CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

May 30, 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 One (Q1) Progress Report (Report) to the Centers for Medicare & Medicaid Services, covering the reporting period of January 1, 2023 through March 31, 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)

FIRST QUARTER REPORTING PERIOD: JANUARY 1, 2023 – MARCH 31, 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) new CalAIM Section 1115 demonstration initiatives; and (3) Medi-Cal 2020 Section 1115 demonstration initiatives continued via the Medi-Cal State Plan or CalAIM Section 1915(b) waiver.

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

eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.

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

- **CalAIM Initiatives Newly Authorized in the CalAIM Section 1115 Demonstration:**
  - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
  - **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and (2) support justice-involved pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
  - **Contingency Management** to offer Medi-Cal beneficiaries, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
  - **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, in order to provide this service in DMC-ODS and Drug Medi- Cal (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 Med-Cal 2020 Section 1115 demonstration transitioned into a new, statewide dental benefit for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

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

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

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

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

GENERAL REPORTING REQUIREMENTS

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. On January 9, 2023, CMS and DHCS discussed CalAIM 1115 specific items related to SUD, PATH, and GPP protocols; SUD, Contingency Management and PATH/GPP/Duals Evaluation Designs; quarterly reporting; and budget neutrality. For the remainder of DY 19-Q1, DHCS and CMS mutually agreed to cancel the CalAIM 1115 portions of the monitoring calls since separate CalAIM 1115 deliverable-specific calls took place during the quarter.

STCs Item 14.9: Post Award Forum

In DY 19-Q1, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On February 16, 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: Unwinding of the COVID-19 public health emergency (PHE); CMS Approval of CalAIM Justice-Involved Initiative; EPSDT/Medi-Cal for Kids and Teens Education Campaign; Integration of Dual Eligibles into Managed Care; Medications for Addiction Treatment in Residential Substance Use Disorder Care; Youth Substance Use Disorder Prevention; and California Behavioral Health Community-Based Continuum Demonstration. 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 January 6, 2023, February 3, 2023, and March 3, 2023. The meetings included discussion of DHCS programmatic implementation updates, such as: CalAIM Duals Integration; Medi-Cal Churn During PHE Among Children; Medi-Cal and Covered California Notice of Action During PHE; Assets Limits Elimination; Age 26-49 Expansion; Continuous Coverage Unwinding; Hearing Aid Coverage for Children Program Update; Medi-Cal and Covered California Notice of Action During PHE. The purpose of the CFSW was to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on March 9, 2023. DHCS discussed the following topics: Continuity of Care; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); the Managed Care Accountability Sets (MCAS) Providing Access and Transforming Health (PATH); Incentive Payment Program (IPP); Network Adequacy (Subcontractor Networks); and Housing and Homeless Incentive Program (HHIP). The purpose of the MCAG is to facilitate active communication between the managed care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders and advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

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

PROGRAM UPDATES

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 19-Q1, 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, January 26, 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 K on July 8, 2022, requesting to end the TAS flexibility effective October 1, 2022, prior to the previously approved flexibility period of six-months post the end of the federal PHE. In ending the CBAS TAS flexibility, the state 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 ERS is a new service delivery method approved by CMS in the 2022 1115 waiver renewal, to provide time-limited services in the home, community, via doorstep, and/or telehealth during specified emergencies for individuals already receiving CBAS. 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 is collaborating 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 is using lessons learned from the implementation and operation of CBAS TAS during the PHE to assist with constructing processes and parameters that keep the CBAS 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. Refer to the "Operational Updates" section 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.

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 – Q1		DY18 – Q2		DY18 – Q3		DY18 – Q4	
	Jan – March 2022		Apr – June 2022		July – Sept 2022		Oct - Dec 2022	
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	462	74%	479	76%	474	76%	476	76%
Butte	22	22%	24	24%	25	25%	26	26%
Contra Costa	131	35%	142	38%	131	35%	127	34%
Fresno	880	40%	960	44%	1,008	46%	1,025	47%
Humboldt	96	16%	85	14%	97	16%	86	15%
Imperial	267	44%	269	45%	275	46%	275	46%
Kern	217	21%	224	22%	198	19%	277	27%
Los Angeles	25,048	58%	24,391	55%	24,983	57%	23,584	54%
Merced	113	54%	112	53%	110	52%	118	56%
Monterey	77	41%	110	59%	96	52%	91	49%
Orange	2,748	62%	2,796	61%	2,871	58%	2,718	55%
Riverside	513	30%	520	30%	536	31%	649	37%
Sacramento	508	44%	504	57%	485	55%	552	63%
San Bernardino	734	73%	789	79%	798	52%	744	48%
San Diego	1,869	58%	1,731	54%	1,760	55%	1,725	54%
San Francisco	854	54%	875	56%	895	57%	924	59%
San Joaquin	36	15%	33	14%	31	13%	32	13%
San Mateo	67	66%	69	68%	74	73%	74	73%
Santa Barbara	8	5%	9	5%	4	2%	4	2%
Santa Clara	622	45%	615	44%	641	46%	511	37%
Santa Cruz	98	64%	85	56%	86	56%	78	51%
Shasta	1	1%	2	1%	0	0%	8	6%
Stanislaus	8	1%	6	1%	26	4%	6	1%
Ventura	809	54%	832	55%	845	56%	804	54%

Yolo	232	61%	227	60%	239	63%	225	59%
Marin, Napa, & Solano	82	16%	78	16%	81	16%	83	17%
Total	**36,502**	**54%**	**35,968**	**53%**	**36,769**	**53%**	**35,222**	**51**

FFS and MCP Enrollment Data 12/2022

***Note: Information is not available for DY19-Q1 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.

During DY 18-Q4, only Santa Clara County reported a greater than five percent decrease in utilization capacity. 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 slight drop in enrollment numbers. Although Santa Clara County is the only county with a greater than five percent decrease, many of the counties did drop a percent point. Since the MCP's data will not be available in this report, DHCS is anticipating a few changes in the next quarterly report as MCPs are now required to report discharge data which may provide additional information in the change of numbers. Additionally, during DY 19-Q1, the only center within San Joaquin County closed. The data will be shown in the next quarterly report.

Most counties maintained consistent enrollment and capacity utilization, with fluctuations of less than five percent. Sacramento, Riverside, and Kern Counties experienced a greater than five percent increase due to higher attendance. 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.

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

Figure 2: CBAS Assessments Data for MCPs and FFS

Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
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-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS are collected and assessed by the MCPs and DHCS. According to the previous figure, during DY 18, 11,453 assessments were completed by the MCPs, of which 11,088 were determined to be eligible, and 365 were determined to be ineligible. For DHCS FFS beneficiaries in DY 19-Q1, two assessments were performed for CBAS benefits, with one being eligible and one being ineligible. As demonstrated in Figure 2, 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. The MCP data will be shown in the next quarterly report.

CBAS Provider-Reported Data (STC 5.6.b)

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. Figure 3 identifies the number of counties with CBAS centers and the average daily attendance (ADA) for DY 19-Q1. On average, the ADA at the 280 operating CBAS centers is approximately 23,326 participants, which corresponds to 54.2 percent of total capacity. Provider-reported data identified in Figure 3 reflects data through March 2023. The ADA decreased 32.9 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, but not qualifying under the new ERS policy; transportation shortages; and provider difficulties hiring and retaining qualified staff.

Figure 3: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
CA Counties with CBAS Centers	28
Total CA Counties	58
CDA - CBAS Provider Self-Reported Data	
Number of CBAS Centers	280
Non-Profit Centers	51
For-Profit Centers	234
ADA at 280 Centers	23,326
Total Licensed Capacity	40,746
Statewide ADA per Center	54.2%
CDA - MSSR Data 12/2022	

*Note: *CDA CBAS Provider Self-Reported information is not reported for DY 19-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report. During DY 19-Q1, the only center within San Joaquin County closed.*

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 CBAS News Alerts
- CBAS webinars
- CAADS conferences
- CAADS/ALE/CDA 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-Q1:

- CBAS ACLs (**1**)
- CBAS Updates Newsletter (**0**)
- CBAS News Alerts (**29**)
- CBAS Webinars - Co-Hosted with DHCS (**1**) and with CAADS/ALE (**1**)
- CAADS/ALE Vision Team Meetings with CBAS providers and CDA staff (**7**)
- CAADS/ALE- MCP-CDA meetings (**3**)
- DHCS-CDA-MCP meetings (**2**)
- Responses to CBAS Mailbox Inquiries (**579**)

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; (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 reporting of COVID-19 and Influenza 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

CDA in collaboration with DHCS provided webinar training on EVV to CBAS staff, providers, and MCPs as the state published the CBAS ERS EVV billing codes and distributed policy guidance specific to EVV. Guidance to CBAS providers included CBAS ERS EVV reporting processes and procedures to be utilized when personal care and home health care services are provided in participants' homes. 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 Q1, 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 two meetings with MCPs and has scheduled monthly meetings on an ongoing basis.

CBAS Quality Strategy Advisory Committee Meetings

CDA convenes meetings with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, MCPs, DHCS staff, and representatives from CAADS and ALE to provide updates and receive guidance on program activities, and to accomplish the goals and objectives identified in the CBAS Quality Strategy. CDA did not convene a CBAS Quality Advisory Committee meeting during the first 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 this past quarter 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 579 CBAS mailbox inquiries, which included questions about: (1) the interpretation and implementation of ERS policies; (2) current public health guidance that addresses COVID-19 infection risk and mitigation to address infection outbreaks at the center; (3) the provision of CBAS in-center services, ERS, and staffing requirements; (4) staffing shortages and the challenge of meeting staffing requirements while providing in-center services and ERS; (5) challenges with the transition of participants to full in-center operations amidst uncertainties of infection risks; (6) CDA reporting requirements for ERS and submission of the CBAS ERS Initiation Form (CEIF) in the CBAS internal provider database to initiate ERS; (7) MCP denials of some CEIFs preventing the implementation of ERS according to ERS policy directives requiring policy clarification by CDA and DHCS; and 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.

Program Highlights:

Public Health Emergencies During ERS Implementation

Personal and public health emergencies have reinforced the value of the CBAS ERS benefit. 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. 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 Q1, 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 events as of March 2023 include:

Total ERS Events	2,812
Percentage of CBAS Participants Receiving ERS	8%
Public Emergencies	639
Personal Emergencies	2,173

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.

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. CDA and the ATI consulting team will compile results

of the interviews and surveys in the coming months and develop a report that includes actionable recommendations for meeting the project's goals. CDA anticipates final results will be ready by August 2023.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY18-Q1 (Jan – Mar 2022)	0	0	0
DY18-Q2 (Apr – Jun 2022)	0	0	0
DY18-Q3 (Jul – Sep 2022)	0	0	0
DY18-Q4 (Oct – Dec 2022)	0	4	4
CDA Data – Complaints 12/2022			

*Note: *CDA CBAS information is not reported for DY 19-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Participant Complaints	Provider Complaints	Total Complaints
DY18-Q1 (Jan – Mar 2022)	9	0	9
DY18-Q2 (Apr – Jun 2022)	7	0	7
DY18-Q3 (Jul – Sept 2022)	3	0	3
DY18-Q4 (Oct – Dec 2022)	2	0	2
Phone Data – Phone Center Complaints 12/2022			

*Note: *MCP assessment information is not reported for DY 19-Q1 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 4 and 5 detail complaint data received by CDA and MCPs from CBAS beneficiaries and providers. Figure 4 demonstrates a total of four complains received in DY 18-Q4. DHCS will report CBAS MCP complaint data for DY 19-Q1 in the next quarterly report. For DY 18, Figure 5 illustrates that there were at total of 21 beneficiary complaints, and zero provider complaints submitted. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 6: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY18-Q1 (Jan – Mar 2022)	2	1	1	6	10
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
MCP Data - Grievances 12/2022					

*Note: *CDA CBAS information is not reported for DY 19-Q1 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Figure 7: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
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 04/2023					

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

Grievance and appeals data are provided to DHCS by the MCPs. The data for DY 19-Q1 will be shown in the next quarterly report. The data provided in Figure 6 reflects a total of 41 grievances filed with MCPs, during DY18 only. Twenty-two of the grievances were regarding CBAS providers; two pertained to contractor assessments or reassessments; one related to excess travel time; and sixteen grievances are designated as "other". DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports.

In Figure 7, for DY 19-Q1, 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 first quarter the Committee has not yet met.

Figure 8: CBAS Centers Licensed Capacity

County	DY18-Q1 Jan-Mar 2022	DY18-Q2 Apr-Jun 2022	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	370	0.0%	76%
Butte	60	60	60	60	0.0%	26%

County	DY18-Q1 Jan-Mar 2022	DY18-Q2 Apr-Jun 2022	DY18-Q3 Jul-Sept 2022	DY18-Q4 Oct-Dec 2022	Percent Change Between Last Two Quarters	Capacity Used ***
Contra Costa	220	220	220	220	0.0%	34%
Fresno	1,297	1,297	1,297	1,297	0.0%	47%
Humboldt	349	349	349	349	0.0%	15%
Imperial	355	355	355	355	0.0%	46%
Kern	610	610	610	610	0.0%	27%
Los Angeles	25,531	25,958	26,003	26,003	0.0%	54%
Merced	124	124	124	124	0.0%	56%
Monterey	110	110	110	110	0.0%	49%
Orange	2,603	2,723	2,903	2,903	0.0%	55%
Riverside	1,025	1,025	1,025	1,025	0.0%	37%
Sacramento	680	520	520	520	0.0%	63%
San Bernardino	590	590	911	911	0.0%	48%
San Diego	1,903	1,903	1,903	1,903	0.0%	54%
San Francisco	926	926	926	926	0.0%	59%
San Joaquin	140	140	140	140	0.0%	13%
San Mateo	60	60	60	60	0.0%	73%
Santa Barbara	100	100	100	100	0.0%	2%
Santa Clara	820	820	820	820	0.0%	37%
Santa Cruz	90	90	90	90	0.0%	51%
Shasta	85	85	85	85	0.0%	6%
Stanislaus	360	360	360	360	0.0%	1%
Ventura	886	886	886	886	0.0%	54%
Yolo	224	224	224	224	0.0%	59%
Marin, Napa, Solano	295	295	295	295	0.0%	17%
SUM	**39,813**	**40,200**	**40,746**	**40,746**	0.0%	51%

***Capacity Used information is not available for DY 19-Q1 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 8 reflects that the average licensed capacity used by CBAS participants. 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.

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 are able to 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 provided evidence to CDA that it completed required discharge planning and referrals. 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' managed care plans. Since

no other CBAS centers are located nearby, participants are eligible for unbundled services from their managed care plans as they choose and as needed. Beneficiaries who received unbundled CBAS services in DY 19-Q1 will be included with Q2 data.

Figure 9: CBAS Center History

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
June 2022	275	0	2	2	277
May 2022	276	2	1	-1	275
April 2022	276	0	0	0	276
March 2022	274	0	2	2	276
February 2022	272	0	2	2	274
January 2022	270	0	2	2	272

DHCS and CDA continue to monitor the opening and closing of CBAS centers since April 2012 when CBAS became operational. During DY 18, CDA had 280 CBAS center providers operating in California. According to Figure 9, no CBAS centers closed, and three centers opened in DY 18-Q3.

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:

MCP payment relationships with CBAS Centers have not affected statewide CBAS capacity to date.

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. This site is located in Los Angeles County, which serves 30 percent of California's Medi-Cal population. Additional sites will be approved on a rolling basis as they complete the Implementation Training and Readiness Review process.

In January, the DHCS Recovery Incentives Program team met regularly with the training and technical assistance vendor, the University of California, Los Angeles (UCLA), and the incentive manager (IM) vendor to ensure the IM software adheres to the CM protocol outlined in Behavioral Health Information Notice (BHIN) BHIN 22-056. The team updated the Recovery Incentives Program FAQ document and started a bi-weekly payment process meeting to discuss data requirements and procedures needed to process payments and meet federal reporting requirements. Additionally, throughout January, the team continued to respond to questions from participating counties and provider sites and supported the development of training materials for counties and providers.

In February, the DHCS Recovery Incentives Program team continued weekly planning meetings with UCLA and the IM vendor, and bi-weekly payment process meetings. On February 15, 2023, UCLA launched the Recovery Incentives Program Implementation Training which is required for all CM coordinators supervisors. DHCS added proposed language to Behavioral Health Information Notice (BHIN) 22-056 and sent the draft to counties and County Behavioral Health Directors Association (CBHDA) for feedback. To help expedite the processing of Clinical Laboratory Improvement Amendments (CLIA) waivers and state lab registration by the California Department of Public Health (CDPH), DHCS surveyed counties and provided weekly reports to CDPH for expedited processing. Additionally, throughout February, the team continued to respond to questions from participating counties and provider sites and supported the development of training materials for counties and providers.

In March, the DHCS Recovery Incentives Program team continued weekly planning meetings with UCLA and the IM vendor, and bi-weekly payment process meetings. The team reviewed the feedback on BHIN 22-056 and worked to obtain necessary reviews and will post the BHIN for public comment in April. Additionally, throughout March, 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 CLIA waivers.

Recovery Incentives: California's Contingency Management Program – Training and Technical Assistance Activities, DY 19, Quarter 1 (Q1)

Statewide Contingency Management (CM) pilot training curriculum and readiness review and fidelity assessment tool development activities: *K*ey activities were focused on the continued development of the Recovery Incentives website. A total of 189 individuals completed the CM Overview Training on-demand course between January 1, 2023, and March 31, 2023. Fourteen Implementation Trainings were delivered (with 295 total participants), 19 Readiness Assessment calls were made, and one site was approved to initiate provider CM Services. Five one-hour Zoom office hours for Readiness Assessment preparedness were also conducted. The two-step Readiness Assessment process was finalized, and 27 sites received a link to the Qualtrics self-study to initiate the Readiness Assessment process. Five point-of-care urine drug test (UDT) kits were evaluated for potential inclusion into the UDT protocol. None of the products were deemed to meet the requirements of the program. Development of the fidelity monitoring tool has not yet commenced.

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 March 15, 2023, 3,222 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 10 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 10: Peer Support Specialist Applications and Certifications

Applications/ Certifications by Status[3]	Number
Certified	534
Certification exam in progress	909
Approved to take certification exam	36
Certification exam not passed	39
Training in progress	1,228
Application in revision	451
Application pending	25
Total	**3,222**

Throughout Q1 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 Q1, DHCS released guidance related to eligibility criteria for Medi-Cal Peer Support Specialist grandparenting applications, deadlines for certification programs to implement trainings for additional areas of specialization, and approval criteria for Medi-Cal Peer Support Specialist Certification Program fee schedules. DHCS also published FAQs addressing telehealth, Medi-Cal Peer Support Specialist supervision, and plan of care requirements for Medi-Cal Peer Support Services.

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 18-Q4 and DY 19-

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

Q1, only partial data is available since counties have up to six months to submit claims after the month of service.

Figure 11: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY 18-Q2	9,021	3,424	12,445
DY 18-Q3	9,173	3,478	12,651
DY 18-Q4	8,620	3,323	11,943
DY 19-Q1	4,573	1,735	6,308

**Affordable Care Act*

Figure 12: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees to date
ACA	17,042	17,297	17,586	DY 18-Q2	17,850
ACA	17,753	17,960	18,111	DY 18-Q3	18,428
ACA	18,247	18,333	18,373	DY 18-Q4	18,670
ACA	18,314	18,207	18,183	DY 19-Q1	18,485
Non-ACA	7,635	7,575	7,486	DY 18-Q2	7,987
Non-ACA	7,447	7,387	7,315	DY 18-Q3	7,770
Population	**Month 1**	**Month 2**	**Month 3**	**Quarter**	**Current Enrollees to Date**
Non-ACA	7,251	7,216	7,187	DY 18-Q4	7,533
Non-ACA	7,181	7,211	7,172	DY 19-Q1	7,406

Figure 13: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	384,687	$58,595,261.98	$51,915,788.78	$5,813,869.14	$865,604.06	DY 18-Q2
Non-ACA	129,794	$19,469,898.78	$10,951,384.73	$6,911,858.18	$1,606,655.87	DY 18-Q2

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	364,712	$60,749,873.57	$53,811,304.71	$6,033,009.49	$905,559.37	DY 18-Q3
Non-ACA	126,621	$20,816,342.27	$11,689,358.14	$7,495,202.54	$1,631,781.59	DY 18-Q3
ACA	353,981	$57,926,480.45	$51,216,823.08	$5,857,216.83	$852,440.54	DY 18-Q4
Non-ACA	121,632	$19,529,749.28	$10,971,006.90	$7,085,425.83	$1,473,316.55	DY 18-Q4
ACA	121,410	$19,112,315.35	$16,923,452.19	$1,893,969.89	$294,893.27	DY 19-Q1
Non-ACA	47,468	$7,013,982.04	$3,942,849.34	$2,509,811.24	$561,321.46	DY 19-Q1

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

Performance Metrics Enclosures/Attachments:

The attachment listed below 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-Q1 as of April 13, 2023.

CalAIM Progress Report - DY19 Q1 Data.xlsx

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 Information Notices communication via email to stakeholders. The information provided includes announcements of finalized and draft BHINs, and upcoming webinars.

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 March 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 23-001** – Drug Medi-Cal-Organized Delivery System (DMC-ODS) Requirement for the Period of 2022 – 2026
- **BHIN 23-005** – Updated Guidance for CalAIM Behavioral Health Quality Improvement Program (BHQIP)
- **BHIN 23-006** – BHIN 23-006 Ongoing Monitoring Activities Process for MHP and DMC-ODS counties

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. In Q1, two (2) incidents regarding an issue, complaint, and grievance from a beneficiary were received. DHCS continues to work with the counties to resolve the two reported complaints for Q1.

Quality Control/Assurance Activity:

Both DHCS FY 2022-23 and DY 18-Q3 began on July 1, 2022. During DY 18-Q4, DHCS scheduled the annual DMC-ODS compliance monitoring review dates and began sending counties the FY 2022-23 DMC-ODS monitoring protocol. DHCS requested the counties' supporting documentation to demonstrate compliance with federal regulations, state regulations, program requirements, and contractual obligations. DHCS began reviewing the submitted documentation in preparation for DMC-ODS compliance monitoring reviews scheduled to begin in DY 19-Q1.

Figure 14 on the next page demonstrates when county DMC-ODS monitoring reviews were completed during DY 19-Q1.

Figure 14: DY 19-Q1 Monitoring Reviews

County	Dates
Fresno	January 2023
San Bernardino	January 2023
San Mateo	January 2023
Stanislaus	January 2023
Contra Costa	February 2023
San Benito	February 2023
San Francisco	February 2023
Santa Clara	February 2023
Tulare	February 2023
Alameda	March 2023
Imperial	March 2023
Merced	March 2023
Sacramento	March 2023
Ventura	March 2023

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 made a presentation on the Overview of the Opioid Crisis and Evaluation of the State Programs for the Joint Hearing of the Senate Public Safety Committee and the Senate Health Committee on February 27, 2023. The presentation can be found on the Senate website. Presenters from UCLA included Darren Urada, Richard Rawson, and Joseph Friedman, which was approved by DHCS as technical assistance under this contract.
- UCLA continued to develop data collection strategies to address the hypothesis and research questions posed in both the Recovery Incentives Program and DMC-ODS evaluation designs. These include county administrator surveys, provider surveys, as well as provider and consumer interviews. UCLA's Evaluation contract has been executed and UCLA has addressed initial feedback from CMS.

- 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 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.
- UCLA completed and posted a recorded webinar to support the implementation of the publicly available ASAM Criteria Assessment Interview Guide. The Interview Guide can be found on the ASAM website and the Introduction Webinar recording can be found on the Vimeo website. The evaluation team is coordinating with UCLA's training department (who is using the Interview Guide as the primary tool in their current ASAM trainings) to incorporate a feedback survey into post-training data collection from training attendees. UCLA is finalizing a website landing page with the introduction webinar, the feedback survey, and other supportive material. UCLA intends to launch the site in April 2023, followed by the first implementation report due in June 2023.
- UCLA completed the 2022 Treatment Perception Survey (TPS) data collection from October 17-21, 2022. During this reporting period, UCLA completed all analyses, provided counties with their reports, and is finalizing the statewide report for DHCS, which is expected to be delivered in April 2023. UCLA provided 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. Overall, 14,717 respondents statewide submitted surveys (6,923 via paper forms and 7,794 online) for both adults and youth. Compared to prior survey administrations, changes in satisfaction scores have remained relatively small and the ratings for all domains have remained high across time for both adults and youth (scores on average over 4.0 on a scale from 1.0 to 5.0).
- UCLA continued to analyze data from the statewide spring 2022 Consumer Perceptions Survey (CPS) which occurred May 16-20, 2022. In this reporting period, UCLA submitted the raw data to DHCS, submitted a Statewide Summary report, and provided counties with their local reports. Technical assistance was provided via two data information sessions in March to discuss how to use the data for quality improvement. In addition, DHCS has prepared for the CPS 2023 data collection scheduled for May 15-19, 2023. Further information can be found on the UCLA CPS website.

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. National PHEs will be 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.

On February 16, 2023, Centers for Medicare & Medicaid Services (CMS) approved the GPP Funding and Mechanics Protocol (Attachment K), and Valuation Methodology Protocol (Attachment L), and Disproportionate Share Hospital (DSH) Coordination Methodology (Attachment Q) as attachments to the STCs for California's section 1115 demonstration project entitled "CalAIM".

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Figure 15: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
Payment Year (PY) 7 Final Reconciliation	$40,553,743.01	$31,605,942.07	DY 17	$72,159,685.08
Total	**$40,553,743.01**	**$31,605,942.07**		**$72,159,685.08**

DY 19-Q1 GPP reporting activity includes payments made in February 2023, for PY 7 Final Reconciliation where the public health care system (PHCS) received $40,553,743.01 in federally funded payments and $31,605,942.07 in intergovernmental transfer (IGT)-funded payments. Within those payments San Francisco General Hospital (SFGH) received interim quarterly GPP payments based on their 95.64 percent of threshold met as reported in the interim report. Their final report indicated a decrease to 94.92 percent of threshold met. Therefore, the payments previously received by the PHCS exceeded the amounts earned as reported in the final report. On February 15, 2023, DHCS adjusted the payments previously made to SFGH for GPP PY 7 and recouped the difference in the amount of $1,149,195.37 and returned the associated non-federal IGT overpayment funds to SFGH in the amount of $294,168.31. The final year-end report served as the basis for the final reconciliation of GPP payments and recoupments for GPP.

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 by ensuring access to health care services and improving health outcomes, with particular attention to communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors. PATH funding is available for various entities such as providers, counties, 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 Enhanced Care Management (ECM) and Community Supports (previously known as In Lieu of Services (ILOS)), which are vital elements of CalAIM on the community level, and support for the expansion of access to services that will enable the transition from Medi- Cal 2020 to CalAIM.

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

1. WPC Services and Transition to Managed Care Mitigation Initiative – PATH funding will directly support former WPC Pilot LEs to pay for existing WPC services before those services are transitioned to be paid for by 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. DHCS will engage a Third-Party Administrator (TPA) to launch and administer the TA Marketplace.
3. Collaborative Planning and Implementation Initiative – PATH funding is available for community stakeholders to work with the PATH TPA to establish collaborative planning and implementation efforts that support the CalAIM launch.
4. Capacity and Infrastructure Transition, Expansion and Development Initiative (CITED) – PATH funding will enable transition, expansion, and development of ECM and Community Supports capacity and infrastructure. The TPA will administer and facilitate this initiative.

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

- TA Marketplace
- Collaborative Planning and Implementation
- 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 18 Q4.

Operational Updates:

During this quarter, 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 is currently in the process of reviewing and validating utilization reports as part of the payment process. Data validation is required to ensure accurate reporting for services provided. Due to data discrepancies, DHCS is working with LEs to ensure all reports are accurate before payment is made. The

second payment for this initiative will be processed by DY 19-Q2.

The TA Marketplace website was made live in January 2023. As of April 4, 2023, 69 TA Recipient Eligibility applications have been received and 39 of those TA Recipient Eligibility applicants have been approved. Additionally, for TA Project Eligibility applications, as of April 4, 2023, 11 applications were received for consideration. Entities are able to shop and access TA resources from curated and approved TA Vendors. The Round 2 TA vendor application period opened March 28, 2023 and will go through April 28, 2023. There are two types of vendor applications. New organizations can apply to become TA vendors and contracted TA vendors can apply 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 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. 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.

For the Collaborative Planning Initiative, ten facilitators and 25 collaborative groups have been developed based on regional location, size, and with consideration to preserving existing collaboratives. The TPA and facilitators 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 March 2023 the TPA received a total of 641 registered participants. Participant registrations are accepted on a continual basis and participants are connected with selected facilitators. The Collaborative Planning Initiative Alternative Facilitator application was approved as a contingency if current collaborative facilitators are not performing as expected.

CITED Round one applications were split into two rounds, Round 1A and 1B, due to a larger number of applications received than expected and a total funding request far exceeding the original allocated amount. Round two applications reopened on January 1, 2023 and closed on March 31, 2023. A total of 42 applications were received with a total funding request of $62,582,580.62. On January 31, 2023, DHCS announced $119 million was awarded to 98 organizations in Round 1A of funding for PATH CITED. On March 24, 2023, DHCS announced $88 million was awarded to 41 organizations in Round 1B of funding for CITED. The total awarded was $207 million in funding to 139 organizations to CITED Round 1A and Round 1B. DHCS opened the Round two application on February 28, 2023.

DHCS anticipates that initial awards will be completed by May 30, 2023. Round two guidance was expanded to allow for additional permissible uses of funding. DHCS continues discussions on how the Department can provide support and other resources.

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 Program
- CITED
- JI Initiatives - Planning and Capacity Building Round two

In September 2022, DHCS amended the TPA contract with PCG to formalize the fiscal intermediary process between DHCS, PCG, and PATH funding recipients. The amended contract was executed on September 28, 2022.

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

- 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 monthly as of September 2022. The workgroup participants include county agencies, advocates, and stakeholders. Topics discussed in these meetings range from suspension processes and funding guidance to pre-release processes and data-sharing guidance.
- The Inmate Workgroup 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.

  In addition, DHCS in conjunction with the County Welfare Director's Association of California has conducted three surveys with counties regarding concerns and barriers in implementing pre-release services. Responses from the surveys guide the development of best practices for suspension, pre-release, eligible PATH funding uses, and data sharing processes.

CITED Initiative

- On March 3, 2023 DHCS held an informational webinar about CITED funds and the Round two application process.
- On March 23, 2023, DHCS released a streamlined progress report process and guidance.
- DHCS hosted a two-part Webinar series titled "Improve your Grant Application", to provide application support to interested entities, on March 24 and March 28, 2023.
- DHCS has spent DY 19-Q1 actively working on engagement strategies with the following CITED eligible group: Tribes, Indian health programs, and urban Indian organizations.

[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.

TA Marketplace

- DHCS invited interested entities to visit the virtual PATH Technical Assistance Marketplace on January 31, 2023, a one-stop-shop website where entities can access TA resources from curated and approved vendors.
- DHCS announced the opening of the TA Marketplace on February 2, 2023.
- On February 23, 2023, DHCS announced that the TA Marketplace Project Eligibility Application would open on February 27, 2023.
- On February 28, 2023, DHCS hosted an informational webinar for entities interested in accessing no-cost resources through the TA Marketplace.
- On March 7, 2023, DHCS held an informational webinar for all PATH TA Marketplace vendors.
- On March 24, 2023, DHCS announced the opening of the TA Marketplace Round two Vendor Application.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

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.

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.

Figure 16: 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	$3,939,000	$1,969,500	$1,969,500	
DY 18 - Q4				
JI	$3,775,953	$1,887,976.50	$1,887,976.50	
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

Figure 17: Total Approved Amounts by PATH Initiative, DY 19 Q-1

PATH Initiative	Total Payment
JI	$0
WPC Mitigation	$0
TA Marketplace	$0
Collaborative Planning	$2,610,000.00
CITED	$207,433,952.46
TPA	
Public Consulting Group LLC	$6,495,802.30
TOTAL	$216,539,754.76

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.

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

Community Supports are optional for MCPs to offer and for members to utilize. MCPs cannot require members to use 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 website as a state-approved Community Support.

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

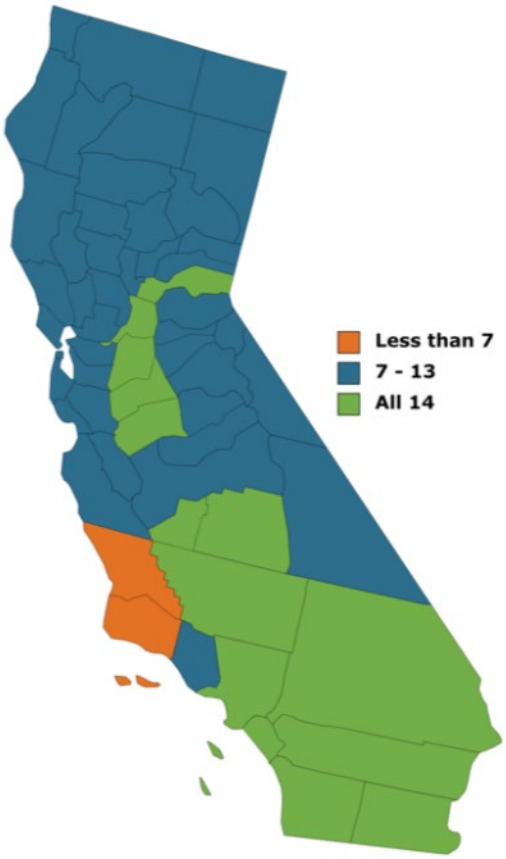
Demonstration monitoring covers reporting of performance metrics data related to the state's Recuperative Care and Short-Term Post-Hospitalization housing services, and where possible, informs the progress in addressing access needs of communities that have been historically under-resourced because of 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 18: Number of Community Supports by County Live on January 1, 2023.

Figure 18: Number of Community Support by County Live on January 1, 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 January 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	194	58
Housing Deposits	135	58
Housing Tenancy & Sustaining Services	159	58
Recuperative Care	62	42
Short-term Post Hospitalization	34	37
Day Habilitation	8	23
Medically Tailored Meals	29	58
Sobering Centers	20	19

At this time, at least one plan in all 58 California counties have elected to offer all three of the housing supports by January 1, 2024. Additionally, DHCS expects every plan in each county to 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 first four quarters of 2022 for DHCS' available Community Supports:

Community Support	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Grand Total
Housing Transition/ Navigation Services	4,769	5,767	6,826	8,803	15,108
Housing Deposits	111	232	382	391	870
Housing Tenancy and	11,555	6,566	3,250	8,345	15,018

Community Support	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Grand Total
Sustaining Services					
Short-Term Post-Hospitalization Housing	7	81	96	185	283
Recuperative Care	818	658	695	948	2,397
Respite Services	0	27	1	6	32
Nursing Facility (NF) Transition/Diversion to Assisted Living Facility	146	156	146	163	249
Community Transition Services/Nursing Facility Transition to a Home	14	17	22	137	164
Personal Care and Homemaker Services	5	17	29	69	98
Day Habilitation Programs	0	1	34	103	120
Environmental Accessibility Adaptations	3	17	29	69	98
Medically Tailored Meals/ Medically-Supportive Food	375	1,160	1,694	4,600	6,125
Sobering Centers	7	17	87	222	304
Asthma Remediation	24	42	86	73	208
Grand Total of Unique Members[5]	**17,085**	**13,855**	**12,428**	**22,517**	**36,253[6]**

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,

[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.

[6] Grand total may not equal the sum of the individual totals due to some members receiving more than one (1) Community Support service.

plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through transition challenges, provides critical review of decisions and documents before DHCS releases them more broadly, provides input on infrastructure needs to be supported by new performance incentives and PATH funding opportunities, and advises on TA needs in the market. Topics of discussion include:
  - Experience with implementation
  - Member experience of ECM and Community Supports
  - Progress of contracting between MCPs and providers
  - Referrals and authorization of members into Community Supports

- Monthly MCP TA and Guidance webinars geared towards health plan executives and personnel, who have a significant role in the implementation of Community Supports.

- Weekly meetings with the Local Health Plans of California and the California Association of Health Plans to provide TA and receive regular updates on the implementation of ECM and Community Supports.

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

On March 14, 2023, DHCS staff visited Wellspace Health at their Gregory Bunker Recuperative Care Facility located in Sacramento. Founded in 1953, Wellspace Health is an integrated, non-profit 501(c)(3) Federally Qualified Health Center serving over 125,000 patients in over 30 locations in Sacramento, Placer, and Amador counties. Staff had candid discussions and learned more about potential best practices and the outstanding obstacles providers continue to manage in the field, all of which will help inform future policy revisions, guidance considerations, and overall contribute to enhancing the program's design.

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.

Figure 19: Program History for Members Receiving Community Support Services as of September 2022: Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:

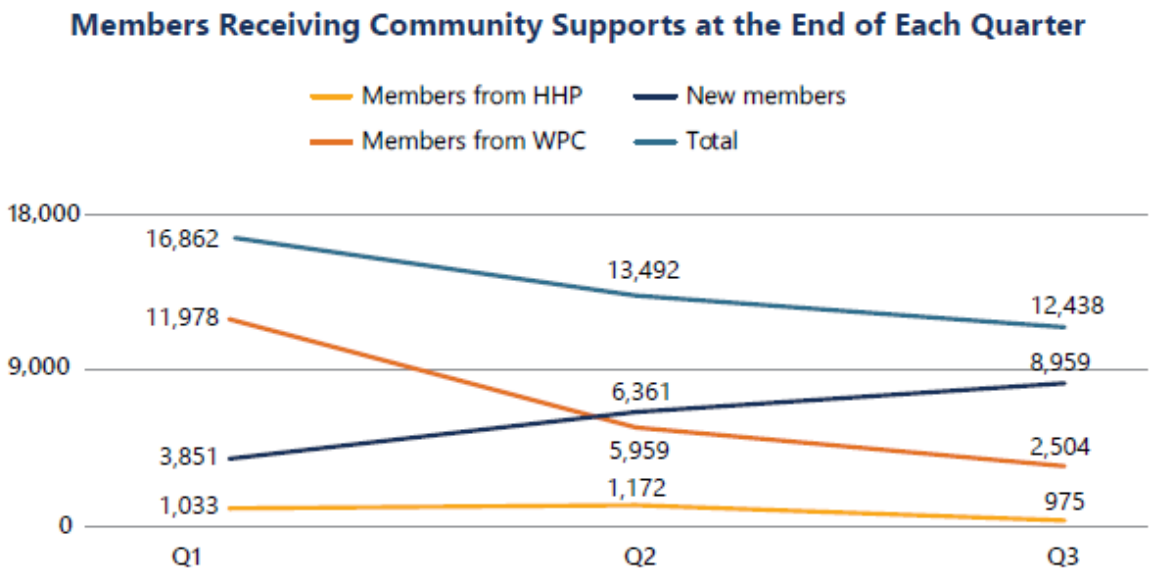
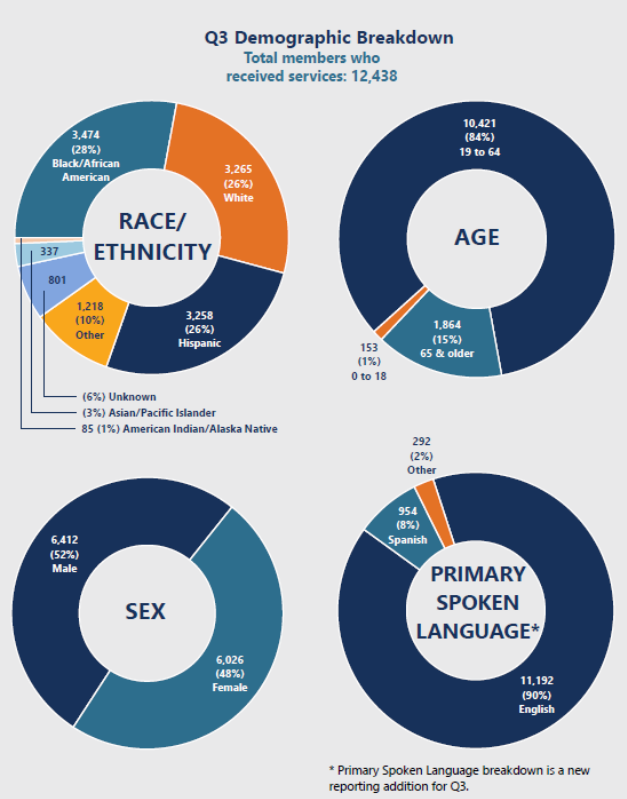


Figure 20: Demographics of Members Receiving Community Support Services as of September 2022. Examples of outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:



Operational Updates:

In January 2023, DHCS updated its Community Supports Policy Guide and All Plan Letter language to revise policies that include: 1) The acceptability of an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status; 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless to 30 days; and 3) MCPs are encouraged to bring in network new members' out-of-network Community Supports providers.

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 February 15, 2023, DHCS received final updated Models of Care (MOCs) from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections are planned to be posted on the DHCS website in mid-June, once DHCS issues 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. In Q3 2022, DHCS launched a survey and over 200 MCPs and ECM and Community Supports providers responded with feedback about which updates should be

considered. DHCS has since analyzed all survey data and made updates to the ECM and Community Supports guidance documents based on this feedback. Updates made to the Quarterly Implementation Monitoring Report guidance are labeled throughout and included in corresponding footnotes, as well as catalogued in the Appendix. Minor updates and additional clarification have also been added to the Billing and Invoicing Guidance, including about the use of the homelessness indicator.

Additional Guidance in Production

Many Community Supports providers are community-based organizations who are delivering and billing for Medicaid services for the first time. Through the first year of Community Supports implementation, DHCS heard consistent feedback that Community Supports providers and MCPs were challenged by the variation with which information exchange was occurring to support the delivery of Community Supports. Specifically, Community Supports providers are receiving, and being asked to share, non-standardized member level data elements with MCPs in different formats and transmission methods, which is giving rise to excessive administrative burden.

Based on this feedback, DHCS has worked on developing additional guidance over the course of Q1 2023 to define standards for two key exchanges of information between MCPs and Community Supports providers:

1. MCP Community Supports Authorization Status File, in which the MCP shares updated authorization status with each contracted Community Supports provider for all members referred by and/or assigned to their organization to receive Community Supports services.
2. Community Supports Provider Return Transmission File, in which Community Supports providers share timely updates about service delivery with MCPs.

Similar to the information sharing guidance issued in December 2021 for the ECM benefit, the guidance will define a standard set of "minimum necessary" data elements, as well as file formats, transmission methods, and transmission frequencies, to initiate and track the progress of Community Supports service delivery. It is informed by extensive stakeholder engagement conducted at the end of 2022 and beginning of 2023, including through a market survey and conducting interviews with MCPs, Community Supports providers, and Health Information Organizations (HIOs).

Increased statewide standardization, as overwhelmingly requested by the market, will ultimately support MCPs and Community Supports providers to:

- Implement batch reporting from MCPs to Community Supports providers about 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.

MCPs and Community Supports providers will be required to adopt the common standards described in the guidance unless there is a strong rationale, mutually agreed to by both organizations, to depart from these standards.

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 July 2022.

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, 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, with the exception of 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, 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, a number of 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, a number of dual eligible beneficiaries requested an exemption to enrollment in Medi-Cal managed care, and an exemption to the Medi-Cal matching plan policy. DHCS conducted extensive provider and beneficiary outreach for providers and beneficiaries from September 2022 through April 2023, 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-Q2	9,021	3,424	12,445
DY18-Q3	9,173	3,478	12,651
DY18-Q4	8,620	3,323	11,943
DY19-Q1	4,573	1,735	6,308

Figure XX: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	17,042	17,297	17,586	DY18-Q2	17,850
ACA	17,753	17,960	18,111	DY18-Q3	18,428
ACA	18,247	18,333	18,373	DY18-Q4	18,670
ACA	18,314	18,207	18,183	DY19-Q1	18,485
Non-ACA	7,635	7,575	7,486	DY18-Q2	7,987
Non-ACA	7,447	7,387	7,315	DY18-Q3	7,770
Non-ACA	7,251	7,216	7,187	DY18-Q4	7,533
Non-ACA	7,181	7,211	7,172	DY19-Q1	7,406

Figure XX: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	384,687	$ 58,595,261.98	$ 51,915,788.78	$ 5,813,869.14	$ 865,604.06	DY18-Q2
Non-ACA	129,794	$ 19,469,898.78	$ 10,951,384.73	$ 6,911,858.18	$ 1,606,655.87	DY18-Q2
ACA	364,712	$ 60,749,873.57	$ 53,811,304.71	$ 6,033,009.49	$ 905,559.37	DY18-Q3
Non-ACA	126,621	$ 20,816,342.27	$ 11,689,358.14	$ 7,495,202.54	$ 1,631,781.59	DY18-Q3
ACA	353,981	$ 57,926,480.45	$ 51,216,823.08	$ 5,857,216.83	$ 852,440.54	DY18-Q4
Non-ACA	121,632	$ 19,529,749.28	$ 10,971,006.90	$ 7,085,425.83	$ 1,473,316.55	DY18-Q4
ACA	121,410	$ 19,112,315.35	$ 16,923,452.19	$ 1,893,969.89	$ 294,893.27	DY19-Q1
Non-ACA	47,468	$ 7,013,982.04	$ 3,942,849.34	$ 2,509,811.24	$ 561,321.46	DY19-Q1

ACA Expenditures by Level of Care for DY18-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	191,597	$ 27,757,827.55	$ 24,492,104.00	$ 3,075,435.54	$ 190,288.01
3.3 Residential	3,871	$ 394,052.79	$ 350,305.75	$ 42,135.70	$ 1,611.34
3.5 Residential	154,602	$ 25,537,159.16	$ 22,726,556.68	$ 2,684,599.20	$ 126,003.28
RES 3.2-WM	34,617	$ 4,906,222.48	$ 4,346,822.35	$ 11,698.70	$ 547,701.43

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	190,205	$ 29,077,122.71	$ 25,722,096.47	$ 3,143,144.11	$ 211,882.13
3.3 Residential	2,615	$ 403,271.51	$ 360,630.62	$ 41,830.49	$ 810.40
3.5 Residential	141,539	$ 26,252,397.43	$ 23,276,745.36	$ 2,833,645.47	$ 142,006.60
RES 3.2-WM	30,352	$ 5,017,081.92	$ 4,451,832.26	$ 14,389.42	$ 550,860.24

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	190,018	$ 28,027,276.95	$ 24,820,570.87	$ 3,016,318.64	$ 190,387.44
3.3 Residential	2,213	$ 342,995.21	$ 308,694.55	$ 33,629.16	$ 671.50
3.5 Residential	135,640	$ 25,072,581.85	$ 22,152,825.99	$ 2,795,201.30	$ 124,554.56
RES 3.2-WM	26,110	$ 4,483,626.44	$ 3,934,731.67	$ 12,067.73	$ 536,827.04

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	66,082	$ 9,509,914.74	$ 8,446,686.39	$ 988,474.06	$ 74,754.29
3.3 Residential	1,150	$ 130,882.84	$ 117,794.08	$ 12,533.23	$ 555.53
3.5 Residential	43,502	$ 7,928,014.68	$ 6,998,327.36	$ 886,225.90	$ 43,461.42
RES 3.2-WM	10,675	$ 1,543,503.09	$ 1,360,644.36	$ 6,736.70	$ 176,122.03

Non-ACA Expenditures by Level of Care for DY18-Q2					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	60,143	$ 8,145,394.44	$ 4,578,569.14	$ 3,078,516.46	$ 488,308.84
3.3 Residential	1,999	$ 274,244.90	$ 154,125.69	$ 116,798.84	$ 3,320.37
3.5 Residential	56,866	$ 9,453,668.67	$ 5,320,338.72	$ 3,706,642.62	$ 426,687.33
RES 3.2-WM	10,786	$ 1,596,590.77	$ 898,351.18	$ 9,900.26	$ 688,339.33

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	60,818	$ 8,585,529.54	$ 4,816,039.56	$ 3,258,236.51	$ 511,253.47
3.3 Residential	642	$ 154,500.18	$ 86,828.88	$ 66,865.52	$ 805.78
3.5 Residential	56,083	$ 10,472,472.73	$ 5,883,381.38	$ 4,159,226.45	$ 429,864.90
RES 3.2-WM	9,077	$ 1,603,839.82	$ 903,108.32	$ 10,874.06	$ 689,857.44

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	58,617	$ 8,175,467.30	$ 4,603,488.85	$ 3,128,939.98	$ 443,038.47
3.3 Residential	588	$ 140,026.30	$ 78,694.80	$ 58,828.35	$ 2,503.15
3.5 Residential	53,477	$ 9,713,548.89	$ 5,443,908.73	$ 3,888,350.67	$ 381,289.49
RES 3.2-WM	8,951	$ 1,500,706.79	$ 844,914.52	$ 9,306.83	$ 646,485.44

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	26,031	$ 3,382,376.02	$ 1,901,739.52	$ 1,268,178.38	$ 212,458.12
3.3 Residential	241	$ 60,735.78	$ 34,133.71	$ 24,418.79	$ 2,183.28
3.5 Residential	17,544	$ 3,032,771.17	$ 1,704,288.57	$ 1,210,442.22	$ 118,040.38
RES 3.2-WM	3,651	$ 538,099.07	$ 302,687.54	$ 6,771.85	$ 228,639.68