DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

November 27, 2023

THIS LETTER SENT VIA EMAIL

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

QUARTERLY MONITORING REPORT FOR CALIFORNIA'S SECTION 1115(A) DEMONSTRATION TITLED CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) (PROJECT NUMBER 11-W-00193/9)

Dear Ms. Young:

The Department of Health Care Services is officially submitting the Demonstration Year (DY) Nineteen (19) Quarter Three (Q3) Progress Report (Report) to the Centers for Medicare & Medicaid Services, covering the reporting period of July 1, 2023, through September 30, 2023. The Report is required by Section 15.5 of Special Terms and Conditions of California's Section 1115 Waiver, titled "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) (the "Demonstration").

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

Sincerely,

[redacted]

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Assistant State Medicaid Director
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Enclosures and cc: See next page.

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

SECTION 1115(A) WAIVER QUARTERLY REPORT

DEMONSTRATION/QUARTER REPORTING PERIODS:

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

THIRD QUARTER REPORTING PERIOD: JULY 1, 2023 – SEPTEMBER 30, 2023

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INTRODUCTION

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

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

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

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

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

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Renewed in the CalAIM Section 1115 Demonstration:**
  - **Global Payment Program (GPP)** to renew California's statewide pool of funding for care provided to California's remaining uninsured populations, including streamlining funding sources for California's remaining uninsured population with a focus on addressing social needs and responding to the impacts of systemic racism and inequities.

- **Substance Use Disorder (SUD) Institutions for Mental Disease (IMD)** authority to continue short-term residential treatment services to eligible individuals with a SUD in the Drug Medi-Cal-Organized Delivery System (DMC-ODS).
- **Coverage for Out-of-State Former Foster Care Youth** to continue Medi- Cal coverage for this population during the renewal period, up to age 26.
- **Community Based Adult Services (CBAS)** to continue to authorize CBAS for eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.
- **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.

- **CalAIM Initiatives Authorized in the CalAIM Section 1115 Demonstration:**
  - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; 12 other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
  - **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and (2) support justice-involved (JI) pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
  - **Contingency Management** to offer Medi-Cal members, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
  - **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, to provide this service in DMC-ODS and Drug Medi-Cal (DMC) counties and county mental health plans (MHPs).
- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**
  - **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authorities** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
  - **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to 109 to 138 percent of the federal poverty level (FPL) transitioned from Section 1115

authority to the Medi-Cal State Plan.

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

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

Since the initial approval of the CalAIM Section 1115 demonstration, CMS has approved several amendments which can be viewed on DHCS' website. During DY 19-Q3, CMS issued technical corrections to the STCs and approved protocols related to PATH. In addition, during DY 19-Q3, CMS approved authorities in the Attachment K that are effective from March 1, 2023, through November 11, 2023, six months after the end of the public health emergency. These authorities apply in all locations served by the demonstration for anyone impacted by COVID-19 who receives home and community-based services through the CBAS program in the demonstration. Lastly, in DY 19-Q3, CMS approved the Managed Care expenditure authority that will allow California to limit choice of managed care plans in Metro, Large Metro, and Urban counties and to allow counties to participate, or continue participating in, County organized Health System (COHS) and Single Plan managed care models.

Further, DHCS continues to finalize with CMS on protocols and attachments related to CalAIM Section 1115 demonstration initiatives that were approved as part of the Section 1115 renewal.

GENERAL REPORTING REQUIREMENTS

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

CMS and DHCS mutually agreed to hold joint monthly CalAIM 1115/1915(b) waiver monitoring calls. During DY 19-Q3, DHCS and CMS held a monitoring call on August 14, 2023. DHCS and CMS mutually agreed to cancel the CalAIM 1115 portion of the monitoring call during the months of September and October. In lieu of a call, DHCS shared updates via email. As needed, separate CalAIM 1115 deliverable-specific calls also took place during the quarter.

STCs Item 15.9: Post Award Forum

In DY 19-Q3, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On July 20, 2023, DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting. The purpose of the SAC and BH-SAC is for stakeholders to provide DHCS with input on ongoing implementation efforts for CalAIM and the state's Section 1115 waiver and behavioral health activities. DHCS provided updates on: Highlights of 2023-24 California State Budget; Justice-Involved Waiver; Medi-Cal Redeterminations; Behavioral Health Modernization; Birthing Care Pathway Project; Health Plan Transitions and Status of Readiness for 2024; Contingency Management; Behavioral Health Bridge Housing; Behavioral Health Continuum Infrastructure Program; and Documentation Redesign. Past meeting materials are available on the DHCS website: SACMeetingMaterials (ca.gov).

During this quarter, DHCS Consumer-Focused Stakeholder Workgroup (CFSW) meetings also took place on July 7, 2023, August 4, 2023, and September 8, 2023. The meetings included discussion of DHCS programmatic implementation updates, such as: Continuous Coverage Unwinding; Assets Limits Elimination; Age 26-49 Expansion/Older Adult Expansion; Home and Community-Based Alternative Waiver Medical Interpreter Pilot Project; Hearing Aid Coverage for Children Program (HACCP); Medi-Cal Communication Project; Institutional Deeming (ACWDL 23-13); Long Term Care Notice of Action; 250% Working Disabled Program; BenefitsCal; and Conlan. The purpose of the CFSW was to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on September 14, 2023. DHCS discussed the following topics: Intermediate Care Facilities (ICF) and Subacute Care Services Carve-In; CalAIM: Community Supports; Community Health Workers; PATH Updates; Updates on (26-49) Adult Expansion & CMS Monthly Unwinding Report for Appeals; Auto-Assignment Algorithm Updates; Birth Equity Population of Focus (POF) Under ECM; and Medi-Cal MCP Contract: MCP Transitions and 2024 Readiness. The purpose of the MCAG is to facilitate active communication between the managed care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders and advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

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

PROGRAM UPDATES

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 19-Q3, as required in item 15.5[1] of the CalAIM 1115 demonstration STCs. For each program area, this section describes program highlights, performance metrics, outreach activities, operational updates, consumer issues and interventions, quality control/assurance activity, budget neutrality and financial updates, and progress on evaluation interim findings. Key program areas described in this section include:

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

[1] The Department of Health Care Services, CalAIM 1115 Demonstration & 1915(b) Waiver, August 23, 2023, CalAIM Managed Care Amendment Approval.

COMMUNITY BASED ADULT SERVICES (CBAS)

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

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

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

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

Program Requirements:

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

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

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

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

The state must maintain CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[2]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service (FFS) benefit. On July 1, 2012, 12 of the 13 COHS began providing CBAS as a benefit. The final transition of the CBAS benefit to managed care took place beginning October 1, 2012, into the Two-Plan Model, (available in 14 counties), Geographic Managed Care Plans (available in

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

two counties), and the final COHS County (Ventura) at that time. As of December 1, 2014, Medi-Cal FFS only provided CBAS coverage for CBAS eligible participants who had an approved medical exemption from enrolling into managed care. The four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.Effective April 1, 2012, eligible participants can receive "unbundled services" if there is insufficient CBAS center capacity to satisfy the demand. Unbundled services refer to component parts of the CBAS benefit delivered outside of centers with a similar objective of supporting participants and allowing them to remain in the community. Unbundled services include local senior centers to engage members in social and recreational activities; coordination with home delivered meals programs; group programs; home health nursing and/or therapy visits to monitor health status and provide skilled care; and In-Home Supportive Services (IHSS), which consists of personal care and home chore services to assist participants with Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). If the participant is enrolled in a managed care plan, the MCP will be responsible for facilitating the appropriate services on the members' behalf.

Beginning in March 2020, in response to the COVID-19 PHE, DHCS and CDA worked with stakeholders including the California Association for Adult Day Services (CAADS), CBAS providers, and the MCPs, to develop and implement CBAS Temporary Alternative Services (TAS). On October 9, 2020, CMS approved DHCS' disaster 1115 amendment, which allowed flexibilities pertaining to the delivery of CBAS TAS and permitted CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (if proper safety precautions were implemented). These flexibilities are described in greater detail below. CBAS TAS was a short-term, modified service delivery approach, that granted CBAS providers time-limited flexibility to reduce day-center activities, and to provide services, as appropriate, via telehealth, live virtual video conferencing, or in the home, if proper safety precautions are taken, and if no other option for providing services was available to meet the participant's needs. Due to the ongoing COVID-19 PHE, CBAS TAS continued to be provided through October 2022, as appropriate, to address CBAS participants identified and expressed needs.

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

previously approved flexibility period of six-months post the end of the federal PHE. In ending the CBAS TAS flexibility, the state did not alter or reduce the eligibility criteria, available services, or rate of payment for the CBAS benefit. All services included in the CBAS TAS flexibility are included in the core service package and additional services package. These service packages are what is included in the CBAS in-center services, which comprise the per diem rate. More information about the ending of CBAS TAS and the transition to full in-center services is provided in subsequent sections of this report.

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

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

CBAS TAS ended on September 30, 2022, and CBAS ERS were implemented as of October 1, 2022. For details about the program activities completed by CDA (in

collaboration with DHCS, CDPH, CBAS providers, and MCPs) to prepare CBAS providers and MCPs for the end of CBAS TAS and implementation and ongoing support of ERS in compliance with 1115 waiver requirements and CDA CBAS ERS policy, please refer to the "Operational Updates" section. Please refer to the "Program Highlights" section for details about the first 12 months of ERS implementation, which concluded at the end of DY19-Q3.

Performance Metrics:

CDA and DHCS internal partners are meeting and working towards the development of the performance measures identified in STC 5.8. In addition, per STC 5.9, "The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually."

Enrollment and Assessment Information:

Per STC 5.6, CBAS enrollment data for both MCP and FFS participants per county is shown in Figure 1 below. The CBAS Center's licensed capacity by county is also incorporated into the same figure.

Each quarter the MCPs self-report enrollment data, which sometimes results in data lags, thus additional analysis within this report is included for previous quarters. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

See next page for **Figure 1: Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS.**

County	DY 18 – Q3 July – Sept 2022		DY 18 – Q4 Oct - Dec 2022		DY 19-Q1 Jan – Mar 2023		DY 19-Q2 April – June 2023	
	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used	Unduplicated Participants (MCP & FFS)	Capacity Used
Alameda	474	76%	476	76%	448	71%	436	70%
Butte	25	25%	26	26%	24	24%	20	20%
Contra Costa	131	35%	127	34%	116	53%	81	37%
Fresno	1,008	46%	1,025	47%	1,009	46%	962	44%
Humboldt	97	16%	86	15%	88	15%	101	17%
Imperial	275	46%	275	46%	278	46%	298	50%
Kern	198	19%	277	27%	191	18%	231	22%
Los Angeles	24,983	57%	23,584	54%	22,838	52%	17,008	38%
Merced	110	52%	118	56%	110	52%	137	65%
Monterey	96	52%	91	49%	91	49%	89	48%
Orange	2,871	58%	2,718	55%	2,638	48%	2,578	46%
Riverside	536	31%	506	29%	602	35%	648	37%
Sacramento	485	55%	478	54%	451	51%	403	46%
San Bernardino	798	52%	744	48%	829	54%	926	60%
San Diego	1,760	55%	1,996	62%	2,252	70%	2,193	59%
San Francisco	895	57%	924	59%	959	61%	922	59%
San Joaquin	31	13%	36	15%	51	N/A	0	N/A
San Mateo	74	73%	74	73%	138	56%	121	119%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	641	46%	559	40%	554	40%	486	35%
Santa Cruz	86	56%	78	51%	74	49%	74	49%
Shasta	*	*	*	*	*	*	*	*
Stanislaus	*	*	*	*	*	*	*	*
Ventura	845	56%	804	54%	821	55%	840	56%
Yolo	239	63%	225	59%	244	64%	246	65%
Marin, Napa, & Solano	81	16%	83	17%	48	10%	50	13%
Total	**36,769**	**53%**	**35,222**	**51%**	**34,927**	**50%**	**28,917**	**41%**

FFS and MCP Enrollment Data 10/2023

***Note: Information is not available for DY 19-Q3 due to a delay in the availability of data and will be presented in the DY 19 Annual Report.*

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

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

In DY 19-Q2, the following counties showed a decrease in utilization capacity greater than 5 percent: Contra Costa County by 16 percent, Los Angeles County by 14 percent, and San Diego County by 11 percent. San Diego County's utilization capacity decreased due to the opening of new centers, which increased licensing capacity. Contra Costa County's utilization capacity decreased due to a center closure. Los Angeles County's decrease in utilization capacity is likely a result of the end of TAS and the return to in-center congregate services. Effective October 1, 2022, CBAS TAS was no longer permitted, and it is likely that individuals who did not wish to return to center are the reason for the drop in enrollment numbers. The decrease may have occurred in this quarter due to the delay in reporting discharges by the MCPs.

In DY 19-Q2, the following counties showed an increase in utilization capacity of greater than five percent: Merced County by 13 percent and San Bernardino County by six percent. However, even with the increase in utilization capacity for Merced and San Bernardino Counties, neither county is close to 100% capacity utilized (Merced – 65% and San Bernardino – 60%), which will allow services to continue being offered to eligible recipients. Additionally, the implementation of CBAS ERS, effective October 1, 2022, allowed participants the opportunity to retain continuity of CBAS care during personal and public emergencies in addition to helping stabilize access and enrollment levels on average statewide.

Overall, most CBAS centers have not operated at full or near-to-full capacity. Licensed capacity allows the CBAS centers to enroll more managed care and FFS members should the need arise. However, utilization of full licensed capacity varies by region and center and is related to numerous factors including, but not limited to: determinations of eligibility for CBAS and days of service authorized by MCPs; individuals unable to transition due to declined health/functional capacity, or individuals choosing not to transition to center-based services after the elimination of TAS in October 2022; continuing COVID infection risks and/or concerns regarding services in a congregate setting; desire on the part of participants/caregivers to receive CBAS remote services, but not qualifying under the new ERS policy; transportation shortages; and provider difficulties hiring and retaining qualified staff.

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

Demonstration Year and Quarter	Number of CBAS Participants	Enrolled in Enhanced Care Management (ECM)	Enrolled in Community Supports (CS)	Enrolled in Enhanced Care Management (ECM) & Community Supports (CS)
DY 18-Q4 (Oct - Dec 2022)	36,704	438	303	78
		1.19%	0.83%	0.21%
DY 19-Q1 (Jan - March 2023)	34,463	494	473	65
		1.43%	1.37%	0.19%
DY 19-Q2 (Apr – June 2023)	34,183	993	959	54
		2.90%	2.81%	0.16%

DHCS Data 10/2023

**ECM/CS information is not reported for DY 19-Q3 due to a delay in the availability of the data and will be presented in the DY 19 Annual Report.*

The figure above displays the number of CBAS participants who also receive Enhanced Care Management and Community Supports through their Medi-Cal managed care plans. DHCS will be including this data from DY 18-Q4 onward. Enhanced Care Management and Community Supports are a new statewide Medi-Cal benefit as part of CalAIM. ECM is available to select "Populations of Focus" that will address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet members wherever they are – on the street, in a shelter, in their doctor's office, or at home. Members receiving ECM have a lead care manager who coordinates care and services among the physical, behavioral, dental, developmental, and social services delivery systems. Community Supports are designed to address social drivers of health (factors in people's lives that influence their

health). All Medi-Cal managed care plans are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are available to eligible Medi-Cal members regardless of whether they qualify for Enhanced Care Management services. As of DY 19-Q2, there were a total of 34,183 CBAS participants – 993 received ECM, 959 received CS and 54 received both benefits.

Figure 3: CBAS Assessments Data for MCPs and FFS

Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 18-Q4 (Oct - Dec 2022)	2,863	2,803 (98.0%)	60 (2.0%)	5	1 (20%)	4 (80%)
DY 19-Q1 (Jan - Mar 2023)	3,036	2,988 (98.4%)	48 (1.6%)	2	1 (50%)	1 (50%)
DY 19-Q2 (Apr - Jun 2023)	3,225	3,155 (97.8%)	70 (2.2%)	2	0 (0%)	2 (100%)
DY 19- Q3 (Jul - Sept 2023)	*	*	*	0	0	0
5% Negative change between last Quarter		No	No		No	Yes

**MCP assessment information is not reported for DY 19-Q3 due to a delay in the availability of the data and will be presented in the DY 19 Annual Report.*

Assessments for MCPs and FFS Participants

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

Figure 3 identifies the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the figure above is reported by DHCS.

Requests for CBAS are collected and assessed by the MCPs and DHCS. According to the previous figure, for DHCS FFS members in DY 19-Q3, 0 assessments were performed for CBAS benefits, with 0 being eligible and 0 being ineligible. The MCP data will be shown in the DY 19 Annual Report. As demonstrated in Figure 3, the number of CBAS FFS participants are low, given that most participants are in a managed care plan (although there are occasional requests for CBAS FFS).

Figure 4: CDA and CBAS Provider Self-Reported Data

DY 19-Q1

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	27
Total CA Counties	58
CDA - CBAS Provider Self-Reported Data	
Number of CBAS Centers	281
Non-Profit Centers	47
For-Profit Centers	234
ADA at 281 Centers	23,426
Total Licensed Capacity	41, 084
Statewide ADA per Center	57%
CDA – Monthly Statistical Summary Report (MSSR) Data 03/2023	

DY 19-Q2

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	26
Total CA Counties	58
CDA - CBAS Provider Self-Reported Data	
Number of CBAS Centers	283
Non-Profit Centers	46
For-Profit Centers	237
ADA at 283 Centers	24,685

CDA - CBAS Provider Self-Reported Data	
Total Licensed Capacity	41, 809
Statewide ADA per Center	59%
CDA - MSSR Data 06/2023	

DY 19-Q3

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

The opening or closing of a CBAS center effects the CBAS enrollment and CBAS center licensed capacity. The closing of a CBAS center decreases licensed and enrollment capacity while conversely new CBAS center openings increase licensed and enrollment capacity. CDPH licenses CBAS centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. Since January 2023, three CBAS centers closed, and 12 centers opened. Two counties that had only one licensed and certified center – San Joaquin and Marin – lost 100 percent of capacity when the centers closed. Contra Costa County lost 40 percent of capacity when one of three centers in the county closed. Figure 4, above, reflects the reduction of CBAS centers in 28 counties at the close of 2022, to 26 counties at the close of DY 19-Q2.

Figure 4, above, identifies the number of counties with CBAS centers and the average daily attendance (ADA) for DY 19-Q3. ADA data fluctuates somewhat from month to month, but for DY 19-Q3 the average ADA at the 290 operating CBAS centers was approximately 24,240 participants, which corresponds to 58 percent of total capacity

statewide. Data identified in Figure 4 reflects CDA and provider-reported data through September 2023. ADA has decreased since October 1, 2022, due to the program returning to a congregate setting, and individuals who were unable or chose not to transition to center-based services after the elimination of TAS. Some of the explanations reported by CBAS providers and participants for not transitioning to center-based services included: continuing COVID infection risks; desire on the part of participants/caregivers to receive CBAS remote services because of preference or physical deconditioning, but not qualifying under the new ERS policy; transportation shortages; and provider difficulties hiring and retaining qualified staff.

The differences between Q2 and Q3 are: 1) the increase in the number of CBAS Centers from 283 to 290; 2) the increase by 7 in for-profit centers. The total ADA at 290 centers increased by 555, decreasing the ADA percentage by 1 percent. Lastly, the total licensed capacity increased by 1,638.

Outreach Activities:

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

- CBAS Updates
- CBAS ACLs and CBAS News Alerts
- CBAS webinars
- CAADS conferences
- CAADS/ALE/CDA joint webinar presentations
- CAADS/ALE Vision Team Meetings (includes CDA, CBAS and DHCS staff, and CBAS providers)
- CAADS/ALE MCP meetings (includes CDA, CBAS staff, and CBAS providers)
- CDA meetings with MCPs that contract with CBAS centers
- CDA meetings with the CBAS Quality Advisory Committee

The following are CDA's outreach activities during DY 19-Q3:

- CBAS News Alerts (**14**)
- CBAS Webinars **(1)**
- CAADS/ALE Vision Team Meetings with CBAS providers and CDA staff (**3**)
- CAADS/ALE- MCP-CDA meetings **(0)**
- DHCS-CDA-MCP meetings **(2)**
- CDA DHCS meetings **(3)**

- CDA CDPH meetings **(1)**
- Responses to CBAS Mailbox Inquiries **(400)**

In addition to the outreach activities mentioned above, CDA also responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders. Outreach, education, and training activities focused on the following topics: (1) CBAS program operations, particularly for newly certified providers; (2) CDA ACL on policies and procedures for the CBAS provider application process; (3) CBAS ERS and EVV requirements, including reporting policy clarification and new code requirements for claims submission, the CBAS ERS Initiation Form (CEIF), MSSR (which includes ERS data), and the CBAS Incident Report (which requires, among other issues, reporting of COVID-19 and other infectious diseases outbreaks at the center reportable to local or state public health officials which could trigger the provision of ERS and require the temporary pause of in-center services); and (4) Education and training opportunities to promote quality of care and to comply with CBAS program requirements for the provision of in-center services and ERS.

CBAS Webinar Updates

In DY 19-Q3, CDA provided webinar training on enhanced features of the CDA CBAS provider portal which providers utilize when submitting data to CDA. Based on feedback from CBAS providers, CDA enhanced existing processes for input of participant names and data for the purpose of maintaining current center rosters to expedite data submission and reduce administrative burden for providers. All CBAS webinar recordings and slides are posted on the CDA CBAS Training webpage.

CAADS/ALE Vision Team Meetings

CDA continues to collaborate every two weeks with the CAADS/ALE Vision Team (which includes CDA CBAS staff, DHCS, and CBAS providers) in the implementation of ERS policy, identification of operational issues and concerns, and the planning of webinars for CBAS providers, MCPs, and other interested stakeholders. The collaboration efforts supported the end of TAS and CBAS participants' return to full in-center services on October 1, 2022, and now focus on ongoing policy and operational issues.

Additionally, in DY 19-Q3, CDA participated in three CBAS provider learning collaborative meetings on ECM and CS, which was started by some Vision Team provider members, and is now open to all providers interested in learning more about ECM and CS under the CalAIM waiver.

MCP Meetings

CDA convenes meetings with MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs on issues of concern by the MCPs; (2) update MCPs on CBAS activities and data collection, policy directives, and the number, location, and approval status of new center applications; and (3) request feedback from MCPs on CBAS provider issues that require CDA assistance. During this quarter, CDA convened two meetings with MCPs and has scheduled monthly meetings on an ongoing basis.

CBAS Quality Strategy Advisory Committee Meetings

CDA convenes meetings with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, MCPs, DHCS staff, and representatives from CAADS and ALE to provide updates and receive guidance on program activities, and to accomplish the goals and objectives identified in the CBAS Quality Strategy. CDA did not convene a CBAS Quality Advisory Committee meeting during the third quarter of DY 19 due to multiple competing meetings with CBAS providers and MCPs. CDA plans to reconvene meetings by the end of 2023 to continue discussions about data to be collected in the CBAS IPC and reported to CDA by CBAS providers, as well as collecting data to comply with the 1115 waiver performance measure requirements. Accomplishing these goals requires CDA IT support. In the past months, CDA's IT priority has been to establish mechanisms to collect and report ERS data to assist program in the evaluation of the ERS benefit utilization. Another priority has been to identify what technical assistance is needed for CBAS providers to utilize the CBAS ERS benefit as required. Background and details about the CBAS Quality and Improvement Strategy and the CBAS Quality Advisory Committee are provided in the "Quality Control/Assurance Activity" section of this report.

CBAS Mailbox Inquiries

During this quarter, CDA responded to 400 CBAS mailbox inquiries, which included questions about: (1) the interpretation and implementation of ERS policies; (2) CBAS program requirements and operational issues; (3) CDA reporting requirements for ERS and submission of the CBAS ERS Initiation Form (CEIF) in the CBAS internal provider database to initiate ERS; and (4) new ERS EVV requirements for reporting and claims submission.

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

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

Due to the COVID-19 pandemic and implementation of CBAS TAS requirements through September 30, 2022, CDA continued to conduct telephonic/virtual recertification surveys. During DY 18-Q3 in place of onsite surveys that includes determining compliance with the federal HCB settings requirements, all existing CBAS compliance determination processes for the HCB settings requirements continued during the provision of CBAS TAS. This included the completion and validation of CBAS Provider Self-Assessment and CBAS participant surveys via telephonic/virtual methods that comply with public health guidance. CDA resumed on-site recertification surveys during DY 18-Q4.

DHCS submitted the STP and CTP for tribal review on October 10, 2022. The public comment period was held from October 14, 2022, through November 13, 2022, with the intention of submitting the STP and CTP to CMS for final approval following the public comment period and incorporation of STP actions taken in response to comments. CDA distributed public notices to CBAS providers and interested stakeholders about the public comment period and was available to address any questions related to the CTP submitted to DHCS or to CDA during the public comment period. DHCS revised the STP and CTP on March 9, 2023, for final approval. CMS notified DHCS via email on June 28, 2023, that it has granted approval of the final STP.

Program Highlights:

Public and Personal Emergencies During ERS Implementation

Public and personal emergencies occurring over the past 12 months since implementation of ERS on October 1, 2022, have reinforced the value of the CBAS ERS

benefit. There has been a total of 22,566 times that participants received remote services as a result of an ERS event since the inception of ERS, with 14,536. CBAS providers initiated ERS for participants experiencing public emergencies 13,196 times, including: 287 related to power outages or extreme weather conditions, 721 flood related events; and 10,917 related to epidemic infectious disease outbreak (COVID-19). In addition, CBAS providers also initiated ERS for participants experiencing personal emergencies 9,370 times, including: 8,017 serious illness/injury (falls, decline in health, and surgery); 761 crises (includes transportation issues, loss of caregiver, and deterioration of health, or fear of returning to in center congregate setting); and 591 care transition related events, which include hospitalization.

As the transition from the provision of CBAS TAS to in-center services proceeded through the winter, the risk of COVID-19 and Influenza infections continued into early DY 19-Q1. CBAS providers reported that the rise of COVID-19 and Influenza infections resulted in personal emergencies (i.e., serious illness) for some participants and infectious disease outbreaks occurred at some of the centers. This resulted in a temporary pause of in-center services for health and safety reasons. Congregate services are restarted once the center nurse and physician determine, in alignment with local public health guidance, that it is safe to resume in-center services. In DY 19-Q1, statewide public emergencies caused by natural disasters, such as storms and flooding, also caused temporary pauses of in-center services and provision of ERS to participants who could otherwise not access in-center services.

As winter turned to spring, disease outbreaks and weather-related emergencies declined, and the percentage of ERS reported events shifted to personal emergencies that are relatively common among the population served by CBAS. Some examples of personal emergencies included: serious illness or injury; personal crises such as sudden loss of caregivers or housing; and transitions from the hospital. The high point of ERS usage occurred in mid-December 2022 with 5,840 active events, then dropped sharply to 2,178 at the end of June 2023. Seventy-five percent of the active ERS events at the end of June 2023 were personal emergencies experienced by CBAS participants that required continuity of care while they were temporarily unable to attend the center. Percentages of ERS events related to public emergencies shifted again during DY 19-Q3 to their highest point since January 2023 because of increased COVID-19 outbreaks. By the end of DY19-Q3, numbers for reported outbreaks again trended down slightly.

Before CBAS ERS, many CBAS providers (without reimbursement) delivered essential services to their participants who were not able to access in-center services but who required them. With the new CBAS ERS benefit, CBAS providers can provide essential

services to their participants during emergency situations and participants can continue to receive necessary care.

Policy Guidance Regarding Implementing ERS

During the past 12 months since its inception, CDA and DHCS continued to meet with CAADS/ALE, CBAS providers, and MCPs on a regular basis and respond to inquiries from MCPs and providers to improve understanding and ensure consistent implementation of ERS policy and procedures. In addition, ERS policy training continued for CDA CBAS staff to equip them with tools to provide guidance and technical assistance to the staff at their assigned CBAS centers. The training also focuses on the process of determining a CBAS center's compliance with ERS policies during an onsite recertification survey. This process includes a review of health records of participants who received or are currently receiving ERS.

Mechanisms for ERS Reporting and Data Collection

CDA developed new ERS reporting mechanisms to collect data on the ERS implementation and for ongoing oversight. ERS data includes public and personal emergency categories and subcategories, the total number of active ERS events, the percentage of CBAS participants receiving ERS, the number of centers utilizing ERS, and other data points. CDA reports weekly ERS data to DHCS, CDA CBAS staff, CDA Executive Leadership, CAADS/ALE, and other stakeholders. Beginning in October 2022, each month, CDA posts the average number of participants receiving ERS per diem on its website. Data is included for each center and provided statewide. For example, statewide current ERS active events as of September 2023 includes:

Total ERS Events	3,078
Percentage of CBAS Participants Receiving ERS	41%
Public Emergencies	1,701
Personal Emergencies	1,377

CDA will continue to collect, distribute, and post ERS data on the CDA website for transparency and analysis. Data regarding ERS events that providers report to CDA and MCPs facilitate timely tracking of emergency events, coordination of care for participants affected by such events, and oversight of provider activities regarding ERS.

Compliance with CBAS EVV Requirements

CDA worked closely with DHCS during DY19-Q1 and Q2 to develop billing codes for the following categories: 1) CBAS ERS, and 2) CBAS ERS provided in the home subject to EVV (CBAS ERS EVV). The CBAS ERS EVV codes were published in February 2023 in the Medi-Cal Provider Manual. Further, CDA and DHCS developed policy guidance pertaining to how CBAS services are subject to EVV if provided in the home, and how CBAS providers must submit claims for the provision of CBAS ERS and CBAS ERS EVV. In addition, CDA issued guidance and instructional information to CBAS providers, focusing on the promotion of provider registration, to support successful EVV implementation. This process has been a time-intensive, collaborative effort and continues to require extensive training for CBAS staff, providers, and MCPs. Monitoring of EVV data is ongoing.

Policy Development/Issues

To address goals specified in California's Master Plan for Aging (MPA), many of which align with goals of the CalAIM waiver, ATI Advisory received outside funding to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of the CBAS program. Specifically, the work of the consultants, with support from MPA Funders via The SCAN Foundation and in partnership with CDA, focuses on identifying ways to improve statewide access to CBAS and how the program could be leveraged to further equity and reduce health care disparities in California. ATI conducted interviews of key stakeholders (providers, advocates, state staff and MCPs) and broadly distributed written surveys in March of 2023. During DY 19-Q2, the ATI consulting team compiled results of the interviews and surveys and drafted a report that includes actionable recommendations for meeting the project's goals. ATI will share results of their analysis with the state, advocates, and providers in October 2023, with a written report to follow.

Figure 5: Data on CBAS Complaints

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY 18-Q3 (Jul – Sep 2022)	0	0	0
DY 18-Q4 (Oct – Dec 2022)	0	3	3
DY 19-Q1 (Jan – Mar 2023)	0	4	4

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY 19-Q2 (Apr – June 2023)	0	0	0
DY 19-Q3 (Jul – Sep 2023)	0	1	1
CDA Data – Complaints 09/2023			

Figure 6: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY18-Q2 (Apr – Jun 2022)	7	0	7
DY18-Q3 (Jul – Sep 2022)	3	0	3
DY18-Q4 (Oct – Dec 2022)	2	0	2
DY 19-Q1 (Jan – Mar 2023)	6	0	6
DY 19-Q2 (Apr – Jun 2023)	1	0	1
Phone Data – Phone Center Complaints 10/2023			

*Note: *MCP phone center complaint information is not reported for DY 19-Q3 due to a delay in the availability of the data and will be presented in the DY 19 Annual Report.*

Consumer Issues and Interventions:

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

DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the press, and members of the Legislature on various aspects of the CBAS program. DHCS and CDA maintain webpages to provide information on CBAS to stakeholders. In addition, providers and members can submit inquiries to CBASinfo@dhcs.ca.gov for assistance from DHCS, and CBASCDA@Aging.ca.gov for assistance from CDA.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs

and CDA for research and resolution. Complaints collected by MCPs during were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current managed care plan partner. Figures 5 and 6, above, detail complaint data received by CDA and MCPs from CBAS members and providers. CDA was able to provide Q3 data in time for submission to CMS. Figure 5, above, demonstrates a total of four complaints received in DY 19-Q1, none in DY-19-Q2, and one in DY19-Q3. Figure 6, above, demonstrates a total of six complaints received in DY 19-Q1 and one complaint in DY 19-Q2. DHCS will report CBAS MCP complaint data for DY 19-Q3 in the DY 19 Annual Report. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 7: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY18-Q3 (Jul - Sept 2021)	11	1	0	4	16
DY18-Q4 (Oct – Dec 2021)	6	0	0	5	11
DY 19-Q1 (Jan – Mar 2023)	12	0	2	2	16
DY 19-Q2 (Apr – June 2023)	4	1	0	2	7
MCP Data - Grievances 10/2023					

*Note: *MCP information is not reported for DY 19-Q3 due to a delay in the availability of the data and will be presented in the DY 19 Annual Report.*

Figure 8: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY18 – Q3 (Jul – Sept 2022)	5	0	0	0	5

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY18 – Q4 (Oct – Dec 2022)	4	0	0	0	4
DY19 – Q1 (Jan – Mar 2023)	0	0	0	0	0
DY19 – Q2 (Apr – Jun 2023)	4	1	0	0	5
MCP Data - Appeals 10/2023					

Note: MCP information is not reported for DY 19-Q3 due to a delay in the availability of the data and will be presented in the DY 19 Annual Report.

CBAS Grievances/Appeals (FFS/MCP) (STC 5.6.e.iii)

Grievance and appeals data are provided to DHCS by the MCPs. Under Figure 7 for DY 19-Q2, there were a total of 7 complaints received regarding CBAS services. The data provided for DY 19-Q2 for Figure 8 shows five appeals for any of CBAS services. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

For DY 19-Q3, there were no requests for a hearing related to CBAS. The California Department of Social Services (CDSS) continues to facilitate the state fair hearings/appeals processes, with Administrative Law Judges hearing all cases filed. CDSS reports the fair hearings/appeals data to DHCS.

Quality Control/Assurance Activity:

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

CDA established the CBAS Quality Advisory Committee (Committee), comprised of CBAS providers, MCPs, and representatives from DHCS, CAADS, and ALE, to review/evaluate progress on achieving the Quality Strategy's original goals and objectives and to identify new goals and objectives that will support and promote the delivery of quality CBAS.

This is a continuous quality improvement effort designed to support CBAS providers in meeting program standards, while continuing to develop and promote new approaches to improving service delivery.

During DY 18, the Committee recommended continued focus on the following objectives: (1) review identified long-term objectives that have not yet been completed; (2) identify completed objectives which require ongoing evaluation and monitoring; (3) identify new objectives that will promote and support the quality of CBAS services (for example, collecting more participant characteristic data to include on the CDA website and to develop a consumer guide; (4) identify obsolete licensing and Medi-Cal regulations that have been replaced with new laws; (5) train providers on end of life care best practices that support participants and families; (6) view quality objectives through the lens of equity, access and inclusion; and (7) collect more information from the CBAS IPC to better understand who is receiving CBAS services and the complexity of their needs, what IPC data would best identify this complexity, and how are CBAS centers addressing their needs (e.g., quality of care).

In general, the Committee has been discussing who the target audiences would be for the data collected, and for what purpose; what questions would CDA be trying to address with the data collected; and what data should be published on the CDA website. In addition, the Committee will be helpful in determining how to collect and report performance measures identified in the CalAIM 1115 waiver. CDA will convene the Committee in 2023, but as of the third quarter the Committee has not yet met.

Figure 9: CBAS Centers Licensed Capacity

CBAS Centers Licensed Capacity						
County	**DY 18-Q4 (Oct-Dec 2022)**	**DY 19-Q1 (Jan – Mar 2023)**	**DY 19-Q2 (Apr-June 2023)**	**DY 19-Q3 (Jul-Sep 2023)**	**Percent Change Between Last Two Quarters**	**Capacity Used *****
Alameda	370	370	370	370	0.0%	81%
Butte	60	60	60	60	0.0%	27%
Contra Costa	220	130	130	130	0.0%	41%
Fresno	1,297	1,297	1,297	1297	0.0%	63%
Humboldt	349	349	349	349	0.0%	12%
Imperial	355	355	355	355	0.0%	56%

CBAS Centers Licensed Capacity						
County	**DY 18-Q4 (Oct-Dec 2022)**	**DY 19-Q1 (Jan – Mar 2023)**	**DY 19-Q2 (Apr-June 2023)**	**DY 19-Q3 (Jul-Sep 2023)**	**Percent Change Between Last Two Quarters**	**Capacity Used *****
Kern	610	610	610	610	0.0%	32%
Los Angeles	26,003	26,083	26,520	26,520	0.0%	64%
Merced	124	124	124	124	0.0%	70%
Monterey	110	110	110	110	0.0%	56%
Orange	2,903	3,241	3,321	3,321	0.0%	59%
Riverside	1,025	1,025	1,025	1,025	0.0%	41%
Sacramento	520	520	520	520	0.0%	53%
San Bernardino	911	911	911	1,446	58.7%	32%
San Diego	1,903	1,903	2,186	2,359	7.9%	46%
San Francisco	926	926	926	926	0.0%	58%
San Joaquin	140	0	0	0	0.0%	0%
San Mateo	60	60	60	60	0.0%	57%
Santa Barbara	100	100	100	180	80.0%	33%
Santa Clara	820	820	820	820	0.0%	46%
Santa Cruz	90	90	90	90	0.0%	62%
Shasta	85	85	85	85	0.0%	42%
Stanislaus	360	510	510	510	0.0%	0%
Ventura	886	886	886	886	0.0%	60%
Yolo	224	224	224	224	0.0%	68%
Marin, Napa, Solano	295	295	220	220	0.0%	40%
SUM	**40,746**	**41,804**	**41,809**	**42,597**	**1.88%**	**58%**

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

As shown in Figure 9, in DY 19-Q3, the following counties had increases over five percent between the last two quarters due to the opening of new CBAS centers in: San Bernardino County, San Diego County and Santa Barbara County. In San Bernardino County, two new CBAS centers were certified, which increased licensing capacity by 535. In San Diego County and Santa Barbara County, two CBAS centers were approved for capacity increases by CDPH, which increased their capacity (San Diego County -173 capacity increase; Santa Barbara – 80 capacity increase). The overall total licensing capacity increased by almost two percent.

Unbundled Services (STC 5.6 e.i.)

CDA certifies and provides oversight of CBAS Centers. DHCS continues to review and monitor any possible impact on participants due to CBAS Center closures. For counties that do not have a CBAS Center, the MCPs will work with the nearest available CBAS Center to provide the necessary services. This may include, but not be limited to, the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Members can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA and their contracted MCPs of their planned closure date and to conduct discharge planning for each of the CBAS participants to which they provide services. CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. Some CBAS participants in the 26 counties served by CBAS can choose an alternate CBAS Center within their local area.

In February 2023, the only CBAS center in San Joaquin County closed. At the time of closure, the center reported serving 50 participants, with an average daily attendance of 35. The center reported that upon closure one individual was placed in a nursing facility, 11 individuals declined referral to other services, and information regarding the discharges was provided to the participants' MCPs. In April of 2023, the only CBAS center in Marin County closed. At the time of closure, the center served 30 participants, 26 of whom were Medi-Cal and six private pay. One person was placed in a nursing home and 21 discharged and information regarding their discharges was provided to their MCPs. Since no other CBAS centers are in either San Joaquin or Marin County, participants are eligible for unbundled services from their managed care plans as they choose and as needed.

In April 2023, one of the three CBAS centers in Contra Costa County closed. At the time of closure, the center served 54 total participants, 36 of whom were Medi-Cal and 18 private pay. One participant transferred to another center, 12 declined other services, one lost Medi-Cal eligibility, and the remaining 30 were discharged (information regarding their discharges was provided to their MCPs).

All three centers provided evidence to CDA that it completed required discharge planning and referrals.

No additional CBAS centers closed during DY 19-Q3.

Figure 10: CBAS Center History

CBAS Center History					
Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
Sep 2023	286	0	3	3	289
Aug 2023	284	0	2	2	286
Jul 2023	283	0	1	1	284
June 2023	283	0	0	0	283
May 2023	282	0	1	1	283
April 2023	281	1	2	1	282
March 2023	278	0	3	3	281
February 2023	280	2	0	-2	278
January 2023	280	0	0	0	280
December 2022	280	0	0	0	280
November 2022	280	0	0	0	280
October 2022	280	0	0	0	280
September 2022	279	0	1	1	280
August 2022	277	0	2	2	279
July 2022	277	0	0	0	277

DHCS and CDA continue to monitor the opening and closing of CBAS centers since April 2012 when CBAS became operational. According to Figure 10 above, for DY 19-Q1, two centers closed in February 2023, but three more opened in March 2023. For DY 19-Q2, one center closed in April, but another opened in the same month, and one more center opened in May. Six new centers opened in DY19-Q3 – one in July, two in August, and three in September 2023. No centers closed in DY 19-Q3.

Figure 10 shows there was no negative change of more than five percent in DY 19-Q3, therefore, no analysis is needed to address such variances.

Budget Neutrality and Financial Updates:

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

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

The DMC-ODS is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal eligible individuals with a SUD that resides in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS members). Since the DMC-ODS pilot program began in 2015, all California counties had the option to participate in the program to provide their resident Medi-Cal members with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan.

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

Contingency Management Updates:

On March 28, 2023, DHCS approved the first site to offer CM services as part of the Recovery Incentives Program. On April 3, 2023, CM services began in Los Angeles County.

Since the launch of CM services in April 2023, eight DMC-ODS counties have implemented CM services. These counties include Los Angeles, San Francisco, Kern, Riverside, Santa Barbara, Orange, San Diego, and Fresno. Collectively, these counties cover 59 percent of Medi-Cal members. Among these eight counties, there are 42 approved sites providing CM services to 565 members, as of September 30, 2023. Los Angeles County has 28 approved sites, San Francisco County has two approved sites, Kern County has one approved site, Riverside County has five approved sites, Santa Barbara has two approved sites, Orange has one approved site, San Diego has two approved sites, and Fresno County has one approved site. In total, 24 DMC-ODS counties have opted into the Recovery Incentives Program pilot, covering 88 percent of Medi-Cal members.

In addition to the 42 sites offering CM services, there are 39 sites, located in 12 additional counties, that have completed the required Implementation Training and are working to complete the Readiness Assessment prior to launching CM services. Additional sites will be approved on a rolling basis as they complete the Implementation Training and Readiness Assessment process.

As part of the Recovery Incentives Program, $125,364 in gift cards (motivational incentives) have been earned by eligible members for meeting the treatment goal of submitting a urine drug test negative for stimulants. DHCS' incentive manager (IM) portal allows members to redeem their gift card immediately when earned, or they can choose to 'bank' the incentive amount to save up for a larger gift card to be disbursed at a later date. Of the total incentives earned, 65 percent were immediately redeemed during the member visit, and 35 percent were banked to be redeemed later. When a member chooses to redeem a gift card, they can choose from a list of pre-approved vendors. The most common gift card redemptions include Walmart (68 percent), Nike (11 percent), and Burger King (4 percent).

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

Throughout Q3 of 2023, the DHCS Recovery Incentives Program team continued weekly planning meetings with the CM training and technical assistance provider, UCLA, and the Incentive Manager (IM) vendor, Q2i. The team published the revised BHIN 23-040 in August 2023. Oversight and monitoring activities included continued coaching calls which will be ongoing to provide support to CM providers, and fidelity reviews started in July 2023 with sites and counties participating to discuss adherence to the CM protocol. In Q4, DHCS will release a quarterly progress report template to counties to use for tracking oversight activities. On July 28, CMS approved the DMC-ODS evaluation design including a more in-depth data collection and analysis specific to the Recovery Incentives Program, including efforts to measure the effects of this program above and beyond that of DMC-ODS. Specific CM evaluation activities in Q3 included creating and distributing a provider survey and creating a client survey which will be distributed in Q4 2023. Additionally, the Recovery Incentives Program team continued to respond to questions from participating counties and provider sites, supported the refinement of training materials for counties and providers, and coordinated with the California Department of Public Health for expedited processing of Clinical Laboratory Improvement Amendments waivers.

Recovery Incentives: California's Contingency Management Program – Training and Technical Assistance Activities, DY 19-Q3

DY 19-Q3 (July-September 2023)

Statewide Contingency Management (CM) pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities included working closely with staff from Q2i to make slight refinements to the IM Portal slides that are presented in the Part II Implementation Training and developing a process for and conducting Fidelity Monitoring #1 interviews with launched sites. The Recovery Incentives Program Manual and Implementation Training slides were updated. Additional activities included determination of the CLIA Certificate and State Lab Registration status of proposed sites. The Recovery Incentives website was updated as materials were refined. A total of 79 individuals completed the CM Overview Training on-demand course between July 1, 2023, and September 30, 2023. Thirteen Implementation Trainings were delivered (with 250 total participants), 30 Readiness Assessment interviews were conducted. Two 1-hour Zoom Office hours and 26 outreach calls for Readiness Assessment preparedness were conducted. The 2-step Readiness Assessment process was initiated by 25 sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process). The Fidelity Monitoring #1 self-study template was approved by DHCS, and 13 fidelity monitoring interviews were completed during Q3.

Peer Support Services Updates:

Medi-Cal Peer Support Specialist services are an optional behavioral health Medi-Cal benefit that can be implemented within DMC-ODS, DMC, and/or SMHS delivery systems. As of September 30, 2023, 4,562 individuals applied for Medi-Cal Peer Support Specialist Certification through the California Mental Health Services Authority (CalMHSA). CalMHSA is currently the sole DHCS-recognized certification program for Medi-Cal Peer Support Specialists (see Figure 11 for a breakdown of applicants by application/certification status). As of September 30, 2023, 50 out of 58 California counties provide Medi-Cal Peer Support Services, including 32 DMC-ODS, 49 MHP, and 10 DMC programs. DHCS provides the opportunity for counties to opt-in to provide Medi-Cal Peer Support Services on an annual basis.

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

Applications/ Certifications by Status[3]	Number
Certified	1,956
Approved to take certification exam	1,037
Certification exam not passed	141
Training in progress	1,228
Application in revision	200
Total	**4,562**

Throughout Q3 of 2023, DHCS conducted stakeholder engagement on program implementation, addressed stakeholder questions on service delivery and billing, and coordinated regularly with CalMHSA to ensure responsiveness to stakeholders and alignment with policy. In DY 19-Q3, DHCS also published new frequently asked questions providing clarification on certification standards, lapsed certification, opting-in, billing and claiming requirements, and Behavioral Health professional supervision requirements. DHCS also integrated stakeholder feedback into an all-inclusive Medi-Cal Peer Support Services BHIN, which is expected to be released in early November 2023.

DHCS continued to gather feedback from internal and external stakeholders to inform policy development around requiring Medi-Cal Peer Support Specialists and other unlicensed providers to obtain a National Provider Identifier (NPI) number. NPI guidance is expected to be developed by early 2024.

Performance Metrics

Prior quarters have been updated based on new claims data. For DY 19-Q2 and DY 19-Q3, only partial data is available since counties have up to six months to submit claims after the month of service.

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

Figure 12: Demonstration Quarterly Report Members with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY 18-Q4	9,069	3,535	12,604
DY 19-Q1	8,956	3,398	12,354
DY 19-Q2	6,881	2,676	9,557
DY 19-Q3	597	179	776

**Affordable Care Act*

Figure 13: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees to date
ACA	15,538	15,760	15,964	DY18-Q4	16,174
ACA	16,130	16,183	16,339	DY19-Q1	16,633
ACA	16,370	16,414	16,416	DY19-Q2	16,729
ACA	16,355	16,261	16,019	DY19-Q3	16,605
Non-ACA	6,790	6,725	6,665	DY18-Q4	7,072
Non-ACA	6,615	6,618	6,517	DY19-Q1	6,937
Non-ACA	6,506	6,448	6,425	DY19-Q2	6,775
Non-ACA	6,390	6,385	6,521	DY19-Q3	6,880

Figure 14: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	381,115	$ 62,604,653.85	$ 55,338,280.99	$ 6,337,233.22	$ 929,139.64	DY18-Q4
Non-ACA	132,519	$ 21,540,982.08	$ 12,104,145.45	$ 7,808,621.06	$ 1,628,215.57	DY18-Q4
ACA	323,363	$ 55,289,872.24	$ 48,911,265.53	$ 5,562,352.89	$ 816,253.82	DY19-Q1
Non-ACA	122,652	$ 19,534,627.06	$ 10,985,853.29	$ 7,148,572.83	$ 1,400,200.94	DY19-Q1
ACA	229,385	$ 37,356,247.67	$ 33,138,518.10	$ 3,645,704.48	$ 572,025.09	DY19-Q2
Non-ACA	94,993	$ 13,672,247.36	$ 7,532,378.50	$ 5,052,820.22	$ 1,087,048.64	DY19-Q2
ACA	10,654	$ 2,640,285.75	$ 2,303,290.69	$ 295,611.03	$ 41,384.03	DY19-Q3
Non-ACA	2,426	$ 644,522.57	$ 340,156.58	$ 251,491.02	$ 52,874.97	DY19-Q3

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

Performance Metrics Enclosures/Attachments:

The attachment, CalAIM 1115 Waiver Progress Report DY19-Q3_ODS-RES V2.xlsx, contains the Enrollment data, Member Month data, and Aggregate Expenditures data referenced in this section of the report. Additionally, the attachment contains the ACA and Non-ACA Expenditures reported for DY 19-Q3 as of October 4, 2023.

Outreach Activities:

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

- DHCS held webinars through the monthly All County Behavioral Health Call to provide technical assistance and program updates regarding contractual and regulatory compliance. The dates of these webinars and topics presented are as follows:

    - July 19, 2023
        - Screening and Transition of Care Tool
        - Provider Integration Project
        - Child Adolescent Need and Strengths (CANS) Assessment Data
    - August 2023 – No Meeting
    - September 20, 2023
        - Program Updates
            - MCPAR FY 2022/23 Submission
            - 1915(b) Waiver – Quarterly Appeals & Grievance Reporting for SMHS and DMC-ODS
            - MHP and DMC-ODS Beneficiary Handbook 2024
            - Network Adequacy BHIN Release
            - Network Adequacy Webinar
            - Network Adequacy FAQ
        - Medi-Cal Mobile Crisis Services Benefits

- Medi-Cal Peer Support Specialist H00050 Short-Doyle Update
- Performance Monitoring – Key Informant Interviews
- Documentation Redesign FAQ Update
- Screen and Transition Tools: Translation Update

Operational Updates:

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including: 1) updates to the criteria to access SMHS; 2) implementation of standardized statewide screening and transition tools; 3) behavioral health payment reform; and 4) streamlining and standardizing clinical documentation requirements through documentation reform. DMC-ODS counties are utilizing policy guidance that was released from December 2021 through June 2023 (related to these items) to update and implement policies and procedures.

Following is a list of Behavioral Health Information Notices (BHINs) updated during this quarter:

- 23-030 – SMHS, DMC and Drug Medi-Cal Organized Delivery System Postpartum Claiming
- 23-032 – Interoperability and Patient Access Final Rule Compliance Monitoring Process
- 23-035 – Supersedes BHIN 23-005.Updated Guidance for the CalAIM Behavioral Health Quality Improvement Program (BHQIP).
- 23-036 – CalAIM Behavioral Health Payment Reform Allocation
- 23-041 – Supersedes BHIN 22-033. 2023 Network Certification Requirements for County MHPs, and DMC-ODS Plans.
- 23-042 – County Drug Medi-Cal Organized Delivery System 274 Provider Network Data Reporting
- 23-044 – Behavioral Health Audit for SMHS, DMC-ODS Services, and DMC Services for Fiscal Year (FY) 2023-2024
- 23-045 - California Ethical Treatment for Persons with SUD Act: Implementation of Senate Bill 349 (SB 349)
- 23-047 – Supersedes 22-043. Annual County Monitoring Activities (ACMA) for MHPs, DMC-ODS, and DMC for FY 2022/23.
- 23-048 – Supersedes 22-060. MHP and DMC-ODS Beneficiary Handbook Requirements and Templates.
- 23-049 – Administration and Utilization Review/Quality Assurance (UR/QA) Reimbursement Under Payment Reform (Revised 9/22/2023)

Consumer Issues and Interventions:

DHCS continues to respond to issues, complaints, or grievances related to DMC-ODS counties delivering DMC-ODS services from members. Issues that generate complaints or grievances related to DMC-ODS are minimal. DHCS did not receive any grievances for DY 19-Q3.

Quality Control/Assurance Activity:

DHCS scheduled and conducted the annual DMC-ODS compliance monitoring reviews during DY 19-Q3. The compliance monitoring reviews listed in Figure 15 begins DHCS' FY 2023-24 annual reviews.

Figure 15 demonstrates when county DMC-ODS monitoring reviews were completed during DY 19-Q3.

Figure 15: DY 19-Q3 Monitoring Reviews

County	Dates
Merced	August 2023
Contra Costa	September 2023
San Mateo	September 2023
Placer	September 2023

DHCS continues to provide technical assistance and support to DMC-ODS counties to resolve outstanding CAPs. There are no major activities to provide an update on regarding quality control/assurance during DY 19-Q3.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

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

- On July 28, 2023, the Centers for Medicare and Medicaid Services notified DHCS that the state's DMC-ODS Evaluation Design was approved. Information about

Evaluation Design can be found on the CalAIM 1115 Demonstration Evaluations website and the approved Evaluation Design is available in this document.

- UCLA is in the process of seeking a Certificate of Confidentiality, which will provide an additional layer of protection for any data obtained through the evaluation. The application requires signature from the UCLA or State Institutional Review Board, which UCLA is pending the review/outcome of this request.
- UCLA continued to develop data collection strategies addressing the hypothesis and research questions posed in both the Recovery Incentives Program and DMC-ODS evaluation designs. In July 2023, DHCS approved UCLA's first report deliverable entitled "*Short Report: The Recovery Incentives Program's Contingency Management Benefit: Early Implementation Lessons Learned, February – June 2023*". This report contained observed and perceived challenges and areas for potential improvement, voiced by providers and staff from Recovery Incentive Program implementation trainings, readiness assessment interviews, and monthly coaching call. Six major themes emerged in these discussions related to: (1) eligibility requirements; (2) UDT testing procedures; (3) use of UDT results outside of the Recovery Incentives Program; (4) concerns about incentives; (5) incentive manager software; and (6) logistical challenges.
- UCLA presented two areas of work from the DMC-ODS evaluation efforts at two sessions in the DHCS SUD Integrated Care Conference (Aug 15-17, 2023). (1) The CA County Experience: Implementing Contingency Management in Outpatient Treatment Settings, and (2) Treatment Perception Surveys: Assessing the Client Experience to Enhance Care.
- UCLA finalized the initial/baseline Recovery Incentives Program Provider Survey and began dissemination to programs that launched in March and April 2023. This initial survey will continue to be sent to all programs at specific timepoints set following their launch. In addition, UCLA submitted a draft of the client survey for timepoint one and is currently in review with DHCS.
- UCLA continued to receive, clean, merge, and analyze administrative datasets (e.g.: California Outcomes Measurement System Treatment (Cal-OMS-Tx), Medi-Cal Claims and Managed Care FFS to prepare our analysis per the approved Evaluation Design.
- In July 2023, UCLA submitted the Implementation Report of the ASAM Criteria Assessment Interview Guide. This report summarizes feedback from Behavioral Health County administrators and providers on how the Interview Guide is impacting the process of incorporating the ASAM Criteria in the treatment process. Additionally, and in preparation for the upcoming revision to the ASAM Criteria (4th Edition), UCLA is working to establish an agreement with ASAM defining the terms

of our collaboration to update the ASAM Assessment Interview Guide to map accordingly to the 4th Edition.

- UCLA continued to prepare for the 2023 Treatment Perception Survey (TPS) scheduled for October 16-20, 2023 (see information notice BHIN 23-024).. In September 2023, UCLA received approval from DHCS to add a new item requesting client consent allowing UCLA to contact them directly for a follow up survey or interview. A follow up opportunity allows for more in-depth understanding of patient experiences and opens a new opportunity to obtain additional patient feedback to bring into the evaluation findings. At this time, this option will only be available through the secure Health Insurance Portability and Accountability Act (HIPAA)-compliant online survey platform (in English and Spanish) to assure confidentiality of patient identifying information. A larger launch of this effort will be evaluated for future collection dates. At this time, all 2023 TPS survey forms, links, and instructions have been disseminated and communicated to TPS County Coordinators. UCLA continues to provide ongoing technical assistance to counties, as needed, and utilizes the TPS website (which is updated frequently) as a hub for all participating counties to access information.
- UCLA continued the data cleaning process from the 2023 Consumer Perception Survey (CPS) data collection from May 15-19, 2023. All collected data (paper forms) and electronic data) were received by the final submission date of July 14, 2023. Data cleaning and analysis will continue into the next quarter with the expectation to submit Uniform Reporting System tables by November 2023 and a statewide report by end of year. UCLA continues to provide ongoing technical assistance to counties, as needed, and utilizes the CPS website (which is updated frequently) as a hub for all participating counties to access information.

GLOBAL PAYMENT PROGRAM (GPP)

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

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

Performance Metrics:

Nothing to report.

Outreach Activities:

Nothing to report.

Operational Updates:

The Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA-increased FMAP was effective January 1, 2020, and extends through the last day of the calendar quarter of the PHE. During DY 19-Q1, the Secretary of Health and Human Services extended the COVID-19 PHE, effective January 11, 2023, and again on February 9, 2023, through May 11, 2023. The national PHE was terminated on May 11, 2023, and the amended FFCRA will implement a step-down of the increased FMAP until December 31, 2023.

The step-down of the increased FMAP was signed on December 29, 2022, under the House of Representatives 2617 Consolidated Appropriations Act (2023). The FMAP remains increased by 6.2 percentage points until March 31, 2023, then begins the step-down to 5 percentage points between April 1, and June 30, 2023, 2.5 percentage points between July 1, and September 30, 2023, and 1.5 percentage points between October 1, and December 31, 2023.

CMS published the preliminary Federal share (FS) DSH allotments for Federal fiscal year (FFY) 2022 and FFY 2023 on April 14, 2023.

On September 7, 2023, CMS authorized a 10 percent reduction of GPP system thresholds for PY 8, calendar year 2022. The threshold reduction provides relief to PHCS on continued impact of the COVID-19 public health emergency on hospital operations and programs.

CMS released the draft final ARPA adjusted FS DSH allotment for FFY 2022, and the revised preliminary ARPA adjusted DSH allotment for FFY 2023 on September 29, 2023. GPP received the updated DSH allotments for FFYs 2022-2024, and then updated the associated GPP budgets for PYs 8-9.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (H.R. 133) was enacted, which postponed implementation of the DSH reduction until FFY 2024. On September 30, 2023, Congress passed H.R. 5860 which further delayed the implementation of DSH Reduction until November 18, 2023.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Figure 16: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 9 Quarter 2	$361,271,298.16	$326,864,507.84	DY 19	$688,135,806.00
Total	**$361,271,298.16**	**$326,864,507.84**		**$688,135,806.00**

DY 19-Q3 reporting activity includes payments made in August 2023, for GPP PY 9-Q2. PHCS received $361,271,298.16 in federally funded payments and $326,864,507.84 in intergovernmental transfer (IGT)-funded payments for the PY 9-Q2 payment round.

Evaluation Activities and Interim Findings:

Nothing to report.

PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH) SUPPORTS

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

PATH is comprised of two aligned programs:

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

PATH includes the following four initiatives:

1. WPC Services and Transition to Managed Care Mitigation Initiative – PATH funding will directly support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM on or before January 1, 2024.
2. Technical Assistance (TA) Marketplace Initiative – PATH funding is available for the provision of TA for qualified applicants that intend to provide ECM and/or Community Supports.
3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH TPA to establish collaborative planning and implementation efforts that support the CalAIM launch.
4. Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative – PATH funding will enable transition, expansion, and development of ECM and Community Supports capacity and infrastructure.

DHCS has contracted with Public Consulting Group, LLC (PCG) to serve as the Third-Party Administrator (TPA) to implement and administer the multiple initiatives under PATH. The TPA will serve as a program administrator that will market, facilitate, develop

support tools, and ensure successful implementation of the following PATH initiatives:

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

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

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

Performance Metrics:

Enrollment and Utilization data was collected for the WPC Services and Transition to Managed Care Mitigation Initiative and was reported in DY 19-Q2.

Operational Updates:

WPC Services and Transition to Managed Care Mitigation Initiative

During DY 19-Q3, approved grantees of the PATH WPC Services and Transition to Managed Care Mitigation Initiative submitted their mid-year invoices and PATH Utilization Reports to DHCS for expenditures from January 1, 2023, to June 30, 2023. DHCS reviewed and validated utilization reports as part of the payment process. Data validation is required to ensure accurate reporting for services provided. Due to data discrepancies, DHCS worked with LEs to ensure all reports are accurate before payment

is made. The third payment for this initiative will be processed by the end of DY 19-Q3. Many services were adopted in CalAIM earlier than originally anticipated in DY 18.

TA Marketplace

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

The TA Marketplace website was made live in January 2023. Recipient registration and project applications windows will remain open the duration of the TA Marketplace and are reviewed on a rolling basis. As of September 30, 2023, 168 TA Recipient registration requests have been received and 142 of those have been approved. Additionally, as of September 30, 2023, 65 projects have been approved or fully executed. Entities are able to shop and access TA resources from curated and approved TA Vendors. Currently there are 79 approved vendors from two rounds of vendor procurement. A third round will open in DY 19-Q4. As of June 30, 2023, there are 47 approved TA Vendors. In Round 2, which was completed in DY 19-Q2, and Round 3, new organizations can apply to become TA vendors and currently contracted TA vendors can apply for an expansion to provide additional TA, as defined below:

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

The seven (7) TA domains are listed below and will be expanded and revised through the lifespan of the initiatives as needed to meet the needs of ECM and Community Supports providers. All domains have cross-cutting competencies focused on rural communities. These domains include:

- Domain 1: Building Data Capacity: Data Collection, Management, Sharing, and Use

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

Each domain listed above must also incorporate a focus on rural communities to ensure providers in those vulnerable areas receive comprehensive technical support.

The Round Three Vendor Application period is expected to open from October 1, 2023, to October 31, 2023.

Collaborative Planning and Implementation (CPI) Initiative

For the Collaborative Planning and Implementation Initiative, ten facilitators conducted 25 collaborative groups throughout the State. These collaborative groups were established based on regional location, size, and with consideration to preserving existing collaboratives. The TPA and facilitators continue to meet monthly to review updates, provide outreach, discuss deliverables, address gaps in services, share ideas, challenges, and successes. Facilitators hold roundtables with their collaborative groups monthly. Between August 2022 through July 2023, the TPA has registered a total of 825 participant organizations. Participant registrations are accepted on a continual basis and participants are connected with selected facilitators.

In DY 19-Q3, DHCS and the TPA drafted and finalized facilitator budgets and agreements for Program Year 2 contracts, which will be effective for 2024. A DY 19-Q3 lookback analysis indicated the TPA collected and reviewed 351 Q2 deliverables and conducted 50 one-one-one coaching sessions with facilitators with $2,610,00 in approved facilitator funds. The drop-in coaching sessions from previous quarters is due to changing time for one-on-one facilitator meetings from two, 30-minute meetings per month to one, 60-minute meeting per month in June 2023. During DY 19-Q1, DHCS and the TPA identified a gap regarding engagement with Tribal entities. In ongoing discussions in DY 19-Q2 and Q3, there has been joint collaboration for outreach to better engage this identified group, and DHCS is meeting with communications groups internally to leverage resources and strategies for improved outreach to Tribal entities. To meet the needs identified in Q1, DHCS and the TPA worked in Q3 to rollout a new Tribal-focused collaborative in early 2024.

For Q4DHCS and PCG will host a CPI Best Practices Webinar on October 27, 2023, for all

interested stakeholders to discuss implementation challenges and solutions and best practices learned in year one of CPI. DHCS and PCG also plan to hold an in-person Facilitator Support Meeting on November 8, 2023, to discuss activities conducted over the past year and lessons learned.

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

CITED Round Two applications opened on February 28, 2023, and closed on May 31, 2023. A total of 301 applications were received. DHCS completed review of Round Two applications at the end of September 2023, and is preparing to announce Round Two awardees in DY 19-Q4. During DY 19-Q1 Round Two guidance was expanded to allow for additional permissible uses of funding. DHCS is continuing discussions on how to support and provide additional resources. Applicants that receive CITED funding must be actively contracted with the Medi-Cal CP to provide ECM/Community Supports or have a signed attestation from the MCP or other entity that they intend to contract with to provide ECM/Community Supports in a timely manner. MCPs are not eligible to receive CITED funding.

The availability of WPC Transition initiative funding and increased demand for CITED initiative grants presented an opportunity for DHCS to leverage WPC Transition funds to support funding for CITED and maximize funding across programs. DHCS is repurposing unclaimed funds into a specific CITED-IGT Round to be available for eligible entities. During DY 19-Q3, DHCS leveraged the availability of additional funding through a CITED-IGT round of funding that provides an opportunity to further support cities, counties, public hospitals, and other local government agencies to further develop and expand infrastructure as they implement ECM and Community Supports. To be eligible for CITED-IGT, applicants must be able to contribute the non-federal share through IGT. Through CITED-IGT there are $85 million in total computable unencumbered funds ($42.5 million from federal funding and $42.5 million non-federal share contributed by IGT eligible entities).

Justice-Involved Capacity Building Program (JI)

The application period for PATH JI Round Two is closed as of March 31, 2023, with $151 million allocated for the round. A total of 42 applications were received with an initial total funding request of $62,585,580.62. The PATH JI Round Two review process was completed in September 2023. As of October 12, 2023, $61.4 M has been approved and award notifications are targeted for release in October. On October 5, 2023, a PATH Round Two Interim Progress Report guidance was released. The application period for PATH JI Round Three is closed as of August 31, 2023, with $410 million allocated for the

round. DHCS and PCG completed review of all applications and are pending final items for approval. DHCS is now working with stakeholders to develop implementation plans for the Round Three funding. As of October 10, 2023, DHCS and PCG have reviewed a total of 76 applications for Round Three and the total funds approved is $217,662,543.27. DHCS and PCG have continued to hold office hours and provided targeted responses to questions via the mailbox or during scheduled office hours. In addition, during DY 19-Q3 the Round Three FAQ was shared.

DHCS released an updated Policy and Operational Guide for planning and implementing the CalAIM JI Reentry Initiative for stakeholder comment on September 30, 2023. DHCS will be requesting additional comments and feedback on the new draft guidance. The draft guidance updates are intended to provide clarification on stakeholder feedback and comments.

TPA Support Activity:

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

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

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

Stakeholder Engagement:

JI Initiative

- DHCS and the California Department of Corrections and Rehabilitation (CDCR) meet on a weekly basis to discuss the pre-release application process, policy and technical issues, concerns, and barriers to the implementation of mandatory pre-release processes.
- The JI Pre-Release Application Sub-Workgroup meets bi-weekly as of January

but previously met monthly beginning in September 2022. The workgroup participants include county agencies, advocates, and stakeholders. DHCS uses this forum to provide additional guidance and technical assistance to implementation partners to support the ongoing efforts regarding the broader pre-release Medi-Cal enrollment and suspension processes mandate. The sub-workgroup participants include county agencies, county correctional agencies, advocates, and stakeholders.

- The Inmate Workgroup meets monthly and consists of county sheriffs from all 58 counties, representatives from the California Statewide Automated Welfare System, California Work Opportunity, and Responsibility to Kids Information Network (CalWIN[4]), and the Chief Probation Officers of California.
- The Data Sharing Workgroup meets with county social services departments (SSDs) throughout the state and all Medi-Cal providers to gain knowledge on issues relating to data-sharing among agencies. The feedback from these agencies is assisting in the drafting of a new data-sharing agreement in compliance and alignment with the HIPAA rules and regulations.
- On April 13, 2023, DHCS released "Medi-Cal Eligibility Division Information Letter No.: I 23-24, to notify counties that they must comply with establishing the mandatory Pre-Release Medi-Cal Application Process by June 30, 2023, and provide specific data necessary to evaluate overall compliance with the mandated processes. Counties which do not attest to successful implementation of all operational criteria prior to June 30, 2023, will be subject to a Plan of Action and Milestones which details necessary next steps to achieve compliance, including potential participation in PATH activities to address operational deficiencies.
- In addition, DHCS in conjunction with the County Welfare Director's Association of California has conducted four surveys with counties regarding concerns and barriers in implementing pre-release services. Responses from the surveys guide the development of best practices for suspension, pre-release, eligible PATH funding uses, and data-sharing processes.

CITED Initiative

- For CITED Round Two office hours were held on July 7 and July 14, 2023, to assist with awardees who completed their Q2 progress reports.
- DHCS and the TPA are actively working on identifying opportunities for engagement of historically marginalized populations. DHCS and the TPA

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

organized an outreach and engagement plan geared toward optimizing engagement efforts to tribal entities.
- On September 29, DHCS held a webinar to discuss the PATH CITED funding opportunity offered through the CITED IGT round with IGT eligible entities during which DHCS included clarification that this funding opportunity is for IGT eligible entities that meet general CITED Initiative guidelines.

TA Marketplace

- On September 19, 2023, there was an informational onboarding webinar for new TA Vendors during which frequently asked questions were covered, including progress and overall TA Marketplace engagement.
- On September 29, 2023, DHCS hosted a quarterly TA Recipient webinar. Recipient applications were approved on a rolling basis, with the informational webinar scheduled for September 29, 2023; organizations interested in qualifying as a TA Recipient were encouraged to apply by September 19, 2023, to receive an invitation to the webinar. During the webinar, the TA Marketplace Access Policy change was covered to share that all TA recipients may access both off-the-shelf and hands-on TA projects in all seven of the available domains.

CPI Initiative

- A monthly newsletter is sent out to CPI Facilitators with updates on ECM, Community Supports, and MCP guidance and reporting policies, including various PATH Initiative updates.
- DHCS and the TPA host monthly facilitator support meetings to discuss implementation challenges along with potential solutions, and facilitate communication and collaboration between DHCS, the TPA and the facilitators. In Q3, these meetings were held on July 11, August 7, and September 6, 2023.
- The TPA conducted a CPI Facilitator Experience Survey and a CPI Participant Experience Survey in June 2023, and presented the results to DHCS in August 2023, to help DHCS identify issues and successes in CPI.
- In July 2023, the TPA prepared a high-level summary gap and solution report to DHCS based on feedback from the facilitators and participants. The report described issues that CPI participants have identified as high priority in each county/collaborative region and CPI facilitators continue to implement solutions and identify gaps and best practices based on the priorities identified by CPI participants.

Consumer Issues and Interventions:

DHCS and the TPA received stakeholder feedback on the TA Marketplace initiative overall useability. One highlighted challenge was the use of multi-factor authentication (MFA). The recommendation to remove MFA was not approved as this is a requirement of California's State Information Security Office. The TPA developed additional technical assistance resources, including instructional videos to assist applicants and recipients with MFA access.

Some recipients have expressed concerns with the process to request TA Projects, as there are multiple approval steps. The TPA is continuing to develop additional resources to assist recipients with the process and is working to streamline approval activities. One of these additions is the enhancement of the TA Marketplace website. These enhancements went live on September 29, 2023, and include the consolidation of the initiative and Shop TA Marketplace pages, the depreciation of the steps 1- and 2-page flow, and the anonymous browsing versus the recipient application to shop features.

Quality Control/Assurance Activity:

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

Budget Neutrality and Financial Updates:

For the WPC Mitigation Initiative, services are claimed through invoicing biannually. Out of the ten Lead Entities, seven submitted invoices for PATH WPC Services and Transition and Mitigation for DHCS expenditures for the period July 1, 2022 to December 31, 2022. These payments were paid during DY 19-Q2. The next payment will be paid and reported during DY 19–Q1.

The CPI Initiative awarded ten facilitators to oversee 25 collaborative planning groups for a total of $14,750,000 for meeting milestones in 2023. Some facilitators will be overseeing multiple groups across different counties/regions. During this quarter, payments totaling $2,610,000.00 were made to facilitator groups.

The CITED Initiative awarded $207,433,952.46 to Round One approved applicants. With the split for Round One, the total for Round 1A is $118,896,581.50 and for Round 1B is $88,537,370.96. However, funds are only disbursed for completed milestones. Awarded applicants are required to submit quarterly progress reports detailing movement toward goals, purchases made, challenges encountered, and milestones accomplished. During DY 19-Q3 DHCS has been reviewing CITED Progress Reports for Round 1A and 1B. As of September 30, 2023, $27,443,631.11 has been paid out to Round One entities. DHCS is reviewing applications for CITED Round Two at this time and awards are expected to be announced in DY 19-Q4.

PATH JI Capacity Building efforts have awarded $4,550,952.95 across 39 counties, including CDCR, to support initial planning efforts in Round One of the initiative. In Q2 of DY 19, $26,432,362.01 in additional funds have been approved for distribution in Round Two and $18,744,437.73 in Round Three for infrastructure development and salary support for positions necessary to support implementation of the Pre-Release Application Mandate. DHCS anticipates that PATH JI Round Two will complete the review process by the end of DY 19-Q3. DHCS is also still reviewing applications for JI Round Three and awards are expected to be announced in DY 19-Q4.

Figure 17: PATH Initiative Amounts

PATH Initiative Amounts				
PATH Initiative	**Approved Amount**	**Federal Financial Participation**	**State**	**Intergovernmental Transfer**
DY 18-Q1				
n/a	$0	$0	$0	$0
DY 18-Q2				
n/a	$0	$0	$0	$0
DY 18-Q3				
JI	$775,000	$387,500	$387,500	$0
DY 18-Q4				
JI	$3,775,952.95	$1,887,976.50	$1,887,976.48	$0

PATH Initiative Amounts				
WPC Mitigation	$16,314,792.73	$8,157,321.37	$0	$8,157,321.37
Collaborative Planning	$1,450,000	$725,000	$725,000	$0
CITED	$0	$0	$0	$0
DY 19-Q1				
JI	$0	$0	$0	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$207,433,952.46	$103,716,976.23	$103,716,976.23	$0
DY 19-Q2				
JI	$2,115,577.90	$1,057,788.95	$1,057,788.95	$0
WPC Mitigation	$19,778,113.42	$9,889,056.71	$0	$9,889,056.71
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$5,220,000.00	$2,610,000.00	$2,610,000.00	$0
CITED	$0	$0	$0	$0
DY 19-Q3				
JI	$16,209,737.68	$8,104,868.84	$8,104,868.84	$0
WPC Mitigation	$0	$0	$0	$0
TA Marketplace	$0	$0	$0	$0

PATH Initiative Amounts				
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$1,604,311.50	$802,155.75	$802,155.75	$0

Figure 18: Total Approved Amounts by PATH Initiative, DY 19-Q3

PATH Initiative	Total Payment
JI	$16,209,737.68
WPC Mitigation	$0.00
TA Marketplace	$0.00
Collaborative Planning	$2,610,000.00
CITED	$1,604,311.50
TPA	
Public Consulting Group LLC	$ 1,401,513.36
TOTAL	$21,825,562.54

Evaluation Activities and Interim Findings:

DHCS released the 1115 Demonstration Independent Evaluation Request for Information (RFI) to provide information and solicit input from parties interested in conducting the required evaluation of several CalAIM components, including the PATH Initiative, the GPP, Medi-Cal matching plan policy for dually eligible members(duals), and the Reentry Initiative for justice-involved individuals. Several organizations provided substantive responses to this RFI. DHCS decided to move forward with UCLA-RAND as the vendor for this RFI evaluation work. based on its capacity to analyze DHCS data and create the reports required, as well an extensive experience working on other projects with DHCS. DHCS is negotiating a contract with this vendor for these CalAIM 1115 Evaluation activities. For the CalAIM 1115 Evaluation, the independent evaluator will revise the Draft Evaluation Design for PATH, GPP, and the duals matching plan policy based on CMS' comments, in addition to adding a plan for evaluation of the Reentry Demonstration Initiative to the Evaluation Design. The due date for DHCS to submit this evaluation design to CMS has been formally extended to January 25, 2024.

COMMUNITY SUPPORTS: RECUPERATIVE CARE AND SHORT-TERM POST HOSPITALIZATION

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

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

Pursuant to 42 Code of Federal Regulations (CFR) 438.3, MCPs cannot provide Community Supports without first applying to the state and obtaining state approval to offer the Community Support and demonstrating the requirements will be met. MCPs may voluntarily agree to provide any service to a member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining the MCP rates. Once approved by DHCS, the Community Support will be added to the MCP's contract and posted on the DHCS ECM & Community Supports website as a state-approved Community Support.

The full list of Community Supports includes:

1. **Housing Transition Navigation Services** - Assistance and support for individuals in transitioning from homelessness to stable housing.
2. **Housing Deposits** - Financial assistance for housing deposits to help individuals secure stable housing.
3. **Housing Tenancy & Sustaining Services** - Services aimed at helping individuals maintain their housing stability, such as ongoing support for rent and tenancy-related needs.
4. **Short-Term Post-Hospitalization Housing** - Provision of temporary housing for individuals who require it after a hospitalization.
5. **Recuperative Care (Medical Respite)** - Care services for individuals who need a safe and stable place to recover after a medical procedure or illness.
6. **Respite Services (for caregivers)** - Temporary relief and support for caregivers of individuals with disabilities or special needs.
7. **Day Habilitation Programs** - Programs that provide structured activities and support for individuals with disabilities during the day.
8. **Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly** - Support for transitioning individuals

from nursing facilities to assisted living facilities like Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF).

9. **Community Transition Services/Nursing Facility Transition to a Home** - Assistance for individuals transitioning from nursing facilities to community-based living arrangements.
10. **Personal Care and Homemaker Services** - Assistance with personal care and homemaking tasks for individuals who need support to remain independent in their homes.
11. **Environmental Accessibility Adaptations** - Modifications to homes to make them accessible and safe for individuals with disabilities.
12. **Medically Tailored Meals** - Provision of specialized meals or food for individuals with specific medical conditions.
13. **Sobering Centers** - Facilities that provide a safe environment for individuals under the influence of alcohol or substances to sober up and receive support.
14. **Asthma Remediation** - Services and support aimed at addressing environmental factors that contribute to asthma.

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

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

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

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

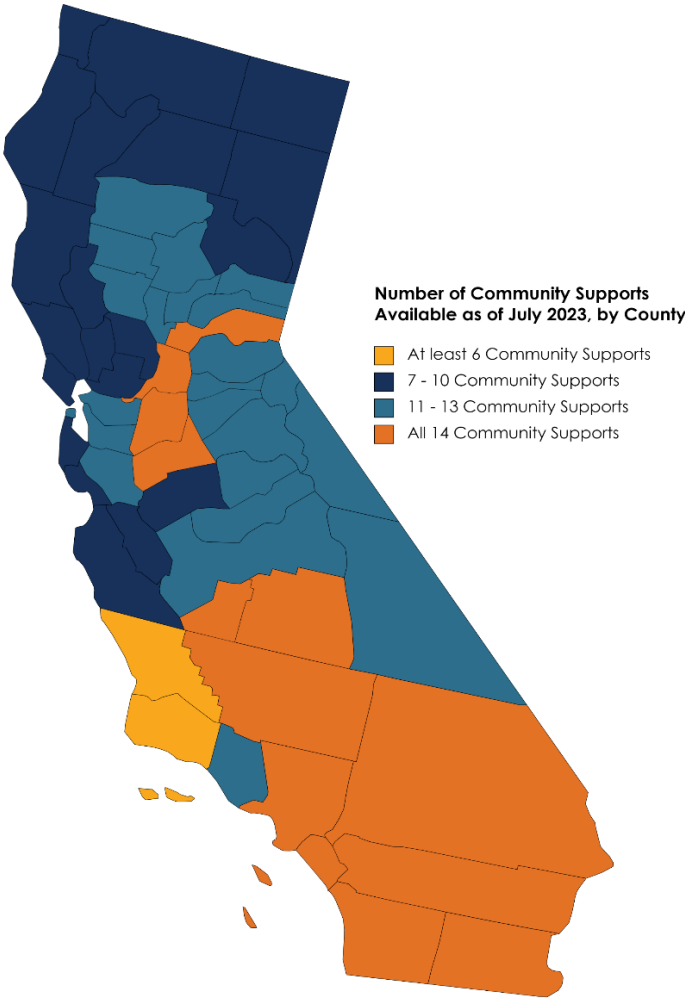
Demonstration monitoring covers reporting of performance metrics data related to the state's Recuperative Care and Short-Term Post-Hospitalization housing services, and where possible, informs the progress in addressing access needs of communities that have been historically under-resourced because of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

The evaluation of the Recuperative Care and Short-Term Post-Hospitalization Housing Community Supports will focus on studying the impact on member health outcomes and will include an assessment of whether the services lead to an avoidance of emergency department use and reductions in inpatient and LTC. The state will also conduct a thorough cost-effectiveness analysis of these Community Support, as required.

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

See next page for Figure 19: Number of Community Supports, by County, Live as of July 30, 2023.

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



Performance Metrics (i.e. Enrollment and Utilization Data):

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

DHCS is working with MCPs to better understand initial data submissions over the

course of the first year of program implementation and is targeting to make the data publicly available at the earliest opportunity, factoring in privacy concerns and de-identifying all data prior to dissemination. Dashboards in Microsoft Power Business Intelligence (BI) are developed and being continuously refined to better help accurately visualize data for the program and capture all metrics necessary to ensure quality monitoring.

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

Community Supports offer MCPs the opportunity to better address critical health-related social needs for their members, and the services most widely offered by MCPs have included Housing Transition/Navigation, Housing Deposits, Housing Tenancy and Sustaining Services, Medically Tailored Meals, and Recuperative Care (Medical Respite). Currently available data as of September 2023 indicates the following number of providers and counties where services are available throughout California for the following Community Supports:

Community Supports	Number of Providers	Number of Counties Offering CS
Housing Transition Navigation Services	549	58
Housing Deposits	409	58
Housing Tenancy & Sustaining Services	441	58
Recuperative Care (Medical Respite)	137	46
Short-term Post Hospitalization Housing	89	40
Day Habilitation Programs	41	39
Medically Tailored Meals	277	58
Sobering Centers	31	21

Currently, at least one plan in all 58 California counties have elected to offer all three of the housing supports by January 1, 2024. Medically Tailored Meals/Medically-Supportive Food is also now available in all 58 counties. Short-Term Post-Hospitalization Housing and Recuperative Care continue to expand and are now available in 69 percent (40 out of 58) and 79 percent (46 out of 58) of counties respectively.

Utilization data for Community Supports

Current available data indicates the following number of unique individuals served across the last four quarters (Q3 2022 – Q2 2023) for DHCS' available Community Supports:

Community Support	2022 Q3	2022 Q4	2023 Q1	2023 Q2
Housing Transition/ Navigation Services	8,101	9,545	12,629	16,873
Housing Deposits	401	422	562	625
Housing Tenancy and Sustaining Services	10,642	8,673	3,616	12,616
Short-Term Post-Hospitalization Housing	123	194	232	277
Recuperative Care	828	1,059	1,149	1,427
Respite Services	1	6	83	141
Nursing Facility (NF) Transition/Diversion to Assisted Living Facility	146	167	185	243
Community Transition Services/Nursing Facility Transition to a Home	22	137	161	128
Personal Care and Homemaker Services	29	70	227	430
Day Habilitation Programs	34	103	238	286
Environmental Accessibility Adaptations	14	28	15	35
Medically Tailored Meals/ Medically Supportive Food	1,906	4,724	12,368	20,650
Sobering Centers	114	227	390	512
Asthma Remediation	97	91	308	919
Grand Total of Unique Members[5]	**20,933**	**23,791**	**29,848**	**51,985**

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

Outreach Activities:

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

- CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through transition challenges, provides critical review of decisions and documents before DHCS releases them more broadly, provides input on infrastructure needs to be supported by new performance incentives and PATH funding opportunities, and advises on TA needs in the market. Topics of discussion include:
  - Experience with implementation
  - Member experience of ECM and Community Supports
  - Progress of contracting between MCPs and providers
  - Referrals and authorization of members into Community Supports
- Monthly MCP TA and Guidance webinars geared towards health plan executives and personnel, who have a significant role in the implementation of Community Supports.
- Weekly meetings with the Local Health Plans of California and the California Association of Health Plans to provide TA and receive regular updates on the implementation of ECM and Community Supports.

Over the course of the reporting period, DHCS also met with several MCPs to reconcile differences found in their member noticing policies for Community Supports. These calls helped in reducing variation between policies across plans/counties and ensuring eligible members can easily access Community Supports.

On July 12, 2023, DHCS was pleased to share the recent updates made to the ECM and Community Supports Policy Guides, which are aimed at supporting greater uptake and delivery of ECM and Community Supports to eligible members while reducing administrative burden and duplication. These updates reflect the policy refinements discussed at the June 9th Summit, and cover key areas including eligibility, referrals and authorizations, provider networks, payment, market awareness, and data exchange. All

updated areas are marked with red “Updated July 2023” or “Added July 2023” indicators throughout both policy guides.

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

On August 18, 2023, DHCS hosted a virtual webinar for all stakeholders to provide an overview of the progress of Community Supports implementation and to discuss important policy refinements and areas of reinforcement. The webinar covered a range of topics, including eligibility, referrals and authorizations, provider networks, payment, market awareness, and data exchange. Key insights from the ECM and Community Supports calendar year 2022 implementation report were also unveiled.

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

On August 24, 2023, DHCS hosted its August ECM & Community Supports Implementation Advisory Group meeting series, and discussed proposed updates to DHCS’ ECM and Community Supports Coding Guidance document. In late 2022, DHCS administered a survey to MCPs and ECM and Community Supports providers about their first year of CalAIM implementation, including their experience using the HCPCS codes contained in this document. DHCS received over 200 responses. Based on feedback from the survey and other stakeholder sessions, DHCS is updating certain ECM and Community Supports billing codes, which are labeled throughout the document and summarized in a new Appendix.

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

of upcoming future planned activities and policy updates.

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

Quarterly Implementation Monitoring Report

DHCS successfully worked with MCPs to better understand initial data submissions over the course of the first year of program implementation and has made the data publicly available through its recently released ECM & Community Supports Year One (CY 2022) Implementation Report, factoring in privacy concerns and de-identification requirements for all data prior to dissemination. The details of this report are included below, under "Operational Updates."

Dashboards are developed and being continuously refined to accurately visualize data for the program and capture all metrics necessary to ensure quality monitoring. These dashboards are currently internal for Department use only, but external versions are being created to share publicly by the end of CY 2023.

DHCS continues towards working to ensure a high level of data quality covering the first year of implementation and recognizes the gaps that exist in new providers' reporting capabilities which MCPs must address. DHCS currently has six quarters of data available for Community Supports, but MCPs have communicated caution due to the significant data lag they are experiencing with their providers, many of whom are brand new to Medi-Cal and/or the managed care delivery system.

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

The transition to JSON will begin in January 2024, when DHCS will officially begin transitioning the quarterly reporting performed via the Quarterly Implementation Monitoring Report (QIMR) Excel Reports by requiring additional monthly JSON file submissions. JSON, or JavaScript Object Notation, is an open standard file format that streamlines the collection and transmission of implementation data and is utilized by the Department for other mandatory reporting purposes. Currently, QIMR data lags

real-time implementation by approximately four to six months; the transition to JSON is expected to significantly reduce lag on data collection.

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

The transition from QIMR to JSON will occur across several phases:

- Phase One (January 2024): Limited data elements specific to ECM and Complex Care Management (CCM) enrollment status.
- Phase Two (July 2024): ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
- Phase Three (January 2025): All remaining QIMR data elements specific to Community Supports, including member-level details, utilization, authorizations, and provider networks.

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

DHCS continues to work on visualizing program data through its Power BI solution, which enables connections with other data sources to add layers of information, such as demographic data, to the information received via the QIMR. Some examples of how the data are visualized are included in Figure 20 and Figure 21 on the next page.

The next QIMR, which will include data through Q3 2023, was due to DHCS on November 15, 2023.

Figure 20: Program History for Members Receiving Community Support Services as of September 2023: Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:

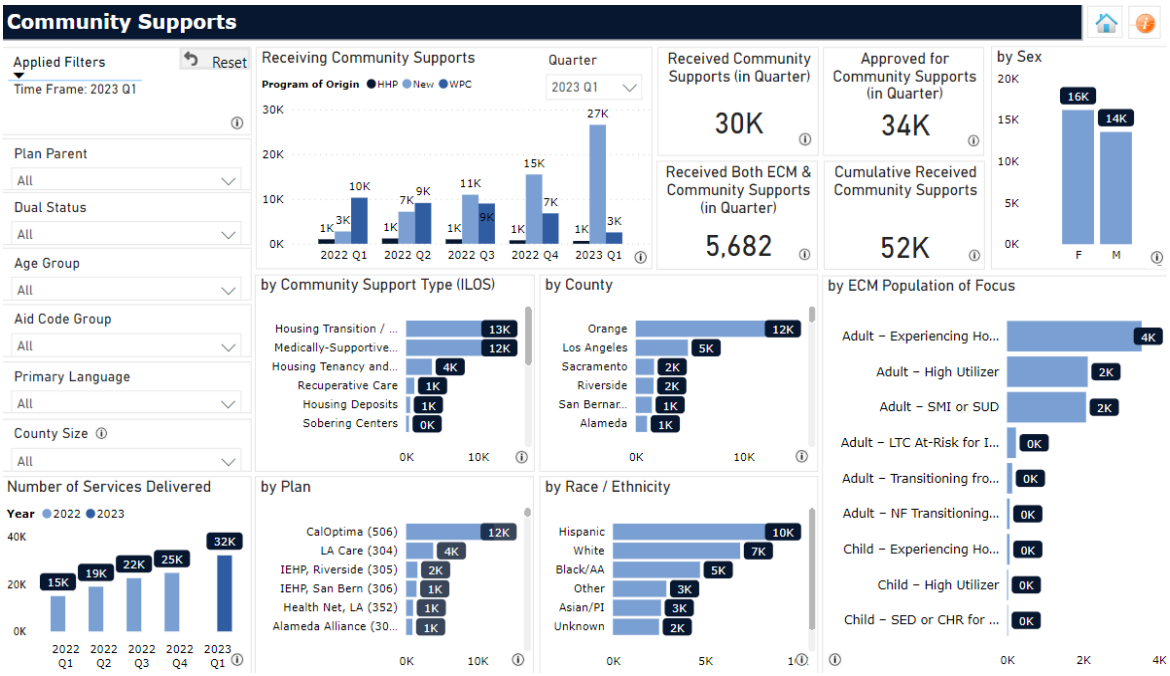
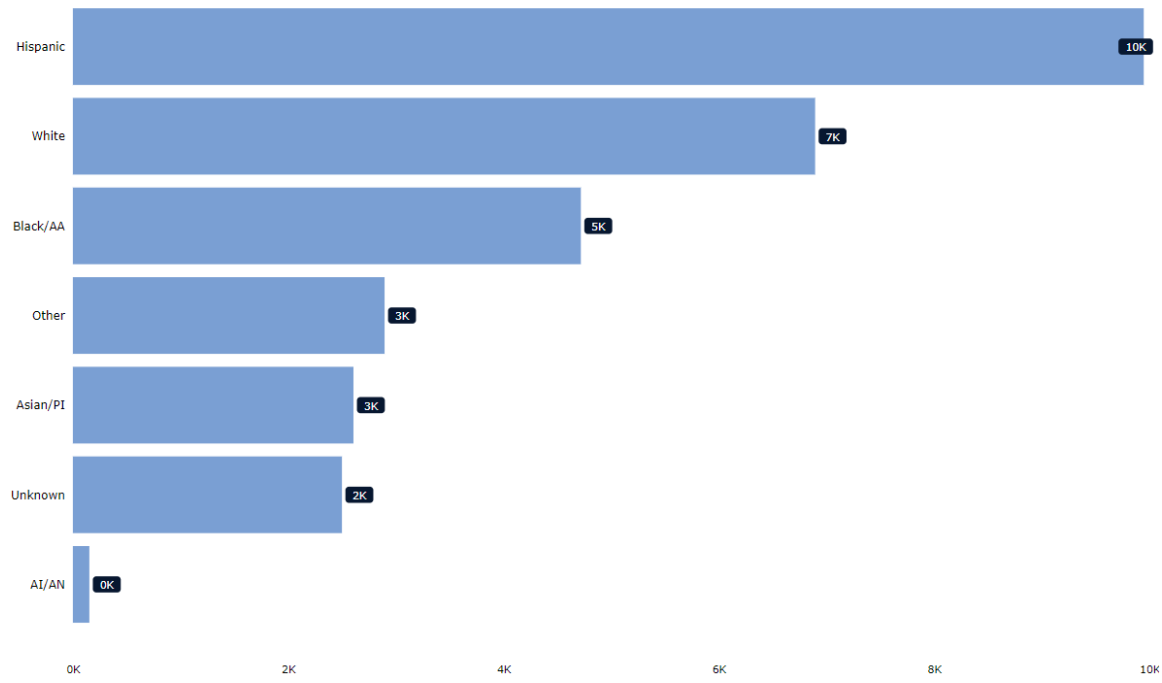


Figure 21: Demographics of Members Receiving Community Support Services as of September 2023. Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:



Operational Updates:

DHCS regularly updates its ECM and Community Supports webpage with guidance materials and program documents, in timely response to stakeholder and consumer feedback.

On July 1, 2023, DHCS received final updated MOCs and final 2024 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections will be posted on the DHCS website in mid-December, once DHCS issues its final approval for all outstanding MCP MOCs (by November 30, 2023). DHCS will continue to update Community Supports elections semi-annually. Technical assistance and guidance webinars are recorded and hosted on the DHCS website and are updated regularly. DHCS also maintains a regularly updated frequently asked questions (FAQs) document on its ECM and Community Supports webpage, which highlights several FAQs from MCPs, providers, and stakeholders, and includes answers and policy clarifications provided by DHCS.

On August 3, 2023, DHCS published its first ECM & Community Supports Year One (CY 2022) Implementation Report[6]. California has embarked on a multi-year journey to transform Medi-Cal and provide members with more coordinated, person-centered, and equitable care. In 2022, ECM and Community Supports launched statewide and reached more than 125,000 MCP members in the first 12 months of implementation. This Medi-Cal ECM and Community Supports Calendar Year (CY) 2022 Implementation Report provides a comprehensive overview of ECM and Community Supports implementation in the programs' first year. It includes data at the state, county, and plan levels on total members served, utilization, and provider networks. The Report is structured to provide the following detail on MCPs' progress towards implementing Community Supports over Year One (2022):

- Total services offered / launch timeline for 2022
- Cumulative Members Receiving ECM in 2022
    - Total services offered / launch timeline
    - Total members served
    - Total services
    - CS by service
    - Total members served stratified by race/ethnicity, gender, language,

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

HPI
- Quarter-Over-Quarter Trends for CS
    - Total number of members served in each CS by quarter
    - Total number of services in each CS by quarter
- Cumulative Provider Network
    - By Community Support
    - By Provider Type

DHCS is additionally finalizing further policy to clarify several ongoing, planned, and future activities specific to updating Community Supports policy and facilitating a higher degree of standardization of services and service delivery between counties. These activities are discussed more fully below in the "Updated Guidance in Production" section.

Other Monitoring Activities

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

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

- **Community Supports Provider Networks**: MCPs are required to list all Community Supports providers in their provider directories as follows:
    - MCPs are to list all Community Support providers in the provider directories as "Other Services Providers," and should specify if a provider is an ECM, Community Supports Provider, or both.

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

In late 2022, DHCS began conducting focused reviews of MCP websites to ensure that all required information relevant to Community Supports is available and accessible to members and providers. Reviews for all MCP websites are conducted on a semiannual basis as Community Supports elections are updated.

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

The purpose of this Monitoring RFI is to understand specific service uptake issues and solutions the MCP has implemented, or plans to implement, in order to address low uptake. After reviewing RFI submissions, DHCS may schedule a follow-up meeting with the MCP to further discuss uptake issues and the approach for addressing these issues. MCPs were required to submit responses for each Community Support service flagged in an email they received from DHCS and were encouraged to highlight county-specific uptake issues or strategies in their RFI responses.

Updated Guidance in Production

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

TA domains.

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

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

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

Standardizing Eligibility

Towards increasing standardization, DHCS is requiring that MCPs remove any previously approved restrictions or limitations and adhere with the full Community Supports service definitions by January 1, 2024. MCPs will no longer have the option to narrow the eligibility criteria or impose additional limitations on the service definitions (which include eligibility criteria), geographic or otherwise. In the second half of 2023 and beyond, DHCS is working on refining the Community Supports service definitions in response to market and stakeholder feedback. The Department looks forward to continued work with its stakeholders to provide these needed inputs.

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

Streamlining and Standardizing Referral/Authorization Processes

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

working on standardizing Community Supports authorization and reauthorization periods for implementation in 2024.

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

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

Expanding Provider Networks and Streamlining Payment

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

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

DHCS will be reinforcing existing timely provider payment requirements with its MCPs implementing Community Supports after receiving reports of non-payment or delayed invoice payments by MCPs, especially to CBOs new to billing Medi-Cal. As a reminder, Community Supports services are subject to the standard reimbursement timelines for other Medi-Cal services as specified in both its managed care boilerplate contract (i.e. "MCPs must pay 90 percent of all clean claims within 30 days of the date of receipt and 99 percent of all clean claims within 90 days") and California Health and Safety Code Section 13711 (i.e. "MCPs must reimburse claims or any portion of any claim, as soon as practicable, but no later than 30 working days after receipt of the claim and are subject to interest payments if failing to meet the standards"). These requirements pertain to both claims and invoices. MCPs are required to train their contracted network of Community Supports providers on how to submit clean claims; furthermore, they must have personnel available to troubleshoot issues. Additionally, in July 2023, DHCS issued APL 23-020,[7] offering clarifying guidance to MCPs about timely payment of claims.

Strengthening Market Awareness

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

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

[7] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf

Finally, DHCS noticed that some MCPs were delivering services to address Members' health-related social needs that were funded through other mechanisms outside of Community Supports, such as through value-added services. Moving forward, DHCS is requiring MCPs that are delivering such services to evaluate and determine the feasibility of transitioning them into the Community Supports program. Doing so will increase the awareness of Community Supports across the communities where other similar services are currently being provided and will drive enrollment into Community Supports. This strategy also allows MCPs to take advantage of the funding DHCS has allocated for Community Supports. Evaluating the feasibility of transitioning existing services to Community Supports may involve modifying current eligibility criteria and confirming existing providers can meet the requirements to serve as a Community Supports provider. DHCS stands ready to assist its MCP partners with focused technical assistance in this area.

Improving Data Exchange

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

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

Further details about these policy refinements can be found in the Community Supports Policy Guide[8] on the DHCS ECM and Community Supports webpage. DHCS has also published a "Cheat Sheet"[9] to help providers and other stakeholders navigate the ECM and Community Supports policy updates that summarizes key policies, as well as the distinction between state-standardized policies and where there is flexibility for MCPs to define their own policies and procedures.

[8] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
[9] https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Policy-Cheat-Sheet.pdf

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Nothing to report.

Enclosures/Attachments:

Community Supports Elections (by MCP and County) – PDF chart showing the Community Support Elections MCPs have elected to offer, current as of June 2023.

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

DUALLY-ELIGIBLE ENROLLEES IN MEDI-CAL MANAGED CARE

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

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

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

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

Two other related policy changes were implemented on January 1, 2023: 1) all dually eligible members statewide were required to enroll in Medi-Cal managed care, except

for those with a SOC who were not in a LTC facility; and 2) all dually eligible members residing in LTC facilities, including those with a share of cost, were required to enroll in Medi-Cal managed care. As of 2022, most dually eligible members in COHS counties and the seven CCI counties were already enrolled in Medi-Cal managed care plans. This policy for the remaining 31 counties is intended to help meet the statewide goals of improving care integration and person-centered care for dually eligible members, under both CalAIM and the California Master Plan for Aging.

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

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

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

Performance Metrics:

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

Outreach Activities:

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

Operational Updates:

DHCS has implemented the waiver authority provisions to enroll a member in an affiliated Medicaid plan once the member has selected a MA plan, in the twelve counties identified above. In 2023 DHCS is planning operational changes to expand the Medi-Cal matching plan policy to Kings, Madera, Orange, San Mateo, and Tulare counties in 2024.

Consumer Issues and Interventions:

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

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Nothing to report.

Figure XX: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY18-Q4	9,069	3,535	12,604
DY19-Q1	8,956	3,398	12,354
DY19-Q2	6,881	2,676	9,557
DY19-Q3	597	179	776

Figure XX: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	15,538	15,760	15,964	DY18-Q4	16,174
ACA	16,130	16,183	16,339	DY19-Q1	16,633
ACA	16,370	16,414	16,416	DY19-Q2	16,729
ACA	16,355	16,261	16,019	DY19-Q3	16,605
Non-ACA	6,790	6,725	6,665	DY18-Q4	7,072
Non-ACA	6,615	6,618	6,517	DY19-Q1	6,937
Non-ACA	6,506	6,448	6,425	DY19-Q2	6,775
Non-ACA	6,390	6,385	6,521	DY19-Q3	6,880

Figure XX: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	381,115	$ 62,604,653.85	$ 55,338,280.99	$ 6,337,233.22	$ 929,139.64	DY18-Q4
Non-ACA	132,519	$ 21,540,982.08	$ 12,104,145.45	$ 7,808,621.06	$ 1,628,215.57	DY18-Q4
ACA	323,363	$ 55,289,872.24	$ 48,911,265.53	$ 5,562,352.89	$ 816,253.82	DY19-Q1
Non-ACA	122,652	$ 19,534,627.06	$ 10,985,853.29	$ 7,148,572.83	$ 1,400,200.94	DY19-Q1
ACA	229,385	$ 37,356,247.67	$ 33,138,518.10	$ 3,645,704.48	$ 572,025.09	DY19-Q2
Non-ACA	94,993	$ 13,672,247.36	$ 7,532,378.50	$ 5,052,820.22	$ 1,087,048.64	DY19-Q2
ACA	10,654	$ 2,640,285.75	$ 2,303,290.69	$ 295,611.03	$ 41,384.03	DY19-Q3
Non-ACA	2,426	$ 644,522.57	$ 340,156.58	$ 251,491.02	$ 52,874.97	DY19-Q3

ACA Expenditures by Level of Care for DY18-Q4					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	204,810	$ 30,306,235.38	$ 26,830,279.44	$ 3,264,438.62	$ 211,517.32
3.3 Residential	2,541	$ 423,602.79	$ 381,240.70	$ 41,664.04	$ 698.05
3.5 Residential	145,517	$ 27,049,883.09	$ 23,889,770.99	$ 3,018,884.35	$ 141,227.75
RES 3.2-WM	28,247	$ 4,824,932.59	$ 4,236,989.86	$ 12,246.21	$ 575,696.52

ACA Expenditures by Level of Care for DY19-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	179,120	$ 27,908,171.27	$ 24,742,922.30	$ 2,961,845.06	$ 203,403.91
3.3 Residential	2,854	$ 539,558.70	$ 485,599.88	$ 53,156.24	$ 802.58
3.5 Residential	114,809	$ 22,386,497.06	$ 19,747,595.08	$ 2,535,208.54	$ 103,693.44
RES 3.2-WM	26,581	$ 4,455,645.21	$ 3,935,148.27	$ 12,143.05	$ 508,353.89

ACA Expenditures by Level of Care for DY19-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	122,010	$ 18,614,216.59	$ 16,531,748.72	$ 1,971,185.98	$ 111,281.89
3.3 Residential	1,028	$ 254,451.87	$ 229,004.56	$ 25,402.88	$ 44.43
3.5 Residential	81,873	$ 14,803,571.59	$ 13,113,966.40	$ 1,634,720.09	$ 54,885.10
RES 3.2-WM	24,474	$ 3,684,007.62	$ 3,263,798.42	$ 14,395.53	$ 405,813.67

ACA Expenditures by Level of Care for DY19-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	7,489	$ 1,779,274.85	$ 1,539,229.04	$ 237,333.97	$ 2,711.84
3.3 Residential	-	$ -	$ -	$ -	$ -
3.5 Residential	1,484	$ 428,626.07	$ 378,295.04	$ 49,994.79	$ 336.24
RES 3.2-WM	1,681	$ 432,384.83	$ 385,766.61	$ 8,282.27	$ 38,335.95

Non-ACA Expenditures by Level of Care for DY18-Q4					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	63,849	$ 9,012,221.72	$ 5,074,196.96	$ 3,416,495.00	$ 521,529.76
3.3 Residential	824	$ 197,471.80	$ 110,980.15	$ 83,949.74	$ 2,541.91
3.5 Residential	58,381	$ 10,745,369.88	$ 6,025,925.43	$ 4,298,869.49	$ 420,574.96
RES 3.2-WM	9,466	$ 1,585,918.68	$ 893,042.91	$ 9,306.83	$ 683,568.94

Non-ACA Expenditures by Level of Care for DY19-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	62,841	$ 8,850,673.95	$ 4,976,308.83	$ 3,365,967.49	$ 508,397.63
3.3 Residential	809	$ 197,109.02	$ 110,776.43	$ 83,785.85	$ 2,546.74
3.5 Residential	50,880	$ 9,133,966.60	$ 5,137,023.27	$ 3,687,749.41	$ 309,193.92
RES 3.2-WM	8,122	$ 1,352,877.49	$ 761,744.76	$ 11,070.08	$ 580,062.65

Non-ACA Expenditures by Level of Care for DY19-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	44,767	$ 5,994,460.07	$ 3,299,782.05	$ 2,363,178.26	$ 331,499.76
3.3 Residential	290	$ 68,692.94	$ 37,781.39	$ 30,520.91	$ 390.64
3.5 Residential	42,149	$ 6,402,354.36	$ 3,530,920.03	$ 2,646,731.39	$ 224,702.94
RES 3.2-WM	7,787	$ 1,206,739.99	$ 663,895.03	$ 12,389.66	$ 530,455.30

Non-ACA Expenditures by Level of Care for DY19-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	1,326	$ 330,616.90	$ 175,356.39	$ 153,862.67	$ 1,397.84
3.3 Residential	10	$ 4,471.50	$ 2,347.50	$ 2,124.00	$ -
3.5 Residential	654	$ 196,655.47	$ 103,243.74	$ 89,239.76	$ 4,171.97
RES 3.2-WM	436	$ 112,778.70	$ 59,208.95	$ 6,264.59	$ 47,305.16