DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

August 28, 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
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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 Two (Q2) Progress Report (Report) to the Centers for Medicare & Medicaid Services, covering the reporting period of April 1, 2023, through June 30, 2023. The Report is required by Section 14.5 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").

If you have any questions or need additional information regarding this report, please contact Amanda Font by email at Amanda.Font@dhcs.ca.gov.

Sincerely,

[redacted]

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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)

SECOND QUARTER REPORTING PERIOD: APRIL 1, 2023 – JUNE 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 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) 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; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
  - **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and (2) support justice-involved (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 beneficiaries, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
  - **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, in order to provide this service in DMC-ODS and Drug Medi-Cal (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% 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.

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. For example, the Designated State Health Programs (DSHPs) that will be eligible to support the non-federal share funding for the PATH program. The DSHP authority is available from DY19 through DY22. Once CMS approves, the complete DSHP list will be added to the STCs as Attachment Y, while Attachment Z will contain the DSHP Claiming Protocol.

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

Special Terms and Conditions (STCs) Item 14.8: Monitoring Call

CMS and DHCS mutually agreed to hold joint monthly CalAIM 1115/1915(b) waiver monitoring calls. During DY 19 Q2, DHCS and CMS mutually agreed to cancel the CalAIM 1115 portion of the monitoring call and instead share updates via email. As needed, separate CalAIM 1115 deliverable-specific calls also took place during the quarter.

STCs Item 14.9: Post Award Forum

In DY 19-Q2, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On May 24, 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: May Revise; Unwinding of the COVID-19 Public Health Emergency (PHE) and Redetermination Efforts; Health Plan Quality Measures and Sanctions; 2024 Health Plan Contract Implementation and Health Plan Transitions; CalAIM Update; New Waiver for California Behavioral Health Community- Based Continuum Demonstration; and Behavioral Health Payment Reform 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 April 7, 2023, May 5, 2023, and June 2, 2023. The meetings included discussion of DHCS programmatic implementation updates, such as: Continuous Coverage Unwinding; Statement of Citizenship, Alienage, and Immigration Status (MC 13); BenefitsCAL; 250% Working Disabled Program; Medicare Part A, B and D; Hearing Aid Coverage for Children Program Update; Medi-Cal Access Program (MCAP) Eligibility and Notice of Action; and Assets Limits Elimination, Age 26/49 Expansion/Older Adult Expansion, 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 June 8, 2023. DHCS discussed the following topics: Renewals/Redeterminations; 2024 Transition Policy Guide; Transportation Benefit; Community Health Worker Benefit; and Population Health Management, Enhanced Care Management: Children/Youth and Preventative Services Report; and Community Supports Standardization. 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 beneficiary advocacy organizations and representatives of various Medi-Cal provider groups.

PROGRAM UPDATES

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 19-Q2, as required in item 14.5[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, June 28, 2023, ca-calaim-ca1.pdf (medicaid.gov).

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 California Advancing and Innovating Medi-Cal (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 Community-Based Adult Services (CBAS) program to eligible older adults and adults with disabilities in an outpatient facility-based setting while now also allowing flexibility for the provision and reimbursement of remote services under specified emergency situations, i.e., Emergency Remote Services (ERS). This flexibility will allow beneficiaries to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization."

Program Requirements:

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

CBAS beneficiaries' place of residence and the CBAS center when needed. CBAS 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 County Organized Health Systems (COHS) began providing CBAS as a benefit. The final transition of the CBAS benefit to managed care took place beginning October 1, 2012, into the Two-Plan Model, (available in 14 counties), Geographic Managed Care Plans (available in two counties), and the final COHS County (Ventura) at that time. As of December 1, 2014, Medi-Cal FFS only provided CBAS coverage for CBAS eligible participants who had an approved medical exemption from enrolling into

[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.

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.

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.**

	DY18 – Q2		DY18 – Q3		DY18 – Q4		DY 19-Q1	
	Apr – June 2022		July – Sept 2022		Oct - Dec 2022		Jan – Mar 2023	
County	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	479	76%	474	76%	476	76%	448	71%
Butte	24	24%	25	25%	26	26%	24	24%
Contra Costa	142	38%	131	35%	127	34%	116	53%
Fresno	960	44%	1,008	46%	1,025	47%	1,009	46%
Humboldt	85	14%	97	16%	86	15%	88	15%
Imperial	269	45%	275	46%	275	46%	278	46%
Kern	224	22%	198	19%	277	27%	191	18%
Los Angeles	24,391	55%	24,983	57%	23,584	54%	22,838	52%
Merced	112	53%	110	52%	118	56%	110	52%
Monterey	110	59%	96	52%	91	49%	91	49%
Orange	2,796	61%	2,871	58%	2,718	55%	2,638	48%
Riverside	520	30%	536	31%	506	29%	602	35%
Sacramento	504	57%	485	55%	478	54%	451	51%
San Bernardino	789	79%	798	52%	744	48%	829	54%
San Diego	1,731	54%	1,760	55%	1,996	62%	2,252	70%
San Francisco	875	56%	895	57%	924	59%	959	61%
San Joaquin	33	14%	31	13%	36	15%	51	N/A
San Mateo	69	68%	74	73%	74	73%	138	136%
Santa Barbara	9	5%	4	2%	6	4%	13	8%
Santa Clara	615	44%	641	46%	559	40%	554	40%
Santa Cruz	85	56%	86	56%	78	51%	74	49%
Shasta	2	1%	0	0%	8	6%	44	31%
Stanislaus	6	1%	26	4%	6	1%	21	2%
Ventura	832	55%	845	56%	804	54%	821	55%

Yolo	227	60%	239	63%	225	59%	244	64%
Marin, Napa, & Solano	78	16%	81	16%	83	17%	48	10%
Total	**35,968**	**53%**	**36,769**	**53%**	**35,222**	**51%**	**34,927**	**50%**

FFS and MCP Enrollment Data 03/2023

***Note: Information is not available for DY19-Q2 due to a delay in the availability of data and will be presented in the next quarterly report.*

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

The data provided in the previous figure demonstrates a slight decrease in enrollment for the previous 12 months, with the exception being DY 18-Q3 having an increase in unduplicated participants utilizing CBAS. The data reflects ample capacity for participant enrollment into all CBAS centers.

Monterey and San Bernardino Counties experienced a decrease in capacity utilization in DY 18-Q3 of greater than five percent. The decrease in percentages of utilization were within normal fluctuations, except for San Bernardino where the used capacity was lower due to an opening of a new center.

In DY 19-Q1, the following counties showed a decrease in utilization capacity: Alameda County by five percent, Kern County decreased by six percent, Orange County by seven percent, and Marin, Napa, and Solano Counties by seven percent. 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. Additionally, the data is more current since MCPs are now required to report discharge data.

In DY 19-Q1, the following counties showed an increase in utilization capacity: Contra Costa County by 19 percent, Riverside County by six percent, San Bernardino County by six percent, San Diego County by eight percent, San Mateo County by 63 percent, Shasta County by 25 percent and Yolo County by five percent. The implementation of CBAS Emergency Remote Services (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.

DHCS received newly resubmitted data from our managed care plans for DY 18-Q4 and Figure 1 above, reflects the new enrollment data and utilized capacity. One of the significant changes is for San Diego County, originally it was reported at 54 percent utilization capacity. However, with the resubmission, it is 62 percent due to increase in enrollment, making it a seven percent increase in comparison to DY 18- Q3 reported at

55 percent. In the DY 18 Annual Report, it was reported that Sacramento and Riverside counties experienced a greater than five percent increase due to higher attendance, which is no longer accurate.

Sacramento County originally reported to be at 63 percent utilized capacity, however, with the resubmission, it is 54 percent. In comparison to DY 18-Q3, the difference is a decrease in one percent. Riverside County originally reported to have 37 percent utilization capacity, however, with the resubmission, it is now 29 percent. In comparison to DY 19- Q3 at 31 percent, the difference is a decrease in two percent.

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)
DY18 -Q4 (Oct 2022 – Dec 2022)	36,704	438	303	78
		1.19%	0.83%	0.21%
DY19 -Q1 (Jan 2023-March 2023)	34,463	494	473	65
		1.43%	1.37%	0.19%
DHCS Data 03/2023				

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 beneficiaries wherever they are – on the street, in a shelter, in their doctor's office, or at home. Beneficiaries 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-Q1, there were a total of 34,463 CBAS participants and 494 received ECM, 473 received CS and 65 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
DY18-Q2 (Apr-Jun 2022)	2,874	2,765 (96.2%)	109 (3.8%)	5	4 (80%)	1 (20%)
DY18-Q3 (Jul – Sept 2022)	2,956	2,840 (96.1%)	116 (3.9%)	0	0 (0%)	0 (0%)
DY18-Q4 (Oct – Dec 2022)	2,863	2,803 (98.0%)	60 (2.0%)	5	1 (20%)	4 (80%)
DY 19- Q1 (Jan 1 –Mar 2023)	*	*	*	2	1	1
5% Negative change between last Quarter		No	No		No	No

**MCP assessment information is not reported for DY 19-Q2 due to a delay in the availability of the data and will be presented in the next quarterly 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 beneficiaries in DY 19-Q2, 2 assessments were performed for CBAS benefits, with 0 being eligible and 2 being ineligible. The MCP data will be shown in the next quarterly 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 - 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	24,643
Total Licensed Capacity	41, 809

Statewide ADA per Center	59%
CDA - MSSR Data 06/2023	

***Note: Sixteen providers have not submitted MSSR as of 7/12/23.*

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 six centers opened. Two counties that had only one licensed and certified center – San Joaquin and Marin – lost 100% of capacity when the centers closed. Contra Costa County lost 40% 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 DY19 Q2.

Figure 4, above, identifies the number of counties with CBAS centers and the average daily attendance (ADA) for DY 19-Q2. ADA data fluctuates somewhat from month to month but averaged for DY 19-Q2 the ADA at the 283 operating CBAS centers was approximately 24,643 participants, which corresponds to 59 percent of total capacity. Data identified in Figure 3 reflects CDA and provider-reported data through June 2023. ADA has decreased approximately 30 percent 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 Q1 and Q2 are, the decrease by 1; in how many counties in California have CBAS Centers, the increase by 2; in the number of CBAS Centers, the decrease by 1 in non-profit centers, and the increase by 3; in for-profit centers. The total ADA at 283 centers increased by 1,217, bumping up the ADA percentage increased by 2 percent. Lastly, the total licensed capacity increased by 725.

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-Q2:

- CBAS ACLs (**1**)
- CBAS News Alerts (**23**)
- CBAS Webinars **(1)**
- CAADS/ALE Vision Team Meetings with CBAS providers and CDA staff (**6**)
- CAADS/ALE- MCP-CDA meetings (**3**)
- DHCS-CDA-MCP meetings **(3)**
- CDA DHCS meetings **(3)**
- CDA CDPH meetings **(3)**
- Responses to CBAS Mailbox Inquiries **(331)**

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 Electronic Visit Verification (EVV) requirements, including reporting policy clarification and new code requirements for claims submission, the CBAS ERS Initiation Form (CEIF), the Monthly Statistical Summary Report (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-Q2, CDA provided webinar training on a new streamlined process for providers to utilize when submitting electronic data to CDA during widespread emergencies. Based on feedback from CBAS providers, CDA enhanced the existing process to

expedite data submission and reduce administrative burden at times when providers need to focus efforts on quickly responding to participant needs. 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-Q2, CDA participated in three CBAS provider learning collaborative meetings on Enhanced Care Management (ECM) and Community Supports (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 three 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 second quarter of DY 19 due to multiple competing meetings with CBAS providers and MCPs. CDA plans to reconvene meetings in 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. CDA's IT priority the past months has been to establish mechanisms to collect and report ERS data to assist program in the evaluation of the ERS benefit utilization and 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 331 CBAS mailbox inquiries, which included questions about: (1) the interpretation and implementation of ERS policies;(2) CBAS program requirements, including operational challenges such as meeting staffing and transportation requirements post-pandemic and the transition of participants to full in-center operations amidst uncertainties of infection risks; (3) CDA reporting requirements for ERS and submission of the CBAS ERS Initiation Form (CEIF) in the CBAS internal provider database to initiate ERS; (4) MCP denials of some CEIFs preventing the implementation of ERS according to ERS policy directives requiring policy clarification by CDA and DHCS; and (5) 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, which 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, including 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 since implementation of ERS on October 1, 2022, have reinforced the value of the CBAS ERS benefit. There has been a total of 16,870 ERS events since the inception of ERS. Public emergencies reported by CBAS providers include—192 power outages or extreme weather conditions, 721 flood related events, 7,799 epidemic infectious disease outbreak (COVID-19), and 799 which fall under other (this includes transportation issues, decline in physical/mental health, and hospitalizations). In addition, CBAS providers also initiated ERS for personal emergencies—6,209 serious illness/injury (falls, decline in health, and surgery), 606 crises (includes transportation issues, loss of caregiver, and deterioration of health, or fear of returning to in center congregate setting), and 513 care transition related events which includes 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. The centers are re-opened 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 5840 active events, then dropped sharply to 2178 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. 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.

Policy Guidance Regarding Implementing ERS

During DY-19 Q1 and Q2, 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 June 2023 include:

Total ERS Events	2,178
Percentage of CBAS Participants Receiving ERS	6%
Public Emergencies	535
Personal Emergencies	1,643

CDA will continue to collect, distribute, and post ERS data on the CDA website for transparency and analysis.

Compliance with CBAS EVV Requirements

CDA worked closely with DHCS 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, CDA contracted with ATI Advisory to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of the CBAS program. Specifically, the work of the consultants, 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 DY19 Q2, CDA and 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. CDA anticipates the final report will be ready by August 2023.

Figure 5: Data on CBAS Complaints

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY18-Q3 (Jul – Sep 2022)	0	0	0
DY18-Q4 (Oct – Dec 2022)	0	3	3
DY 19- Q1 (Jan – Mar 2023)	0	4	4
DY 19- Q2 (Apr – June 2023)	0	0	0
CDA Data – Complaints 06/2023			

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 – Sept 2022)	3	0	3
DY18-Q4 (Oct – Dec 2022)	2	0	2
DY 19 – Q1 (Jan – Mar 2023)	6	0	6
Phone Data – Phone Center Complaints 03/2023			

*Note: *MCP assessment information is not reported for DY 19-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report*

Consumer Issues and Interventions:

CBAS Beneficiary/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 beneficiaries and providers. CDA was able to provide Q2 data in time for submission to CMS. Figure 5, above, demonstrates a total of four complaints received in DY 19-Q1 and none in DY-19-Q2. Figure 6, above, demonstrates a total of six complaints received in DY 19-Q1. DHCS will report CBAS MCP complaint data for DY 19-Q2 in the next quarterly 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-Q2 (Apr – Jun 2022)	3	0	0	1	4
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
MCP Data - Grievances 03/2023					

*Note: *MCP information is not reported for DY 19-Q2 due to a delay in the availability of the data and will be presented in the next quarterly 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 – Q2 (Apr – Jun 2022)	4	0	0	0	4
DY18 – Q3 (Jul – Sept 2022)	5	0	0	0	5
DY18 – Q4 (Oct – Dec 2022)	4	0	0	0	4
DY19 – Q1 (Jan – Mar 2022)	0	0	0	0	0
MCP Data - Appeals 03/2023					

Note: MCP information is not reported for DY 19-Q2 due to a delay in the availability of the data and will be presented in the next quarterly report.

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

Grievance and appeals data are provided to DHCS by the MCPs. Under Figure 7 for DY 19-Q1, there were a total of 16 complaints received regarding CBAS services. The data provided for DY 19-Q1 for Figure 8 shows zero 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-Q2, 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 second quarter the Committee has not yet met.

Figure 9: CBAS Centers Licensed Capacity

County	DY18-Q2 Apr-Jun 2022	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	DY 19-Q1 (Jan – Mar 2023)	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	370	0.0%	71%
Butte	60	60	60	60	0.0%	24%
Contra Costa	220	220	220	130	-41.0%	53%
Fresno	1,297	1,297	1,297	1,297	0.0%	46%
Humboldt	349	349	349	349	0.0%	15%
Imperial	355	355	355	355	0.0%	46%
Kern	610	610	610	610	0.0%	18%
Los Angeles	25,958	26,003	26,003	26,083	0.0%	52%
Merced	124	124	124	124	0.0%	52%
Monterey	110	110	110	110	0.0%	49%
Orange	2,723	2,903	2,903	3,241	12.0%	48%
Riverside	1,025	1,025	1,025	1,025	0.0%	35%
Sacramento	520	520	520	520	0.0%	51%
San Bernardino	590	911	911	911	0.0%	54%
San Diego	1,903	1,903	1,903	1,903	0.0%	70%
San Francisco	926	926	926	926	0.0%	61%
San Joaquin	140	140	140	0	-100.0%	0%

County	DY18-Q2 Apr-Jun 2022	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	DY 19-Q1 (Jan – Mar 2023)	Percent Change Between Last Two Quarters	Capacity Used ***
San Mateo	60	60	60	60	0.0%	136%
Santa Barbara	100	100	100	100	0.0%	54%
Santa Clara	820	820	820	820	0.0%	40%
Santa Cruz	90	90	90	90	0.0%	49%
Shasta	85	85	85	85	0.0%	31%
Stanislaus	360	360	360	510	42.0%	2%
Ventura	886	886	886	886	0.0%	55%
Yolo	224	224	224	224	0.0%	64%
Marin, Napa, Solano	295	295	295	295	0.0%	10%
SUM	**40,200**	**40,746**	**40,746**	**43,906**	**0.0%**	**55%**

***Capacity Used information is not available for DY 19-Q2 due to the delay in the availability of the data.*

**** 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.*

Figure 9, above, reflects that the average licensed capacity used by CBAS participants. The following counties had a greater than five percent increase due to a change in license capacity: Contra Costa, Orange, San Joaquin, and Stanislaus. San Joaquin's only CBAS Center closed in DY 19-Q1, therefore it has a 100-percentage decrease. Contra Costa's licensed capacity went decreased from 220 to 130, totaling a 41-percentage decrease. Stanislaus county's licensed capacity increased from 360 to 510 totaling 42 percentage increase. Orange county's capacity increased from 2,903 to 3,241 totaling a 12-percentage increase. 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 from region to region and from center to center 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.

Data for the total sum of license capacity for previous quarters has been updated to reflect current capacity.

Figure 10: DY 19-Q2 CBAS Centers Licensed Capacity

Note: Figure 10 is the same as above but with the addition of Q2 as CDA made it available in time for submission to CMS.

County	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	DY 19-Q1 (Jan – Mar 2023)	DY 19-Q2 (Apr-June 2023)	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	370	0.0%	71%
Butte	60	60	60	60	0.0%	24%
Contra Costa	220	220	130	130	0.0%	53%
Fresno	1,297	1,297	1,297	1,297	0.0%	46%
Humboldt	349	349	349	349	0.0%	15%
Imperial	355	355	355	355	0.0%	46%
Kern	610	610	610	610	0.0%	18%
Los Angeles	26,003	26,003	26,083	26,520	2.0%	52%
Merced	124	124	124	124	0.0%	52%
Monterey	110	110	110	110	0.0%	49%
Orange	2,903	2,903	3,241	3,321	2.0%	48%
Riverside	1,025	1,025	1,025	1,025	0.0%	35%
Sacramento	520	520	520	520	0.0%	51%
San Bernardino	911	911	911	911	0.0%	54%
San Diego	1,903	1,903	1,903	2,186	15.0%	70%
San Francisco	926	926	926	926	0.0%	61%
San Joaquin	140	140	0	0	0.0%	0%
San Mateo	60	60	60	60	0.0%	136%

County	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	DY 19-Q1 (Jan – Mar 2023)	DY 19-Q2 (Apr-June 2023)	Percent Change Between Last Two Quarters	Capacity Used ***
Santa Barbara	100	100	100	100	0.0%	54%
Santa Clara	820	820	820	820	0.0%	40%
Santa Cruz	90	90	90	90	0.0%	49%
Shasta	85	85	85	85	0.0%	31%
Stanislaus	360	360	510	510	42.0%	2%
Ventura	886	886	886	886	0.0%	55%
Yolo	224	224	224	224	0.0%	64%
Marin, Napa, Solano	295	295	295	220	-25.0%	10%
SUM	**40,746**	**40,746**	**43,906**	**41,809**	**-5.0%**	**55%**

***Capacity Used information is not available for DY 19-Q2 due to the delay in the availability of the data.*

**** 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 10, in DY 19-Q2, the following counties had changes over five percent between the last two quarters: San Diego County and Marin/Napa/Solano Counties. San Diego County's licensing capacity increased by 15 percent due to the opening of a new center. Marin's only CBAS Center closed in Q2 leading to a 25-percentage decrease as Marin, Napa and Solano's total licensed capacity is combined. The overall total licensing capacity decreased by five 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. Beneficiaries can choose to participate in other similar programs should a CBAS Center not be present in their county or within the travel distance requirement of participants traveling to and from a CBAS Center. Prior to closing, a CBAS Center is required to notify CDA and their contracted MCPs of their planned closure date and to conduct discharge

planning for each of the CBAS participants to which they provide services. CBAS participants affected by a center closure and who are unable to attend another local CBAS Center can receive unbundled services in counties with CBAS Centers. The majority of CBAS participants in most counties 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 and information regarding their discharges was provided to their MCPs. The data will be shown in the next report.

All three centers provided evidence to CDA that it completed required discharge planning and referrals. Beneficiaries who received unbundled CBAS services in DY 19-Q2 will be included with Q3 data.

Figure 11: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
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

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
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 11, 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.

Figure 9 shows there was no negative change of more than five percent in DY 18-Q4, 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 neutral.

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 an SUD that reside in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS beneficiaries). Since the DMC-ODS pilot program began in 2015, all California counties had the option to participate in the program to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan.

Originally authorized by the Medi-Cal 2020 demonstration, most of the components of DMC-ODS are authorized under California's Section 1115 CalAIM demonstration approved through December 31, 2026 [for expenditure authority for services provided to DMC-ODS beneficiaries receiving short-term SUD treatment in Institutions 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 beneficiaries 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, five DMC-ODS counties have implemented CM services. These counties include Los Angeles, San Francisco, Kern, Riverside, and Fresno. Collectively, these five counties cover 45 percent of Medi-Cal beneficiaries. Among these five counties, there are 19 approved sites offering CM services to 188 beneficiaries, as of June 30, 2023. Los Angeles County has 11 approved sites, San Francisco County has two approved sites, Kern County has one approved site, Riverside County has four approved sites, and Fresno County has one approved site. In total, 24 DMC-ODS counties will participate in the Recovery Incentives Program pilot, covering 88 percent of Medi-Cal beneficiaries.

In addition to the 19 sites offering CM services, there are 47 sites, located in 10 additional counties, that have completed the required Implementation Training and 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, $19,810 in gift cards (motivational incentives) have been earned by eligible beneficiaries for meeting the treatment goal of submitting a urine drug test negative for stimulants. The department's incentive manager (IM) portal allows beneficiaries 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, 49 percent were immediately redeemed during the beneficiary visit, and 51 percent were banked to be redeemed later. When a beneficiary chooses to redeem a gift card, they can choose from a list of pre-approved vendors. The most common gift card redemptions include Walmart (66 percent), Burger King (13 percent), and Old Navy (six percent).

DHCS is working with the IM vendor to finalize 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.

Throughout Q2 of 2023, the DHCS Recovery Incentives Program team continued weekly planning meetings with the CM training and technical assistance provider, UCLA, and the IM vendor, Q2i, and bi-weekly payment process meetings. The team reviewed stakeholder feedback on BHIN 22-056 and will post the updated BHIN in Q3. Additionally, the team continued to respond to questions from participating counties and provider sites, supported the development of training materials for counties and providers, and provided weekly reports to CDPH for expedited processing of Clinical Laboratory Improvement Amendments waivers.

Recovery Incentives: California's Contingency Management Program – Training and Technical Assistance Activities, DY 19, Quarter 2 (Q2)

Statewide Contingency Management (CM) pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities included working closely with staff from to make slight refinements to the IM Portal slides that were presented in the Part II Implementation Training. The sample beneficiary consent form, 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 136 individuals completed the CM Overview Training on-demand course between April 1, 2023, and June 30, 2023. Eighteen Implementation Trainings were delivered (with 328 total participants), 21 Readiness Assessment interviews were conducted, and 18 new sites were approved to initiate providing CM Services (for a total of 19 sites) and there are approximately 182

beneficiaries enrolled. California also conducted 9 one-hour Zoom office hours and 35 outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was finalized, and 46 sites received a link to the Qualtrics self-study to initiate the Readiness Assessment process. The Fidelity Monitoring tool is drafted and is in its final review stages at DHCS. The first Fidelity Monitoring interview will be scheduled in mid to late July 2023.

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, as well as Drug Medi-Cal (DMC), and the Specialty Mental Health Services (SMHS) delivery systems. As of May 15, 2023, 3,588 individuals applied for 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 12 for breakdown of applicants by application/certification status). As of March 31, 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 12: Peer Support Specialist Applications and Certifications (as of May 15, 2023)

Applications/ Certifications by Status[3]	Number
Certified	1031
Approved to take certification exam	942
Certification exam not passed	91
Training in progress	1,226
Application in revision	298
Total	**3,588***

*the total above does not include applications pending payment or denied applications

Throughout Q2 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 DY19-Q2, DHCS also published FAQs addressing certification standards, lapsed certification, opting-in and claiming requirements, professional development for peers, and Provider Application and Validation for Enrollment (PAVE).

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

DHCS is also integrating feedback into an all-inclusive Medi-Cal Peer Support Services BHIN, which is expected to be released in late September 2023.

Throughout February and March of 2023, DHCS gathered feedback from stakeholders to inform policy development requiring Medi-Cal Peer Support Specialists and other unlicensed providers to obtain National Provider Identifiers (NPI). NPI guidance is expected to be developed by late 2023 or early 2024.

Performance Metrics

Prior quarters have been updated based on new claims data. For DY 19-Q1 and DY 19-Q2, only partial data is available since counties have up to six months to submit claims after the month of service.

Figure 13: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY 18-Q3	9,225	3,500	12,725
DY 18-Q4	9,022	3,514	12,536
DY 19-Q1	8,390	3,157	11,547
DY 19-Q2	2,597	926	3,523

**Affordable Care Act*

Figure 14: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees to date
ACA	16,679	16,967	17,195	DY18-Q3	17,466
ACA	17,430	17,602	17,730	DY18-Q4	17,998
ACA	17,817	17,810	17,836	DY19-Q1	18,176
ACA	17,782	17,729	17,702	DY19-Q2	18,007
Non-ACA	7,335	7,272	7,198	DY18-Q3	7,677
Non-ACA	7,100	7,035	6,993	DY18-Q4	7,392
Non-ACA	6,957	6,965	6,912	DY19-Q1	7,267
Non-ACA	6,909	6,897	6,874	DY19-Q2	7,143

Figure 15: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	368,250	$61,161,836.82	$54,168,788.34	$6,073,775.71	$919,272.77	DY1 8-Q3
Non-ACA	127,871	$20,999,861.70	$11,792,495.45	$7,539,228.28	$1,668,137.97	DY1 8-Q3
ACA	376,036	$61,801,841.04	$54,646,595.37	$6,240,636.65	$914,609.02	DY1 8-Q4
Non-ACA	131,272	$21,288,545.40	$11,961,822.45	$7,707,333.01	$1,619,389.94	DY1 8-Q4
ACA	307,952	$52,148,060.89	$46,155,039.00	$5,224,089.17	$768,932.72	DY1 9-Q1
Non-ACA	115,274	$18,048,810.19	$10,156,750.80	$6,582,749.33	$1,309,310.06	DY1 9-Q1
ACA	55,035	$9,212,532.58	$8,108,146.56	$923,680.52	$180,705.50	DY1 9-Q2
Non-ACA	18,879	$3,046,671.61	$1,682,122.42	$1,075,622.99	$288,926.20	DY1 9-Q2

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-Q2_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-Q2 as of April 13, 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:
  - April 19, 2023
    - Fiscal Year 23/24 Behavioral Health Compliance Review
  - May 17, 2023
    - CalAIM Performance Monitoring: Program Implementation Feedback
  - June 21, 2023
    - Behavioral Health Documentation Redesign

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:

- **BHIN 23-013** – CalAIM Behavioral Health Payment Reform Readiness Check list
- **BHIN 23-017** – Specialty Mental Health Services and Drug Medi-Cal Services Rates
- **BHIN 23-018** – Update Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal
- **BHIN 23-020** – Rollback of Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and the Statewide Maximum Allowance (SMA) Rates for Specialty Mental Health Services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Non-Narcotic Treatment Program (non-NTP) Services Due to the End of the COVID-19 Public Health Emergency (PHE)
- **BHIN 23-024** – Drug Medi-Cal Organized Delivery System (DMC-ODS) Treatment Perception Survey (TPS)
- **BHIN 23-025** – Medi-Cal Mobile Crisis Services Benefit Implementation

Consumer Issues and Interventions:

DHCS continues to respond to issues, complaints, or grievances related to DMC-ODS counties delivering DMC-ODS services from beneficiaries. Issues that generate complaints or grievances related to DMC-ODS are minimal. DHCS did not receive any grievances for DY19-Q2.

Quality Control/Assurance Activity:

DHCS scheduled and conducted the annual DMC-ODS compliance monitoring reviews during DY19-Q2. The compliance monitoring reviews listed in Figure 16 concludes DHCS' FY 2022-23 annual reviews.

Figure 16 demonstrates when county DMC-ODS monitoring reviews were completed during DY19-Q2.

Figure 16: DY 19-Q2 Monitoring Reviews

County	Dates
Butte	April 2023
Calaveras	April 2023
Marin	April 2023
Monterey	April 2023
Placer	April 2023
Plumas	April 2023
Riverside	April 2023
San Diego	April 2023
San Joaquin	April 2023
San Luis Obispo	April 2023
Alpine	May 2023
Del Norte	May 2023
Kern	May 2023
Kings	May 2023
Los Angeles	May 2023
Orange	May 2023

El Dorado	June 2023
Humboldt	June 2023
County	**Dates**
Lassen	June 2023
Mendocino	June 2023
Modoc	June 2023
Mono	June 2023
Napa	June 2023
Nevada	June 2023
Santa Barbara	June 2023
Santa Cruz	June 2023
Shasta	June 2023
Sierra	June 2023
Siskiyou	June 2023
Solano	June 2023
Yolo	June 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 DY19-Q2.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

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

- UCLA worked with DHCS to revise the DMC-ODS Evaluation Plan following further inquiry from CMS regarding the Medi-Cal 2020 Calendar Year 2021 temporary extension and how the data would be incorporated into the overall analysis plan. A new version of the Evaluation plan for CMS review was drafted on June 9, 2023.

Approval from CMS is pending.

- 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. Pending CMS approval, UCLA continues to engage in discussions with implementation partners and stakeholders to coordinate topic areas of interest and finalize metrics for the Recovery Incentives Program. UCLA coordinated with the Training and Implementation Support team to observe readiness assessment activities and began tracking for evaluation data collection timepoints among active sites. UCLA has procured survey/interview incentives in preparation for the evaluation activities at both the provider and client level. Finally, a draft of the provider survey for timepoint one (early implementation) was developed and is currently in review with DHCS for approval.
- UCLA has received rulings from both the state and UCLA institutional review boards that the waiver evaluation is exempt from their review due to the rules on 1115 waivers detailed in the 2018 Common Rule at 45 CFR 46.104(d)(5)(i). Per the 2018 requirements, UCLA is awaiting formal approval of the evaluation design and posting of the project by CMS. In response to UCLA's request, DHCS has asked CMS to clarify whether the posting requirement has been met.
- UCLA is in the process of seeking a Certificate of Confidentiality through SAMHSA, which will provide an additional layer of protection for any data obtained through the evaluation. The application requires signature from the State Institutional Review Board, which UCLA is pending the review/outcome of this request.
- 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 for the evaluation plans, pending CMS approval.
- In June 2023, UCLA launched a website to support the implementation of the publicly available ASAM Criteria Assessment Interview Guide. The Interview Guide can be found on the ASAM website. On this site, providers can access the Interview Guide, the introduction webinar, the feedback survey, and other supportive material. UCLA is finalizing a progress report which will incorporate 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.
- UCLA completed and submitted the 2022 Treatment Perception Survey (TPS) statewide report in April 2023, and began the process of preparing for the 2023 TPS. Collection period dates were approved for October 16-20, 2023, and an information notice (BHIN 23-024) was posted on June 28, 2023. Updates to the data collection form were approved to incorporate additional questions addressing perceptions of telehealth, craving, and social services coordination. In addition, language updates

were made to the selection options for race, sexual orientation, and gender identity, aligning with current standards. Language translation (to statewide threshold languages) and form restructuring are underway, as well as initiating coordination with county representatives for the Fall 2023 TPS data collection. 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 prepared for and completed the 2023 Consumer Perception Survey (CPS) data collection from May 15-19, 2023. UCLA updated all forms (paper and online), codebooks, instructions, and flyers for the 2023 collection period. UCLA held a training session on April 28, 2023, and posted all required materials on the UCLA CPS website. The County deadline to submit all data for analysis is July 14, 2023. At the end of this reporting period, UCLA can confirm that all counties participated in CPS 2023 and to date has received a total of 40,949 forms (26,776 paper and 14,173 online). These numbers are preliminary as data is still being received. Data cleaning and analysis will continue into the next quarter with the expectation to submit Uniform Reporting System tables by November 2023.

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 beneficiaries under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. Under the CalAIM waiver, GPP continues the work accomplished under the Medi-Cal 2020 waiver and adds 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:

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.

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

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Figure 17: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
(PY) 8 Quarter 4	$164,045,492.81	$134,219,039.58	DY 18	$298,264,532.39
PY 9 Quarter 1	$363,440,258.16	$297,360,211.22	DY 19	$660,800,469.38
Total	**$527,485,750.97**	**$431,579,250.80**		**$959,065,001.77**

DY 19-Q2 GPP reporting activity includes payments made in April 2023, for PY 8 Q4 and PY 9-Q1.

In GPP PY 8-Q4 the PHCS received $164,045,492.81 in federally funded payments and $134,219,039.58 in intergovernmental transfer (IGT)-funded payments. The total fund payment includes overpayment collection of $48,810,946.42 in total computable from three PHCS. The recoupments were due to overpayment to San Francisco General Hospital in the amount of $27,001,223.86, San Mateo Medical Center in the amount of $858,309.17, and Ventura County Medical Center in the amount of $20,951,413.39.

In PY 9-Q1, the PHCS received $363,440,258.16 in federally funded payments and $297,360,211.22 in IGT-funded funded payments.

Evaluation Activities and Interim Findings:

Nothing to report.

PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH) SUPPORTS

California's Section 1115 waiver renewal includes expenditure authority for the 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 participate in the Medi-Cal delivery system as California widely implements Enhanced Care Management (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 Whole Person Care (WPC) Lead Entities (LEs), community-based organizations (COBs), public hospitals, Medi-Cal Tribal and designees of Indian Health Programs, and others as approved by the Department of Health Care Services (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 managed care plans (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.
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.

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:

Whole Person Care Transition and Mitigation

During DY 19-Q2, approved grantees of the PATH WPC Services and Transition and Mitigation submitted their annual invoices and PATH Utilization Reports to DHCS for expenditures from July 1, 2022, to December 31, 2022. 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 second payment for this initiative will be processed by the end of DY 19-Q2.

Technical Assistance (TA) Marketplace

The PATH TA Marketplace initiative provides funding for providers, community-based organizations, counties, and others to obtain TA resources to establish the infrastructure needed to implement Enhanced Care Management (ECM) and Community Supports. Organizations interest 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 Third-Party Administrator (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. As of June 28, 2023, 125 TA Recipient Eligibility applications have been received and 98 of those TA Recipient Eligibility applicants have been approved. Additionally, for TA Project Eligibility applications, as of June 28, 2023, 68 applications were received for consideration. Entities are able to shop and access TA resources from curated and approved TA Vendors. The Round Two TA vendor application period opened March 28, 2023, and closed on April 28, 2023. As of June 30, 2023, there are 47 approved TA Vendors. The TPA and DHCS are currently reviewing the Round Two TA Vendor Applications to make new vendors and resources available on the TA Marketplace. There were two types of vendor applications in this round. New organizations could apply to become TA vendors and contracted TA vendors could apply for an expansion to provide additional TA as well, 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 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.

Collaborative Planning and Implementation (CPI) Initiative

For the Collaborative Planning and Implementation Initiative, ten facilitators conduct 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 to June 2023, the TPA has registered a total of 660 participant organizations. Participant registrations are accepted on a continual basis and participants are connected with selected facilitators.

Q2 lookback analysis indicated the TPA collected and reviewed over 250 Q1 deliverables and conducted 100 one-on-one coaching sessions with facilitators with $4 million in approved facilitator funds. On April 12, 2023, CPI facilitators convened with the TPA in Sacramento to discuss initiative challenges and opportunities, discuss evaluation and measurement approaches, and align efforts across the 10 different facilitators implementing 25 workgroups throughout the state. Facilitators also took time during the convening to gain greater understanding of ECM and Community Supports implementation challenges and collaboration opportunities from the Department's perspective, as well as to hear initial information on changes within DHCS, including activities related to the 2024 Medi-Cal Managed Care Plan transition. The collaborative facilitators also shared updates on implementation and promising practices with DHCS leadership at this convening. DHCS approved the Collaborative Planning Initiative Alternative Facilitator application, which may be utilized as a contingency if current collaborative facilitators are not performing as expected. During DY 19--Q1, DHCS and the TPA identified a gap around engagement with Tribal Entities. In ongoing discussions in DY 19-Q2, there has been joint collaboration for outreach to better engage this identified group.

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 299 applications were received. DHCS is currently reviewing Round Two applications. Round Two guidance was expanded to allow for additional permissible uses of

funding. DHCS is continuing discussions on how the Department can provide support and other resources. Applicants that receive CITED funding must be actively contracted with the Medi-Cal managed care plan (MCP) 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. DHCS anticipates that CITED initial Round Two awards will be completed announced by May 30, 2023DY 19-Q4.

Justice-Involved Capacity Building Program (JI)

The application period for PATH JI Round Three is open from May 1, 2023, until July 31, 2023. DHCS, PCG, and the TPA, are approving applications on an ongoing basis. PATH JI Round Three is a planning grant funding opportunity that provides small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support both planning and implementation of justice-involved re-entry services, including investments in capacity and IT systems that are needed to effectuate Medi-Cal justice-involved re-entry service.

On June 12, 2023, DHCS released the Policy and Operational Guide for Planning and Implementing the CalAIM JI Reentry Initiative for stakeholder comment. This draft guidance memorializes policy and operational requirements for implementing the Medi-Cal JI Reentry Initiative. The draft guidance is intended to lay out to implementing stakeholders – correctional facilities, behavioral health agencies, providers, CBOs, and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.

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
- 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 Health Insurance Portability and Accountability Act (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

[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.

of best practices for suspension, pre-release, eligible PATH funding uses, and data-sharing processes.

CITED Initiative

- DHCS awarded $88.5 million for Round 1B. These capacity and infrastructure grants will assist counties, local agencies, community-based organizations, and others to deliver successful ECM and Community Supports services to Medi-Cal members. This brings the total funding awarded for CITED Round One to $207 million. The CITED Round Two application window opened on February 28 and closed on May 31.
- Every Friday from March 10 to May 26, 2023, the TPA and DHCS held office hours and provided technical assistance on the CITED application process and general guidelines. CITED awardees report on progress toward completion of milestones tied to funding to earn payment through quarterly Progress Report submissions. During office hours the TPA and DHCS answered questions from prospective applicants for Round Two and provide clarifying guidance on Round One awardee progress reporting requirements.
- On April 4, 2023, DHCS hosted a webinar for Round 1A and 1B awardees who were invited and discussed the progress reporting process and answered questions regarding the updated progress report guidance.
- On April 14, 2023, DHCS hosted a webinar geared toward tribal entity engagement. Noting that there were no tribal entity applicants in CITED Round One. This was an effort to have a targeted information session to foster engagement in time for the Round Two application close.
- On May 8, 2023, DHCS hosted a webinar to provide an overview of the CITED and JI initiatives. The purpose of the joint webinar was to highlight key differences between the initiatives, how to apply for funds, and share the purpose of each initiative.
- On May 18, 2023, DHCS announced CITED applicants may request retroactive funding from January 1, 2022, until the release of applications for the CITED funding round for which the entity is applying. DHCS and the PATH third-party administrator previously communicated during CITED webinars that the earliest date for retroactive funding requests is January 1, 2021.

TA Marketplace

- On March 28, 2023, DHCS opened the PATH Technical Assistance (TA) Marketplace Round Two vendor application. Organizations interested in qualifying as a TA Marketplace vendor were encouraged to join an informational webinar on April 6, 2023 to learn more about the application process. The deadline to apply to qualify as a vendor during Round Two was April 28, 2023.
- On June 20, 2023, DHCS hosted an informational onboarding webinar for TA Recipients.

CPI Initiative

- A monthly newsletter is sent out to Collaborative Planning Initiative Facilitators with updates on ECM, Community Supports, and Managed Care Plan guidance and reporting policies, including various PATH Initiative updates.
- On April 12, 2023, the TPA hosted an in-person facilitator convening. Topics discussed included evaluation methods to have measurable initiative goals and better address any existing challenges.
    - The TPA and DHCS met with collaborative facilitators at the convening to discuss initiative challenges and opportunities.
- On June 12, 2023, the TPA and DHCS met with collaborative facilitators to provide updates and better understand how the collaboratives can support ECM and Community Supports implementation, and to discuss areas that DHCS is focusing on that directly impact the CPI work.

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.

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, which are currently under review. These payments will be processed during DY 19-Q2.

The Collaborative Planning and Implementation Initiative awarded ten facilitators to oversee 25 collaborative planning groups $14,750,000 for meeting milestones. 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 Capacity and Infrastructure Transition, Expansion and Development 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 will only be 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-Q2 DHCS has been reviewing CITED Progress Reports for Round 1A and 1B. As of June 30, 2023, $11,706,064.88 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 DY19, $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.

Figure 18: 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	
DY 18 - Q4				
JI	$3,775,952.95	$1,887,976.50	$1,887,976.48	
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	$45,176,799.74	$22,588,399.87	$22,588,399.87	$0
WPC Mitigation	$19,778,113.42	$9,889,056.71	$0	$9,889,056.71
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$2,610,000.00	$1,305,000.00	$1,305,000.00	$0
CITED	$0	$0	$0	$0

Figure 19: Total Approved Amounts by PATH Initiative, DY 19 Q-1

PATH Initiative	Total Payment
JI	$45,176,799.74
WPC Mitigation	$19,778,113.42
TA Marketplace	$0.00
Collaborative Planning	$2,610,000.00
CITED	$0.00
TPA	
Public Consulting Group LLC	$ 0.00
TOTAL	**$67,564,913.12**

Evaluation Activities and Interim Findings:

DHCS submitted to CMS a Draft Evaluation Design for the first three components of the 1115 Waiver Demonstration, including the Providing Access and Transforming Health (PATH) Initiative, the Global Payment Program (GPP), and Medi-Cal matching plan policy for dually eligible beneficiaries (duals), on June 27, 2022. DHCS received CMS comments on the Draft Evaluation Design on December 5, 2022, which included suggestions and recommendations to identify an external evaluator and involve them in the development of a revised Evaluation Design. DHCS is in the process of releasing a 1115 Demonstration Independent Evaluation Request for Information (RFI) to provide information and solicit input from interested parties. DHCS intends to execute a contract with an entity from September 1, 2023, through June 30, 2029, for the CalAIM 1115 Evaluation activities. For the CalAIM 1115 Evaluation, CMS and DHCS would like the independent evaluator to draft the revision of the Draft Evaluation Design based on CMS' comments and add to the Evaluation Design a plan for evaluation of the Reentry Demonstration Initiative. The due date for PATH/GPP/Duals Evaluation Design has been formally extended by CMS 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
2. Housing Deposits
3. Housing Tenancy & Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services (for caregivers)
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

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.

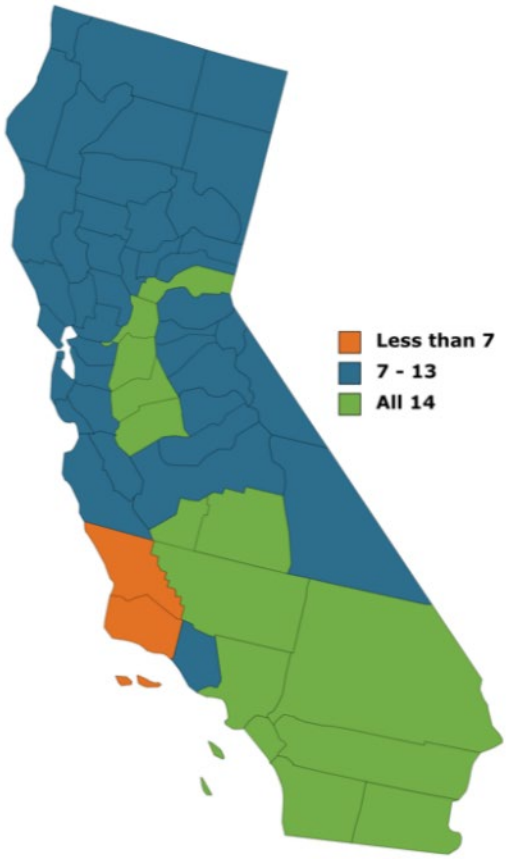
Demonstration monitoring covers reporting of performance metrics data related to the state's Recuperative Care and Short-Term Post-Hospitalization housing services, and where possible, informs the progress in addressing access needs of communities that have been historically under-resourced because of 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 beneficiary health outcomes and will include an assessment of whether the services lead to an avoidance of emergency department use and reductions in inpatient and LTC. The state will also conduct a thorough cost-effectiveness analysis of these Community Support, 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 20: Number of Community Supports, by County, Live as of June 30, 2023.

Figure 20: Number of Community Supports, by County, Live as of June 30, 2023



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

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

DHCS is working with MCPs to better understand 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 deidentifying 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 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 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 June 2023 indicates the following number of providers, beneficiaries, and counties throughout California for the following available Community Supports:

Community Supports	Number of Providers	Number of Counties Offering CS
Housing Transition	523	58
Housing Deposits	402	58
Housing Tenancy & Sustaining Services	423	58
Recuperative Care	121	42
Short-term Post Hospitalization	92	37
Day Habilitation	33	24
Medically Tailored Meals	213	58
Sobering Centers	41	17

Currently, at least one plan in all 58 California counties have elected to offer all three of the housing supports by January 1, 2024. Additionally, every plan in each county will have at least one housing Community Support by 2024.

Utilization data for Community Supports

Current available data indicates the following number of unique individuals served across the last four quarters (Q2 2022 – Q1 2023) for DHCS' available Community Supports:

Community Support	2022 Q2	2022 Q3	2022 Q4	2023 Q1
Housing Transition/ Navigation Services	5,733	7,293	9,275	12,572
Housing Deposits	234	393	415	561
Housing Tenancy and Sustaining Services	6,538	3,343	8,271	3,600

Community Support	2022 Q2	2022 Q3	2022 Q4	2023 Q1
Short-Term Post-Hospitalization Housing	79	94	183	232
Recuperative Care	647	711	1,024	1,143
Respite Services	27	1	6	79
Nursing Facility (NF) Transition/Diversion to Assisted Living Facility	156	146	163	185
Community Transition Services/Nursing Facility Transition to a Home	17	22	137	161
Personal Care and Homemaker Services	17	29	69	220
Day Habilitation Programs	1	34	103	238
Environmental Accessibility Adaptations	17	14	28	15
Medically Tailored Meals/ Medically Supportive Food	1,158	1,751	4,645	12,337
Sobering Centers	17	97	223	390
Asthma Remediation	5,733	7,293	9,275	12,572
Grand Total of Unique Members[5]	**13,855**	**12,428**	**22,517**	**29,695**

Outreach Activities:

During this reporting period, DHCS continued to strategize with leadership to 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:

- Bi-weekly CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through transition challenges, provides critical review of decisions and documents before

[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.

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 authorization policies for new Community Supports. These calls were brief, yet effective, and helped in reducing variation between policies across plans/counties.

On April 14, 2022, DHCS hosted a webinar which provided an Overview of CalAIM's ECM and Community Supports for California Regional Centers, Directors, and Executive Staff to learn more about these new CalAIM initiatives. DHCS reviewed ECM, the Population Health Care Management Continuum, and Community Supports, providing details on the roles and responsibilities of managed care plans and providers, reviewing eligibility criteria, and discussing how members can access the two programs. The presentation ended with details on how Regional Centers could apply to become ECM and/or Community Supports providers.

On May 22, 2023, DHCS held a webinar for all MCP Chief Executive Officers and Chief Financial Officers to attend and preview guidance changes planned for ECM and Community Supports. This included a historical review of utilization data which informed many of the policy update positions advertised during the webinar.

On June 9, 2023, DHCS hosted MCP staff for an in-person ECM and Community Supports One-Day Summit. The Summit convened key staff responsible for overseeing the implementation of ECM, Community Supports, and the JI Initiative to discuss policy refinements and key design areas for the second year of implementation and beyond. Additional sessions throughout the day focused on rate setting, the JI initiative, and a provider panel discussion.

On June 14, 2023, DHCS released its updated January 2024 Model of Care (MOC) to MCPs via email and on the ECM and Community Supports website. A redline copy of the Community Supports MOC in PDF format was made available upon request. The purpose of the minor updates made to the Community Support MOC template were to bring the MOC questions into alignment with subsequent updates that had been made to the Community Supports Policy Guide.

Quarterly Implementation Monitoring Report

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 services that were requested, approved, and denied, as well as provider capacity. The data from this report is designed to provide DHCS with information to monitor the initial rollout of ECM and Community Supports and inform the implementation of MCP performance incentives.

DHCS is working with MCPs to better understand 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-identification requirements for all data prior to dissemination. 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 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.

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. Currently, QIMR data lags real-time implementation by approximately 4-6 months; the transition to JSON is expected to significantly reduce lag on data collection. DHCS plans to continue the system of continuous monitoring that feeds routine "360 Implementation Reviews" with MCPs spanning ECM and Community

Supports, including in and around the transition to the 2024 MCP contract, which will bring with it MCP changes in certain counties. As CalAIM becomes integrated into regular Medi-Cal operations across DHCS, monitoring of the two programs will be woven into standard MCP monitoring.

DHCS continues its 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 19 and Figure 20 on the next page.

The next Quarterly Implementation Monitoring Report, which will include data through and including Q2 2023, is due to DHCS by August 15, 2023.

Figure 21: Program History for Members Receiving Community Support Services as of September 2022: Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:

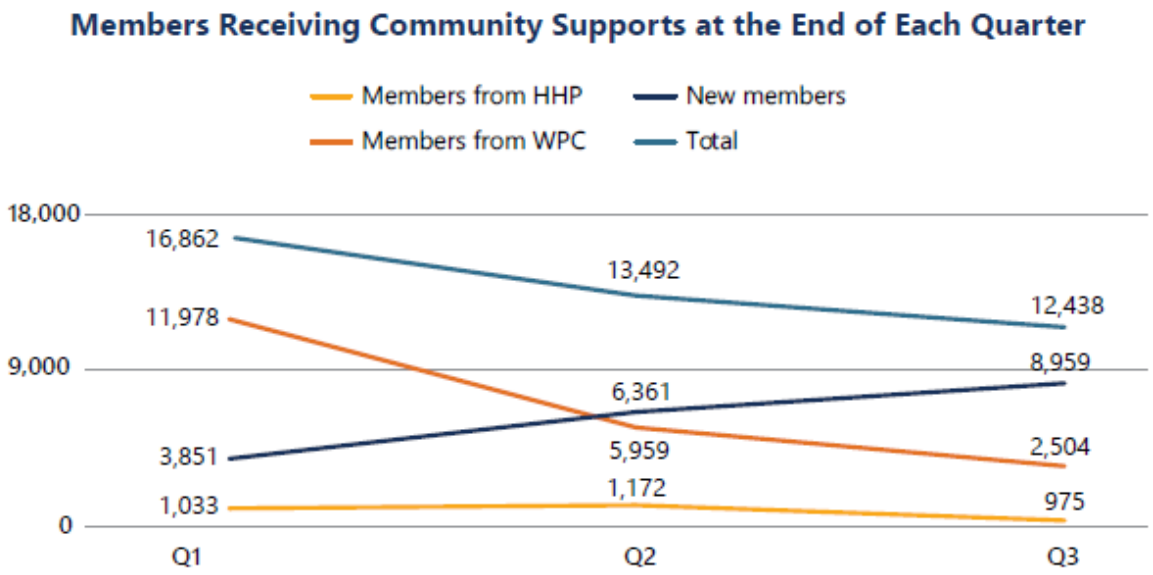
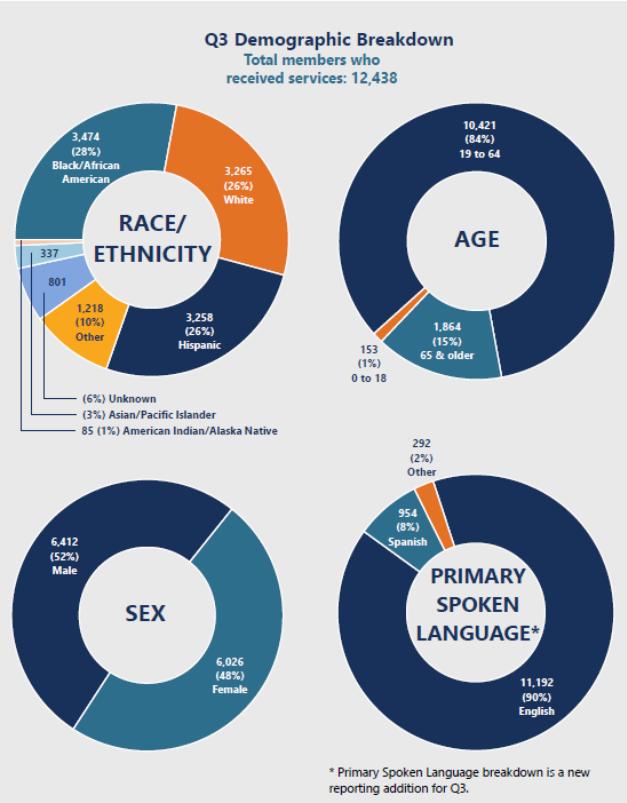


Figure 22: Demographics of Members Receiving Community Support Services as of September 2022. Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:



Operational Updates:

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

On April 15, 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 were posted on the DHCS website in mid-June, once DHCS issued its final approval for all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually. Technical assistance and guidance webinars are recorded and hosted on the DHCS website and are updated regularly. DHCS also maintains a regularly updated frequently asked questions (FAQs) document on its ECM and Community Supports webpage. The document highlights several FAQs from MCPs, providers, and stakeholders and includes answers provided by DHCS. In Q2 2023, DHCS plans on releasing a revised FAQ document updating existing FAQs to the market about:

- Requirements for MCPs if they limit the provision of Community Supports to certain regions.
- The specific responsibility of the prime plan to ensure Community Supports are equitably available to all members when a prime MCPs' subcontracted plan does not offer a specific Community Support.

DHCS is additionally finalizing further policy to clarify that prime plans have the option of facilitating changes of coverage for members who cannot receive a Community Support through a subcontracted plan, but who could receive that Community Support if moved to another subcontracted plan or to the prime.

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 all of the Community Supports being offered by the MCP, including, at minimum:
    - A short description of each available service that is consistent with the service definitions listed in the 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.

DHCS in late 2022 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.

Guidance Revisions

Now that ECM and Community Supports have been implemented for one year, DHCS has prioritized updating existing data guidance documents based on stakeholder input.

At the start of the programs, DHCS developed guidance to standardize information exchange between MCPs and ECM and Community Supports Providers, as well as between MCPs and DHCS. Standardization is designed to promote efficiency and reduce administrative burden. DHCS initially released standards for information sharing and reporting in 2021. In April 2023, DHCS unveiled new standards standardizing information exchange between Community Supports Providers and MCPs and shared key updates that have been made to the existing data guidance documents.

DHCS developed new standards for data exchange and updated the existing data guidance documents based on market feedback. Throughout the first year of implementation, DHCS heard feedback about the need for data exchange standardization between MCPs and Community Supports Providers. From Q2 – Q4 2022,

DHCS conducted 10+ interviews and launched a survey (200+ MCP & Provider respondents) to collect feedback on updates to the existing data guidance documents and to see if new standards should be created.

Community Supports Providers reported variation in how MCPs shared information about Members who had been assigned to them to receive Community Supports, resulting in significant administrative burden to reconcile and track Member information across contracted MCPs. Providers noted that Member data from MCPs was often not available in batch queries and required manual processes to obtain updated information in aggregate about the clients they serve. MCPs also indicated it would be helpful for DHCS to develop a minimum set of necessary data elements required for Community Supports Providers to share more timely updates about service delivery.

With this context in mind, here are the goals of what these data sharing standards are trying to achieve:

- Implement batch reporting from MCPs to Community Supports Providers with Member-level information, including the status of authorizations.
- Facilitate more efficient outreach to Members.
- Improve MCPs' ability to track the status and progress of service delivery.
- Reduce administrative burden for MCPs and Community Supports Providers.

DHCS' new guidance comprises standards for two types of data exchange:

1. **MCP Community Supports Authorization Status File**: MCPs generate a cumulative list of all Members referred by and/or assigned to their organization to receive Community Supports services.
    - In the Authorization Status File, MCPs generate a cumulative list of all Member entries for Members referred by and/or assigned to their organization to receive Community Supports services.
    - By having standardized, aggregated Member-level information, Community Supports Providers will be able to:
        i. Follow up on Member authorizations more easily.
        ii. Access and utilize information to better engage and serve Members.
    - This new data flow is not intended to disrupt or delay existing MCP systems and process for real time or near real time authorization status alerts and sharing of Member-level information with Community Supports Providers.

2. **Community Supports Provider Return Transmission File**: Community Supports Providers share timely updates about Member-level service delivery with MCPs.
    - The purpose of this file is to allow Community Supports Providers to share timely updates about service delivery with MCPs in a standardized and streamlined

manner.
- Although MCPs can track Community Supports service delivery through invoices and claims, there is an inherent data lag with solely relying on these data sources which this guidance attempts to help solve.

DHCS is requiring that all Plans implement the requirements articulated in the Community Supports Member Information Sharing Guidance by September 1, 2023.

In addition to developing the new Community Supports data guidance standards, DHCS also reviewed market feedback and engaged stakeholders to make updates to the existing ECM and Community Supports data guidance documents.

Initiatives under the CalAIM Section 1115 waiver are part of a broad Medi-Cal Transformation to create a more coordinated, person-centered, and equitable health system that works for all Californians, which requires the exchange of information about individuals enrolled in Medi-Cal across sectors, including physical health, behavioral health, and social services. On June 8th, 2023, DHCS released the updated CalAIM Data Sharing Authorization Guidance (Version 2.0) for a three-week public comment. This document provides specific guidance on data privacy and data sharing consent laws, regulations, and rules individuals and organizations that are providing or overseeing the delivery of health services to people receiving services under the conditions of Assembly Bill 133—a 2021 law that permits disclosure of personal information if such disclosure helps implement CalAIM and is consistent with federal law—that makes it easier for providers to share data.

Additional Guidance in Production

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.

For ECM, future planned guidance will address:
- Standardization of authorization timeframes.
- More emphasis on requiring MCPs to contract with ECM Providers who have expertise and who are qualified to serve each of the unique Populations of Focus.
- More transparency on DHCS' ECM rate build up assumptions, including around provider outreach and administrative functions.
- More emphasis on promoting multiple referral pathways into ECM from the community.
- Reduction of provider burden associated with documentation requirements across MCPs.

For Community Supports, future planned guidance will address:

- The Cost-Effectiveness concept behind Community Supports.
- MCPs must come into alignment with the full Community Supports service definitions by 1/1/2024.
- More emphasis on presumptive eligibility.

For both ECM and Community Supports, DHCS is planning updates to its MCP/Provider data sharing guidance, including releasing new standards focused on Community Supports. DHCS is also working on updating and refining its ECM and Community Supports HCPCS Coding Options guidance and reinforcing standardized application of codes at the provider level. It is also considering reinforcing requirements to help ensure timely provider payments.

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 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. 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 beneficiary notice regarding this policy, to explain the policy more clearly, effective January 1, 2023.

In a separate but related policy, on January 1, 2023, beneficiaries 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, 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. For these plans, DHCS is committed to implementing integration through integrated beneficiary member materials, integrated appeals and grievances, and care coordination that extends across Medicare and Medicaid benefits. Aligned Medicare and Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care. 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries, 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 beneficiaries 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 beneficiaries where the Medi-Cal matching plan policy applies.

DHCS developed beneficiary notices for these transitions, in coordination with CMS and stakeholders. DHCS also conducted stakeholder meetings to discuss all aspects of these transitions related to beneficiary 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 beneficiaries 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 beneficiary in an affiliated Medicaid plan once the beneficiary 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 beneficiaries 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 beneficiaries 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 beneficiary outreach for providers and beneficiaries from September 2022 through the present, to address these concerns and educate providers and beneficiaries.

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-Q3	9,225	3,500	12,725
DY18-Q4	9,022	3,514	12,536
DY19-Q1	8,390	3,157	11,547
DY19-Q2	2,597	926	3,523

Figure XX: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	16,679	16,967	17,195	DY18-Q3	17,466
ACA	17,430	17,602	17,730	DY18-Q4	17,998
ACA	17,817	17,810	17,836	DY19-Q1	18,176
ACA	17,782	17,729	17,702	DY19-Q2	18,007
Non-ACA	7,335	7,272	7,198	DY18-Q3	7,677
Non-ACA	7,100	7,035	6,993	DY18-Q4	7,392
Non-ACA	6,957	6,965	6,912	DY19-Q1	7,267
Non-ACA	6,909	6,897	6,874	DY19-Q2	7,143

Figure XX: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	368,250	$ 61,161,836.82	$ 54,168,788.34	$ 6,073,775.71	$ 919,272.77	DY18-Q3
Non-ACA	127,871	$ 20,999,861.70	$ 11,792,495.45	$ 7,539,228.28	$ 1,668,137.97	DY18-Q3
ACA	376,036	$ 61,801,841.04	$ 54,646,595.37	$ 6,240,636.65	$ 914,609.02	DY18-Q4
Non-ACA	131,272	$ 21,288,545.40	$ 11,961,822.45	$ 7,707,333.01	$ 1,619,389.94	DY18-Q4
ACA	307,952	$ 52,148,060.89	$ 46,155,039.00	$ 5,224,089.17	$ 768,932.72	DY19-Q1
Non-ACA	115,274	$ 18,048,810.19	$ 10,156,750.80	$ 6,582,749.33	$ 1,309,310.06	DY19-Q1
ACA	55,035	$ 9,212,532.58	$ 8,108,146.56	$ 923,680.52	$ 180,705.50	DY19-Q2
Non-ACA	18,879	$ 3,046,671.61	$ 1,682,122.42	$ 1,075,622.99	$ 288,926.20	DY19-Q2

ACA Expenditures by Level of Care for DY18-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	192,951	$ 29,389,321.53	$ 25,991,470.54	$ 3,179,313.91	$ 218,537.08
3.3 Residential	2,634	$ 407,281.36	$ 364,239.48	$ 42,213.94	$ 827.94
3.5 Residential	141,879	$ 26,299,383.76	$ 23,318,793.08	$ 2,837,895.71	$ 142,694.97
RES 3.2-WM	30,785	$ 5,065,850.17	$ 4,494,285.24	$ 14,352.15	$ 557,212.78

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	202,680	$ 30,012,856.01	$ 26,574,853.97	$ 3,231,090.75	$ 206,911.29
3.3 Residential	2,379	$ 384,638.37	$ 346,173.19	$ 37,793.68	$ 671.50
3.5 Residential	143,080	$ 26,615,584.84	$ 23,521,148.86	$ 2,959,506.01	$ 134,929.97
RES 3.2-WM	27,897	$ 4,788,761.82	$ 4,204,419.35	$ 12,246.21	$ 572,096.26

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	170,082	$ 26,208,757.78	$ 23,234,900.14	$ 2,777,838.01	$ 196,019.63
3.3 Residential	2,594	$ 455,104.64	$ 409,590.94	$ 44,711.12	$ 802.58
3.5 Residential	110,155	$ 21,367,738.01	$ 18,878,531.03	$ 2,389,434.26	$ 99,772.72
RES 3.2-WM	25,122	$ 4,116,460.46	$ 3,632,016.89	$ 12,105.78	$ 472,337.79

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	24,449	$ 3,652,951.78	$ 3,236,056.98	$ 392,223.41	$ 24,671.39
3.3 Residential	197	$ 46,369.55	$ 41,732.23	$ 4,624.16	$ 13.16
3.5 Residential	21,988	$ 4,355,828.58	$ 3,817,749.32	$ 520,406.00	$ 17,673.26
RES 3.2-WM	8,400	$ 1,157,382.67	$ 1,012,608.03	$ 6,426.95	$ 138,347.69

Non-ACA Expenditures by Level of Care for DY18-Q3					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	61,399	$ 8,649,415.61	$ 4,851,943.58	$ 3,266,445.70	$ 531,026.33
3.3 Residential	664	$ 159,008.38	$ 89,362.51	$ 66,865.52	$ 2,780.35
3.5 Residential	56,608	$ 10,571,229.26	$ 5,938,881.71	$ 4,195,043.00	$ 437,304.55
RES 3.2-WM	9,200	$ 1,620,208.45	$ 912,307.65	$ 10,874.06	$ 697,026.74

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	63,583	$ 8,977,361.31	$ 5,054,151.83	$ 3,403,774.17	$ 519,435.31
3.3 Residential	682	$ 162,245.86	$ 91,182.51	$ 68,521.44	$ 2,541.91
3.5 Residential	57,595	$ 10,571,260.51	$ 5,928,076.55	$ 4,225,730.57	$ 417,453.39
RES 3.2-WM	9,412	$ 1,577,677.72	$ 888,411.56	$ 9,306.83	$ 679,959.33

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	58,813	$ 8,107,792.47	$ 4,564,740.47	$ 3,063,545.88	$ 479,506.12
3.3 Residential	740	$ 175,354.49	$ 98,550.44	$ 74,257.31	$ 2,546.74
3.5 Residential	48,128	$ 8,524,260.13	$ 4,794,363.91	$ 3,433,876.06	$ 296,020.16
RES 3.2-WM	7,594	$ 1,241,403.10	$ 699,095.98	$ 11,070.08	$ 531,237.04

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	7,374	$ 1,189,250.92	$ 655,347.60	$ 428,525.31	$ 105,378.01
3.3 Residential	81	$ 17,382.09	$ 9,560.21	$ 7,821.88	$ -
3.5 Residential	8,881	$ 1,514,174.81	$ 837,532.80	$ 634,782.78	$ 41,859.23
RES 3.2-WM	2,543	$ 325,863.79	$ 179,681.81	$ 4,493.02	$ 141,688.96