved by the PATH TPA and/or the State as appropriate.
iv. The Qualified Applicant must be in good standing with the State Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other relevant state and federal governmental agencies, and not excluded from participation in any federal health care program under section 1128 or 1128A of the Social Security Act.
v. The Qualified Applicant must attest that funding received through PATH will not supplant funding provided by other Federal, state or local programs, or that the applicable PATH-funded activities will not duplicate reimbursement from such other programs, consistent with clause vi., on an ongoing basis and in a form and manner as required by DHCS.

vi. Other Federal, state or local funding sources and programs that are complementary to or enhance PATH funds will not be considered supplanted by PATH funds or duplicate reimbursement. If applicable, the Qualified Applicant must describe how similar or related services and activities supported by other Federal, state or local funding sources are complemented or enhanced by efforts funded by PATH. For example, if other funding 1) does not fully reimburse activities with the exception of the services provided through the Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative, 2) may allow additional/different populations to be served, or 3) may allow additional/different services to be provided beyond those funded by PATH. To the extent otherwise allowable PATH activities are reimbursed by other Federal, state or local programs, PATH funding must not duplicate such reimbursement.

vii. Consistent with federal "free care" guidance, other sources of funding do not need to be exhausted before PATH reimbursement is available.

viii. The Qualified Applicant must submit all necessary progress reports and meet program oversight requirements associated with receipt of PATH funding as outlined in *Section (4): Program Integrity, Oversight and Monitoring* of *Attachment O: PATH Operational and Monitoring Protocol.*

B. Initiative-Specific Award Criteria

In addition to meeting the global award criteria outlined in *Section A: Global Award Criteria For PATH,* Qualified Applicants must also include the following initiative-specific information in applications in order to be considered for funding, as further described and specified in DHCS guidance, applications and related documents:

i. **Support for Sustaining Services Through the Transition to Managed Care**. Initiative specific award criteria include:
   a. Inclusion of appropriate and accurate documentation showing that the former WPC Lead Entity provides a service eligible for PATH-funding (see STC 5.14a-b. for additional information on WPC services that are eligible for PATH funding under this initiative).
   b. Inclusion of FFS or PMPM rate used to bill for the service, for DHCS review and approval.
   c. Inclusion of estimated utilization of services eligible for PATH funding.
   d. The Qualified Applicant must attest that funding received through PATH will only be claimed for allowable services as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

ii. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care.** Initiative specific award criteria include:
   a. Inclusion of appropriate and accurate documentation showing that the former WPC Lead Entity provides a service eligible for PATH-funding (see STC 5.14c.

for additional information on WPC services that are eligible for PATH funding under this initiative).

b. Inclusion of DHCS-approved FFS or PMPM rate used to bill for the service.
c. Inclusion of estimated utilization of services eligible for PATH funding.
d. The Qualified Applicant must attest that funding received through PATH will only be claimed for allowable services as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

iii. **Technical Assistance Marketplace.** Initiative specific award criteria include:

a. Inclusion of appropriate and accurate documentation of the need and goals for the requested technical assistance resource.
b. Inclusion of a copy of all existing, executed contracts with a Medi-Cal Managed Care Plan(s) (MCP) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.
c. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

iv. **Collaborative Planning and Implementation for ECM and Community Supports/Health-Related Social Needs (HRSN).** Qualified Applicants responsible for facilitating the Collaborative Planning and Implementation initiative must include the following initiative specific award criteria:

a. Inclusion of a robust description of the approach to collaborative planning and goals.
b. Provision of a detailed description of the process to engage potential collaborative planning participants that includes the following:
    i. List of a diverse set of partners that intend to participate in the collaborative in order to meet its goals and objectives, including, but not limited to: MCPs; city, county, and other government agencies; community-based providers including, but not limited to, public hospitals, community-based organizations (CBOs), and Medi-Cal Tribal and Designees of Indian Health Programs; and others as specified by DHCS.
    ii. A detailed approach for engaging and including providers / organizations that are under-resourced and/or serve historically underserved populations.
c. Submission of required letter(s) of support from collaborative participants in the region served indicating a commitment to work with a facilitator.
d. Inclusion of a copy of all existing, executed contracts with MCP(s) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.

e. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

v. **Support for Expanding Access to Services:** Qualified Applicants may apply for up to one year's worth of funding at a time. Qualified Applicants that request PATH funding to sustain allowable activities for longer than one year must reapply for subsequent funding each year and demonstrate a continued funding purpose as follows:

a. Submission of a detailed justification for why funds are needed to support delivery and/or bolster capacity to support of ECM and/or Community Support/HRSN services.
b. Submission of a detailed description of how the Qualified Applicant intends to coordinate with MCPs to ensure alignment of activities and avoid duplication of MCP reimbursement.
c. Inclusion of a detailed description of approach to sustaining items/activities funded via PATH after PATH funding ends.
d. Inclusion of a detailed description of how funding request will align with CalAIM goals.
e. Inclusion of a copy of all existing, executed contracts with Managed Care Plan(s) (MCP) in the State of California for CalAIM-related activities or a copy of a signed letter from an MCP stating the Qualified Applicant's intent to contract with the MCP in a timely manner for CalAIM related activities.
f. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

vi. **Reentry Demonstration Initiative Planning and Implementation Program**

a. Inclusion of a detailed description of all correctional institutions within the applicable jurisdiction including number of facilities and average daily census by facility.
b. Inclusion of a detailed description of current pre-release enrollment, suspension, and Medi-Cal screening processes, and the proposed approach to modifications that need to be made to align with related state mandates.
c. Inclusion of a detailed summary of current IT capabilities including booking / management systems and EHR platform, and the proposed approach to modifications that need to be made to improve data linkages with county departments of social services.
d. Inclusion of a plan to collaborate with local correctional institutions and county departments of social services to support planning and implementation of pre-release Medi-Cal enrollment and suspension processes.

e. The Qualified Applicant must attest that funding received through PATH will only be applied towards allowable purposes as outlined in the program application and in *Section (1): Allowable Expenditures* of *Attachment O: PATH Operational and Monitoring Protocol*, on an ongoing basis and in a form and manner as required by DHCS.

II. Milestones for Ongoing Funding for Qualified Applicants

Qualified Applicants must achieve milestones in order to receive PATH funding for all PATH programs and initiatives. Milestones will be aligned with PATH performance metrics, described in *Attachment O: PATH Operational and Monitoring Protocol*. The TPA will monitor achievements of milestones for the Technical Assistance Marketplace, Collaborative Planning and Implementation, and Support for Expanding Access to Services initiatives, as well as the Reentry Demonstration Initiative Planning and Implementation Program. Achievement of milestones for the Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative will be assessed by the State. Receipt of PATH funding for other initiatives will be contingent upon meeting requirements and milestones based on the category of PATH funding, described in B below.

A. Milestone Categories for Support for Sustaining Services Through the Transition to Managed Care initiative and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiative

i. **Support for Sustaining Services Through the Transition to Managed Care**
   a. The Qualified Applicant has submitted and completed all required elements of the invoice and progress reports outlined in *Section (3): Progress Reporting* of *Attachment O: PATH Operational and Monitoring Protocol* in a timely manner.

ii. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care**
   a. The Qualified Applicant has submitted and completed all required elements of the invoice and progress reports outlined in *Section (3): Progress Reporting* of *Attachment O: PATH Operational and Monitoring Protocol* in a timely manner.

B. Standardized Milestone Categories for Remaining PATH Programs and Initiatives

For the remaining PATH program/initiatives, Qualified Applicants must meet milestones across the first two standardized milestone categories listed below, and depending on the scope of the requested funding, may be required to fulfill interim milestones in order to receive PATH funding.

i. **Written Approval of Application**. Qualified Applicants must submit and receive approval from DHCS or its contracted TPA on their application prior to receiving PATH funding.

ii. **Documented Completion of Activities Outlined in Application.** In order to receive PATH funding, Qualified Applicants must complete the activities outlined in their original application and submit an invoice, utilization or progress report (as requested by DHCS) documenting completion. Activities may include, for example:
   a. Timely submission of required progress reports and reporting on performance metrics.
   b. Timely submission of an invoice for the delivery of approved services as part of the Support for Sustaining Services Through the Transition to Managed Care and/or Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care initiatives.
   c. Successful completion of the technical assistance goals outlined by the Qualified Applicant in Technical Assistance initiative application.
   d. Completion of a collaborative planning and implementation webinar series.
   e. Hiring of a community health worker to support the delivery of ECM and/or Community Supports/HRSN.
   f. Successful collaboration between a county Sheriff's office and a county department of social service to identify funding needs to support implementation of pre-release enrollment and suspension processes for the Reentry Demonstration Initiative Planning and Implementation Program.

iii. **Progress Towards Organization/Project Specific Milestones Approved in Application.** Depending on the nature of the project and/or funding request, Qualified Applicants may propose organization / project-specific milestones/deliverables as part of their applications. Ongoing PATH funding may be contingent upon the Qualified Applicant meeting such interim milestones, as determined by DHCS, and defined by Qualified Applicants as part of their initial applications, and approved by the State and its TPA. Sample interim milestones/deliverables may include, for example:
   a. Facilitation of a certain percentage of planned convenings in a collaborative planning series.
   b. Completion of an assessment of current organizational capabilities prior to determining hiring needs.
   c. Conducting a certain number of collaborative planning sessions between correctional institutions and county social service departments to assist with the coordination of Medi-Cal enrollment and suspension processes.

Attachment O
Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol

In accordance with the State's section 1115 demonstration Special Terms and Conditions (STC 5.13 – 5.25) this protocol outlines key operational features of the Providing Access and Transforming Health (PATH) initiative as required by STC 5.24. The State is authorized for up to $1.85 billion (total computable) in expenditure authority for two approved PATH Programs: the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program (which is comprised of five initiatives) and the Reentry Demonstration Initiative Planning and Implementation Program. PATH is a one-time transitional funding that will support the State's efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) Pilot Program and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This protocol outlines: (1) allowable state expenditures for activities permitted under PATH; (2) required performance metrics; (3) progress reporting; and, (4) the State's approach to PATH-related program integrity, oversight and monitoring across the two approved PATH Programs. *See Attachment N: PATH Funding and Mechanics Protocol for the award criteria and milestones for Qualified Applicants to receive funding through PATH.*

(1) **Allowable Expenditures.** Allowable state expenditures under all PATH programs and their associated initiatives are described below. Expenditures under the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program are organized by initiative, as described below. PATH funding must complement or enhance, but not supplant related funding provided by other federal, state or local funding sources. To the extent otherwise allowable, PATH activities are reimbursed by other federal, state or local programs, and PATH funding must not duplicate such reimbursement.

Consistent with the federal "free care" guidance with respect to third party payment, other sources of funding do not have to be exhausted before a Qualified Applicant receives and applies PATH funding, or an authorized provider bills an Medi-Cal Managed Care Plan (MCP) for an approved Community Supports/Health Related Social Needs (HRSN) service that the Medi-Cal MCP has elected to offer. For example, where a county or local provider may access funding for comparable housing support services under another program, the county or local provider is not required to use that funding before providing and seeking PATH funding or Medi-Cal MCP reimbursement for a Community Supports/HRSN housing support service to an eligible Medi-Cal enrollee. Double billing or duplicative reimbursement for the same delivered service is not permitted. Other available funding should be used to provide additional and complementary services or supports that may benefit Medi-Cal members or other community residents depending on the purposes of the funds.

Allowable expenditures by PATH program and initiative include:

Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program:

A. Support for Sustaining Services Through the Transition to Managed Care: Qualified Applicants may receive PATH funding for the continued operation of allowable WPC services that will transition to Enhanced Care Management (ECM) and Community Supports/HRSN[1] by January 1, 2024, as approved in their application to the State. *(See Attachment N: PATH Funding and Mechanics Protocol for more details).*

B. Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care: Qualified Applicants may receive PATH funding for the delivery of allowable WPC reentry demonstration initiative services and supports that will transition to ECM by January 1, 2024, as approved in their application to the State. *(See Attachment N: PATH Funding and Mechanics Protocol for more details).*

C. Technical Assistance Marketplace: Qualified Applicants must apply received PATH funding for the purchase of resources or to engage with approved vendors in the technical assistance marketplace to provide customized project specific technical assistance in one or more of the domains listed below**:**

i. Contracting between Medi-Cal MCPs and providers;
ii. Collecting, documenting and exchanging data between MCPs and providers;
iii. Billing for ECM and Community Supports/HRSN services;
iv. Building provider capacity and developing care plans to support ECM and Community Supports/HRSN service delivery;
v. Designing new workflows/service delivery models to support ECM and Community Supports/HRSN service delivery;
vi. Supporting applicants in applying for regional CalAIM collaborative planning and implementation efforts or other types of PATH funding;
vii. Organizational strategic planning to support CalAIM implementation;
viii. Promoting health equity through the delivery of ECM and Community Supports/HRSN;
ix. Engaging with stakeholders to support the implementation of ECM and Community Supports/HRSN;
x. Aiding entities in understanding and navigating CalAIM program requirements;
xi. Supporting applicant compliance with monitoring, oversight and program integrity requirements; and/or,
xii. Other domains approved by the State.

[1] As described in the State's 1115 demonstration and 1915(b) waiver. Community Supports/HRSN are equivalent to in-lieu-of-services (ILOS).

D. Collaborative Planning and Implementation for ECM and Community Supports/HRSN**:** Funding from this initiative will support facilitation of local collaborative planning groups. Qualified Applicants must apply received funds for one or more of the activities described below. The State may consider providing funding to Qualified Applicants for allowable activities performed prior to the start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Identifying ECM and Community Support/HRSN needs and gaps within the community;
ii. Working with MCPs to review Incentive Payment Program (IPP) Needs Assessment and Gap Filling Plans to prevent duplication with PATH[2];
iii. Educating stakeholders on key topics related to CalAIM and PATH;
iv. Facilitating convenings to identify, discuss, and resolve local implementation issues that arise as CalAIM is rolled out across a county/region;
v. Conducting quality improvement activities to ensure the delivery of high-quality services;
vi. Monitoring how PATH and other funds are being used to address implementation issues to ensure funding is going towards identified and prioritized uses, e.g., closing ECM or Community Supports/HRSN service gaps, addressing community level infrastructure needs to expand access to ECM or Community Supports/HRSN in certain geographic areas;
vii. Disseminating written materials or hosting webinars on best practices on ECM or Community Supports/HRSN service delivery or operational processes and/or providing guidance to collaborative planning entities that addresses implementation issues;
viii. Identifying and inviting entities to participate in local collaborative planning groups;
ix. Conducting outreach to entities that have been historically underutilized and/or under-resourced (as defined by DHCS), and/or that serve the diverse needs of the state's population to encourage participation in CalAIM; and/or,
x. Other activities approved by the State (e.g., hosting topical roundtables on key issues that arise during the collaborative planning process, forming population specific collaboratives such as those serving tribes/tribal entities, providing support to entities in accessing other PATH resources via the Technical Assistance Marketplace or Support for Expanding Access to Services, etc.).

E. Support for Expanding Access to Services. Qualified Applicants must use received funding for one or more or the activities described below. The State may consider providing funding to Qualified Applicants for allowable activities performed prior to the

[2] The State has designed and is implementing a $1.5 billion CalAIM Incentive Payment Program (IPP) to stimulate Managed Care Plan (MCP) investments in ECM and Community Supports/HRSN infrastructure and capacity (https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx). To be eligible for incentive payments, MCPs must assess ECM and Community Supports/HRSN capacity and infrastructure gaps in their region and demonstrate progress in filling those gaps against a set of DHCS established metrics and must meet or exceed specified thresholds.

start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Increasing the provider workforce, including, for example, by assessing current organizational capabilities and capacity to deliver ECM and Community Supports/HRSN and supporting initial hiring, recruiting, onboarding, and training for staff that have a direct role in executing ECM and Community Supports responsibilities/HRSN;
ii. Modifying, purchasing and/or developing the necessary referral, billing, data reporting or other infrastructure and IT systems, to support integration into CalAIM;
iii. Providing upfront funding needed by Qualified Applicants to support capacity and infrastructure necessary to deliver ECM and Community Supports/HRSN services (e.g., support for hiring additional team members needed to provide ECM/Community Supports/HRSN;
iv. Evaluating and monitoring ECM and Community Supports/HRSN service capacity to assess gaps and identifying strategies to address gaps (e.g., conducting a community health needs assessment to identify where there are gaps in capacity for one or more Community Supports/HRSN);
v. Developing a plan to conduct outreach to populations who have traditionally been under-resourced and/or underserved to engage them in care; and/or
vi. Other activities approved by the State.

PATH Reentry Demonstration Initiative Planning and Implementation Program

F. **PATH Reentry Demonstration Initiative Planning and Implementation Program**: Qualified Applicants must apply received funding for the activities described below. The State may consider providing funding to Qualified Applicants for activities performed prior to the start of the application period, but not before January 1, 2022, and only on a case by case basis:

i. Modifying technology and IT systems needed to support Medi-Cal enrollment and suspension processes. This includes development of electronic interfaces for correctional facilities to communicate with Medicaid county welfare department eligibility and enrollment IT systems to support Medi-Cal enrollment and suspension;
ii. Recruiting, hiring, onboarding, and training staff to assist with the coordination of Medi-Cal enrollment and suspension for justice-involved individuals;
iii. Development or modification of protocols and procedures that specify steps to be taken in preparation for and execution of the Medi-Cal enrollment and suspension processes for eligible individuals;
iv. Facilitating collaborative planning activities between correctional institutions, correctional agencies, county welfare and social services departments, and other stakeholders as needed to support planning, implementation, and modification of Medi-Cal enrollment and suspension processes;
v. Activities to support a milieu appropriate for provision of Medi-Cal pre-release services including accommodations for private space such as movable screen

walls, desks, and chairs to conduct assessments and screenings within correctional institutions, and support for installation of audio-visual equipment or other technology to support pre-release services delivered via telehealth.

vi. Planning focused on development or modification of processes and information sharing protocols to:
    a. Identify uninsured individuals who are potentially eligible for Medi-Cal;
    b. Assisting with the completion of a Medi-Cal application;
    c. Submitting an application to the county welfare eligibility and enrollment departments or coordinating suspension;
    d. Establishing on-going oversight and monitoring of processes upon implementation; and,

vii. Other activities approved by the State.

(2) **Performance Metrics.** Progress reports submitted by Qualified Applicants will include information detailing their progress towards milestones and performance metrics that are standardized by the initiative. In order to receive ongoing funding, Qualified Applicants must meet both milestones set forth in *Attachment N: PATH Funding and Mechanics Protocol* as well as submit all required progress reports informing progress towards performance metrics detailed here. When appropriate, the Third-Party Administrator (TPA) will summarize and report on performance metrics across Qualified Applicants that have received PATH funding.

A. Support for Sustaining Services Through the Transition to Managed Care: Qualified Applicants must report directly to the State at regular intervals on the following performance metrics, including, at a minimum:

i. Utilization of PATH-funded services as reported in semi-annual utilization reports that include the following information:
    a. Client identification numbers;
    b. FFS/PMPM service codes;
    c. Dates of service; and,
    d. Demographic data on individuals receiving services (if available).[3]

ii. Funding claimed for eligible services as reported in semi-annual invoices summarizing services delivered; and,

iii. Other metrics as defined by the State.

B. Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care: Qualified Applicants must report directly to the State at regular intervals on the following performance metrics, including, at a minimum:

[3] In addition, the State will crosswalk demographic data provided through Support for Sustaining Services Through the Transition to Managed Care reporting with existing data from the State's Medi-Cal Eligibility Data System (MEDS).

i. Utilization of PATH-funded services as reported in semi-annual utilization reports that include the following information:
    a. Client identification numbers;
    b. FFS/PMPM service codes;
    c. Dates of service; and,
    d. Demographic data on individuals receiving services (if available).[4]
ii. Funding claimed for eligible services as reported in semi-annual invoices summarizing services delivered; and,
iii. Other metrics as defined by the State.

C. Technical Assistance Initiative: The TPA must report to the State at regular intervals across the following Technical Assistance Initiative performance measures, including, at a minimum:

i. Total funding dispersed to entities by county and by Qualified Applicant (to ensure fair distribution of resources);
ii. Which Qualified Applicants have applied for Technical Assistance services;
iii. Which Qualified Applicants were funded to receive Technical Assistance services and how much funding was allocated to the Qualified Applicant;
iv. Which Qualified Applicants applied for Technical Assistance and were not funded and the reason(s) why funding was rejected;
v. Utilization of different Technical Assistance resources by domain and by Qualified Applicant;
vi. Number of Qualified Applicants that met self-defined milestones during the performance period;
vii. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period;
viii. Outreach efforts to reach Qualified Applicants that are under-resourced and/or serve historically underserved communities (as defined by the State and to be documented via a future demonstration Monitoring Report);
ix. Outreach efforts to entities in counties that are not on track to hit target funding disbursements;
x. Number of Qualified Applicants that are under-resourced, and/or serve historically underserved communities (as defined by the State);
xi. Summary of complaints/grievances; and,
xii. Other measures as defined by the State.

D. Collaborative Planning and Implementation Initiative: The TPA must report to the State at regular intervals across the following Collaborative Planning and Implementation Initiative performance measures, including, at a minimum:

[4] In addition, the State will crosswalk demographic data provided through Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care reporting with existing data from the State's Medi-Cal Eligibility Data System (MEDS).

i. Entity participation in collaborative planning groups, including which entities are under-resourced, and/or serve historically underserved communities (as defined by the State);
ii. Agendas and meeting summaries of collaborative planning convenings;
iii. Identified successes and challenges experienced by participants in the collaborative planning initiative;
iv. Lessons learned and best practices identified in the collaborative planning group;
v. Results from a participant survey assessing satisfaction with collaborative planning facilitators and recommendations for future topics and convenings;
vi. Summary of complaints/grievances received related to the initiative; and,
vii. Other metrics as defined by the State.

E. Support for Expanding Access to Services Initiative: The TPA must report to the State at regular intervals across the following Support for Expanding Access to Services Initiative performance measures, including, at a minimum**:**

i. Total funding dispersed to entities by county (to ensure fair distribution of resources);
ii. Outreach efforts to entities in counties that are not on schedule to provide target funding disbursements;
iii. Number of Qualified Applicants that met self-defined milestones during the performance period;
iv. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period;
v. Number of Qualified Applicants that received funding, and amount of funding received by type of entity (e.g., county, provider, community-based organization, etc.);
vi. Number of Qualified Applicants that are under-resourced and/or serve historically underserved communities (as defined by the State), and amount of funding received by type of entity (e.g., county, provider, community-based organization, etc.);
vii. Number of Qualified Applicants that were denied funding, and rationale indicating why;
viii. Summary of how funding was applied, including by allowable activity type;
ix. Number of Qualified Applicants that reported applying received funds for purposes that were not documented in applications;
x. Summary of complaints/grievances received related to the initiative; and,
xi. Other metrics as defined by the State.

F. Reentry Demonstration Initiative Planning and Implementation Program: The TPA must submit a report to the State by December 31, 2023 that summarizes performance measures for this program. The report will document at a minimum:

i. Number of Qualified Applicants that received funding, including by type of Qualified Applicant (e.g., Sheriff's Office, Probation Office, County Department of Social Service etc.);

ii. Number of qualified applicants that were denied funding, and rationale indicating why;
iii. Total funding dispersed by type of Qualified Applicant;
iv. Summary of the payments made by type of Qualified Applicant broken out by allowable activities type;
v. Number of Qualified Applicants that met self-defined milestones during the performance period;
vi. Number of Qualified Applicants that failed to meet self-defined milestones during the performance period; and,
vii. Other metrics as defined by the State.

(3) **Progress Reporting**. Qualified Applicants that receive PATH funding must provide progress reports to the State or the TPA (as required) documenting progress toward approved, entity-specific milestones and standardized[5] performance metrics.

i. Progress reports for all PATH initiatives must be submitted to the State or the TPA, at a minimum, bi-annually.
ii. Progress reports for the Support for Sustaining Services Through the Transition to Managed Care and the Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care will be submitted directly from funding recipients to the State. Progress reports for all other PATH initiatives and programs will be submitted by the funding recipient to the TPA, who will then collate information in these progress reports into performance metrics, review them, and provide status reports to the State.
iii. Progress reports from Qualified Applicants must include, at a minimum:
    a. Narrative description of achieved milestones, as defined in the Qualified Applicant's application, or progress towards milestones during the reporting period *(described further in Attachment N: PATH Funding and Mechanics Protocol);*
    b. Reporting to inform progress towards standardized performance metrics, including progress towards specific State-specified targets, as appropriate (described in detail in *Section (2): Performance Metrics*);
    c. Description of how funds were applied during reporting period.
    d. Description of activities/milestones that were not achieved as expected during the reporting period, and an explanation indicating why they were not achieved, and the strategies to overcome hurdles to achieve them. Future progress reports should include subsequent progress in completing those activities/milestones, or other mitigation strategies, as applicable;
    e. Requests to modify activities/milestones and the budget, as needed, including the rationale for modification; and,

[5] DHCS works with the TPA to develop standardized criteria and implement appropriate performance metrics for each of the PATH initiatives. DHCS provides oversight and is accountable for setting criteria, and standardized reporting requirements and metrics. The TPA is responsible for developing recommended criteria and performance metrics for DHCS consideration and for operationalizing the reporting processes (i.e., collecting reports from qualified applicants and analyzing findings) and implementing initiative requirements per DHCS's direction.

f. Attestation of non-duplication of reimbursement and supplantation of PATH funding consistent with the requirements in Attachment N.

iv. For applicable initiatives, the TPA must summarize progress report findings and report them to DHCS.
   a. Upon request, the TPA must make available to the State any individual progress report submitted by a Qualified Applicant, for any initiative.

v. Upon receipt, the State or TPA (as appropriate, based on initiative) is responsible for reviewing and approving the progress report. In the event that progress reports are rejected, the Qualified Applicant will have 30 days to rectify any deficiencies and submit an updated report to the State. If an entity fails to submit an appropriately updated report then the State may pursue corrective action in accordance with Section (4) below.

(4) **Program Integrity, Oversight and Monitoring:** The State will monitor and enforce program integrity standards in the PATH program, across all initiatives, including through the following mechanisms as required by STC 5.24(a)-(c):

A. Regular Progress Reporting

i. As described in Section (2) (i) above, all Qualified Applicants that receive PATH Funding must submit regular progress reports to the State or its contracted TPA, as applicable, including all required attestations, including updated attestations as needed.

ii. The State or its contracted TPA will monitor for funding irregularities and potential supplantation of federal, state and/or local programs across all PATH programs and initiatives.

iii. The State or its contracted TPA will monitor for funding irregularities and potential duplication of reimbursement by federal, state and/or local programs across all PATH programs and initiatives.

B. Participating in Audit Processes

i. The State or its TPA, as appropriate, must perform spot check audits of funding disbursements across all PATH initiatives. Spot check audits must include, at a minimum:
   a. Review of documentation to support activities identified on PATH invoices to ensure funds were appropriately applied;
   b. With respect to the Technical Assistance, Collaborative Planning and Implementation, Support for Expanding Access, and Reentry Demonstration Initiative Planning and Implementation Program Initiatives, identifying instances where PATH funds have potentially been applied on activities outside of those that are approved;
   c. Detecting irregularities, discrepancies or outliers requiring further investigation; and
   d. Identifying instances of potential payment duplication or supplantation of federal, state and/or local funds. Such review shall take into account

the Qualified Applicant's description of how other support from state, federal or local programs are complementary to PATH funding consistent with Attachment N.

C. Actions Taken to Correct Underperformance

i. The State and its contracted TPA will utilize a standardized Corrective Action Plan process for Qualified Applicants who are not meeting progress reporting or other requirements for receipt of PATH funding.

ii. Underperformance is defined as, at a minimum:
   a. Failure to submit timely progress reports or invoices to the State or TPA;
   b. Failure to adequately correct progress reports that have been rejected by the State or TPA;
   c. Invoice, utilization report or progress report submission errors;
   d. With respect to the Technical Assistance, Collaborative Planning and Implementation, Support for Expanding Access to Services, and Reentry Demonstration Initiative Planning and Implementation Program Initiatives, applying PATH funding for non-approved activities, or duplicating reimbursement; and,
   e. Significant discrepancies between planned application of PATH funds and actual program activities.

iii. Upon identifying underperformance, the State or its contracted TPA must issue a written notice to the Qualified Applicant detailing their underperformance and requesting a written Corrective Action Plan Strategy that will describe how the Qualified Applicant will improve on areas of underperformance.

iv. Qualified Applicants that receive a request for a Corrective Action Plan Strategy must submit a written plan that will describe how the Qualified Applicant will improve on areas of identified underperformance. The Qualified Applicant must include in their submission a "performance improvement plan" that clearly states the steps taken to rectify the underperformance.

v. Failure to implement steps in the written plan in a timely manner may result in discontinuation and/or recoupment of awarded PATH funding (see addressing non-compliance below).

vi. The TPA will report to the State on any Qualified Applicants that are subject to a Corrective Action Plan process.

D. Actions Taken to Addressing Non-Compliance

i. Funding to Qualified Applicants will be discontinued and/or recouped in the following instances, at a minimum:
   a. Instance where corrective action has been imposed and underperformance continues.
   b. Cases of fraud, waste and/or abuse.

ii. Qualified Applicants that have funding discontinued and/or recouped may also be precluded from being approved to receive additional PATH funding in the future.

iii. The TPA will report to the State on any Qualified Applicants that have had funding discontinued, recouped, and/or have been precluded from being approved to receive additional PATH funding in the future.

Attachment P
Historical Information-Budget Neutrality Test
(Reserved)

Attachment Q
DSH Coordination Methodology

During any year in which the State of California conducts the Global Payment Program ("GPP"), the state shall make the modifications listed in this Attachment Q to its methodologies for making disproportionate share hospital payments under the DSH State Plan provisions (Attachment 4.19-A, commencing with page 18).

1. The state shall not make disproportionate share hospital payments during a state fiscal year to any designated public hospital that participates in the Global Payment Program during that year.

2. Prior to the start of the applicable GPP PY, or as soon thereafter as possible, the amount of the preliminary federal DSH allotment under SSA § 1923(f) for the FFY that commences prior to the start of (for GPP PYs 7-12) or commences in (for GPP PYs 1-6) the applicable GPP PY shall be determined. For this purpose, the allotment identified for California for the applicable FFY in the Preliminary Disproportionate Share Hospital Allotments file that is released by CMS shall be initially used.

3. Hospitals that meet DSH eligibility criteria and are "non-cost-based DSH facilities," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-cost-based DSH facilities, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

4. Hospitals that meet DSH eligibility criteria and are "non-government operated hospitals," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-government operated hospitals, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

5. The federal DSH allotment set-aside amounts determined above for non-cost-based DSH facilities in paragraph 3, and for non-government operated hospitals in paragraph 4, will be subtracted from the full federal DSH allotment amount identified in paragraph 2.

6. Hospitals that meet DSH eligibility criteria, and are "cost-based DSH facilities" as defined under the DSH State Plan provisions, and which are licensed to the University of California and not participating in GPP for the applicable PY, will receive DSH payments pursuant to the applicable State Plan methodology, subject to an annual aggregate cap on the associated federal DSH allotment for those payments. The annual aggregate cap is equal to an applicable percentage multiplied by the amount of the federal DSH allotment that is left after the set-asides for non-cost-based DSH facilities and non-government operated hospitals, as calculated in paragraph 5, which shall be the DSH allotment amount set aside

for the University of California DSH facilities. The applicable percentages for each GPP PY are as follows:

GPP PY 1:	26.296%
GPP PY 2:	24.053%
GPP PY 3:	23.150%
GPP PY 4:	21.896%
GPP PY 5:	21.896%
GPP PY 6:	21.896%
GPP PY 7:	21.896%
GPP PY 8:	21.896%
GPP PY 9:	21.896%
GPP PY 10:	21.896%
GPP PY 11:	21.896%
GPP PY 12:	21.896%

Should any cost-based DSH facility licensed to the University of California elect to forego DSH payments to participate in GPP beginning with any GPP PY in the Demonstration, this percent shall be modified to reflect the appropriate shift of funds. Any modification to this percent shall be approved by CMS prior to implementation, and the list of GPP-participating PHCS in Attachment C will be amended accordingly.

7. The full federal DSH allotment amount, less the aggregate DSH allotment set-aside amounts determined for non-cost-based DSH facilities in paragraph 3, for non- government operated hospitals in paragraph 4, and for cost-based DSH facilities licensed to the University of California in paragraph 6, shall constitute the initial "Adjusted DSH" component of the funding for the GPP described in STC 78. For GPP PY 6, the "Adjusted DSH" component shall reflect an additional reduction of 50%. To align federal DSH allotment funding with GPP PYs 7 through 12, 50% of this Adjusted DSH amount will fund a portion of the GPP PY.

8. For GPP PYs 7-12, the remaining allotment funding for the GPP PY will be determined pursuant to the same steps in paragraph 3-7 based on the FFY preliminary federal DSH allotment under SSA § 1923(f) allocated to California for the FFY that commences during the GPP PY, including the application of the 50% reduction to ensure alignment with the GPP PY. Until the Preliminary Disproportionate Share Hospital Allotment file for the FFY commencing during the GPP PY is released by CMS, an estimated 2% increase over the prior FFY DSH allotment will be used.

9. The initial combined Adjusted DSH component pursuant to paragraphs 7 and 8 is determined no later than May 15 prior to the start of GPP PYs 1 through 6 and no later than November 15 prior to the start of GPP PYs 7 through 12.

10. The final combined Adjusted DSH component of the GPP shall be determined pursuant to the steps in paragraphs 1 – 8 above, which shall take into account the following:

a) The allotment identified for California in the Final Disproportionate Share Hospital Allotments file that is released by CMS for the applicable FFY that commences during the GPP PY (for PY 1-6) and for the applicable FFY that commences prior to the start of the GPP PY (for PY 7-12).

b) The actual amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year; and

c) The results of the applicable DSH audits for the hospitals, including any adjustments that increase or decrease DSH payments to the hospitals.

11. Adjustments shall be made to the GPP total computable annual limit and GPP annual budgets to take into account the final Adjusted DSH component for the applicable GPP PY determined in paragraph 10, and, notwithstanding the final payment timeline set forth in Attachment K, all final reconciliation payments for the applicable GPP PY made pursuant to Attachment K shall be subject to these adjustments.

12. Within 30 days of its determination of the initial "Adjusted DSH" component discussed in step 9, the state will submit a report to CMS stating the amount of the initial "Adjusted DSH" component for the applicable GPP PY (with explanation for how "Adjusted DSH" component was calculated) and projected DSH payment amounts for all hospitals that will receive DSH payments.

13. Within 30 days of its determination of the final "Adjusted DSH" component discussed in step 10, the state will submit a report to CMS stating the amount of the final "Adjusted DSH" component for the applicable GPP PY, the actual and final amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the final GPP total paid to each GPP hospital.

The state will report all DSH payments to "non-cost-based DSH facilities," "non- government operated hospitals," "cost-based DSH facilities" licensed to the University of California, and designated public hospitals not participating in the Global Payment Program, on Forms CMS-64.9 WAIVER, with waiver number 11-W-00193/9, under Waiver Name "DSH," and with project number extension indicating the demonstration year corresponding to the federal fiscal year of the DSH allotment for which the payments were made.

Attachment R

Negative Balance
Payment Schedule
(Reserved)

Attachment S
CBAS Program Integrity

Following a determination that a credible allegation of fraud exists with respect to a CBAS provider, and that there is no good cause not to suspend payments, the State will initiate an email notification within one business day to all contracted Managed Care Plans (MCPs) that have provider networks in which the CBAS provider participates. Commencing with payments made by an MCP on or after April 1, 2016, MCPs will be required to report to the State all payments made to a CBAS provider for whom a credible allegation of fraud exists for dates of services rendered after the date the MCP was notified. The procedures below outline details regarding the reporting and recoupment process:

- The State's notification email to the MCPs will contain specific instructions for reporting requirements. MCPs will utilize the "Total MCP Payments to CBAS under Credible Allegation of Fraud" form to track total payments made to the applicable CBAS provider on a quarterly basis, commencing with the first quarter that the MCP was notified of the credible allegation of fraud. Reports for all subsequent quarters will indicate the total payments made for the given quarter, as well as the cumulative total payments made to the CBAS provider from the date following initial notification of the credible allegation of fraud.

- MCPs will submit quarterly reports to the State within seven business days from the end date of each quarter. The State will, in turn, submit quarterly reports to CMS reflecting all MCP payments made to applicable CBAS providers within fifteen business days from the end date of each quarter.

- Reporting requirements will remain in effect until the State notifies the MCP that the law enforcement agency investigating the credible allegation of fraud has either charged the CBAS provider with fraud or has informed the State that there is insufficient evidence to bring charges. Upon receipt of such information from the investigating agency, the State will notify the MCPs of the determination via email within three business days.

- The notification of the MCP by the State that there no longer exists a credible allegation of fraud against a CBAS provider will immediately extinguish the MCP's responsibility for quarterly reporting to the State and the State's responsibility for quarterly reports regarding payments to that CBAS provider to CMS.

- If, after investigation, the law enforcement agency brings charges against a CBAS provider for fraud, and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs, the following actions will be required to ensure recovery of all payments made to the CBAS provider:

Recoupment to the State	Recoupment to CMS
1. The MCP will submit to the State within 15 business days of notification of a final report reflecting payments for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs. 2. Within 90 days of receiving the final report, the State will recoup the CBAS provider fraud amount from the MCP capitated payment. The statement issued to the MCP will reflect the CBAS provider fraud amount.	1. The State will submit to CMS within 15 business days of receipt of a final report reflecting MCP payments made to the applicable CBAS provider for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement indicating fault by the provider occurs. 2. The State will reimburse CMS in accordance with its established repayment system by: A. Setting up an Accounts Receivable to reimburse the State General Fund through the MCP's recoupment for the Total Computable (federal and state share), and B. When applicable, completing Federal repayment paper work to reimburse CMS from the State General Fund.

California Drug Medi-Cal Organized Delivery System

Evaluation Design

Part of California Advancing and Innovating Medi-Cal (CalAIM)

A Section 1115 Demonstration Waiver Evaluation

and

Including the Medi-Cal 2020 Calendar Year 2021 Temporary Extension

Revised 6/9/2023

UCLA David Geffen School of Medicine
Integrated Substance Abuse Programs

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General Background Information

The Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 demonstration waiver was created by the California Department of Health Care Services (DHCS) with the intent of addressing many previously existing limitations in the DMC system. Prior to the DMC-ODS, the system was comprised of fragmented services, creating gaps that undermined client access and quality of care. The continuum of substance use disorder (SUD) services was uncoordinated, making it difficult for clients to navigate the system. SUD treatment providers indicated that many important services they provided or wished to provide for clients were not billable, were only reimbursable if delivered by a limited number of provider types or were too limited to provide proper care to clients. Providers were not necessarily required to deliver evidence-based practices in line with current research, and counties lacked the authority to fully ensure the quality and accountability of their local providers.

The DMC-ODS was created to test the impact of organizing SUD services to improve service delivery to Medicaid-eligible individuals with SUDs. The intent was to demonstrate that organized SUD care improves quality, access, and coordination/integration of treatment for beneficiaries while decreasing other health care system costs. Under the DMC-ODS waiver, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed by ASAM to set a standard for appropriate assessment, placement, and treatment planning of clients with SUD and co-occurring disorders as well as to a set standard for SUD providers. Services under the DMC-ODS waiver also create a continuum of care and create requirements allowing for local control, accountability, and greater administrative oversight.

The DMC-ODS waiver was originally approved by CMS in August 2015, and later became part of California's larger Medi-Cal 2020 Waiver, which ended December 31, 2021. It is now part of California Advancing and Innovating Medi-Cal (CalAIM), which is being implemented through a combination of 1115 and 1915b waivers starting January 1, 2022 and continuing through December 31, 2026. Most DMC-ODS services are now covered in the California Medicaid State Plan. This evaluation covers DMC-ODS under CalAIM as an extension of DMC-ODS under Medi-Cal 2020, including an evaluation of the Medi-Cal 2020 calendar year 2021 temporary extension, and will continue to evaluate the impact of DMC-ODS since its inception.

The population targeted by DMC-ODS is Medicaid-eligible individuals with SUDs. As described in the DMC-ODS waiver's Special Terms and Conditions (STCs),[1] for counties that opt-in to the DMC-ODS waiver, beneficiaries must meet the medical necessity criteria and reside in a participating county to receive waiver services. Currently, the DMC-ODS waiver is implemented

[1] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

in 37 counties that cover 95.9% of the state's population.[2] It is anticipated that currently non-participating counties will be given the option to opt-in to DMC-ODS during the CalAIM demonstration. If they do, they will also become part of the DMC-ODS population for evaluation purposes.

To address rapidly rising stimulant overdoses, the DMC-ODS will also cover Contingency Management (CM) under a new pilot program known as the Recovery Incentives Program: California's Contingency Management Benefit. This program began implementation in March 2023. Stimulant-related overdose death rates in California are 7.2 times higher today than they were 10 years ago, putting stimulants approximately on par with opioids in terms of total overdose-related deaths[3]. Methamphetamine use is also associated with hypertension, myocardial infarction, stroke, aortic dissection, and heart failure (Manja et al., 2023). Currently, no Food and Drug Administration-approved medications exist for the treatment of Stimulant Use Disorders (StimUD), but studies have repeatedly supported the use of CM as a highly effective evidence-based practice in the treatment of StimUD, particularly in reducing drug use (De Crescenzo et al., 2018; Farrell et al., 2019; AshaRani et al., 2020; Brown & DeFulio, 2020; Ronsley et al., 2020). County participation in the Recovery Incentives Program is optional.

The previous DMC-ODS evaluation plan was approved by CMS on June 20, 2016. The resulting evaluation documented DMC-ODS implementation and found that the DMC-ODS waiver has improved access to treatment, treatment quality, and coordination of care, and met the initial goals of the DMC-ODS (Urada et al., 2016, 2017, 2018, 2019, 2021, 2022).[4] Health disparities were identified in treatment placement, however. Under the new waiver, aside from the addition of the Recovery Incentives Program, DMC-ODS remains mostly intact with the addition of changes to clarify or streamline billing, benefit rules, and facilitate Health IT. The current evaluation design will look for any effect of the new changes but is otherwise focused on monitoring maintenance of the measured improvements found during the initial waiver, identifying emerging trends, determining opportunities to facilitate further progress, evaluating health equity, and evaluating the new Recovery Incentives Program.

One component of the waiver is still under review: DMC-ODS services that are provided by Traditional Healers and Natural Helpers. If this benefit is approved in the future, the evaluation team will bring methods already being employed in other parts of the evaluation (e.g., analysis of claims, provider interviews, and client perception surveys described below) to bear on these services.

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[2] Projections Prepared by Demographic Research Unit, California Department of Finance, January 2021: https://www.dof.ca.gov/Forecasting/Demographics/Estimates/e-4/2010-21/documents/E-4_2021InternetVersion.xlsx

[3] Based on 12-month rolling averages from Q2 2021 and Q2 2011 data from: https://skylab.cdph.ca.gov/ODdash/. Total overdose deaths based on combination of psychostimulant and cocaine-related deaths.

[4] Due to data availability the 2022 report covered partial data for CY 2021. Analyses of 2021 data will be incorporated into the current evaluation as described in the methodology section.

If substantial external contextual issues arise in the future, the evaluation team will also measure and discuss these impacts, as the team has in the past with COVID-19 (Bass et al., 2022). Examples of potential contextual changes might include a waning (or increasing) impact of COVID-19, changes in the availability of fentanyl and high-potency stimulants, workforce shortages, increasing use of peers, and an expected IRS ruling that could have an impact on the size and total amount of incentives available to beneficiaries.

Evaluation Questions and Hypotheses

The evaluation will examine whether the DMC-ODS continues to achieve the following six goals as required by STC 46, an additional seventh goal on health disparities in the pursuit of CalAIM's goal of improving health equity, and an eighth goal based on STC 57e requirements specific to a contingency management evaluation. The Recovery Incentives Program also shares some overlapping goals with the rest of DMC-ODS (e.g., increased adherence and retention in treatment, reduced overdose deaths).

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate;
6. Improved access to care for physical health conditions among beneficiaries.
7. Improved health equity across DMC-ODS performance and outcome measures.
8. An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

UCLA will also coordinate with DHCS to leverage the monitoring metrics[5] that DHCS is reporting to CMS to incorporate these metrics into the evaluation UCLA will conduct more in-depth analyses and additional quantitative and qualitative data collection to provide important context, insights, and recommendations beyond these metrics.

A short summary of the approaches for each of these goals follows. Additional details on the measures can be found in Table 1.

[5] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf

Increased rates of identification, initiation, and engagement in treatment

UCLA will calculate identification using a combination of data from ASAM level of care screenings and assessments, Managed Care Plan / Fee-for-Service (MCP/FFS), and Drug Medi-Cal claims. Separately, DHCS will report on related metrics: Metric 1 - Assessed for SUD Treatment Needs Using a Standardized Screening Tool, Metric 2 - Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis, Metric 3 - Medicaid Beneficiaries with SUD Diagnosis (monthly) and Metric 4 - Medicaid Beneficiaries with SUD Diagnosis (annually). DHCS will report the initiation and engagement monitoring metric as required (Metric 15 – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment). However, there are data quality limitations to the initiation rate due to low rates of SUD diagnosis coding in the MCP/FFS delivery system.

Therefore, UCLA will enhance DHCS' and CMS' understanding of true initiation rates in the DMC-ODS evaluation by conducting more in-depth analyses that take these limitations into consideration. For example, UCLA can calculate initiation among DMC beneficiaries who were referred after an ASAM brief screening to assess the effectiveness of the DMC referral process. Separately, UCLA can calculate clients initiating DMC-ODS treatment after identification in physical health settings (merging DMC claims and MCP/FFS data) as a measure of coordination between the two systems. Trends in referrals to SUD treatment from health care sources will also continue to be monitored, and data on medications prescribed outside of specialty care settings will be reported for context.

Engagement rates as defined by NCQA can be accurately computed using claims data. Engagement has generally been steady over time among DMC-ODS clients (Padwa et al., 2022).

Earlier evaluation reports described increasing admissions and high levels of engagement in the DMC-ODS. About 23% of beneficiaries who had an ASAM-based brief screening received their indicated level of care within 30 days, leaving room for improvement. However, about 88% of clients who started treatment went on to engage in it by attending at least two more sessions (Padwa et al., 2022). Challenges to increase access included a shortage of qualified medical directors, licensed practitioners of the healing arts, bilingual staff, as well as difficulties in expanding medical withdrawal management, youth treatment, and understanding how to take advantage of the recovery services benefit. Penetration rates were likely limited in part due to the national phenomenon that 97.5% of people who need treatment usually do not recognize that need, and a smaller percentage do not seek treatment despite recognizing the need (SAMHSA, 2021). UCLA has recommended increasing outreach and screening in primary care and other non-specialty care settings as a result (Urada et al., 2022; Bass et al., 2022). SUD treatment referrals from health care sources have been flat, however, since the pre-DMC-ODS period (Lee et al., 2022). This may be in part due to increasing buprenorphine prescribing in primary care settings (Darfler et al., 2020). UCLA will continue to monitor these trends and conduct

stakeholder surveys and interviews to further investigate and recommend the best ways to close gaps in the number of people needing and receiving treatment.

Increased adherence to and retention in treatment

UCLA will analyze DMC-ODS claims to calculate length of stay, produce more in-depth analyses (e.g., by county, primary drug, race/ethnicity), and generate recommendations based on these results. The goal of improving overall retention may be complicated by the goal of reducing the statewide average residential length of stay to 30 days (STC 46). However, UCLA has provided recommendations to reduce the residential average length of stay without compromising quality (Urada et al., 2022, p. 108) and will continue monitoring trends. UCLA will also continue to track transitions in care. A slight increase in the rate of residential transitions to outpatient within 14 days was found among DMC-ODS counties, increasing from 7.1% in 2016 to 9.5% in 2020, as rates fell from 7.0% to 2.8% in state plan counties. Transitions from residential withdrawal management to residential treatment rose slightly from 17.0% to 20.2% in DMC-ODS counties from 2016 to 2020, while they rose from 3.2% to 8.0% in state plan counties (Lee et al., 2022).

Reductions in overdose deaths, particularly those due to opioids

While DHCS will be calculating and reporting required monitoring metrics[6] for this topic, specifically metric 26 – Overdose Deaths (count) and 27 – Overdose Deaths (rate), based on data provided to DHCS from CDPH, it will be important to place these metrics in context and control for them to the extent possible. In recent years, overdoses have risen in California despite the DMC-ODS due to external factors such as increasing availability of fentanyl and high-potency stimulants and the onset of the COVID-19 pandemic. In the future, potential emergence of new substances may further affect overdoses. For example, if xylazine use emerges in California, reducing the effectiveness of naloxone,[7] this could increase overdoses and have important policy ramifications for the use of this important tool. To the extent possible, UCLA will collaborate with DHCS and CDPH to examine the effect of treatment on overdose deaths and conduct in-depth analyses, e.g., by county, primary drug, race/ethnicity, and collect supplementary data from stakeholder surveys and/or interviews to generate recommendations. In addition to opioid overdose deaths, stimulant overdose deaths will be a particular focus of the evaluation of the Recovery Incentives Program.

[6] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf
[7] https://www.sciencedirect.com/science/article/pii/S037687162200117X

Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

While DHCS will examine this among all Medi-Cal beneficiaries (metric 23 – Emergency Department Utilization for SUD and metric 24 – Inpatient Stays for SUD), similar to overdose deaths, it is likely that DMC-ODS effects may be overwhelmed by external trends. In both cases, difference in difference analyses will be employed where possible to separate the DMC-ODS effect (see analytic methods below). A decrease in recurring overdoses were observed for a subset of counties following residential treatment under DMC-ODS compared to pre-waiver period and State Plan counties (Khurana et al., 2022, p. 115-117). UCLA will continue to analyze data among people who received SUD treatment under the DMC-ODS to determine whether utilization of emergency departments and inpatient hospital settings decreased relative to the pre-waiver period and will conduct cost analyses to determine whether savings (if any) in these settings offset increased SUD treatment expenses.

Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

UCLA will continue to use a measure adapted to DMC-ODS settings by focusing on readmissions to withdrawal management within 30 and 90 days of discharge. In 2020, the UCLA evaluation recently found that 17.5% of withdrawal management clients were readmitted within 90 days, down from 20% in 2019 (Padwa et al., 2022, p 64). UCLA will also describe residential readmissions with the understanding that not all readmissions are negative outcomes and examine whether transitions to outpatient treatment reduce residential readmissions.

Improved access to care for physical health conditions among beneficiaries

UCLA will examine improved access to physical health care among clients who participate in DMC-ODS treatment using annual client-reported ratings and administrative data. In 2020, 86% of clients agreed with the UCLA's Treatment Perceptions Survey item: "Staff here work with my physical health care providers to support my wellness," (Padwa et al., p. 66). UCLA will also analyze Medi-Cal MCP/FFS billing data to quantify increases in physical health care following admission to treatment. DHCS will also report metric 32 – Access to Preventative Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD, which identifies the percentage of beneficiaries with ambulatory or preventative care visits.

Additional details on how each measure will be collected and how the hypotheses will be tested are included in the methodology section that follows. A driver diagram for the evaluation can be found in Appendix A.

Improved Health Equity

Past analyses have found that DMC-ODS treatment admissions did trend higher among all racial/ethnic groups (Bass et al., 2022) after DMC-ODS implementation. However, disparities in timely linkage to care have been detected for youth, older adult, Black, and Hispanic Medi-Cal enrollees (Padwa et al., 2022). Also, once admitted, treatment engagement increased among younger clients but decreased among older ones. DHCS plans to use quality improvement efforts via the External Quality Review Organization, for example, to reduce or eliminate disparities. UCLA will also continue to closely examine trends in health equity within each measure included in the six goals previously described above, track these findings over time, investigate causes of any disparities found (e.g., through interviews and surveys), summarize findings, and generate recommendations. At a minimum, groups of interest will include race, ethnicity, age, gender, and location. UCLA and DHCS are examining the feasibility of adding other groups including sexual orientation based on the data availability.

CMS is currently reviewing the addition of Traditional Healers and Natural Helpers to the DMC-ODS. If approved, UCLA will also evaluate the impact of this change, particularly on the American Indian/Alaska Native (AI/AN) population.

An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes.

Due to the large number of studies and systematic reviews that have established the efficacy of CM, the primary goal of the Recovery Incentives Program evaluation is not to conduct research aimed at further re-establishing effectiveness, but rather to evaluate the effectiveness of real-world implementation in the California Recovery Incentives Program, document efforts to scale this proven treatment in a large state, and to facilitate quality improvement. A range of hypotheses will be tested as shown in Table 1.

Consistent with STC 57e, to the extent feasible, the state will conduct evaluation analyses stratified by StimUD and other types of SUD. However, the Recovery Incentives Program is currently aimed exclusively at beneficiaries who have StimUD.

Since the Recovery Incentives Program is part of DMC-ODS, the overall DMC-ODS evaluation and all analyses are inclusive of the participating Recovery Incentives Program treatment sites and clients. However, more in-depth data collection and analysis will be specifically applied to the Recovery Incentives Program, including efforts to measure the effects of this program above and beyond that of DMC-ODS, e.g., comparing Recovery Incentives Program StimUD clients to non- Recovery Incentives Program StimUD clients in DMC-ODS.

Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Table 1 below summarizes the questions, hypotheses, and measures to be used in this study. As previously noted, UCLA will also coordinate with DHCS to incorporate established monitoring metrics[8] that DHCS is reporting to CMS separately. The measures below are meant to supplement DHCS-reported measures to answer remaining DMC-ODS-related questions, often by using data specific to California and DMC-ODS (e.g., California's ASAM LOC Placement data, Incentive Manager data, UCLA-administered surveys).

[8] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Driver	Potential Measures	Measure Steward, Endorsement	Numerator	Denominator	Data Source(s)	Analytic approach
Question: Are rates of overdose deaths impacted by the demonstration? Goal: Reduction in overdose deaths, particularly those due to opioids. Hypothesis: People with opioid use disorders (OUD) who receive MAT and people with StimUD who participate in the Recovery Incentives Program will be less likely to have an overdose death compared to people with OUD and StimUD who do not receive these services, respectively.						
Primary Driver: Reduce overdose deaths	Overdose deaths overall and among opioids and stimulants separately	None	N/A	N/A	California Comprehensive Death File, CA Department of Public Health matched to DMC Claims	Compare individuals with StimUD who participated in the Recovery Incentives Program to those who did not Time period: Start of Recovery Incentives Program (2023) through end of waiver (2026) contingent on data availability Compare individuals with OUD who received MAT to those who did not and determine whether access to MAT increased under DMC-ODS (2015-2026, contingent on data availability) Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc.

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration increase access to and utilization of SUD treatment services? Goal: Increased rates of identification, initiation, and engagement in SUD treatment services. Hypothesis: Counts or rates will be maintained at benchmark year* levels or higher.						
Primary Driver: increased rates of identification, initiation, and engagement in treatment	Number of ASAM level of care screenings and assessments	None	Number of ASAM LOC screenings and assessments	N/A	ASAM LOC Placement data	Descriptive statistics using parametric and/or non-parametric tests of statistical significance and/or regression analysis to confirm identification, IET rates, and timely admission to the indicated level of care are maintained or improve between comparison & waiver periods (2020-2026, contingent on data availability)
	Initiation among beneficiaries with an ASAM brief screening	NQF #0004 adaptation	Number of beneficiaries who initiated treatment within 14 days of the index episode start date	Number of beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	
	Engagement in treatment among DMC-ODS clients	NQF #0004	Initiation of tx and two or more encounters with any SUD diagnosis within 30 days after initiation	Number of beneficiaries (above) who initiated treatment	DMC Claims, ASAM LOC Placement data	
Secondary Driver: Ensure appropriate and timely placement according to ASAM criteria	Timely admission to the indicated level of care within 30 days of ASAM Criteria-based brief screenings	None	Admission within 30 days of an ASAM Criteria-based brief screening	Beneficiaries with an ASAM brief screening with a level of care recommendation	DMC Claims, ASAM LOC Placement data	Descriptive Statistics (2020-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Ensure clients are satisfied with services	UCLA Client Treatment Perceptions Survey ratings, % of clients providing a 4 or higher rating on all questions	UCLA	Clients providing a 4 or 5 rating	All TPS participants	UCLA Client Treatment Perceptions Survey	Descriptive statistics (2020-2025)
Secondary Driver: Quality improvement efforts	UCLA County administrator survey questions on the impact of QI activities and the EQRO	None	N/A	N/A	County administrator survey	Descriptive statistics (2020-2026)
Question: Do enrollees receiving SUD services adhere to and remain in treatment? Goal: Increased adherence to and retention in treatment. Hypothesis: Adherence and retention will be maintained at benchmark year* levels or higher.						
Primary Driver: Adherence to and retention in treatment	Days in treatment	None	N/A	N/A	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis and quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2020-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Secondary Driver: Improve care coordination and transitions between levels of care	Transition to specialty care after withdrawal management	None	Withdrawal management discharges followed by DMC-ODS treatment within 7 or 14 days	WM discharges	DMC claims, MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2026, contingent on data availability)
Question: Do enrollees receiving SUD services experience improved health outcomes? Goal: Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Hypothesis: DMC-ODS implementation will be associated with reductions in utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.						
Primary driver: Reduced utilization of ED and inpatient hospital settings	Utilization (e.g., days)	None	Clients who received DMC-ODS treatment who had any ED and inpatient hospital visits during and after treatment	Clients who receive DMC-ODS treatment	DMC Claims MCP/FFS data**	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)
	Paid claim amounts	None	N/A	N/A	DMC Claims MCP/FFS data**	

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration reduce withdrawal management readmissions? Goal: Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. Hypothesis: DMC-ODS implementation will be associated with fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.						
Primary driver: Readmissions to withdrawal management	Re-admissions within 30 days of discharge	None	Clients re-admitted to withdrawal management within 30 days of discharge from withdrawal management	Clients discharged from withdrawal management	DMC Claims CalOMS-Tx	Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2015-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration improve coordination of care? Goal: Improved access to care for physical health conditions among beneficiaries. Hypothesis: DMC-ODS implementation will be associated with improved access to care for physical health conditions among beneficiaries.						
Primary driver: Ensure client satisfaction with services	Treatment Perceptions Survey item: "Staff here work with my physical health care providers to support my wellness."	None	Clients providing a rating of 4 or 5	All clients responding to the TPS survey	Treatment Perceptions Survey	Confirm client satisfaction w/ coordination is at benchmark year* levels/higher. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2020-2025)
Secondary driver: Improve care coordination	Percentage of clients with ambulatory or preventive care visits before and following treatment	NCQA adaptation	Number of clients with SUD who had an ambulatory or preventive care visit during the measurement period	Number of beneficiaries with DMC-ODS treatment	MCP/FFS data** DMC claims	Compare ambulatory or preventative care visits before & after treatment. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis (2015-2026, contingent on data availability)

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Does the demonstration reduce health disparities? Goal: Improved health equity Hypothesis: Health disparities will decrease.						
Primary Driver: Improve health equity	Timely admission to indicated level of care	None	Clients admitted to their indicated level of care within 30 days of ASAM brief screening	Clients who received an ASAM brief screening	ASAM LOC Placement data DMC Claims	Compare rates by race, ethnicity, and age. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. Quasi-experimental causal inference designs including but not limited to difference-in-differences augmented with propensity score matching as needed, synthetic controls, etc. (2017-2026)
	Treatment engagement	NQF #0004	Initiation of treatment and two or more encounters with any SUD diagnosis within 30 days after initiation	Number of beneficiaries who initiated treatment	DMC Claims	
	Any other measures on which meaningful disparities emerge					

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches						
Driver	**Potential Measures**	**Measure Steward, Endorsement**	**Numerator**	**Denominator**	**Data Source(s)**	**Analytic approach**
Question: Has the Recovery Incentives Program been effectively implemented? Goal: An effective contingency management program, including cost-effectiveness and effects on beneficiary health outcomes. Hypothesis: Effective implementation will lead to improvements in client retention, discharge status, self-reported outcomes, drug test results, deaths, and healthcare utilization among clients participating in the Recovery Incentives Program.						
Primary driver: Improvements in Recovery Incentives Program outcomes	Days in treatment, engagement, discharge status, self-reported satisfaction and improvement in health, SUD, arrests, ED and inpatient hospital utilization, costs, deaths	None	N/A	N/A	Client surveys, DMC claims, MCP/FFS data,** CalOMS-Tx, Death data	Compare outcomes between clients with StimUD participating in the Recovery Incentives Program and those in non-Recovery Incentives Program treatment programs (where available), controlling for background characteristics. Comparisons by demographics. Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis Compare rates of positive, negative, and missed drug screens among individuals with StimUD in the Recovery Incentives Program and compare rates to those found in the literature using a one-sample t-test or analogous procedure (2023-2026)
	Rates of positive, negative, and missed drug screens	None	Negative urinalysis outcomes	Sum of all possible tests over the planned course of treatment	Stimulant drug tests / incentive manager vendor	

Table 1. Summary of key evaluation questions, hypotheses, data sources, and analytic approaches

Driver	Potential Measures	Measure Steward, Endorsement	Numerator	Denominator	Data Source(s)	Analytic approach
Primary driver: Fidelity to the CM model	Drug screen results, Days in treatment, Discharge status, Self-reported improvement, Overdose rates, ED and inpatient hospital utilization (SUD or all diagnoses)	None	N/A	N/A	Data from incentive manager vendor, fidelity assessments, provider surveys, client surveys, CalOMS-Tx, DMC-ODS claims	Compare outcomes (e.g., drug screen results, days in treatment, discharge status, self-reported improvement, overdose rates, ED utilization, inpatient utilization) between higher- and lower-fidelity providers according to measures developed by UCLA Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. (2023-2026)
Secondary driver: Implementation of an effective and accessible CM program	Newly developed survey questions adapted from an existing questionnaire and qualitative interviews	None	N/A	N/A	Provider surveys and interviews	Descriptive analyses from survey to track implementation challenges and successes over time and qualitative analyses of interview transcripts
	Use of CM based on DMC claims	None	Clients receiving CM	Clients with StimUD in eligible levels of care	DMC-ODS claims CalOMS-Tx	Track percentage of people in treatment for StimUD who participate in the Recovery Incentives Program; Descriptive statistics using parametric and/or non-parametric tests of statistical significance, and/or regression analysis. (2023-2026)

* Benchmark year is expected to be 2021 but may be adjusted if appropriate. The benchmark for evaluating 2021 will be 2020 or an alternative (see methodology section). Where pre-DMC-ODS data do not exist and maintenance is hypothesized, the starting year is 2020. Where pre-DMC-ODS data do exist, the starting year is set at 2015 to take advantage of this data. Analyses based on recovery incentives-specific data start in 2023 when collection of the relevant data begins.

** ED, hospital, and associated cost data come from MCP/FFS data is historically subject to reporting delays of about 3 years.

In addition to the hypothesis testing described above, the study team may describe emerging facilitators and barriers to DMC-ODS implementation, e.g., associated with implementation of peer support specialists, potential impacts from payment reform, and other emerging issues. For example, between 2015 and 2021 issues such as COVID-19, rising overdose deaths from fentanyl and stimulants, and increasing rates of homelessness were incorporated into DMC-ODS evaluation reports as special topics as these issues took on increased urgency.

To the extent possible, UCLA will also examine total costs as well as cost drivers measured on a Per Member Per Month (PMPM) basis before and during the demonstration periods (2015-2026 contingent on data availability), e.g., total Medicaid costs and total federal Medicaid costs, 2) SUD-IMD costs, other SUD costs and non-SUD costs, and 3) inpatient costs, non-ED outpatient costs, and ED outpatient costs.

Methodology

Evaluation Design Summary

The evaluation uses a mixed-methods design that takes advantage of different comparisons based on the measure in question.

Where appropriate, administrative data from Drug Medi-Cal (DMC) claims and CalOMS-Tx will be used for a difference-in-difference design to account for different county implementation periods, consistent with CMS recommendations for strong evaluation designs.[9] This approach essentially combines pre-post comparisons and comparisons across counties to test whether changes are detected when counties "go live" but not at the same time in other counties. In other cases, data (e.g., stakeholder surveys, interviews, ASAM Criteria-based Level of Care Placement data) will only be available post-implementation, in which case post-only analyses will be conducted.

Evaluation of the Recovery Incentives Program is focused on initial implementation of a specific set of new practices targeted at a specific set of clients in specific settings, in marked contrast to evaluation of the broader DMC-ODS program that has been in place for several years and affects the entire continuum of care. The evaluation approach for the Recovery Incentives Program therefore necessarily has a different focus, organized around the RE-AIM framework (Glasgow, 1999):

[9] Reschovsky, J.D. and Bradley, K. (2019). Planning Section 1115 Demonstration Implementation to Enable Strong Evaluation Designs. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/enable-strng-eval-dsgn.pdf

1. **Reach**. This will be measured as the percentage of people in treatment for StimUD who participate in the Recovery Incentives Program. UCLA will also evaluate whether there are disparities in its reach to different beneficiary populations (e.g., race, ethnicity, gender, age, county).

2. **Effectiveness.** Effectiveness will be based on results of drug testing, treatment retention, and treatment engagement.

3. **Adoption.** Adoption will be measured by evaluating how many provider agencies deliver Recovery Incentives Program services.

4. **Implementation.** Implementation will be evaluated by the degree to which CM is implemented with fidelity to the Recovery Incentives Program protocols and by tracking adaptations made. Perceptions of challenges and areas for potential improvement will also be collected from provider staff and participants.

5. **Maintenance.** Maintenance will be measured by evaluating the degree to which programs implementing the Recovery Incentives Program continue providing the service throughout the evaluation period, and information from surveys and interviews focusing on factors that could promote or impede the continued delivery of Recovery Incentives Program services after the end of the pilot period.

Target and Comparison Populations

The population targeted by the DMC-ODS is Medicaid-eligible individuals with SUD. Where appropriate, state plan counties and variation in introduction of the DMC-ODS waiver across counties in California over time will be exploited for comparison purposes as described in the analytic methods section below.

In some cases, particularly when analyzing datasets that did not exist prior to DMC-ODS implementation, the evaluation design is focused on monitoring maintenance of previously measured improvements. In these cases, the waiver year 2021 is proposed as a benchmark year to measure maintenance of improvements as CalAIM extends DMC-ODS into 2022 and beyond. However, COVID-19 or other future trends may eventually make another year more appropriate. For example, the DMC-ODS evaluation previously found that COVID-19 reduced admissions (Bass et al., 2022), so if pandemic-driven trends dissipate in the future and DMC-ODS treatment admissions return to pre-pandemic levels, the pre-pandemic year 2019 could become a more appropriate comparison year to avoid confounding the effects of CalAIM with recovery from the pandemic. If a year other than 2021 is adopted as a baseline year, sensitivity analyses will be performed to quantify the effect of this change. To evaluate the year 2021, 2020 will be used as a comparison, with the understanding that COVID-19 may affect both years. Alternatives to 2020 and 2021 including average benchmarks based on the time series of data available for each outcome variable will also be explored.

In other cases, where improvements have not previously been established, data will be analyzed to establish whether the initial waiver was associated with or caused improvements, as well as whether those improvements have been maintained during the current CalAIM waiver.

As a result of the above considerations, time periods in Table 1 differ by measure according to the following rules: 1. Where maintenance is hypothesized, the starting year is 2020 (to provide a comparison for 2021), though 2021 may then serve as a benchmark for the ensuing years. 2. Where administrative data exist prior to DMC-ODS, the starting year is 2015 to provide two years or more (depending on county) of pre-DMC-ODS data to serve as a baseline. 3. Analyses based on data collected specifically for the Recovery Incentives Program starts in 2023 when data collection begins. Although aspirational 2026 end dates are listed, full 2026 data may not always be available for inclusion in the report due in December 2026. In some cases, e.g. county administrator surveys, this is under the evaluator's control and will be complete in 2026. In the case of administrative datasets, cutoff dates will be determined by data availability which may range from partial 2026 data to a much earlier cutoff in the case of MCP/FFS.

The primary target population for the Recovery Incentives Program evaluation will be clients who receive CM for the treatment of StimUD. The comparison population will consist of clients who receive treatment for StimUD but do not receive CM. Administrative data on this population will be available for the treatment programs participating in the Recovery Incentives Program in both the pre-and post-Recovery Incentives Program periods and will be available for other treatment programs that are not participating in the Recovery Incentives Program.

During the DMC-ODS waiver period, the IRS is expected to make a ruling on whether CM incentives are considered income. Should the IRS determine that it is not income, the current $599 annual cap on incentives provided to individuals would increase by amount to be determined. If this were to occur, in addition to the $599 Recovery Incentives Program group and non-Recovery Incentives Program comparison group, a third, higher-dose Recovery Incentives Program group would be created and evaluated separately from the $599 group but using the same methods.

Evaluation Period

DMC-ODS under CalAIM is considered an extension of DMC-ODS under the previous Medi-Cal 2020 waiver. Therefore, the evaluation period will extend from the date the first counties implemented DMC-ODS on February 1, 2017 through the end of the CalAIM waiver on December 31, 2026. However, exact dates will differ by analysis depending on data availability, normal data reporting lag times, and hypotheses. The first DMC-ODS report (mid-point assessment) will also include previously unreported analyses of 2021 data. The evaluation period for Recovery Incentives Program evaluation will have the same end date, but implementation began in March 2023.

Data Sources

Administrative data sources

California Outcome Measurement System, Treatment (CalOMS-Tx)

CalOMS-Tx is California's existing data collection and reporting system for all clients in publicly funded SUD treatment services. Treatment providers collect information from clients at admission and discharge and send this data to DHCS each month. CalOMS-Tx provides California's contribution to the Treatment Episode Dataset (TEDS) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). CalOMS includes client background (e.g. demographics, source of referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), treatment information (e.g.treatment discharge status, use of medications), and 30-day measures at admission and discharge (e.g. number of arrests & jail days, family conflicts, social support). This makes CalOMS-Tx data richer in many respects than other data sources (e.g. claims), though it has its own limitations (see limitations section). More information on CalOMS-Tx can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Death Data

The California Department of Public Health (CDPH) provides data from their California Comprehensive Death File to DHCS for all Medi-Cal beneficiaries. UCLA will collaborate with DHCS and CDPH to use this data to identify overdose deaths as a key outcome measure. All-cause deaths will also be examined if the data allows.

Drug Medi-Cal Claims (DMC Claims)

In California, Medicaid-funded SUD treatment is paid for through DMC claims. DMC is a carve-out for specialty care SUD treatment. For the UCLA evaluation, DMC claims data provides information on patient demographics, access to treatment after DMC-ODS waiver implementation, types of services provided, and costs. New billing procedures under development are expected to record the delivery of CM services and potentially positive or negative drug test results. DMC claims data provides detailed data on services received and is likely to be more complete than other datasets like CalOMS-Tx but is limited in scope to billing-related data.

Incentive Manager Vendor Data

The incentive manager vendor for the Recovery Incentives Program, under contract with DHCS, will collect data on incentive payments while administering these incentives. The following data elements are expected to be collected:

- Beneficiary name (recipient's full name: last, first, and middle initial)
- Beneficiary Client Identification Number (CIN) (recipient's unique identification number established by DHCS
- Provider name (billing and/or rendering provider name)
- National provider identifier (billing and/or rendering provider number)
- Date of service (date drug test was performed, incentive disbursed if test was negative for stimulants, excused or unexcused absence)
- Drug test results (positive or negative for stimulants)
- Calculated incentive amount on date of service (incentive amount owed to client)
- Disbursed incentive amount on date of service
- Cumulative disbursed incentive amounts, per client per calendar year (total incentive amounts disbursed to each beneficiary enrolled in the Recovery Incentives Program per calendar year)
- *Other data to be determined by DHCS*

Managed Care Plan/ Fee-for-Service Data (MCP/FFS)

In California, Medicaid-funded medical care (excluding SUD and serious mental illness) is paid for either through managed care plans or fee-for-service reimbursement. For the UCLA evaluation, MCP/FFS data provides information on client demographics, types of services, and costs.

Mental Health (MH) Claims

In California, Medicaid-funded MH treatment is paid for through Short Doyle Medi-Cal claims (SD/MC). SD/MC is a carve-out for serious mental illness treatment services to persons eligible for Medi-Cal. For the UCLA evaluation, SD/MC claims data provides information on the dates, types, and quantities of MH services provided for beneficiaries accessing services for SMI.

Medi-Cal Eligibility Data System (MEDS)

The MEDS database provides information on all California Medi-Cal beneficiaries. These data, particularly the MEDS Monthly Extract File (MMEF), are used to calculate penetration rates.

Master Provider File (MPF)

The MPF is DHCS's comprehensive list of SUD treatment programs in the state of California. The MPF includes information on all SUD treatment facilities, including mailing addresses and DMC certification and decertification dates, among other provider-level information. In combination with lists of IMD facilities, MPF can be used to identify provider identification numbers for these facilities, therefore enabling IMD-specific analyses using CalOMS and DMC Claims data.

UCLA evaluation data collection activities

ASAM Level of Care (LOC) Placement Data

Given that The ASAM Criteria are a defining feature of the DMC-ODS waiver, a large new data collection effort was initiated across DMC-ODS waiver counties to collect data on the use of ASAM Criteria-based LOC brief initial screenings, initial assessments, reassessments, and services delivered. This endeavor has been a collaborative effort between UCLA, DHCS, and counties to collect these data. DHCS Information Notice 17-035 describing the requirements and procedures to collect ASAM Criteria-based LOC data was released in September 2017 and was superseded by Information Notice 18-046 on October 1, 2018. These data include the date of screening or assessment, type (brief initial screen, initial assessment, follow-up assessment), indicated LOCs (per screener or assessment result), actual placement decision(s), the reason for the difference between indicated and actual LOCs (if any), and the reason for delays in placement (if any). Data on three types of screenings or assessments are possible, defined as follows on the data collection instrument.

- Brief Initial Screen: a brief initial screening that preliminarily determines an LOC placement until a full assessment can be performed
- Initial Assessment: a longer comprehensive assessment meant to determine the LOC recommendation and establish medical necessity
- Follow-up Assessment: following an initial assessment, any re-assessment of the client occurring during the same treatment episode

Up to three indicated and actual levels of care could be recorded. Indicated and actual levels of care defined as:

- Indicated LOC. This is the initially recommended LOC according to the screening/assessment instrument prior to taking client preference into account. For example, this would be listed under "Final Level of Care Recommendations" if using CONTINUUM™ software.
- Actual LOC/Withdrawal Management placement decision. This is the actual LOC decided upon after client input and the LOC where the client is referred.

The options for LOC, as worded in the LOC reporting template, are listed below. These include broad To Be Determined (TBD) options to allow for the results of brief initial screenings that may indicate a general treatment modality the client should report to for further assessment (e.g., outpatient) without specifying the exact LOC to be received there (e.g., 1-outpatient or 2.1-intensive outpatient). The list also includes Withdrawal Management (WM) levels of treatment, which can be combined with other levels of care.

Level of Care

None
Outpatient/Intensive Outpatient (OP/IOP), exact level TBD
Residential, exact level TBD
Withdrawal Management (WM), exact level TBD
Ambulatory WM, exact level TBD
Residential/Inpatient WM, exact level TBD
Narcotic Treatment program/Opiate Treatment program (NTP/OTP)
0.5 Early Intervention
1.0 OP
2.1 IOP
2.5 Partial Hospitalization
3.1 Clinically Managed Low-Intensity Residential
3.3 Clinically Managed Population-Specific High-Intensity Residential
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4.0 Medically Managed Intensive Inpatient Services
1-WM Ambulatory WM without Extended Onsite Monitoring
2-WM Ambulatory WM with Extended Onsite Monitoring
3.2-WM Clinically Managed Residential WM
3.7-WM Medically Monitored Inpatient WM
4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual levels of care do not match, providers are asked to select the reason for the difference. The options are:

Reason for difference

Not applicable - no difference
Clinical judgment
Lack of insurance/payment source
Legal issues
Level of care not available
Managed care refusal
Client preference
Geographic accessibility
Family responsibility
Language
Used two residential stays in a year already.
Other

County Administrator Surveys/Interviews

UCLA will continue to develop and distribute online surveys to obtain information and insights from county SUD/behavioral health administrators participating in the delivery of services under

the DMC-ODS system of care. Surveys will be conducted annually to address DMC-ODS-related perceptions, barriers, and facilitators. Past topics have included, for example, access to care, screening and placement practices, training needs, quality of care, coordination, and integration of services. Additional topics, including on the Recovery Incentives Program, will be included as driven by the evaluation measures and other new issues/external factors as they emerge. UCLA will also conduct in-depth interviews with stakeholders on an as-needed basis to further inform and understand the findings from the administrative and survey data. Surveys will continue to be administered online (e.g., Qualtrics), and will be sent to either all DMC-ODS counties (currently 37) or all counties (58 counties, 57 surveys because Yuba and Sutter counties share a single administrator). Historically nearly all county administrators have responded (most recently 36 out of 37, 97%), eliminating the need for stratification.

Treatment Perceptions Survey (TPS)

The TPS was developed by UCLA as part of the activities for the initial DMC-ODS waiver evaluation activities in 2017. The TPS for adults was based on San Francisco County's Treatment Satisfaction Survey; and the TPS for youth was based on Los Angeles County's Treatment Perceptions Survey (Youth). (Both survey questionnaires include items from the Mental Health Statistics Improvement Program, MHSIP.) Input on the survey development was solicited from and provided by DHCS, the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California, the DMC-ODS External Quality Review Organization (EQRO) Clinical Committee, Behavioral Health Concepts (BHC), the Youth System of Care Evaluation Team at Azusa Pacific University, and other stakeholders. The tool has since been validated (Teruya et al, 2022) and data collection has occurred annually during a five-day survey period among counties participating in the DMC-ODS waiver since 2018. The TPS data serves multiple purposes. 1) it fulfills counties' EQRO requirement to conduct a client satisfaction survey at least annually using a validated tool, 2) it addresses the data collection needs for the CMS required evaluation of the DMC-ODS waiver, and 3) supports DMC-ODS quality improvement efforts and provides key information on the impacts of the DMC-ODS waiver.

The TPS is administered annually as part of a major statewide undertaking by UCLA, counties, and providers during a specified five-day survey period. Providers are directed to administer the survey to every client receiving services both in-person or via tele-health during this time. During the most recent (2021) data collection period, 16,628 surveys were collected. Among adults, the smallest two racial groups were Native Hawaiian/Pacific Islander (n=259) and Asian (n=410). These sample sizes are sufficient to detect a small effect size (D) of 0.16 with a two-sided alpha of .05 and power (beta) of .80 using an independent samples t-test. TPS response rates have historically been estimated at about 60% but dipped during 2020, during the COVID-19 pandemic. If needed, the sample can be weighted for survey nonresponse to match the demographic profile of clients with DMC claims during the survey period. However, since no large differences were found in ratings between demographic groups in 2021, such weighting may have a minimal impact.

The survey for adults includes 14 statements addressing client perceptions of access, quality, care coordination, outcome, and general satisfaction. The survey for youth includes 18 statements in the same five domains as the adult survey plus an additional domain: therapeutic alliance. Survey respondents indicate the extent to which they disagree or agree with statements using a 5-point Likert scale (1= Strongly disagree and 5= Strongly agree). The survey also collects demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

TPS Adult Survey Items by Domain

Access

1. The location was convenient (public transportation, distance, parking, etc.).
2. Services were available when I needed them.

Quality

3. I chose the treatment goals with my provider's help.
4. Staff gave me enough time in my treatment sessions.
5. Staff treated me with respect.
6. Staff spoke to me in a way I understood.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).

Care Coordination

8. Staff here work with my PH care providers to support my wellness.
9. Staff here work with my MH care providers to support my wellness.

Outcome

10. As a direct result of the services I am receiving, I am better able to do things that I want to do.

General Satisfaction

11. I felt welcomed here.
12. Overall, I am satisfied with the services I received.
13. I was able to get all the help/services that I needed.
14. I would recommend this agency to a friend or family member

TPS Youth Survey Items by Domain

Access

1. The location of services was convenient for me.
2. Services were available at times that were convenient for me.
3. I had a good experience enrolling in treatment.

Therapeutic Alliance

4. My counselor and I work on treatment goals together.
5. I feel my counselor took the time to listen to what I had to say.
6. I developed a positive, trusting relationship with my counselor.
7. I feel my counselor was sincerely interested in me and understood me.
8. I like my counselor here.
9. My counselor is capable of helping me.

Quality

10. I received the right services.
11. Staff treated me with respect.
12. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).
13. My counselor provided necessary services for my family.

Care Coordination

14. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).
15. Staff here helped me with other issues and concerns I had related to legal/probation, family, and educational systems.

Outcome

16. As a result of the services I received, I am better able to do things I want to do.

General Satisfaction

17. Overall, I am satisfied with the services I received.
18. I would recommend the services to a friend who is need of similar help.

TPS survey forms for both adults and youth are available in 13 languages (English, Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, Cambodian) and in one-page and two-page (larger font) versions. The relevant MHSUD Information Notices, survey instructions, forms in multiple threshold languages, and other materials (i.e., Frequently Asked Questions, TPS Codebook, sample county and program summary reports) are available online at http://www.uclaisap.org/dmc-ods-eval/html/client-treatment-perceptions-survey.html.

County administrators coordinate the survey administration and data collection within their provider network and submit the paper forms or electronic data files to UCLA for processing. The data are analyzed, and county- and provider-level summary reports are prepared and made available to participating counties. Counties are also given access to their raw data files and respondents' written comments.

Recovery Incentives Program-Specific Data Collection

Recovery Incentives Program Client Surveys

Recovery Incentives Program treatment providers will be asked to distribute a link to an online survey to participating clients. Surveys will be conducted in multiple waves:

- Baseline survey: At the beginning of Recovery Incentives Program treatment (e.g., intake), providers will be asked to provide clients with a link to a UCLA survey and encourage participation. Clients who go to that survey will receive information about the evaluation, provide consent to participate, and will be asked for contact information and a small number of baseline questions.
- Follow-up surveys: Follow-up surveys will be sent to all clients who completed the baseline survey and provided contact information and consent to be contacted for the follow-up survey. The follow-up surveys will occur early and late in treatment, for example five and 13 weeks after the client began treatment. It will capture information on client perceptions of the Recovery Incentives Program, client functioning (e.g., drug use, use of emergency room and hospital services, etc.) including success stories and perceptions of Recovery Incentives Program implementation needing improvement. These surveys will include clients who are still in treatment and those who left treatment. Participants who have left treatment may be more forthcoming in disclosing what aspects of the pilot program did not work well and monitoring for fraud, e.g., if they indicate they weren't using drugs but were recruited by the agency to participate for money. If resources allow, a small cohort may be selected for brief weekly follow-ups to collect information on client perceptions that may help refine the incentive algorithm.

A sample of up to 60 participating provider sites will be asked to provide the baseline survey link and QR code to all new clients who start participating in the Recovery Incentives Program until they reach a target N. Each provider's quota will be based on estimates of Recovery Incentives Program participation that each site provided during the initial application process, or on estimates based on CalOMS-Tx data. The goal of using quotas is to ensure a representative sample across providers, rather than a potentially biased sample from high-performing providers. The total sample will be approximately 600

Participants will be paid a small incentive (e.g., $10) by UCLA to participate. Survey participant eligibility will be verified against data from the incentive manager vendor to avoid participation by people who are not participating in the Recovery Incentives Program. Initially, incentives will likely take the form of an electronic gift card handled separately from the incentive manager. [10]

[10] Although payments would ideally be handled through the incentive manager, this can only occur if the incentive management vendor is able to implement this and the Internal Revenue Service rules that the Recovery Incentives Program incentives are not income. This ruling is pending. If the IRS does not provide a ruling or rules that the incentives are income, then survey incentives cannot be provided through the incentive manager because it could put the participant over the $599 limit and subject the client to income taxes. It is likely the evaluation will begin with electronic gift cards but providing incentives through the incentive management vendor may become possible in later stages of the evaluation.

During a targeted stakeholder Recovery Incentives Program call on 4/12/2022, a large provider confirmed that they would be able to implement baseline surveys this during client enrollment either using iPads, a desktop computer, or asking the client to use their phone to complete the short survey. If needed, they also expressed a willingness to send the link to clients through their approved method of communication.

Once we reach the target N for each provider, they will be asked to stop distribution of the survey link, and new clients from their site will not be allowed to participate (e.g., the survey link may deactivate when a quota for each provider is reached). Based on CalOMS-Tx data, about 5,000 stimulant users participate in publicly funded treatment annually. If only half of these clients participate in the Recovery Incentives Program, as many as 2,500 new clients per month may be admitted. However, previous evaluation findings suggest implementation of new DMC-ODS waiver benefits typically ramp up slowly over time (Urada et al., 2022). We conservatively assume the survey will be initially offered to 600 clients per month. If the response rate is 50% (300/month), it would take only two months to reach the target N of 600.

Data may also be collected from new participants one or more years after implementation has begun to determine whether client responses change after implementation has matured. Methods may mirror those used to collect the initial sample or may involve re-opening the survey for a longer period but only accepting a random sample of respondents to extend the data collection period over a longer period. Methods for these later waves will be based on the degree of success and lessons learned from the initial data collection.

Approximately four weeks after each participant's baseline survey, UCLA will contact the client for a follow-up survey. A 50% response rate from the 600 baseline participants would result in 300 surveys. Participants will also receive incentives for the follow-up survey. This second wave of surveys will include people who may have stopped participating in treatment. Among clients who remained in treatment during the second wave of surveys, a third wave of surveys will occur at a later date, e.g., 13 weeks (estimated N=150), after they have entered the maintenance phase of treatment, resulting in a total of approximately 1,050 client surveys.

Recovery Incentives Program Client Interviews

The study team will conduct semi-structured interviews with approximately 25 clients purposively selected from participants in the baseline Recovery Incentives Program survey who provided permission for UCLA to contact them for an interview during that survey. Participants will be selected to represent a range of perspectives on the Recovery Incentives Program expressed in surveys. Participants will be asked about the program's strengths and ways the program can be improved. Interviews will be recorded, transcribed, and coded using a constructivist grounded theory approach (Charmaz, 2017; Glaser & Strauss, 1967). Recovery Incentives Program client interviews will begin 24 weeks after baseline client survey to allow completion of survey data collection and to allow time for clients to complete or drop out of treatment.

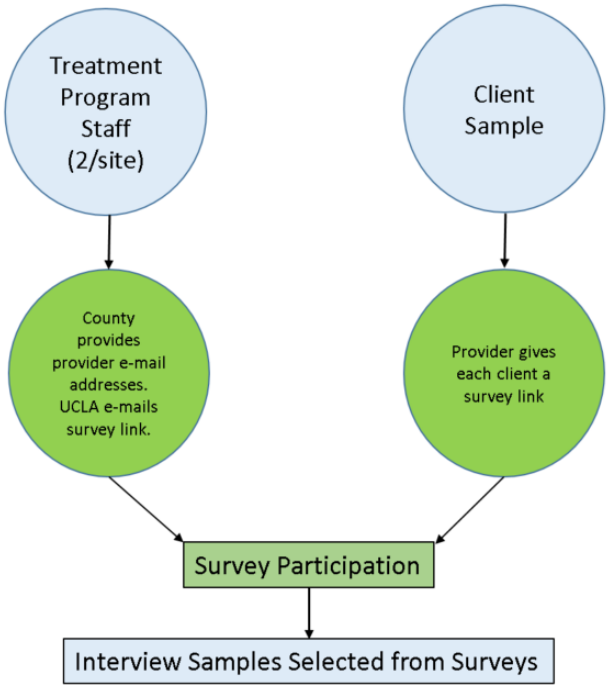
Recovery Incentives Program Provider Surveys

For the Recovery Incentives Program evaluation, provider staff will be surveyed about Recovery Incentives Program implementation, challenges, beliefs, and perceptions and to check for signs of fraud. Counties will be asked to provide an email contact for their participating treatment programs, and evaluators will contact these programs to have online survey invitations sent to the Recovery Incentives Program coordinator and a counselor at each site. The surveys will be conducted online via Qualtrics, early in the implementation process and after the program has participated for approximately six months. A minimum sample of 100 sites will be surveyed and depending on the number of providers sites opting into the Recovery Incentives Program, all sites may be surveyed.

Recovery Incentives Program Provider Interviews

In addition, for the Recovery Incentives Program evaluation the study team will conduct interviews and/or focus groups with a sample of about 25 total provider individuals from agencies that implement the Recovery Incentives Program. Interviews will begin shortly after provider survey data collection has been completed and will end when additional themes cease to emerge from data collection (saturation has been achieved). Interviews and focus groups will focus on identifying the strengths and weaknesses of the Recovery Incentives Program and potential ways to improve the uptake and effectiveness of the program. Interviews and focus groups will be recorded, transcribed, and coded using a constructivist grounded theory approach.

Figure 1. Relationship of Recovery Incentives Program Staff and Client Surveys and Interviews



Fidelity Assessments

California's Recovery Incentives Program training and technical assistance team will collect data on provider knowledge and attitudes during registration for trainings (pre-data), and again after required Recovery Incentives Program trainings have been completed. Following trainings, all participants will receive a link to a post-training test. Providers will also engage in fidelity monitoring sessions twice in the first six months, then every six months thereafter. Tools for these sessions are still in development, but it is anticipated that programs will be rated as high- or low- fidelity through a combination of these fidelity assessments (e.g., trainer's assessments of provider performance on role-playing sessions) and analysis of incentive manager data to measure fidelity to the incentive schedule.

Analytic Methods

Analysis of Quantitative Data

Due to the size of California's population and the associated statistical power available for analysis of statewide databases, comparisons using inferential statistics on many of the datasets used in this report may suggest statistical significance even when these differences are small and not meaningful. Furthermore, inferential statistics are designed to make inferences about a population from a random sample taken from that population. However, many of the datasets used in this evaluation (e.g., DMC claims, CalOMS-Tx, county administrator survey data with near 100% response rates) represent data on essentially the full population of interest rather than a random sample. Therefore, in cases where *p*-values may be inappropriate or misleading, descriptive statistics will be used with percentages, odds ratios, or other methods to convey the size and meaning of differences to readers. However, advanced statistics will also be used to examine multivariate relationships and difference-in-difference analyses as described below.

Event Study (ES) and Difference-in-Difference (DD) designs will be used where appropriate to analyze whether the introduction of the DMC-ODS waiver causally affected certain outcomes of interest. Specifically, we will use these designs when analyzing administrative data (e.g., DMC claims and CalOMS-Tx) for some outcomes. Given the staggered introduction of the DMC-ODS waiver across counties in California over time, exploiting this variation within the ES and DD designs will continue to allow us to estimate a causal effect of the DMC-ODS waiver. These analyses will cover the entirety of the DMC-ODS waiver, including the Medi-Cal 2020 years inclusive of the 2021 extension, and CalAIM. At least 24 months of data (starting in 2015) will also be used for pre-DMC-ODS years.

The canonical difference-in-differences model compares pre-post changes in outcomes in treated units to pre-post changes in outcomes in untreated units, for a single treatment. Given the variation in treatment timing, i.e., the variation in introduction of the DMC-ODS waiver and

programs adopting the Recovery Incentives Program across counties in California over time, exploiting this variation within the ES and DD designs will continue to allow us to estimate a causal effect of the DMC-ODS waiver and the Recovery Incentives Program. This will remain true if new counties opt-in to participate in the DMC-ODS waiver. The widely accepted empirical strategy in this context is the Two-Way Fixed Effect Difference-in-Differences model (2WFE DD) given in the following equation:

$$Y_{it} = \beta_0 + \beta_1 \cdot Treat_{it} + \alpha_t + \theta_i + \epsilon_{it}$$

where *Treat* is a binary variable equal to one when a county or Recovery Incentives Program goes live in the DMC-ODS waiver and equal to zero otherwise; α_t is a time vector containing indicators for the years of data available; and θ_i is a unit vector containing indicators for the 58 counties. Standard errors are clustered by county. The above equation can be modified to include a vector of provider and/or county level time-varying controls. The Average Treatment effect on the Treated (ATT) is given by β_1.

Identification of β_1 comes from within-county variation in DMC-ODS waiver or Recovery Incentives Program implementation during our sample period. The main assumption of DD designs is the parallel trends assumption. This assumption states that in the absence of treatment, the unobserved differences between the treatment and control groups would be similar over time. Although we cannot directly test this assumption, we can assess the assumption in this setting in at least two ways:

1. Include a county-specific linear time trend in the estimating equation. This will control for unmeasured county trends unfolding linearly (e.g., sentiment towards SUD treatments).
2. Perform an event study analysis. This is done by including leads and lags of the DMC-ODS or Recovery Incentives Program indicator variable in the equation above. Ideally, the coefficients on all of the leads of the DMC-ODS or Recovery Incentives Program indicator variable will be statistically insignificant. This will indicate that trends in the main outcomes of interest in the treated and control counties were not trending differently prior to DMC-ODS or Recovery Incentives Program adoption.

We can also modify the above equation to estimate lagged effects and heterogeneous effects of the DMC-ODS waiver or Recovery Incentives Program. Specifically, we can determine if the programs have stronger (or weaker) effects over time and if the effects differ by patient demographics, or by fidelity. For the latter, to determine if the impact of the Recovery Incentives Program differs by high versus low fidelity providers, we can add an interaction term to the above regression, interacting an indicator for high fidelity providers (e.g., high fidelity providers equals one, and zero otherwise) with the Recovery Incentives Program indicator.

Specifically, the DD design will compare the post-treatment (e.g., post-DMC-ODS waiver or Recovery Incentives Program implementation) difference in the outcomes of interest between the

DMC-ODS waiver and State Plan counties (or Recovery Incentives Program and non-Recovery Incentives Program sites/counties) to the pre-treatment (e.g., pre-DMC-ODS implementation/pre-Recovery Incentives Program) difference in the outcomes of interest between DMC-ODS waiver and State Plan counties (or Recovery Incentives Program and non-Recovery Incentives Program sites/counties).

We will do robustness checks to determine if both sets of fixed effects and county/provider controls are needed. Specifically, we will start with a model that only includes time and county fixed effects. We will then estimate another model that includes both sets of FEs plus county and/or provider controls. If the estimates are very similar, we likely do not need to include the controls. However, we will still present both sets of estimates to show how robust they are to strengthen our conclusions about the effect we are seeing. This is standard practice in nearly ever published difference-in-difference paper (including both FEs and time-varying controls). The FEs are only picking up time-invariant county and provider effects. But, if we know things like the poverty rate, unemployment rate, COVID policies, etc. vary across counties and across time, we need to include those in the regression.

The 2WFE DD model captures average treatment effects on the treated but does not allow us to consider time-varying treatment effects. There are several reasons to expect the effects of DMC-ODS waiver to vary over time. To account for potentially time-varying treatment effects, we implement difference-in-differences decomposition (Goodman-Bacon, 2021, Callaway, et. al 2021, Callaway, et. al 2021, Dave, et. al, 2020).

The 2WFE DD estimate is composed of a weighted average of treatment effects estimated from a series of 2x2 treatment/control groups, some of which compare counties treated at the same time to untreated counties, and others compare counties treated at the same time to counties treated at another time (earlier or later).

Comparisons may also be made to always-treated units; however, given that no always-treated counties comprise of only 4% state population and do not form an appropriate comparison group for our treated counties, we cannot pursue this comparison to derive robust average treatment effects. There are 19 timing groups in our data, or groups of counties which experience going live in the DMC-ODS waiver at the same time. There are thus 361 distinct 2x2 treatment/control comparison groups from which the 2WFE DD estimate is constructed: 342 groups in which earlier-treated counties are compared to later-treated counties, or vice versa, and 19 groups in which treated counties are compared to untreated counties. In the presence of time-varying treatment effects, comparisons between earlier and later treated counties may introduce bias into the 2WFE DD estimate. The extent of the bias depends on the share of the 2WFE DD estimate that is derived from these earlier-later comparisons, which in turn depends on group size and the variance of the treatment.

Goodman-Bacon (2021) has developed a method to decompose the 2WFE DD estimate into the 2x2 weighted estimates from which it is derived. Using this difference-in-differences decomposition model, we can uncover the extent to which the 2WFE DD estimate depends on 2x2 DD estimates which compare earlier to later treated counties. The Goodman-Bacon decomposition model is currently only available for strongly balanced panels in which treatment only changes from 0 to 1 over time. To estimate the decomposition model, we define treatment as a binary variable that is equal to one in all years after a county goes live in the DMC-ODS waiver and is equal to zero otherwise. The ES design is similar to the DD design but will allow the effect of the DMC-ODS waiver to vary from a specified number of months prior to introduction of the waiver to a specified number of months after the introduction.

All ES and DD models will continue to use data from either DMC claims or CalOMS-Tx at the county-month-year-level, and control for time-invariant county effects, county-invariant time effects, and the severity of the COVID-19 pandemic, which may be proxied by the county-level COVID-19 case rate per 100,000, and COVID-19 death rate per 100,000 for each month-year cell. All regressions will be weighted by the county population, and standard errors are clustered at the county level (Bertrand, 2004).

The Generalized Synthetic Control (GSC) method introduced by Xu (2017) addresses the case when treatment is imposed at different times for different counties. This approach allows for multiple treated counties and variable treatment periods. This method also has several other advantages. It includes a built-in cross-validation procedure and is easier to implement than other synthetic control methods. The GSC method allows us not only to match counties on pretreatment observables, but also to model unobserved time-varying heterogeneities using interactive fixed effects.

GSC first estimates an Interactive Fixed Effects (IFE) model using only the counties that were never treated and obtains a fixed number of time-varying coefficients (latent factors). It then estimates county-specific intercepts (factor loadings) for each treated county by linearly projecting pretreatment outcomes for treated counties onto the space spanned by the factors. Finally, it generates synthetic control units based on the estimated factors and factor loadings. The method is described as a "bias correction procedure for IFE models when treatment data is heterogeneous across units." (Xu, 2017)

Of note, given that many of DMC-ODS benefits have now been adopted by the state plan,[11] it raises concern regarding the DMC-ODS period under analysis. Since the control group will have similar provisions as DMC-ODS, this falls under spillover effects and violates the assumption of quasi-experimental causal inference methods, called SUTVA (Stable Unit Treatment Value Assumption). This may change the magnitude of estimates. However, since residential treatment will be treated in IMDs in DMC-ODS counties but not in state plan counties, DMC-ODS should

[11] https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

maintain an access advantage to residential treatment and we can continue the analysis with the caveat that the average DMC-ODS effect may be reduced after these changes to the state plan.

Analysis of Cost Data

Using the causal inference study designs mentioned above, including but not limited to Difference-in-Difference with staggered implementation, Synthetic Control Methods, or Generalized Synthetic Control Methods, as applicable, UCLA will examine the changes in costs because of DMC-ODS waiver. These costs analyses will focus on total Medicaid and Federal costs as well as cost drivers measured per member per month. Specifically, the analyses will also focus on changes in inpatient costs, non-ED outpatient costs, and ED outpatient costs. The analyses will be based on administrative data provided by DHCS; namely, DMC-ODS claims and Managed Care/FFS claims starting in 2015 (pre-period) and including DMC-ODS implementation from 2017 through CalAIM (including 2021). The DMC-ODS claims data contain all SUD-related claims of Medi-Cal beneficiaries, whereas the Managed Care/FFS claims are all managed care claims of SUD beneficiaries identified in the DMC-ODS claims. This will allow us to identify increased access to residential treatment (the prime goal of DMC-ODS waiver) from DMC-ODS claims data and follow the cost behavior of beneficiaries through the variables and data provided in the Managed Care/FFS claims. A potential hypothesis that UCLA will explore involves cost shift behavior from high-value emergency services (ED costs) to Residential Treatment. However, given that seven Partnership HealthPlan counties joined the DMC-ODS waiver as a regional model on July 1, 2020, it will be difficult to analyze any changes in costs for these counties, given the data lag in sharing Managed Care/FFS claims. Currently, there is a 2–3-year lag, and UCLA is awaiting Managed Care/FFS claims data for 2021. So, the analyses will focus on counties where sufficient post-waiver data is available (if a balanced panel is desired for computation purposes). For Recovery Incentives Program, the evaluation team will also use managed care/fee-for-service claims data to analyze cost-effectiveness, specifically investigating whether emergency department, inpatient hospital utilization, and other medical costs (including any type of physical health problems) are reduced or made more appropriate (e.g., increased primary care costs but reduced emergency department costs) among clients who participated in the Recovery Incentives Program vs. similar clients who did not. Until this data becomes available (projected 2025), UCLA will rely on client self-reports from surveys and interviews, as described above.

Analysis of Recovery Incentives Program Incentive Manager Data

Rates of positive drug tests will be compared to rates from the CM literature using a one-sample t-test or analogous procedure. UCLA reviewed all studies cited in a recent systematic review of CM trials for the treatment of methamphetamine use (Brown & DeFulio, 2020), supplemented by a PubMed search of 2020-2022 articles with the key terms “contingency management” and “stimulant.” Among these sources, three studies (Roll & Shoptaw, 2006; Stitzer et al., 2020;

Strona et al, 2006) reported information sufficient to calculate the percentage of negative results among submitted tests. The average, weighted for study size, was 85.3%.

However, Miguel et al. (2021) determined that the percent of negative urinalysis outcomes out of *all possible* tests showed the most consistent performance, compared to alternative measures e.g., weeks of continuous abstinence. This measure conservatively treats missed tests the same as positive tests. Therefore, a measure similar to this will also be used for the evaluation. Three articles (Carrico et al., 2015; Shoptaw et al, 2006, Miguel et al, 2021) reported sufficient information to calculate the percentage of negative urinalysis results among all possible tests, producing a weighted average of 47.7%.

If the data allows, more advanced techniques (e.g., growth curve modeling) may be used to examine patterns in the drug test data.

Analysis of Quantitative Survey Data

County administrator, provider, and client surveys will include Likert rating scales and binary measures (e.g., yes/no). While the lower Ns for the administrator surveys will mostly limit analyses to descriptive analyses, the provider and client survey data will be analyzed in greater depth.

Descriptive statistics, including mean and standard deviation for continuous outcomes as well as frequency and percentage for binary outcomes, will be estimated for all survey samples. Bivariate comparisons will be made between coordinators and counselors in the case of provider surveys.

The association between pairs of measures in surveys will be estimated using product-moment correlation for continuous measures, point-biserial correlation for the relationship between categorical and continuous measures, and cross-tabulation for categorical measures.

Multiple regression modeling for a continuous outcome (e.g., a 1-5 Likert rating scale) and/or logistic regression modeling for a binary outcome (i.e., yes/no) will be conducted separately. On provider surveys, the staff's role (i.e., coordinators versus counselors) will be a covariate in regression modeling.

For client data, which will consist of multiple waves, descriptive analyses, and trajectory plots in conjunction with the Generalized Growth Curve Model (GGCM) may be applied to examine the change in client responses across the repeated assessments.

All analyses will be conducted at both statewide and county levels, by fidelity level, and by demographic groups to look for differences in access and outcomes by race, ethnicity, gender, and age.

Power analysis

Since statistical significance is a way of evaluating the likelihood that differences found in a sample would be found in the full population, in the case of the main administrative data analyses statistical power will not come into play because we are analyzing the data from essentially the full population. The same is true of surveys of county administrators, since we will be surveying the entire administrator population among counties participating in the Recovery Incentives Program, and we have historically approached a 100% response rate for surveys of California county administrators. For surveys of treatment providers and clients, however, statistical power will become a consideration, since we will be surveying samples of a broader population.

Although the Ns may need to be adjusted based on resource availability, our current estimated Recovery Incentives Program sample sizes of 600 Wave 1 and 300 Wave 2 client surveys will be sufficient to detect a difference in a continuous measure between the waves with a small effect size (d) of 0.20. Our estimated sample size of 300 Wave 2 and 150 client surveys will be sufficient to detect a small effect size of 0.28. Provider surveys from 100 sites will be sufficient to detect a medium effect size of 0.57 when divided into two groups of 50 (e.g., higher and lower fidelity sites). All power analysis computations were computed with a two-sided alpha of .05 and power (beta) of .80.

Analysis of Qualitative Data

Qualitative data will be collected from providers and county administrators through interviews and focus groups. Qualitative data collection will focus on the major themes of the overall evaluation, as well as emerging trends related to SUD and SUD treatment in California. If client perspectives are needed beyond the information they provide through the treatment perception survey, they may also be interviewed, and UCLA will stratify to the extent possible to ensure a representative sample. Qualitative data will be used to contextualize and inform the interpretation of quantitative findings, and identify areas that warrant further inquiry or focus in the evaluation. All interviews and group discussions will be recorded and transcribed, while qualitative data from surveys (e.g., free text responses to open-ended questions) will be extracted and organized into a spreadsheet. Where applicable, the evaluation team will then analyze these data using a systematic and iterative process according to established and accepted procedures for qualitative research.

Recovery Incentives Program evaluation qualitative data analysis

Qualitative data will be collected from different stakeholders, including clients, providers, and county administrators. All interviews and group discussions will be recorded and transcribed, while qualitative data from surveys (e.g., free text responses to open-ended questions) will be

extracted and organized into a spreadsheet. The evaluation team will then analyze these data using a systematic and iterative process according to established and accepted procedures for qualitative research. This process will begin by organizing data into key study domains (King 2004) related to the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, Maintenance). Within each domain, initial analyses will utilize preliminary codes that are expected to emerge from qualitative data. See Table 2 for a preliminary list of codes that may be used to guide analyses and identify overarching data trends.

Table 2. Preliminary Codes for Recovery Incentives Program Qualitative Data Analysis

RE-AIM DOMAIN	PRELIMINARY CODES
Reach	R1: What determines which StimUD clients receive CM and which do not? R2: What are the barriers and facilitators of Recovery Incentives Program service delivery? R3: Are there disparities in the reach of Recovery Incentives Program services to different treatment populations? What can be done to mitigate these disparities?
Effectiveness	E1: How effective do stakeholders believe the Recovery Incentives Program is in helping clients remain in treatment? Helping them achieve and maintain abstinence from stimulants? E2: Are there aspects of the Recovery Incentives Program (incentives, testing procedures) or other behavioral services and supports delivered in conjunction with CM) that seem to enhance or inhibit the Recovery Incentives Program's effectiveness? E3: What can providers do to enhance the Recovery Incentives Program's effectiveness with the clients they serve? What can administrators and policymakers do to facilitate these changes?
Adoption	A1: What factors do counties consider when deciding whether to participate in the Recovery Incentives Program? What factors do program leaders and individual providers consider? A2: What are the practical barriers to/facilitators of Recovery Incentives Program adoption? A3: What policies and procedures could help promote the effective adoption of the Recovery Incentives Program?

Implementation	I1. What are the barriers to/facilitators of high-fidelity CM implementation? I2. What adaptations are being made to CM as it is being implemented? What impacts do these have on intervention fidelity and effectiveness? I3. What policies and procedures could help promote the effective implementation of the Recovery Incentives Program?
Maintenance	M1. What makes programs and providers decide to participate in the Recovery Incentives Program? What makes them decide to discontinue it? M2. What policies and procedures could help promote the maintenance of the Recovery Incentives program in the future if it becomes a standard Medi-Cal benefit?

After organizing qualitative data with codes, we will use constructivist grounded theory to guide the process of reading transcripts, developing code lists, coding data, and comparing/contrasting emerging patterns and themes using constant comparative methods (Charmaz, 2017; Glaser & Strauss, 1967). Portions of coded transcripts will be randomly and independently coded by two researchers to ensure that the codes are being applied consistently and have acceptable levels of agreement indicating good reliability. The evaluation team will meet regularly to share insights and observations from the interviews and/or focus groups throughout the evaluation and discuss emerging themes. Researchers will review the analytic findings. Qualitative data will be triangulated with survey and other quantitative data to identify areas where the results from the data sets converge, complement one another, and/or expand on one another (Creswell, 2003; Palinkas et al., 2011).

The qualitative data collected from the different stakeholder groups (e.g., county administrators, treatment providers, clients) will be analyzed separately as well as across the different groups, and over time (e.g., early vs. later in the implementation of the project) to identify themes and patterns. Findings will be shared with members of key stakeholder groups (DHCS, county administrators, and program staff) to verify and interpret findings.

Methodological Limitations

The California Administrative data sets used in this evaluation have many of the same shortcomings as other administrative data sets, particularly related to inconsistent reporting and missing data (see, for example, Evans et al., 2010 for a discussion of CalOMS-Tx). Delays in data reporting also limit analyses of recent data. UCLA will analyze CalOMS-Tx and DMC claims using the most recent available complete data, which typically requires disregarding

approximately the most recent 6 months of data due to data reporting lag. This will limit the amount of data that can be used in early reports.

CalOMS-Tx data is partly reliant on self-reported data, particularly with respect to outcome questions (e.g., drug use in the last 30 days). Some terms are also somewhat subjective, like discharge status terms (e.g., completed treatment, satisfactory progress, and unsatisfactory progress). To partly ameliorate this problem, these categories will be combined into "successful" (completed, satisfactory progress) and "unsuccessful" (unsatisfactory progress) discharges.

DMC claims data tend to be more complete than CalOMS-Tx data because providers are more motivated to submit them quickly for payment, but this is not universally true. In some cases, under the DMC-ODS, new billable services (e.g., recovery services) are being delivered but DMC claims are not being submitted, in part due to confusion over what is allowable. While this seems less likely to occur for the relatively well-defined Recovery Incentives Program, UCLA will monitor provider survey and interview responses for signs of billing difficulties that may affect claims data.

While DMC claims data have an advantage over CalOMS in completeness, CalOMS-Tx has advantages in the depth of data. CalOMS includes client background (e.g. demographics, primary and secondary drug, source of treatment referral, number of prior treatment episodes, housing, employment, criminal justice status, number of children), as well as treatment discharge status and a number of outcome measures in the last 30 days, both at admission and discharge (e.g. number of arrests & jail days, family conflicts, social support). These cannot be derived from claims. These datasets are therefore complimentary and can be used together to develop a better understanding of DMC-ODS implementation than either dataset alone.

Interview and survey data are limited by the honesty of respondents and the response rate.

Wherever possible, different types of data will be examined in parallel to converge on underlying constructs being measured and thereby mitigate the limitations of each dataset.

The long time frame since initial implementation of DMC-ODS could introduce challenges in interpreting the data, since external impacts (e.g., COVID-19, changes in the economy and workforce) will affect trends. This will be particularly true if no or few new counties join DMC-ODS and if external impacts have systematically different effects on DMC-ODS and non-DMC-ODS counties. Given that the state's largest counties are all already participating in DMC-ODS, even if new counties do opt-in to DMC-ODS, they would also likely have small beneficiary and treatment client populations and a correspondingly limited impact on statewide analyses. The Recovery Incentives Program evaluation will also depend on implementation of a new program, which has and could continue to experience unforeseen delays or barriers that prevent or limit the planned implementation.

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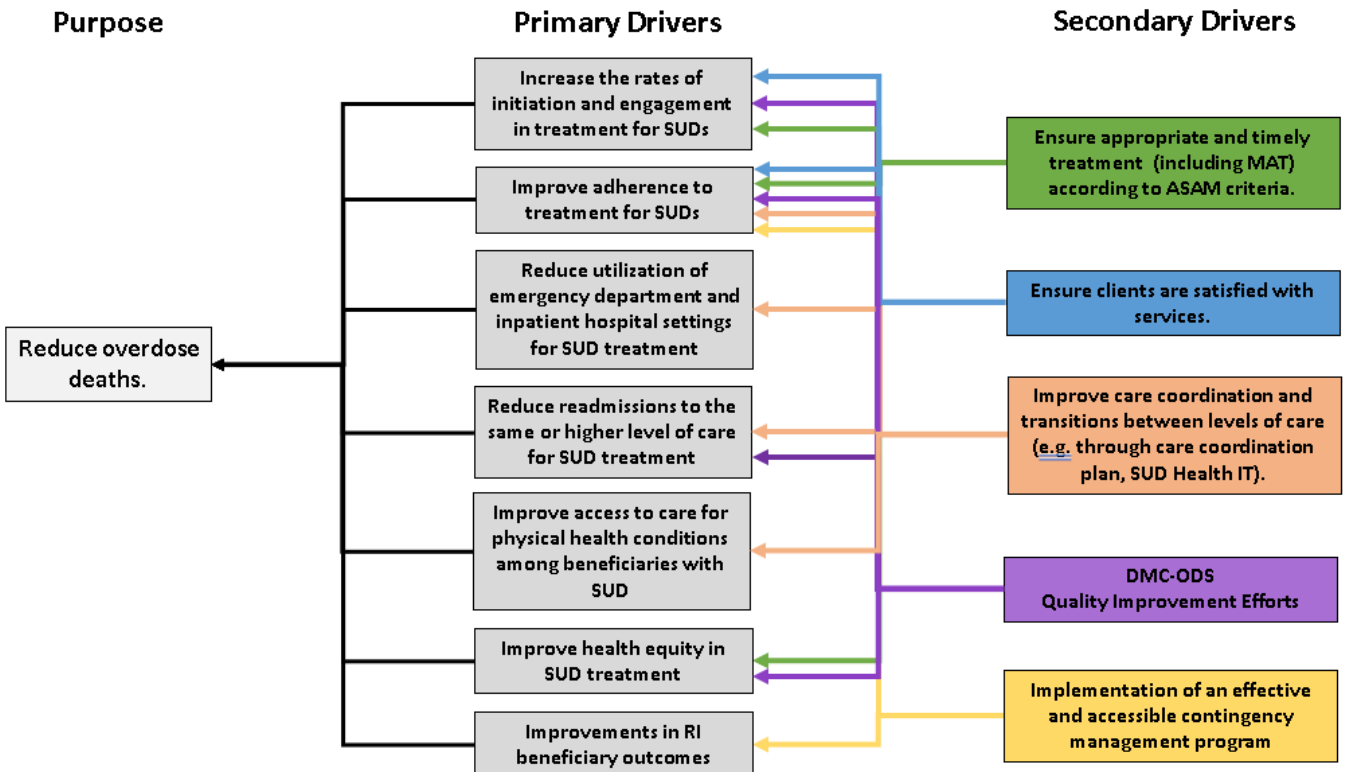
Appendix A: Driver Diagram



Service	Service Definition	Eligibility	Duration	Settings
Short-term Post-hospitalization Housing	Services for eligible individuals who do not have a residence to continue their physical/psychiatric/substance use disorder recovery and need for appropriate medical care upon exiting an institution. Based on the individual's needs and a person's level of care, the services provided may include appropriate physical, mental health, and SUD care, including psychiatric supports as determined by a qualified medical professional, as well as additional supports including: • Support for gaining/regaining ability to perform ADLs • Case management, including connections to Enhanced Care Management The Community Support of housing transition navigation services must be offered to all beneficiaries during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These housing transition navigation services should include a housing assessment and the development of individualized housing	An individual must be exiting an institution. An institution is described as including: recuperative care, inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential SUD or mental health treatment facility, correctional facility, or nursing facility. An individual must have one of the following: • Receiving enhanced care management, or • Have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. • Individuals who meet the U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and	No more than 6 months during the course of the demonstration period.	Only facility types with appropriate clinical supports, consistent with the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness/Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
	support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization.	individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization and (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to thirty (30) days and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious		

Service	Service Definition	Eligibility	Duration	Settings
		mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or • An individual must have on-going physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of post-hospitalization housing.		
Recuperative Care (Medical Respite)	Short-term residential care and ongoing need of medical care, including monitoring of the individual's physical or	Individuals requiring on-going recovery in order to heal from an injury or illness and who meet the	No more than 90 days in duration.	Only facility types, with appropriate clinical supports added, consistent with

Service	Service Definition	Eligibility	Duration	Settings
	behavioral health condition, such as: • monitoring of vital signs • assessments • wound care • medication monitoring • limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs 2 • Coordination of transportation to post-discharge appointments • Connection to any other on-going services an individual may require including mental health and substance use disorder services • Support in accessing benefits and housing • Gaining stability with case management relationships and programs	following criteria: • The U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization and (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to		requirements in the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness/Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
		thirty (30) days.		

Attachment V
Contingency Management Procedures and Protocols

In accordance with the State's "California Advancing and Innovating Medi-Cal (CalAIM)" Section 1115(a) Demonstration Waiver (Project Number 11-W-00193/9) and Special Terms and Conditions (STCs), this protocol provides additional detail regarding the distribution of motivational incentives to Medi-Cal beneficiaries receiving contingency management as required by STCs 55 and 57. The Department of Health Care Services' (DHCS) contingency management program is based on established clinical research demonstrating effective contingency management treatment and California's unique needs. The contingency management treatment program consists of a structured 24-week outpatient contingency management program, during which motivational incentives will be available, followed by six or more months of additional recovery support services, during which motivational incentives will not be available. DHCS' contingency management program may be provided to eligible Medi-Cal beneficiaries and is intended to complement other substance use disorder (SUD) treatment services already offered by Drug Medi-Cal Organized Delivery System (DMC-ODS) providers. Motivational incentives earned through DHCS' contingency management program shall be excluded from participating beneficiaries' modified adjusted gross income (MAGI)-based eligibility determinations, non-MAGI-based eligibility determinations, and share of cost determinations when determining those beneficiaries' eligibility for Medi-Cal.

I. Treatment Framework

A. Beneficiary Eligibility and Participation. Beneficiaries who meet the contingency management eligibility criteria detailed in STC 54 and who consent to treatment may participate in the contingency management program. A participating beneficiary will be considered to have dropped out of the contingency management program if they are absent from contingency management services for more than 30 days. If the beneficiary later returns to the contingency management provider, they will be invited to re-start the contingency management program if they continue to meet eligibility criteria. Participation in contingency management will have no impact on beneficiary eligibility for, or obligation or right to use, other DMC-ODS services.

B. Incentives. Beneficiaries will receive motivational incentives, as defined in STC 55, for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. At the discretion of the State and consistent with STC 55, the definition of target behavior may be revised in accordance with the evidence-base for contingency management as a treatment intervention for SUD to include non-use of substances other than stimulants, and/or other target behaviors such as treatment/medication adherence. During the initial phase of the pilot, DHCS shall set a maximum dollar amount of total incentives in a calendar year that participating beneficiaries will be able to receive for successful completion of the treatment protocol. As described in Attachment V, Section IV below, and consistent with the guardrails described in STC 55, providers have no discretion to determine the size or distribution of motivational incentives.

Attachment V, Sections I.C-F below describe an example of how DHCS will implement the incentive delivery schedule and corresponding dollar amounts. The final delivery schedule and corresponding dollar amounts are subject to change by DHCS.

C. Treatment Schedule Overview. The contingency management program will consist of two phases: 1) contingency management treatment; followed by 2) contingency management aftercare.

Contingency management treatment will consist of a 24-week outpatient program, during which motivational incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of contingency management treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the maintenance period.

After completing 24-weeks of contingency management treatment, the participating beneficiary will receive contingency management aftercare consisting of six months, or more, of aftercare and treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of contingency management aftercare, participating beneficiaries may receive informal engagement and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

D. Weeks 1-12: Escalation/Reset/Recovery Period. During the initial 12 weeks of the contingency management treatment, participating beneficiaries will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. Visits will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help ensure that drug metabolites from the same drug use episode will not be detected in more than one UDT. Participating beneficiaries will be able to earn motivational incentives during each visit the UDT indicates they have a negative sample for stimulants (or other target behaviors, such as a negative sample for other substances, or treatment adherence/medication, as determined by the State and consistent with Section VII of the STCs).

The initial motivational incentive value for the first sample negative for stimulants in a series is $10. For each week the participating beneficiary demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the motivational incentive is increased by $1.50. The maximum aggregate motivational incentive a participating beneficiary can receive during this initial 12-week period is $438.

A "reset" will occur when the participating beneficiary submits a positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their motivational incentive amount will return to the initial value of $10.

A "recovery" of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating beneficiary will recover their previously earned motivational incentive level without having to restart the process.

E. Weeks 13-24: Maintenance Period. During weeks 13–24, participating beneficiaries will be asked to visit the treatment setting for testing a minimum of once a week. During weeks 13–18, participating beneficiaries will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative test, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate motivational incentive a participating beneficiary will be able to receive during weeks 13–24 is $161.

F. Hypothetical Example: Incentive Delivery Schedule for Perfect Performance. Table 1 illustrates an incentive delivery schedule for a participating beneficiary in a scenario where the beneficiary has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant-Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

Note: The incentive delivery schedule and corresponding dollar amounts in the section above are an illustrative example of how DHCS will implement the contingency management program. This incentive delivery schedule and corresponding dollar amounts are subject to change by DHCS.

II. Contingency Management Provider and Staffing Criteria

A. Contingency Management Providers. DMC-ODS providers meeting the criteria detailed in STC 57 and other applicable STCs (e.g., per STC 53, residential providers cannot deliver

contingency management; per STC 56, contingency management providers must comply with data reporting requirements) will be eligible to deliver the contingency management benefit

B. Contingency Management Coordinator. At least one trained contingency management coordinator will administer the participating DMC-ODS provider's contingency management program. The contingency management coordinator must meet the practitioner requirements listed in STC 57(c).

C. Role of the Contingency Management Coordinator. The contingency management coordinator will be the main point of contact for all contingency management program participating beneficiaries and will be responsible for collecting UDT samples, inputting test results, and supporting the delivery of motivational incentives as described in Attachment V, Section IV below.

III. Urine Drug Testing

During each visit, the contingency management coordinator will collect a urine sample from the participating beneficiary. The sample will be tested for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opioid, to rapidly indicate whether recent stimulant use occurred (or other substance use defined by the State and consistent with STC 55). Samples will be collected in a point-of-care test cup with specimen validity measures.

IV. Incentive Delivery

A. Overview. The contingency management coordinator will immediately inform the participating beneficiary of the results of the UDT, and enter the results into a secure incentive management program that includes strict safeguards against fraud and abuse. The incentive management program will compute the appropriate motivational incentive earned according to the protocol detailed above in Attachment V, Section I. The incentive amount can be immediately delivered electronically to participating beneficiaries via e-gift cards sent to participating beneficiaries' emails, sent to the provider to print the gift card, or delivered using other strategies developed by the incentive management program. The immediate delivery of the motivational incentive to the beneficiary following the determination of the motivational incentive amount earned by the incentive management program is a critical component of the contingency management benefit and consistent with the evidence-base.

B. Incentive Calculations. A secure incentive management program will automatically calculate the appropriate motivational incentive amount based on the UDT results with adjustments for the escalating value, reset and recovery features as described above in Attachment V, Section I. The program will be designed to prevent tampering with, modifying or overriding the protocol amounts. Upon each visit, the results of the UDT will be entered into the incentive management program. The incentive management program will operate using an algorithm based on the motivational incentive delivery schedule described above. Using this algorithm, when a result is entered, the program will report the amount of any motivational incentive the participating beneficiary should receive per the protocol. A positive test for stimulants will result in the participating beneficiary receiving no motivational incentive. A negative test for stimulants (or other substances as defined at State

discretion and consistent with STC 56) will result in an incentive amount as indicated by the software, considering escalations and resets.

C. Oversight. As a safeguard against fraud, waste and abuse, the contingency management coordinator, or other staff trained in the delivery of contingency management under the supervision of a Licensed Practitioner of the Healing Arts (LPHA) consistent with STC 57 when the contingency management coordinator is not available, will be permitted to enter the results of the participating beneficiary's UDT into the incentive management program during the visit. On a recurring basis, the DMC-ODS provider must conduct and document that a regular audit of the incentive delivery functions has been completed, including the software calculations recommended and incentive distributed. This provider audit must be conducted by an individual who has responsibility for overseeing the use of organizational funds (e.g., program or fiscal manager). The providers will be required to routinely submit the results of the audit to their DMC-ODS contracted county. The DMC-ODS county will be required to share the results of the audits with DHCS.

D. Incentive Delivery Method and Parameters. After the motivational incentive amount is determined, the incentive management program will disburse the motivational incentive and will track all motivational incentives awarded to all participating beneficiaries, including the date the incentive was distributed and the amount of the motivational incentive.

E. Incentive Types. To redeem earned motivational incentives consistent with the protocol described in this Attachment V, participating beneficiaries will be able to choose gift or debit cards from a range of retail outlet options to use or redeem the incentive balance, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol or lottery tickets.

Attachment W
Reentry Demonstration Initiative Qualifying Conditions and Pre-Release Services

Table 1. Adult Health Care Need Criteria Definitions for the Reentry Demonstration Initiative

Qualifying Condition	Definition
Mental Illness	A person with a "Mental Illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The beneficiary's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder (SUD)	A person with a "Substance Use Disorder" is a person who either: i. Meets SUD criteria, according to the criteria of the current editions of the Diagnostic and/or Statistical Manual of Mental Disorders and/or the International Statistical Classification of Diseases and Related Health Problems; OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, or other state-approved screening tool.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a "Chronic Condition" or a "Significant Non-Chronic Clinical Condition" shall have ongoing and frequent medical needs that require treatment and can include one of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: • Active cancer; • Active COVID-19 or Long COVID-19; • Active hepatitis A, B, C, D, or E; • Advanced liver disease; • Advanced renal (kidney) disease; • Dementia, including but not limited to Alzheimer's disease; • Autoimmune disease, including but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis;

Qualifying Condition	Definition
	• Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy; • Chronic neurological disorder; • Severe chronic pain; • Congestive heart failure; • Connective tissue disease; • Coronary artery disease; • Currently prescribed opiates or benzodiazepines; • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g. anticoagulation) therapy after reentry; • Cystic fibrosis and other metabolic development disorders; • Epilepsy or seizures; • Foot, hand, arm, or leg amputee; • Hip/pelvic fracture; • HIV/AIDS; • Hyperlipidemia; • Hypertension; • Incontinence; • Severe migraine or chronic headache; • Moderate to severe atrial fibrillation/arrhythmia; • Moderate to severe mobility or neurosensory impairment (including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy); • Obesity; • Peripheral vascular disease; • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related); • Previous stroke or transient ischemic attack (TIA); • Receiving gender affirming care; • Active respiratory conditions, such as severe bronchitis, COPD, asthma or emphysema; • Severe viral, bacterial, or fungal infections; • Sickle cell disease or other hematological disorders; • Significant hearing or visual impairment; • Spina Bifida or other congenital anomalies of the nervous system; • Tuberculosis; or • Type 1 or 2 diabetes.

Qualifying Condition	Definition
Intellectual or Developmental Disability	A person with an "Intellectual or Developmental Disability" is a person who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury	A person with a "Traumatic Brain Injury" means a person with a traumatic brain injury or other condition, where the condition has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with "HIV/AIDS" means a person who has tested positive for either human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is "Pregnant or Postpartum" is a person who is either currently pregnant or within the 12-month period following the end of the pregnancy.

Table 2. Service Definitions for the Reentry Demonstration Initiative.

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the client, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; o While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with specialty county behavioral health coordinators and managed care providers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with managed care plans, and, as relevant, to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based

Covered Service	Definition
	providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the client after release, including behavioral health warm linkages. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g. to suggest medication changes or to prescribe appropriate DME for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to clinical assessment, patient education, therapy, counseling, SUD Care Coordination (depending on county of residence), Peer Support services (depending on county of residence), and Specialty Mental Health Services Targeted Case Management covered in the Medi-Cal State Plan.

Covered Service	Definition
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Medication-Assisted Treatment	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT. Services may be provided by correctional facilities that are not DMC-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.
Community Health Worker Services	Community Health Worker Services will be provided consistent with the Community Health Worker State Plan.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan). • DME consistent with Medi-Cal State Plan requirements.

Attachment X

Health-Related Social Needs (HRSN) Community Supports Protocol (Reserved)

Attachment Y

Approved DSHP List (Reserved)

Attachment Z

DSHP Claiming Protocol (Reserved)

Attachment AA

DSHP Sustainability Plan (Reserved)

Attachment BB

California DSHP-Related Provider Payment Increase Assessment Attestation Table (Reserved)

Attachment CC

Reentry Demonstration Initiative Implementation Plan (Reserved)

Attachment DD

Monitoring Protocol (Reserved)

Attachment EE

Reentry Demonstration Initiative Reinvestment Plan (Reserved)

Attachment FF

Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) and title XIX of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall be regarded as expenditures under section 1903 of the Act for the period from March 1, 2020 through the end of the unwinding period, or until all redeterminations are conducted during the unwinding period.

Continuous Coverage for Individuals Aging Out of CHIP. Expenditures to provide continued eligibility for CHIP enrollees who turned 19 between March 1, 2020, and the end of the California's unwinding period and therefore would be ineligible for CHIP due to age, and who are ineligible for Medicaid due to having income above 133 percent of the federal poverty level (FPL), provided such individuals have satisfactory immigration status.

Continuous Coverage for Specified Formerly Pregnant Individuals. Expenditures to provide continued eligibility for formerly pregnant individuals for whom coverage in the Medi-Cal Access Program (i.e., having income above 208 percent and up to and including 317 percent of the FPL) in CHIP has ended, and Health Services Initiative (HSI) postpartum coverage has ended, and who:

a. No longer have coverage under the CHIP unborn child option due to the pregnancy ending;
b. Finished up to 12 months of postpartum coverage under the state's HSI;
c. Are otherwise ineligible for Medicaid or CHIP due to the pregnancy ending; and
d. Have satisfactory immigration status.

Expenditures are not allowed for individuals who do not have satisfactory immigration status.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS no later than 60 days after the demonstration amendment approval. Once approved, the state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e). In developing the Evaluation Design, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The state must also describe its plans to collect and report data on the size of the populations served under this demonstration amendment, and a summary of service utilization. The Evaluation Design must outline plans to assess how demonstration outlays affect the state's response to the PHE. The state must also describe in the Evaluation Design its process to: (1) identify accurately individuals with satisfactory immigration status; and (2) only claim FFP for services for individuals with satisfactory immigration status. CMS will provide additional technical assistance to support developing the Evaluation Design.

which will consolidate the monitoring and evaluation reporting requirements for this demonstration amendment. The Final Report is due no later than one year after the end of the expenditure authority. In addition to capturing data on the number of individuals served and utilization of services under this amendment, the Final Report must undertake qualitative and descriptive assessment on the demonstration implementation, lessons learned, and best practices for similar situations. The state is required to track expenditures associated with this demonstration, as applicable, and may include but not be limited to, administrative costs and program expenditures. Furthermore, the state must include in the Final Report a discussion on how it implemented the process—including any challenges encountered and how those were overcome—to accurately identify claims and capitation payments for individuals with satisfactory immigration status, and to assure that individuals with UIS were not included in FFP claims for services. For each year of the amendment that the state is required to complete an Annual [Monitoring] Report per 42 CFR 431.428(a), the state may submit all applicable information for the amendment approval period in the Final Report. CMS will provide additional guidance on the structure and content of the Final Report.

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: California

B. Waiver Title: CalAIM Section 1115 Demonstration

C. Control Number:
11-W-00193/9

D. Type of Emergency (The state may check more than one box):

●	**Pandemic or Epidemic**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This Attachment K will apply to specific provider types, providing direct-care services through Community-Based Adult Services (CBAS). The State intends to use funds from section 9817 of the American Rescue Plan (ARP) Act for one-time payment meant to help alleviate financial strain and hardships suffered by California's HCBS direct care workforce during the COVID-19 PHE and expand access to providers and incentivize retention of current California's existing HCBS direct care workforce. The State will begin processing the direct care workforce payments September 1, 2023.

F. Proposed Effective Date:
Start Date: March 1, 2023
Anticipated End Date: November 11, 2023

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply to all direct-care HCBS providers impacted by the COVID-19 virus pandemic, across the State of California, providing services through CBAS.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

b. ___ Services

i. ___ Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. __ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___ **Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

c. ___ **Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver**. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. ___ **Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).**

i. ___ **Temporarily modify provider qualifications.**

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii. ___ **Temporarily modify provider types.**

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii. ___ **Temporarily modify licensure or other requirements for settings where waiver services are furnished.**

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e.___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f._X_ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

The State intends to use funds from section 9817 of the American Rescue Plan (ARP) Act for one-time payments meant to help alleviate financial strain and hardships suffered by California's HCBS direct care workforce during the COVID-19 PHE and expand access to providers and incentivize retention of current California's existing HCBS direct care workforce. The State will begin processing the direct care workforce payments September 1, 2023.

In accordance with the American Rescue Plan Act of 2021, Section 9817, allow a one-time incentive payment of $500 to each direct care, non-In-Home Supportive Services (IHSS) provider, identified below, of Medi-Cal CBAS services to Medi-Cal beneficiaries for at least two months during the Public Health Emergency, that are currently providing direct care services through CBAS. These payments are funded through California's HCBS Spending Plan, approved by CMS on January 4, 2022.

The payment will serve as an incentive payment to maintain the pool of provider infrastructure for HCBS. Providers eligible for this incentive payment are currently providing HCBS direct care services and provided services to program recipients during a minimum of two months during the Public Health Emergency, between the dates of March 2020 and March 2022.

- Nurse Case Managers
- Social Work Case Managers
- Social Worker Assistants
- Program Aides
- Activity Coordinators
- Social Worker Aide
- Nurse's Aide
- Activity Coordinator Aide
- Cook
- Driver (Excluding rideshare)
- Nutrition services aide
- Physical therapist
- Physical therapist assistant
- Physical therapist aide
- Occupational therapist
- Occupational therapist assistant
- Occupational therapist aides
- Speech Language Pathologist
- Speech Language Pathologist Aide

The payment will be issued through a self-verification process and provider organizations will apply on behalf of their eligible employees. The State will provide a one-time lump sum payment to the provider organization; and the provider organization will be required to distribute the payments to employees within 30 days of receipt.

These payments are for the direct benefit of direct care service workers and provider organizations cannot take any fees from the $500 direct payment (e.g., administrative costs) and direct care service workers will receive 100% of the payment. If a provider organization is unable to distribute a payment to an eligible employee, they are required to return the funds to the State.

g. ___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h. Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j. Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k. Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l. Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.__Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Nichole
Last Name	Kessel
Title:	HCBS Policy Branch Chief
Agency:	California Department of Health Care Services
Address 1:	1501 Capitol Avenue
Address 2:	P.O. Box 997413, MS 4502
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	916-713-8345
E-mail	Nichole.Kessel@dhcs.ca.gov
Fax Number	N/A

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.

Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: [redacted] **Date: 5/10/2023**

State Medicaid Director or Designee

First Name:	Jacey
Last Name	Cooper
Title:	State Medicaid Director
Agency:	California Department of Health Care Services
Address 1:	1501 Capitol Avenue
Address 2:	P.O. Box 997413, MS 0000
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	916-449-7400
E-mail	Jacey.Cooper@dhcs.ca.gov
Fax Number	916-449-7904

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
Service Definition (Scope)**:**				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority.

States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.