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

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June 3, 2022

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QUARTERLY PROGRESS REPORT FOR THE REPORTING PERIOD OF
JANUARY 1, 2022, THROUGH MARCH 31, 2022, OF CALIFORNIA'S CalAIM SECTION 1115
DEMONSTRATION (11-W-00193/9)

Dear Ms. Young:

Enclosed is the Quarterly Progress Report as required by Section 87 of Special Terms and
Conditions of California's Section 1115 Waiver, titled "California Advancing and Innovating
Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) (the "demonstration"), formally known as
the "Medi-Cal 2020" demonstration, in accordance with section 1115(a) of the Social Security
Act. This is the first quarterly progress report for Demonstration Year (DY) Eighteen, which
covers the reporting period of January 1, 2022, through March 31, 2022.

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

Sincerely,

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs

Enclosures and cc: See next page.

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CALIFORNIA'S CalAIM 1115 DEMONSTRATION (11-W-00103/9)

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:

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

First Quarter Reporting Period: January 1, 2022 – March 31, 2022

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INTRODUCTION

CalAIM Amendment & Renewal

On June 30, 2021, California submitted a renewal request for the CalAIM Section 1115 demonstration. 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, DHCS requested authority through a renewal of the State's longstanding Specialty Mental Health Services (SMHS) Section 1915(b) waiver. This request would transition nearly all Medi-Cal managed care delivery systems to a single authority, streamlining California's managed care programs and applying statewide lessons learned from previous Section 1115 Demonstrations, as described below.

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

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

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Renewed in the CalAIM Section 1115 Demonstration:**
    - **GPP** to renew California's statewide pool of funding for care provided to California's remaining uninsured populations, including streamlining funding sources for California's remaining uninsured population with a focus on addressing social needs and responding to the impacts of systemic racism and inequities.
    - **Substance Use Disorder (SUD) Institutions for Mental Disease (IMD)** authority to continue short-term residential treatment services to eligible individuals with a SUD in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
    - **Coverage for Out-of-State Former Foster Care Youth** to continue Medi-Cal coverage for this population during the renewal period, up to age 26.
    - **Community Based Adult Services (CBAS)** to continue to authorize CBAS services for eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest

changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.

- o **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.

- **CalAIM Initiatives Newly Authorized in the CalAIM Section 1115 Demonstration:**
  - o **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
  - o **Providing Access and Transforming Health (PATH) Supports** expenditure authority to (1) sustain, transition, and expand the successful WPC pilots and HHP services initially authorized under the Medi-Cal 2020 demonstration as they transition to become ECM and Community Supports and (2) support justice-involved pre-release and post-release services and support Medi-Cal pre-release application planning and IT investments.
  - o **Contingency Management** to offer Medi-Cal beneficiaries, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral health treatments.
  - o **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, in order to provide this service in DMC-ODS and Drug Medi-Cal counties and county mental health plans (MHPs).

- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**
  - o **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authority** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
  - o **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to 109 to 138% of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan.
  - o **DTI** authority as outlined under the Med-Cal 2020 Section 1115 demonstration transitioned into a new, statewide dental benefits for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

The WPC Pilots and HHP, which were implemented under the Medi-Cal 2020 Section 1115 demonstration, concluded on December 31, 2021 following approval of the CalAIM Section 1115 demonstration renewal. Under CalAIM, California launched new ECM and Community Supports services that built on the successes of the WPC Pilots and HHP.

ECM is authorized through Medi-Cal managed care authority, and the Community Supports are authorized through a combination of CalAIM Section 1115 demonstration authority and Medi-Cal managed care authority as effectuated through the Section 1915(b) waiver.

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

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

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

GENERAL REPORTING REQUIREMENTS:

STCs Item 18: Post Award Forum
In DY 18-Q1, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On February 17, 2022, DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting. The purpose of the SAC and BH-SAC was 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: Budget Proposal for Fiscal Year 2022-23; Medi-Cal Rx Implementation; Medi-Cal Procurement Status; Quality/Equity Roadmap Measures and Metrics; CalAIM and 1115 Waiver Update and Post-Award Forum. Past meeting materials are available on the DHCS website: 021722BHSACMeetingMaterials (ca.gov).

During this quarter, DHCS Consumer-Focused Stakeholder Working groups (CFSW) also took place on January 7, 2022, February 4, 2022, and March 4, 2022. The meeting included discussion on a wide range of DHCS programmatic implementation updates such as the Older Adult Expansion, COVID-19 Public Health Emergency Unwinding, asset limits increase, and American Rescue Plan Act (ARPA) postpartum care extension. The telehealth policy and Hearing Aid Coverage for Children Program (HACCP) were discussed in multiple meetings this quarter. The purpose of the CFSW was to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on March 10, 2022. DHCS discussed the following topics: updates on the 1915b and 1115 Waiver approvals, the Comprehensive Quality Strategy, Population Health Management, Public Health Emergency unwinding, Ombudsman report, ECM and Community Supports, Medi-Cal Rx, and the COVID-19 Vaccine Incentive program updates. DHCS also presented and engaged feedback on the Children and Youth Behavioral Initiative and CalAIM Providing Access and Transforming Health (PATH). The purpose of the MCAG is to facilitate active communication between the Managed Care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders and advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

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

STCs Item 26: Monthly Calls
This quarter, waiver monitoring conference calls were held on February 14, 2022 and March 13, 2022. The CalAIM 1115 deliverables list and quarterly/annual reports were discussed for the following programs: Community Supports, New Behavioral Health Initiatives/DMC-ODS; Contingency Management; Peer Supports; PATH Supports; Duals Statewide Integration Initiative; Global Payment Program (GPP). CMS and DHCS also discussed upcoming DHCS amendments and Repayment of Payment Management Systems (PMS) Negative Account Balances.

PROGRAM UPDATES:

The Program Updates Section describes key activities and data across CalAIM 1115 program initiatives for DY 18-Q1, as required in STC 87 of the CalAIM 1115 demonstration STCs. For each program area, this Section describes program requirements, recent deliverables, success and accomplishments, program highlights, qualitative and quantitative findings, progress on evaluation findings, and opportunities for DHCS to build on success as the State continues programs under the CalAIM 1115 demonstration or transitions programs to other federal authorities. 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 & Transforming Health (PATH) Supports
- Community Supports: Recuperative Care & Short-Term Post Hospitalization

COMMUNITY-BASED ADULT SERVICES (CBAS)

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

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

CBAS was a CMS-approved benefit through December 31, 2020, under California's 1115(a) "Medi-Cal 2020" waiver approved by CMS on December 30, 2015. With the delayed implementation of CalAIM due to the COVID-19 public health emergency (PHE), DHCS received approval from CMS on December 29, 2020, for a 12-month extension through December 31, 2021.

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

Program Requirements

CBAS is an outpatient, facility-based program, licensed by the California Department of Public Health (CDPH) and certified by CDA to participate in the Medi-Cal program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members who meet CBAS criteria.

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 Individualized Plan of Care (IPC); 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 through a face-to-face assessment which is conducted by a registered nurse with level-of-care experience and by using a standardized tool and protocol approved by DHCS. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the MCP possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through a reauthorization process or up to every 12 months for individuals determined by the MCP to be clinically appropriate. Reauthorization is the process by which CBAS providers reassess members to ensure their needs are being met with the services they are receiving. Denial of services or reduction in the requested number of days for services requires a face-to-face assessment. Note: Due to the COVID-19 PHE, a face-to-face assessment is not required at this time. On October 9, 2020, CMS granted approval of DHCS' disaster 1115 amendment, which allows flexibilities pertaining to the delivery of CBAS Temporary Alternative Services (TAS) and permits CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (if proper safety precautions are implemented). These flexibilities are described in greater detail below.

The State must ensure CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012[1]. From April 1, 2012, through June 30, 2012, CBAS was only provided as a Medi-Cal Fee-For-Service benefit. On July 1, 2012, 12 of the 13 County Organized Health Systems (COHS) began providing CBAS as a benefit which were required to be covered by MCPs. The final transition of CBAS benefits to managed care took place beginning October 1, 2012. In addition, the Two-Plan Model (available in 14 counties) Geographic Managed Care plans (available in two counties) and the final COHS County (Ventura) also transitioned at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties (Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

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

Effective April 1, 2012, eligible participants can receive "unbundled services" if there are insufficient CBAS Center capacity to satisfy the demand. Unbundled services refer to component parts of CBAS delivered outside of centers with a similar objective of supporting participants, 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 or Instrumental Activities of Daily Living). If the participant is residing in a Coordinated Care Initiative County and is enrolled in managed care, the MCP will be responsible for facilitating the appropriate services on the members' behalf.

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

CBAS Emergency Remote Services (ERS) is an approved new service delivery method in the 1115 waiver to provide time limited services for individuals already receiving CBAS to ensure smooth transitions and continuity of care during specified emergencies. Policy guidance is still under development, but many of the lessons learned from the onset of the PHE are assisting the departments with constructing parameters that keep the CBAS Program as a congregate facility-based service. In the event of a geographical isolated, global, or personal emergency; having ERS established facilitate in a smooth transition without losing access to services.

Performance Metrics:

CDA and DHCS internal partners are meeting and working towards the development of the performance measures identified in STC 26. In addition, per STC 27, "the state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually."

Enrollment and Assessment Information:

Per STC 24(a), CBAS enrollment data for both MCP and FFS participants per county is shown in the figure below, titled *Preliminary CBAS Unduplicated Participant - FFS and MCP Enrollment Data with County Capacity of CBAS. CBAS Centers Licensed Capacity* provides the CBAS capacity available per county, which is also incorporated into the same figure.

CBAS enrollment data are self-reported quarterly by the MCPs, which sometimes results in data lags. As such, DHCS will report CBAS MCP data for DY 18-Q1 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

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

See next page.

County	DY 16-Q3 Jan - Mar 2021		DY 16-Q4 Apr – Jun 2021		DY 17-Q1 July – Sept 2021		DY 17-Q2 Oct - Dec 2021	
	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participants (MCP & FFS)	Capacity Used	Undupli-cated Participants (MCP & FFS)	Capacity Used
Alameda	445	71%	451	72%	454	72%	464	74%
Butte	31	31%	31	31%	28	28%	24	24%
Contra Costa	165	44%	155	42%	140	38%	134	36%
Fresno	812	42%	903	47%	856	45%	867	39%
Humboldt	93	16%	84	14%	84	14%	90	15%
Imperial	288	48%	284	47%	276	46%	270	45%
Kern	212	21%	162	16%	187	18%	171	17%
Los Angeles	24,337	61%	24,169	59%	25,029	61%	24,545	59%
Merced	119	57%	120	57%	125	60%	111	53%
Monterey	132	71%	101	54%	112	60%	100	54%
Orange	2,469	54%	2,503	55%	2,545	56%	2,672	61%
Riverside	520	33%	534	34%	526	33%	523	30%
Sacramento	483	42%	512	44%	498	43%	525	46%
San Bernardino	667	67%	668	67%	663	66%	690	69%
San Diego	2,587	64%	2,619	81%	2,006	66%	1,842	57%
San Francisco	826	53%	901	57%	857	55%	841	54%
San Joaquin	48	20%	56	24%	38	16%	25	11%
San Mateo	73	32%	63	62%	68	67%	68	67%
Santa Barbara	*	*	*	*	*	*	9	5%
Santa Clara	618	47%	628	48%	607	46%	585	44%
Santa Cruz	0	0%	79	52%	75	49%	75	49%
Shasta	*	*	*	*	*	*	2	1%
Ventura	926	64%	924	62%	921	61%	819	55%
Yolo	255	67%	245	65%	241	64%	235	62%
Marin, Napa, Solano	63	13%	70	14%	83	17%	79	16%
Total	**36,315**	**57%**	**36,319**	**57%**	**36,432**	**57%**	**35,766**	**55%**

FFS and MCP Enrollment Data 12/2021

**Note: Information is not available for DY 18-Q1 due to a delay in the availability of data and will be presented in the next quarterly report.

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

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

The data provided in the previous figure demonstrate fairly static enrollment in the second half of DY 16 and DY 17-Q1. While total enrollment decreased during DY 17-Q2 by approximately 600 participants it does not represent a significant overall decrease in unduplicated participants or capacity used. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Orange County experienced an increased capacity utilization from DY 17-Q1 to Q2 of greater than 5%. Orange County's increased capacity utilization was due to the closure of a CBAS Center during DY 17-Q2, resulting in the county's licensed capacity decreasing and an increase in licensed capacity utilization.

A majority of counties maintained consistent enrollment and capacity utilization that did not experience fluctuations greater than 5%. These counties include Alameda, Butte, Contra Costa, Humboldt, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Clara, Santa Cruz, Yolo, and the combined counties of Marin, Napa, and Solano.

Fresno, Monterey, San Diego, San Joaquin, and Ventura County all experienced a greater than 5% negative change related to capacity utilization. The Fresno County drop in capacity used is attributed to an opening of a CBAS Center. Although unduplicated participants increased, the addition of a new center resulted in an overall increase in licensed capacity and decrease in licensed capacity utilized in the county. The remaining counties have fluctuations likely as a result of declines in participation. Enrollment fluctuations in counties with fewer participants cause greater percentage variations.

Overall, there is a 2% decrease of capacity utilization statewide as many counties throughout California demonstrate fairly static enrollment in unduplicated participants throughout calendar year 2021, with a slight dip in participants in DY 17-Q2. DHCS will report CBAS Enrollment data for DY 18-Q1 in the next quarterly report.

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

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

Figure 2: CBAS Assessments Data for MCPs and FFS

Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY 16-Q4 (Apr-Jun 2021)	2,645	2,581 (97.6%)	64 (2.4%)	0	0 (0%)	0 (0%)
DY 17-Q1 (Jul-Sept 2021)	2,534	2,481 (97.9%)	53 (2.1%)	1	1 (100%)	0 (0%)
DY 17-Q2 (Oct-Dec 2021)	2,779	2,688 (96.7%)	91 (3.3%)	0	0 (0%)	0 (0%)
DY 18-Q1 (Jan-Mar 2022)	*	*	*	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

*Note: *MCP assessment information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS services are collected and assessed by the MCPs and DHCS. According to the previous figure, for 2021, 10,802 assessments were completed by the MCPs, of which 10,534 were determined to be eligible, and 259 were determined to be ineligible. For DHCS, no assessments were performed for CBAS benefits under FFS. As indicated in the previous figure, the number of CBAS FFS participants has maintained its decline due to the transition of CBAS into managed care. DHCS will report CBAS MCP Assessment data for DY 18-Q1 in the next quarterly report.

CBAS Provider-Reported Data (STC24.b)
The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases licensed and enrollment capacity while conversely new CBAS Center openings increase licensed and enrollment capacity. The California Department of Public Health licenses CBAS Centers and CDA certifies the centers to provide CBAS benefits and facilitates monitoring and oversight of the centers. The figure entitled "*CDA – CBAS Provider Self-Reported Data*" identifies the number of counties with CBAS Centers and the average daily attendance (ADA) for DY 17. As of DY 17-Q2, the

number of counties with CBAS Centers and the ADA of each center are listed below in Figure 3. On average, the ADA at the 270 operating CBAS Centers is approximately 33,987 participants, which corresponds to 88.8%of total capacity. Provider-reported data identified in the figure below, reflects data through December 2021.

Figure 3: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	270
Non-Profit Centers	48
For-Profit Centers	222
ADA @ 270 Centers	33,987
Total Licensed Capacity	38,253
Statewide ADA per Center	88.8%
	CDA - MSSR Data 12/2021

Note: *CDA CBAS Provider Self-Reported information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

Outreach Activities:

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

The following are CDA's outreach activities during DY 18-Q1: CBAS News Alerts (23); CBAS Updates Webinars (two); CAADS/ALE Vision Team meetings (12); MCP meetings (two); CBAS Quality Advisory Committee meetings (one), and Responses to CBAS Mailbox Inquiries (138).

These outreach and educational/training activities focus on various topics including but

not limited to the following: (1) CBAS program operations and public health guidance during the COVID-19 pandemic and PHE, (2) CBAS TAS services, staffing and documentation policy requirements and their implementation per CDA ACLs, (3) CBAS planning activities and policy guidance to support CBAS providers and participants for a safe transition to CBAS in-center congregate services according to public health guidance, (4) CBAS reporting requirements such as the Monthly Statistical Summary Report (MSSR) and Participant Characteristics Report (PCR) to ensure accurate and timely reporting, (5) Education and training opportunities to promote quality of care and to comply with CBAS program requirements and public health guidance, (6) Guidance on ordering Personal Protective Equipment (PPE) and COVID-19 testing supplies to support CBAS provider compliance with public health guidance and state testing requirements, and (7) Policy guidance and reporting requirements for the implementation of CBAS ERS.

CBAS Updates Webinars
CDA presented two webinars during this quarter to provide updates on the following: (1) recent CDPH public health guidance for ADHC facilities, (2) review of existing flexibilities for remote services, (3) review of CBAS ERS in the CalAIM 1115 Waiver, and (4) a presentation by several CBAS providers describing their responses to the current state of the pandemic. All CBAS Updates webinar recordings and slides are posted on the CDA website.

CAADS/ALE Vision Team Meetings
CDA continues to collaborate weekly with the CAADS/ALE Vision Team (which includes CBAS providers) in the development of policy guidance and the planning of webinars for CBAS providers to which MCPs and other interested stakeholders are invited. These webinars have focused on CBAS center best practices in the implementation of CBAS TAS requirements, strategies to transition CBAS participants to full in-center services in preparation for when CBAS licensing and TAS flexibilities will end, public health practices/requirements to mitigate the risks of COVID-19 infection, policy guidance to implement ERS, and other issues that affect the health and wellbeing of CBAS participants, their families and CBAS staff.

MCP Meetings
CDA convenes triannual meetings with MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs, (2) update MCPs on CBAS activities and data collection, policy directives, and the number, location, and approval status of new center applications, and (3) request feedback from MCPs on any CBAS provider issues requiring CDA assistance. During this quarter, CDA participated in two meetings with MCPs on February 2, 2022 and March 2, 2022, convened by CAADS and ALE for collaborative discussions about the transitioning of CBAS participants to full in-center services in preparation for when state licensing flexibilities end, and to provide updates on planning for the implementation of ERS. CAADS and ALE convene monthly

meetings with MCPs in which CDA participates. The next meeting with MCPs convened by CDA will be on April 7, 2022.

CBAS Quality Strategy Advisory Committee Meetings
CDA convenes triannual meetings with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, managed care plans, DHCS staff, and representatives from CAADS and ALE to provide updates and receive guidance on program activities to accomplish the goals and objectives identified in the CBAS Quality Strategy. During this quarter, CDA convened a meeting with the CBAS Quality Advisory Committee on January 20, 2022. Additional details about the CBAS Quality and Improvement Strategy and the CBAS Quality Advisory Committee are provided in the "Quality Control/Assurance Activity" section of this report.

CBAS Mailbox Inquiries
During this quarter, CDA responded to 138 CBAS Mailbox inquiries which included questions about CBAS program operations, public health guidance including testing and vaccination requirements, provision of CBAS TAS and staffing requirements, transition to full in-center operations, the end of CBAS remote services, and CDA reporting requirements.

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

California is tentatively planning to submit the STP to CMS for final approval in September 2022. The State continues to implement the activities and commitments identified in the *Milestones and Timelines* in these plans to comply with the federal HCB Settings requirements. CDA continues to evaluate each CBAS center for compliance with the federal requirements during each center's certification renewal survey process every two years.

Due to the COVID-19 pandemic and implementation of CBAS TAS requirements, CDA continued to conduct telephonic certification/recertification surveys during DY 18-Q1 instead of onsite surveys which includes determining compliance with the federal Home and Community-Based (HCB) Settings requirements. All existing CBAS compliance determination processes for the HCB Settings requirements are continuing during the provision of CBAS TAS, including the completion and validation of CBAS Provider Self-Assessment (PSA) and CBAS Participant surveys via telephonic/virtual methods that comply with public health guidance.

Operational Updates:

COVID-19 Pandemic and Public Health Emergency (PHE)
In response to the COVID-19 pandemic and subsequent PHE declaration, DHCS and CDA developed a new CBAS service delivery model, known as TAS, beginning in March 2020. Under this model, CBAS centers provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants. To authorize this CBAS TAS model, DHCS requested flexibility under a section 1135 waiver on March 19, 2020, and a section 1115 waiver on April 3, 2020. On October 9, 2020, CMS sent a letter to DHCS approving CBAS program modifications effective from March 13, 2020, through March 12, 2021 and on June 9, 2021, CMS approved California's request to extend the duration of the previously approved Emergency Preparedness and Response Attachment K, which is an attachment to California's section 1115(a) demonstration titled, "Medi-Cal 2020" (Project No. 11-W-00193/9), to respond to the COVID-19 PHE. The Attachment K flexibilities are effective, and available to be applied by the state, from March 13, 2021, through six months after the PHE ends.

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

Due to the Omicron variant and increasing incidents of breakthrough infections of vaccinated and boosted CBAS provider staff requiring quarantining, and the hesitancy of some participants to attend in-center services in late 2021 and early months of 2022, some CBAS centers paused in-center services and provided more remote services.

More recently, as a result of declining COVID-19 infections and hospitalizations across the state, the Governor issued Executive Order N-04-22 on February 25, 2022, and

CDPH issued an All Facilities Letter (AFL) on March 16, 2022, notifying ADHC licensees that the flexibility of licensing regulatory requirements, in effect during the COVID-19 PHE, will end as of June 30, 2022. This will require all CBAS centers to be open and operating as of July 1, 2022, on the days and hours of operation specified on their ADHC license, and to be staffed and providing basic services within their centers per licensing requirements. It is yet to be determined if the termination of state licensing flexibilities on June 30, 2022 will result in the termination of CBAS TAS flexibilities and if licensing flexibilities will be required to implement ERS. DHCS is in communication with CMS about the end of CBAS TAS flexibilities related to the federal PHE. Looking forward, CDA, in collaboration with DHCS, MCPs, and stakeholders, continues to plan for the transition back to full in-center services in preparation for the end of the PHE and end of CBAS TAS flexibilities, and is also planning for implementation of CBAS ERS approved by CMS.

These are some of the challenges and uncertainties that CDA in collaboration with providers, their staff, participants/families, and MCPs have been navigating while preparing for the end of ADHC licensing flexibilities and the unwinding of CBAS TAS. The planned ending of ADHC licensing flexibilities on June 30, 2022, requiring the return of participants to full in-center services by July 1, 2022, may result in the discharge of some participants who may not feel ready to return to full in-center services when remote services end. It is unclear at this point how many discharges this may be. Between now and July 1, 2022, many decisions will need to be made by providers and participants in collaboration with MCPs. CDA will continue to issue policy guidance and provide CBAS Updates webinars to assist providers and participants with these decisions.

Consumer Issues and Interventions:

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC24.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 CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBASinfo@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current Plan Partner. Complaint data received by MCPs and CDA from CBAS participants and providers are summarized below in Figure 7 entitled "*Data on CBAS Complaints*" and Figure 4 entitled "*Data on CBAS Managed Care Plan Complaints*."

DHCS will report CBAS MCP Complaint data for DY 18-Q1 in the next quarterly report.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY 16-Q3 (Jan – Mar 2021)	0	0	0
DY 16-Q4 (Apr - Jun 2021)	0	0	0
DY 17-Q1 (Jul - Sep 2021)	0	0	0
DY 17-Q2 (Oct – Dec 2021)	0	0	0
			CDA Data – Complaints 12/2021

Note: CDA information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

For complaints received by MCPs, the figure on the next page illustrates there were 20 beneficiary complaints and two provider complaints submitted for 2021. The data reflects that for DY 17-Q2, no complaints were submitted. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports. DHCS will report CBAS MCP data for DY 18-Q1 in the next quarterly report.

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY 16-Q3 (Jan - Mar 2021)	11	1	12
DY 16-Q4 (Apr - Jun 2021)	9	1	10
DY 17-Q1 (Jul - Sept 2021)	0	0	0

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY 17-Q2 (Oct – Dec 2021)	0	0	0
			Phone Data – Phone Center Complaints 12/2021

*Note: *MCP assessment information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the Final report.*

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

Grievance and appeals data is provided to DHCS by the MCPs. Per the data provided in Figure 6 entitled, "*Data on CBAS Managed Care Plan Grievances*," a total of 36 grievances were filed with MCPs during 2021. Twenty of the grievances were solely regarding CBAS providers. One grievance was related to contractor assessment or reassessment. No grievances were related to excessive travel time to access CBAS services. Fifteen grievances were designated as "other". Overall, total grievances increased from the prior year. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports. DHCS will report CBAS MCP Grievance data for DY 18-Q1 in the next quarterly report.

Figure 6: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY 16-Q3 (Jan - Mar 2021)	2	1	0	2	5
DY 16-Q4 (Apr - Jun 2021)	6	0	0	4	10
DY 17-Q1 (Jul - Sept 2021)	6	0	0	4	10
DY 17-Q2 (Oct – Dec 2021)	6	0	0	5	11
					MCP Data - Grievances 12/2021

Note: CDA assessment information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

Figure 7: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY 16 – Q3 (Jan – Mar 2021)	1	0	0	0	1
DY 16 – Q4 (Apr – Jun 2021)	3	1	0	1	5
DY 17 – Q1 (Jul – Sept 2021)	2	0	0	0	2
DY 17 – Q2 (Oct – Dec 2021)	3	0	1	0	4
					MCP Data - Grievances 12/2021

Note: MCP appeals information is not available for DY 18-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.

During 2021, Figure 7 entitled "*Data on CBAS Managed Care Plan Appeals*"; shows there were 12 CBAS appeals filed with the MCPs. The figure illustrates that nine of the appeals were related to "denial of services or limited services", one was categorized as "denial to see requested provider", one as "excessive travel times" and one as "other CBAS appeals". DHCS will report CBAS MCP appeals data for DY 18-Q1 in the next quarterly report.

The California Department of Social Services (CDSS) continues to facilitate the State Fair Hearings/Appeals processes, with the Administrative Law Judges hearing all cases filed. CDSS reports the Fair Hearings/Appeals data to DHCS. For DY 18-Q1, there were no requests for hearings related to CBAS services which are pending.

Quality Control/Assurance Activity:

The CBAS Quality Assurance and Improvement Strategy (dated October 2016), developed through a year-long stakeholder process, was released for comment on September 19, 2016, and its implementation began October 2016. The Quality Strategy has two overarching goals: 1) to assure CBAS provider compliance with program requirements through improved State oversight, monitoring, and transparency activities,

and 2) to improve service delivery by promoting CBAS best practices, including person-centered and evidence-based care, which continue to guide CBAS program planning and operations.

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

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

DHCS and CDA continue to monitor CBAS Center locations, accessibility, and capacity for monitoring access as required under CalAIM. Figure 8 titled, *CBAS Centers Licensed Capacity* indicates the number of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The figure below also illustrates overall utilization of licensed capacity by CBAS participants statewide for 2021. Quality Assurance/Monitoring Activity reflects data through January 2021 to December 2021.

Figure 8: CBAS Centers Licensed Capacity

See next page.

County	CBAS Centers Licensed Capacity					
	DY 16-Q3 Jan-Mar 2021	DY 16-Q4 Apr-Jun 2021	DY 17-Q1 Jul-Sept 2021	DY 17-Q2 Oct-Dec 2021	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	370	0.0%	74%
Butte	60	60	60	60	0.0%	24%
Contra Costa	220	220	220	220	0.0%	36%
Fresno	1132	1,132	1,132	1,297	+12.8%	39%
Humboldt	349	349	349	349	0.0%	15%
Imperial	355	355	355	355	0.0%	45%
Kern	610	610	610	610	0.0%	17%
Los Angeles	23,636	24,211	24,371	24,371	0.0%	59%
Merced	124	124	124	124	0.0%	53%
Monterey	110	110	110	110	0.0%	54%
Orange	2,678	2,678	2,678	2,603	-2.9%	61%
Riverside	935	935	935	1025	+8.8%	30%
Sacramento	680	680	680	680	0.0%	46%
San Bernardino	590	590	590	590	0.0%	69%
San Diego	2,383	1,903	1,903	1,903	0.0%	57%
San Francisco	926	926	926	926	0.0%	54%
San Joaquin	140	140	140	140	0.0%	11%
San Mateo	135	60	60	60	0.0%	67%
Santa Barbara	100	100	100	100	0.0%	5%
Santa Clara	780	780	780	780	0.0%	44%
Santa Cruz	90	90	90	90	0.0%	49%
Shasta	85	85	85	85	0.0%	1%
Ventura	851	886	886	886	0.0%	55%
Yolo	224	224	224	224	0.0%	62%
Marin, Napa, Solano	295	295	295	295	0.0%	16%
SUM	37,858	37,913	38,073	38,253	+.5%	55%

*Capacity used information is not available for DY 18-Q1 due to the delay in the availability of the data.

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

The previous figure reflects that the average licensed capacity used by CBAS participants is 55% statewide. Overall, most all of the CBAS Centers have not operated at full or near-to-full capacity with the exception of Alameda. Alameda is at 74% capacity. Licensing Capacity allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 24(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. Orange County Licensing capacity went down 2.9% due to a CBAS Center closure, while licensed capacity in Fresno County increased 12.8% due to the opening of a new CBAS Center. Riverside County data reflects increased capacity that took effect in May of 2021, but was not reflected in the data until November of 2021.

No other significant increases or decreases were noted over the last quarter. Over 2021, total licensed capacity has slightly and steadily increased statewide. DHCS will report CBAS Licensing capacity data for DY 18-Q1 in the next quarterly report.

Access Monitoring (STC 24.e.)
DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to the figures titled *Preliminary CBAS unduplicated Participant – FFS and MCP enrollment Data with County Capacity of CBAS*, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. Data for DY 17-Q2 is not reflective in those figures due to a lack of availability but will be reflected in the final report.

Unbundled Services (STC19.b.iii.)
CDA certifies and provides oversight of CBAS Centers. DHCS continues to review any possible impact on participants by CBAS Center closures. For counties that do not have a CBAS Center, the MCPs will work with the nearest available CBAS Center to provide the necessary services. This may include but not be limited to the MCP contracting with a non-network provider to ensure that continuity of care continues for the participants if they are required to enroll into managed care. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA of their planned closure date and to conduct discharge planning for each of the CBAS participants to which they provide services. CBAS participants affected by a center

closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within their local area.

<u>CBAS Center Utilization (Newly Opened/Closed Centers)</u>
DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 17-Q2, CDA had 270 CBAS Center providers operating in California. According to Figure 9 titled *CBAS Center History*, no CBAS Centers closed, and no center opened in DY 17-Q2.
DY 18-Q1 will be presented in the next quarterly report due to a delay in the availability of the data.

Figure 9: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
December 2021	270	0	0	0	270
November 2021	270	0	0	0	270
October 2021	270	1	1	0	270
September 2021	270	0	0	0	270
August 2021	270	0	0	0	270
July 2021	269	0	1	1	270
June 2021	269	0	0	0	269
May 2021	269	1	1	0	269
April 2021	269	2	2	0	269
March 2021	268	0	1	1	269
February 2021	266	0	2	2	268
January 2021	265	1	2	1	266

*Note: *CDA assessment information is not reported for DY 18-Q1 due to a delay in the availability of the data and will be presented in the Final report.*

The previous figure shows there was no negative change of more than 5% in from January 2021 to December 2021, so no analysis is needed to address such variances.

Budget Neutrality and Financial Updates:

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

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

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

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

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

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

Performance Metrics:

DHCS is in the process of creating a new 1115 Waiver data query system capable of identifying metrics specific to the CalAIM demonstration. For this reason future performance metrics for the CalAIM Section 1115 Waiver for DY 18-Q1 may be subject to formatting changes. Further, data for DY 18-Q1 is not considered complete since counties have up to 6 months to submit claims data to DHCS.

Figure 10: Member Months

POPULATION	ELIG_MONTH	MEMBER_MONTHS
DMC_ODS_RESIDENTIAL_DY 18-Q1	JAN	3,589
DMC_ODS_RESIDENTIAL_DY 18-Q1	FEB	3,585
DMC_ODS_RESIDENTIAL_DY 18-Q1	MAR	3,572

Outreach Activities:

- DHCS has monthly calls with each participating DMC-ODS County to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance; including status updates on Corrective Action Plans and reports.
- DHCS host an All County Behavioral Health monthly meeting with counties and stakeholders to address various upcoming and published Behavioral Health Information Notices (BHINs), as well as to providing high-level assistance regarding compliance and reporting.
- DHCS issues a weekly Behavioral Health Stakeholder Updates and Information Notices communication via email to stakeholders. The information provided to stakeholders includes Behavioral Health's announcements such as finalized and draft BHINs and upcoming Webinars.

Recent activities including CalAIM Demonstration guidance are listed below:

- January 19, 2022 – All County Monthly Call
- February 16, 2022 – All County Monthly Call

Operational Updates:

Since the COVID-19 pandemic, there has been an increase in concerns with counties experiencing limited staffing, as well as an increase of services that are needed by beneficiaries. DHCS continues to work closely with counties by providing technical assistance and monitoring support via telephone and/or emails to ensure compliance.

Consumer Issues and Interventions:

From January 2022 through March 2022, DHCS has been made aware by counties that there has been an increase in services needed by beneficiaries due to COVID-19. A few DMC-ODS counties have received complaints as a result of the effect on residential services. DHCS continues to work closely with counties providing technical assistance, monitoring, and support to address any concerns.

Quality Control/Assurance Activity:

DHCS Audits and Investigation Division conducts annual monitoring reviews of counties participating in the DMC-ODS. The following reviews occurred January 2022 through March 2022.

Figure 11: DY 18-Q1 Monitoring Reviews

County	Dates
Contra Costa	01/12/2022
Imperial	02/09/2022
Marin	02/16/2022
Merced	03/16/2022
Napa	02/03/2022
Placer	03/08/2022
San Benito	03/04/2022
San Diego	01/20/2022
San Joaquin	03/08/2022
San Mateo	01/25/2022
Santa Clara	02/22/2022
Stanislaus	01/19/2022

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

UCLA is actively engaged in planning and ongoing data analysis activities and with the goal of submitting design documents for CMS review on time or ahead of schedule. The new CalAIM contingency management benefit has been a particular focus of these efforts. Between January 1, 2022 and March 31, 2022, UCLA actively participated in 22 separate calls and webinars with DHCS and various stakeholders to discuss plans for the implementation and evaluation of the upcoming contingency management benefit. Based in part on UCLA's work, DHCS has posted a Medi-Cal Contingency Management Pilot Program Policy Design document, which includes a draft evaluation plan, here.
UCLA incorporated these plans into a draft evaluation design that was submitted to DHCS on May 16, 2022. Following review and feedback, a draft evaluation design will be submitted to CMS ahead of the launch of the contingency management program no later

than June 27, 2022 consistent with the Section 1115 CalAIM STCs.

In terms of the broader evaluation design, UCLA and DHCS participated in a call with CMS on January 27, 2022 to clarify CMS's expectations. This has helped clarify ongoing discussions with DHCS and UCLA on a contract amendment that is currently underway. In the meantime, UCLA is developing a second evaluation design document to cover the evaluation of the rest (in addition to contingency management) of the DMC-ODS portion of CalAIM. Submission is planned in June, in line with CMS requirements. Both the contingency management and broader evaluation designs will address health disparities and bridging inequities. On February, 28, 2022, UCLA also submitted a 185-page summative report on DMC-ODS. Although this report technically covered the period through the end of the previous waiver, many of the analyses and recommendations also were aimed at anticipated challenges and opportunities under CalAIM.

GLOBAL PAYMENT PROGRAM (GPP)

The Global Payment Program (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 PHCSs in their key role of providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. In addition to providing value-based care, the GPP will incorporate services that are otherwise available to the state's Medi-Cal beneficiaries under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. Under the California Advancing and Innovating Medi-Cal (CalAIM) waiver, GPP continues the work accomplished under the Medi-Cal 2020 Waiver and will add services that aim to address health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries.

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

Performance Metrics:

The Health Equity Monitoring Metrics Protocol is being developed by the State and the Center for Medicare and Medicaid Services (CMS). After the Protocol is developed and finalized, California will report performance metrics.

Outreach Activities:

Nothing to report.

Operational Updates:

The Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the Public Health Emergency (PHE). During DY18-Q1, the Secretary of Health and Human Services extended the COVID-19 PHE effective January 14, 2022. National public health emergencies are effective for 90 days unless extended or terminated.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 6 (formerly 6A) Final Reconciliation	$197,092,067.75	$153,605,561.69	DY 18	$350,697,629.44

DY 18-Q1 reporting includes GPP payments made in February 2022. Payments made in this time period were for PY 6 (formerly 6A) final reconciliation. In GPP PY 6 (formerly 6A) final reconciliation payments, the PHCSs received $197,092,067.75 in federally-funded payments and $153,605,561.69 in IGT-funded payments.

Evaluation Activities and Interim Findings:

Nothing to report.

PROVIDING ACCESS & TRANSFORMING HEALTH (PATH) SUPPORTS

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

PATH is comprised of two aligned programs:
- Justice-Involved (JI) Capacity Building, to maintain and build pre-release services to support implementation of a full suite of statewide CalAIM justice involved initiatives in 2023, and
- Support for Implementation of Enhanced Care Management (ECM) and Community Supports (previously known as In Lieu of Services (ILOS)), which are vital elements of CalAIM on the community level, and support for the expansion of access to services that will enable the transition from Medi-Cal 2020 to CalAIM.

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

administer and facilitate this initiative.

DHCS anticipates to contract with a TPA by the end of DY 18-Q2 to implement and administer the different initiatives under PATH. The TPA will serve as a program administrator that will market, facilitate, develop support tools, and ensure successful implementation of the following PATH initiatives:
- TA Marketplace
- Collaborative Planning and Implementation Program
- CITED Program
- JI Planning and Capacity Building

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

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

Performance Metrics:

During this quarter, DHCS released the PATH WPC Services Transition and Mitigation Registration form to 12 former WPC LEs to apply for PATH funding under this initiative. DHCS expects to provide approval for the applicants by DY 18 Q-2 and to receive utilization data back by DY 18-Q3.

TPA Procurement Activity:

During this quarter, DHCS developed the scope of work and the Invitation for Proposals (IFP) for the PATH TPA to solicit proposals from firms to administer the different initiatives under PATH. The TPA will serve as a program administrator that will market, facilitate, develop support tools, and implement the following PATH initiatives:

- TA Marketplace
- Collaborative Planning and Implementation Program

- CITED Program
- JI Planning and Capacity Building

The TPA will also serve as an intermediary between PATH funding recipients and DHCS. DHCS anticipates securing a completed contract with a TPA by the end of DY 18-Q2.

As part of the procurement development effort, DHCS interviewed another state Medicaid program, MassHealth since they have a TA Marketplace in place as part of their DSRIP/1115 Waiver program. In addition, DHCS conducted research to assess which potential vendors would have the capabilities to administer the PATH initiatives, given the scale and diversity of entities which may apply and be eligible for PATH funding. These efforts were necessary to develop and release the IFP which is targeted for release in Q2 of 2022.

Stakeholder Engagement:

DHCS hosted monthly Justice-Involved Advisory Group meetings to solicit stakeholder input on policy and implementation. Advisory Group leaders and representatives are diverse including counties, prisons, jails, providers, consumers, health plans, and policy organizers. Slides from past meetings are posted on the [CalAIM Justice-Involved Initiative](#) webpage.

Entities interested in participating in the TA Marketplace, as a technical assistance vendor or a potential recipient of technical assistance (i.e., CBOs), have been contacting DHCS to participate in PATH. DHCS has been collecting that information and conducting an inventory of potential entities so that we can conduct outreach to them once the PATH TPA is selected, on boarded and the TA Marketplace, CITED, and Collaborative Planning and Implementation initiatives are launched. DHCS drafted additional protocols in response to the comments received from the Centers for Medicare and Medicaid Services (CMS) on the 1115 Wavier Demonstration Special Terms and Conditions (STCs) for PATH. The additional documents include Attachment N, which outlines the Funding and Mechanics Protocol, and Attachment O, which outlines the Operational and Monitoring. DHCS is currently meeting with stakeholder and associations for feedback and comments. DHCS continues to develop the operational protocols for the PATH program and will submit to CMS in Q2 of 2022. DHCS continued development of PATH initiative work plans, design elements of each PATH initiative, and draft responses to questions that have surfaced from various stakeholders. DHCS incorporates feedback from stakeholders and provides guidance on the different uses of funds between each PATH initiative. A few of the webinars and meetings hosted by DHCS for this quarter included the following:

- On January 28, 2022, DHCS hosted a PATH All-Comer Webinar to discuss updates on the TA and CITED initiatives. In this meeting, DHCS discussed the initiative overview, eligibility criteria to apply for funds, purpose, and application process. Discussion from stakeholders focused on the use of funds for expanding provider capacity, TA to connect providers to MCPs, and the anticipated timeline for funding. The slides are posted on the [CalAIM ECM and Community Supports](#) website.

- On March 9, 2022, DHCS hosted a close out call with former WPC Pilot programs to discuss the sunset of the pilot program and use of PATH funds to support the transition process of former WPC enrollees into ECM and Community Supports. DHCS also presented the PATH WPC Services Transition and Mitigation registration form process and answered questions on the use of funds to sustain ECM and Community Support services. DHCS provided guidance to the former pilots on the JI population and use of PATH supports to provide in-reach services.

- On March 22, 2022, DHCS hosted a CalAIM Monthly ECM and Community Supports Managed Care Plan Meeting. DHCS presented on the PATH JI Capacity Building overview, eligibility, application process, and eligible use details. Although additional funding guidance is pending from CMS, DHCS presented on the goals and purpose of the PATH funds to support pre-release eligibility and enrollment planning and implementation.

- March 15, 2022, DHCS released the PATH WPC Services Transition and Mitigation Registration form to 12 former WPC LEs. Mitigation Registration forms were due back to DHCS by March 23, 2022. DHCS is allowing an extension to the beginning of April for three LEs that requested additional time. DHCS identified 12 former WPC LEs that provided WPC services that will transition to Jail-In Reach and/or Community Support services (these services are not currently covered by MCPs, but will be covered on or before January 1, 2024). Other former WPC LEs were welcome to contact DHCS to discuss if they had services DHCS did not previously identify as eligible for PATH Mitigation funding.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Nothing to report.

COMMUNITY SUPPORTS: RECUPERATIVE CARE & SHORT-TERM POST HOSPITALIZATION

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

Community Supports services are optional for MCPs to offer and for members to utilize. MCPs are prohibited from requiring members to use a Community Support service instead of a service or setting listed in the California Medicaid State Plan.

Pursuant to 42 CFR 438.3, MCPs may not provide Community Supports services without first applying to the State and obtaining State approval to offer the Community Support services, by demonstrating all requirements will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved Community Supports contract; however, the cost of any such voluntary services may not be included in determining MCP rates. Once approved by DHCS, the Community Support services will be added to the MCP's contract and posted on the DHCS website.

Examples of Community Supports services include assistance with medically tailored meals, and transitioning from nursing home care to the community to improve health and lower health care costs (by avoiding preventable emergency room and in-patient hospital visits). Community Supports services are authorized through this CalAIM Demonstration in a manner that assures consistent implementation.

Community Supports services are a significant change and a high priority for DHCS. DHCS recognizes the work MCPs and communities will be doing in CA to operationalize these new initiatives under CalAIM and transition services previously provided under the Whole Person Care Pilot and Health Home Program.

In conjunction with the authority to provide a state-approved Community Supports services program under Title 42 Code of Federal Regulations section 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 services. These two services both play an important role in California's care continuum as settings that are 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 also provide appropriate medical and behavioral health support following an inpatient or institutional stay for electing individuals who are homeless or at risk of

homelessness who may otherwise require additional inpatient care in the absence of recuperative care.

Demonstration monitoring will cover reporting of performance metrics data related to the state's Recuperative Care and Short-Term Post-Hospitalization housing services, and where possible, informs about 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 reduction in avoidable emergency department inpatient and post-acute care. The state will also conduct a cost-effectiveness analysis of these Community Supports services as required.

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

Performance Metrics:

Nothing to report.

Outreach Activities:

During this quarter, DHCS held weekly meetings with the Local Health Plans of California (LHPC) and the California Association of Health Plans (CAHP) to provide technical assistance and receive regular updates on the implementation of ECM and Community Supports.

DHCS also hosted monthly technical assistance and guidance webinars geared towards health plan executives and personnel who have a significant role in the implementation of ECM and Community Supports. Details on the content of these meetings is provided below.

Operational Updates:

In January 2022, DHCS updated its Community Supports Policy Guide and All Plan Letter language to accommodate minor adjustments necessary based on the final CMS STCs released in December 2021 to highlight the 1115 Waiver Authority for the Short-Term Post-Hospitalization and Recuperative Care (Medical Respite) Community Supports and to reconcile reporting timelines.

DHCS continued to strategize with leadership to discuss the development of Community Supports initiative work plans and drafted responses to questions submitted by various stakeholders. DHCS continues to accept stakeholder feedback and intends to continue providing guidance on this unique set of services. A few of the webinars and meetings hosted by DHCS for this quarter included:

- Bi-weekly CalAIM Implementation Advisory Group:
  This group, composed of a select group of MCPs and counties participating in ECM and Community Supports together with DHCS, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched programs as they are occurring. 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 and input on infrastructure needs to be supported by new performance incentives and PATH funding opportunities; and advises on technical assistance needs in the market. Topics of discussion included:

  - Experience with implementation,
  - Member experience with the WPC and Health Homes program transitions to ECM and Community Supports,
  - Progress of contracting between MCPs and providers, and
  - Referrals and authorization of members into Community Supports.

- Early successes, early challenges:
  On January 25, 2022, DHCS hosted its first CalAIM Monthly ECM and Community Supports MCP Meeting. During this meeting, DHCS provided an overview of CMS approvals received for Community Supports implementation; conducted a poll to obtain more information on MCP authorization timeframes for Community Supports; and offered some additional guidance on authorization for data sharing, including highlighting rules around 42 CFR Part 2, Substance Use Disorder data. DHCS relayed that it would continue to refine and update its CalAIM Data Sharing Authorization Guidance, and confirmed it will continue to develop a universal authorization form as an optional tool to support data sharing between CalAIM participants.

- On February 28, 2022, DHCS hosted its CalAIM Monthly ECM and Community Supports MCP Meeting. DHCS reaffirmed ECM and Community Supports expectations for Q1 2022 and issued several reminders for upcoming deliverables. It also provided a brief overview of the Housing and Homelessness Incentive Program, and introduced for the first time its planned Population Health Management initiative.

- On March 9, 2022, DHCS hosted a close-out call with former WPC Pilot programs to discuss the sunset of the pilot program and the use of PATH funds to support the transition process of former WPC enrollees into ECM and Community Supports. DHCS also presented the PATH WPC Services Transition and Mitigation registration form process and answered questions on the use of funds to sustain ECM and Community Supports services.

- On March 22, 2022, DHCS hosted its CalAIM Monthly ECM and Community Supports MCP Meeting, where it held a breakout session to get more feedback on implementation up to that point, with a focus on growth, but acknowledging the challenges still being faced with data exchange and reporting by MCPs and providers in the field.

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

In February 2022, DHCS accepted revisions to MCPs' previously approved ECM and Community Supports Models of Care to incorporate new Community Supports services and ECM populations of focus planned for implementation beginning July 1, 2022.

In March 2022, DHCS updated its Healthcare Common Procedure Coding System Coding Options for ECM and Community Supports to include new "per diem" codes approved by CMS for specific Community Supports, which previously lacked these options.

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

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Enclosures/Attachments:

A PDF chart showing the Community Support Elections MCPs have elected to offer (as of January 2022, through January 2024) is available at [Community Supports Elections (by MCP and County)](#).

DUALLY-ELIGIBLE ENROLLEES IN MEDI-CAL MANAGED CARE

California's section 1115 waiver includes flexibilities to support the state's effort to integrate dually eligible populations statewide into Medi-Cal managed care through the 1915(b) waiver prospectively as well as support integrated care by allowing the state, in specific counties with multiple Medicaid plans, to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage (MA) plan. Beneficiaries impacted by this expenditure authority will be able to change Medicaid plans by picking a new MA plan or original Medicare once a quarter. A dually eligible beneficiary's Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. In the counties where the state is authorizing the exclusively aligned enrollment (EAE) Dual-Eligible Special Needs Plan (D-SNP) model, DHCS is committed to implementing integration through integrated member materials, integrated appeals and grievances, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care.

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

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

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

Performance Metrics:

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

Outreach Activities:

There are a variety of stakeholder and workgroup meetings that are occurring to engage with stakeholders about the current matching plan policy, and ahead of the 2023 transitions.

Operational Updates:

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

Consumer Issues and Interventions:

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

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Nothing to report.

Enclosures/Attachments:

Nothing to report.