DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

March 29, 2023

THIS LETTER SENT VIA EMAIL

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

ANNUAL PROGRESS REPORT FOR THE REPORTING PERIOD OF JANUARY 1, 2022 THROUGH DECEMBER 30, 2022 OF CALIFORNIA'S CalAIM SECTION 1115 DEMONSTRATION

Dear Ms. Young:

The Department of Health Care Services is officially submitting the Demonstration Year (DY) Eighteen (18) Annual Progress Report to the Centers for Medicare & Medicaid Services. The DY 18 Annual Progress Report is required by Section 88 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"), in accordance with Section 1115(a) of the Social Security Act (the Act). The DY 18 Annual Progress Report covers the reporting period of January 1, 2022 through December 2022, including fourth quarter reporting.

Enclosed are the following report attachments:

1. CalAIM 1115 DY 18 Annual Report Cover Letter
2. CalAIM 1115 DY 18 Annual Report
3. CalAIM 1115 Budget Neutrality Workbook-2022 Q4
4. CalAIM 1115 DY 18 - CBAS Annual Report Attachment
5. CalAIM 1115 DY 18 - ODS-RES
6. CalAIM 1115 DY 18 - OOS FFY Eligibility and Enrollment (CY 2021)
7. CalAIM 1115 DY 18 - OOS FFY Utilization Monitoring (CY 2021)

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

Sincerely,

[redacted]

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

Section 1115 Waiver
Demonstration Year (DY) 18
Final Report

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

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INTRODUCTION:

CalAIM Amendment and Renewal

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 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, mostly recently approved in January 26, 2023, (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).
    - **Justice-Involved** authority via the CalAIM Section 1115 demonstration waiver was most recently approved on January 26, 2023. DHCS will partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process that will assist people leaving incarceration connect to the physical and behavioral health services they need prior to release.
- **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.

On January 26, 2023, California became the first state in the nation approved to offer a targeted set of Medicaid services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver announced by the Centers for Medicare & Medicaid Services (CMS), DHCS will partner with state agencies, counties, and community-based organizations; to establish a coordinated community reentry process that will assist people leaving incarceration connect to the physical and behavioral health services they need prior to release. The initiative will help California address the unique and considerable health care needs of justice-involved individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state. In addition, the waiver authorizes $410 million for PATH, Justice-Involved Capacity Building grants to support collaborative planning, and IT investments intended to support implementation of pre-release and reentry planning.

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:

Amendment Process (STCs 8 and 14)[1]

During the reporting period of January 1, 2022, through December 31, 2022, DHCS submitted two CalAIM 1115 waiver amendments to CMS, detailed below:

CalAIM Asset Test Amendment

California State Assembly Bill 1331 directed DHCS to seek federal approval to implement a two phased approach to increase and eventually eliminate the asset limits for non-MAGI coverage groups. DHCS received approval for State Plan Amendment (SPA) 21-0053) that gives DHCS authority to implement the resource disregard to increase the asset limits for most non-MAGI coverage groups. Since the authority to apply disregards under section 1902(r)(2) of the Social Security Act is limited to certain enumerated coverage groups, the approved SPA does not apply to the "Deemed SSI groups," specifically those mandatory Medi-Cal eligibility groups comprised of individuals who would be eligible for Medicaid if they were receiving Supplemental Security Income (SSI) and/or state supplementary payments (SSP) but are no longer receiving such payments and are thus "deemed" eligible for Medi-Cal. On April 06, 2022, the state submitted an amendment to the CalAIM demonstration to assure access to and provide parity with the asset disregard policy for the populations under the approved SPA.

On June 29, 2022, DHCS received federal approval of California's two-phased approach to increase, and eventually eliminate, asset limits for certain Non-Modified Adjusted Gross Income (Non-MAGI) Medi-Cal populations through the CalAIM Section 1115 Demonstration waiver amendment. The changes affect the Non-MAGI Medi-Cal beneficiary population who have historically been limited in the amount of property they can own and retain, and still be eligible for Medi-Cal.

Effective July 1, 2022, asset limits increased to $130,000 per person and $65,000 for each additional household member. The prior asset limits were $2,000 per person and $3,000 for two people. Beneficiaries will be able to keep additional resources, resulting in increased financial stability and improved quality of life. This increase in asset limits makes Medi-Cal coverage accessible to a larger number of potentially vulnerable Californians, including elderly and disabled individuals. The eventual elimination of the asset limit, to be implemented no sooner than January 1, 2024, will significantly improve access to Medi-Cal coverage.

The CalAIM Asset Test approval letter can be viewed on DHCS' website: CalAIM_Asset Test Amendment_Approval Package.pdf.

CalAIM Medi-Cal Managed Care Model Changes (MCP) Amendment

[1] The version of the STC's referenced throughout this document are from December 19, 2022: ca-calaim-ca.pdf (medicaid.gov).

On November 4, 2023, DHCS submitted a request to CMS seeking the CalAIM Section 1115 and 1915(b) amendment approvals to implement county-based model changes in its Medi-Cal Managed Care (MCMC) program. From August 12 to September 12, 2022, California held a public comment period for the draft CalAIM Section 1115 amendment and CalAIM Section 1915(b) amendment overview. During the 30-day period, DHCS received 82 public comments, including 58 comments submitted via email or U.S. mail and 24 comments provided orally or via the Zoom chat box functionality during public hearings. An additional 3 public comments were submitted by email after the public comment timeframe but were reviewed and considered by DHCS. The summary of responses to public comments can be viewed on DHCS' website: CalAIM MCP Model Change Section 1115 Amendment. The CalAIM Medi-Cal MCP Amendment is pending CMS' approval.

Tribal Uncompensated Care (UCC) for Chiropractic Services (STCs 2, 16, and 111)

Indian Health Services (IHS) Uncompensated Care Supplemental Payments are Certified Public Expenditure (CPE) based waiver payments for uncompensated care to support participating IHS and 638 facilities. Under this program, DHCS makes encounter-based payments at a flat rate to the California Rural Indian Health Board (CRIHB). CRIHB then makes supplemental payments to participating IHS and 638 facilities that incurred uncompensated care costs. Supplemental payments will be computed based on the uncompensated cost for services that were eliminated from Medi-Cal coverage through State Plan Amendment (SPA) 09-001. Providers furnish these services to individuals enrolled in the Medi-Cal program and for which no state funds are involved. Tribal uncompensated care chiropractic benefits are the only current services approved to be covered by DHCS because the other services eliminated through SPA 09-001 are now covered. For each eligible service encounter, DHCS pays the published Federal Register, IHS Outpatient Per Visit Rate (Excluding Medicare). Payments are offset by any third-party payments received for eligible encounters. The program is capped at $1,550,000 total computable per year.

In December 2022, an overpayment was received for Quarter 1 dates of service January-March 2022, in the amount of $1,280.00.

The IHS global encounter rate for calendar year 2021 is $519 and the encounter rate for CY 2022 is $640. The payment table below shows IHS payment and recoupment activity in the order of occurrence during DY 18.

Service Month/Year	FFP	No. of Encounters
July-September 2021 (missing claim)	$519.00	1
July-September 2021 (recoupment)	($5,190.00)	(10)

October-December 2021	$73,179.00	141
January-December 2021	$9,861.00	19
January-March 2022	$87,040.00	136
January-March 2022 (recoupment)	($1,280.00)	(2)
April-June 2022	$112,000.00	175
July-September 2022	$92,160.00	144
Total	**$368,289.00**	**604**

Dually-Eligible Enrollees in Medi-Cal Managed Care (STC 46)

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 can change Medicaid plans by picking a new MA plan or original Medicare once a quarter. A dually eligible beneficiary's Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. In the counties where the state is authorizing the exclusively aligned enrollment (EAE) Dual-Eligible Special Needs Plan (D-SNP) model, known as Medicare Medi-Cal 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.

DHCS has implemented the waiver authority provisions to enroll a beneficiary in an affiliated Medicaid plan once they have selected a MA plan, known as the Medi-Cal matching plan policy, in twelve counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, Sacramento, San Diego, San Francisco, Santa Clara, and Stanislaus. On January 1, 2023, beneficiaries of the federal financial alignment initiative known as Cal MediConnect (CMC) transitioned into EAE D-SNPs (Medicare Medi-Cal plans) 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, beneficiaries can enroll in a D-SNP for Medicare benefits and will be enrolled in an MCP for Medi-Cal benefits, both operated by the same parent organization for better care coordination

and integration. In addition, effective January 1, 2023, all dually eligible beneficiaries statewide were mandatorily enrolled in Medi-Cal managed care, except for those with a Share of Cost who are not in a LTC facility. All dually eligible beneficiaries residing in LTC Skilled Nursing Facilities (SNF) were mandatorily enrolled in Medi-Cal managed care. As of 2022, most dually eligible beneficiaries in County Organized Health System counties and the seven CCI counties are already enrolled in Medi-Cal managed care plans. This policy for the remaining 31 counties is intended to standardize SNF services coverage under managed care statewide. As a result, the Medi-Cal matching plan policy will apply to more beneficiaries in 2023. 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.

The table below provides the total number of beneficiaries, broken out by calendar year quarter, enrolled in MA plans (including D-SNPs) that request to change Medi-Cal managed care plans (MCPs) and are referred to the MA plan or 1-800-MEDICARE in the 12 counties in 2022 where DHCS aligned Medi-Cal plan enrollment with Medicare plan choice: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus.

Month	Matched Beneficiaries Requesting Transfer into an Unmatched Plan and Referred to Medicare
1/1/2022	131
2/1/2022	111
3/1/2022	152
Q1 Total	**394**
4/1/2022	125
5/1/2022	138
6/1/2022	178
Q2 Total	**441**
7/1/2022	139
8/1/2022	215
9/1/2022	187
Q3 Total	**541**
10/1/2022	153
11/1/2022	239
12/1/2022	526
Q4 Total	**918**
2022 Grand Total	**2,294**

Post Award Forum (STCs 88a and 92)

The purpose of the Joint Stakeholder Advisory Committee (SAC) and Behavioral Health (BH) Meeting is to provide DHCS with valuable input from the stakeholder community on ongoing implementation efforts for the State's Section 1115 waiver, as well as other relevant health care policy issues impacting DHCS. SAC members are recognized stakeholders/experts in their fields, including, but not limited to, beneficiary advocacy organizations and representatives of various Medi-Cal provider groups. BH-SAC meetings are conducted in accordance with the Bagley-Keene Open Meeting Act, and public comment occurs at the end of each meeting.

In DY18, five BH-SAC meetings were convened on the following dates: February 17, 2022, May 12, 2022, July 21, 2022, October 20, 2022, and November 15, 2022. DHCS agenda items included: CalAIM and 1115 Waiver Update and Post-Award Forum; Quality/Equity Roadmap Measures and Metrics; Contingency Management; PATH funding; Justice-Involved and Natural Healers: Behavioral Health Policy Updates; Medi-Cal Expansion to Eligible Adults Ages 50+, Regardless of Immigration Status; PHE Unwinding and Implementation with Health Plans; Managed Care Readiness and Transition Planning for 2024. To view past meeting agenda's visit DHCS' website at: BHSAC Past Meetings (ca.gov).

Monitoring Reports (STC 88)

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY18, DHCS submitted three quarterly reports to CMS electronically on the following dates:

Quarter:	Reporting Timeframe:	Date submitted to CMS:
One	January 1 – March 31, 2022	June 3, 2022
Two	April 1 – June 30, 2022	August 29, 2022
Three	July 1 – September 30, 2022	November 21, 2022

Per CMS' guidance, the fourth quarterly reporting information has been folded into the annual reports beginning in DY15.

Monitoring Calls (STC 91)

During DY 18, CMS and DHCS held monthly conference calls to discuss any significant or actual anticipated developments affecting the current Demonstration. If a monthly call was canceled (due to lack of agenda items), updates were shared via email. As needed, DHCS and CMS also hold separate meetings to discuss waiver deliverables, with key subject matter experts in attendance.

Financial Report Requirements (STCs 88c, 105-108)

The expenditure related to CalAIM's section 1115 populations for DY 18 were claimed to the CMS-64: Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program forms. Some of the expenditures were claimed under CMS 64.9: Quarterly Medicaid and CHIP Budget and Expenditure Reporting for the Medical Assistance Program, Administration and CHIP forms because the State is still working on the CalAIM waiver break down information. DHCS will move the expenditures from "No Waiver" to "Waivers" after receiving CAPMAN reporting with updated waiver information.

For administrative cost of this demonstration, DHCS reported it on the CMS 64.10 Waiver Path Supports per stated in the STCs: "The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS."

PATH Supports		See STC 109	Follow CMS-64.9 Base Category of Service Definition	Date of Service	ADM	N	1/1/2022	12/31/2026

Monitoring Budget Neutrality (STCs 115-122) **and Medicaid Expenditure Groups (MEGs)** (STCs 109-10) **for the Demonstration**

The State has complied with all quarterly reporting requirements for monitoring budget neutrality set forth in these STCs and is providing an updated budget neutrality worksheet with this report. This workbook will work serve as the annual monitoring report for DY 18 and is consistent with the template provided by CMS for DY 18. The State will continue to work with CMS to receive an updated budget neutrality workbook to reflect changes made in the demonstration amendment approved by CMS on January 26, 2023. The following paragraphs describe key changes or caveats affecting expenditures specific to certain Medicaid Expenditure Groups (MEGs).

PATH Supports. There have been several changes in the PATH Supports Program since the Q3 Projection submission. The total amount of PATH Supports expenditures across DY 18 through DY 22 has increased from $1.44 billion to $1.85 billion consistent with the demonstration amendment approved by CMS on January 26, 2023. Most funds are now projected to be expended in DY 19 and DY 20 with expenditures trending down in DY 21 and DY 22. A few of the changes include finalizing a contract amendment in early Q4 with our third-party administrator (TPA) to set up a pass-through payment process and refinement of the different PATH Supports program initiatives. Program changes include more time needed to set

up payment processes with the TPA, lower than anticipated grant requests received for the PATH Justice Involved initiative, a delay in contracting with the PATH Collaborative facilitators, and milestone payments for CITED awards extending beyond the end of this demonstration year DY 18.

With the delay in the Reentry Demonstration Initiative and Justice Involved to April, 2024 and the associated delay in PATH Supports Justice Involved initiative expenditures, the State falls well below the PATH Supports budget neutrality total for DY 18. Projections Expenditures are currently lower than previous projections due to the following and actuals are only reflected for the PATH Justice Involved (JI) initiative.

HRSN Services. With the demonstration amendment approved by CMS on January 26, 2023, HRSN Services are now subject to a Capped Hypothetical Budget Neutrality Test, however, the budget neutrality workbook has not yet been updated to reflect this change. HRSN service (Recuperative Care and Short Short-Term Post Hospitalization Housing) actual expenditures exceeded original projections. The overspending was by approximately 15 percent mainly due to higher enrollment as a result the extension of the Public Health Emergency (PHE) extending throughout DY 18, allowing disenrollment to continue into DY 19. Due to delay of disenrollment, eligible member months exceeded original projections leading to the overspending in expenditures. Even though our actual expenditures exceed the original projected amounts, they fall below the capped hypothetical amount of $353,702,693 approved via the demonstration amendment.

CBAS. CBAS expenditures for DY 18 are higher than previous projections, in part due to higher enrollment as a result of the PHE extending through DY 18. Per STC 17.7, actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration.

GPP and DSH. The BN workbook currently displays a variance between the Without-Waiver and With-Waiver on the ‘Summary TC’ tab of roughly $615 Million. This is roughly $215 Million greater than our originally projection of $400 Million overspending in DY 18. The change is mainly due to the misalignment of With-Waiver and Without-Waiver treatment of DSH described in the 3rd paragraph. If the difference of Without-Waiver DSH and With-Waiver DSH and GPP is reduced to the $472M, the DY 18 variance drops to ($391M), slightly below the ($400M) original projection due to differences on Contingency Management.

Under the ‘Summary TC’ Tab, GPP expenditures and projections listed under the With-Waiver Total Expenditures are inclusive of both Adjusted DSH allotment and UC Pool federal funding ($472 Million annually). Projections for DSH payments also under the With-Waiver Total Expenditures include NDPH and UC DSH hospital payments, also known as Traditional DSH, funded only by the federal DSH allotment and various non-federal funding sources (IGTs, CPEs, & General Fund). With-Waiver amounts for GPP and DSH projections have been updated to reflect the recent PHE extension (now effective through March 2023).

The State's understanding of DSH reporting is that Without-Waiver should equal the full DSH allotment (Adjusted + Traditional DSH), while the With-Waiver reporting should be GPP as a summation of Adjusted DSH and UC Pool and "DSH" as the amount associated with Traditional DSH. DHCS understands that CMS is working to adjust the Without-Waiver DSH amount in the locked workbook to reflect the combination of Traditional and Adjusted DSH. The adjustment would correct both the omission of Traditional DSH from the Without-Waiver side and account for increases of federal funding in association with the extension of the PHE within the DSH allotment and GPP projections. This would bring the Without-Waiver DSH amount to equal the summation of GPP and DSH amounts associated with the With-Waiver bucket net of the UC Pool ($472 Million).

During DY 18, the State was updating our reporting system to map to the new CalAIM waiver logic. However, during this period we were informed by CMS that we needed to account for Unsatisfactory and Satisfactory Immigration Status (UIS and SIS respectively) dating back to SFY 19-20. Due to this overhaul of our reporting system, majority of the MEG expenditures were reported manually. For DY 19 and forward, our system has been updated and will be able to map expenditures to the correct lines in the CMS 64. For DY 18, our system will be updated for retro reporting in October of 2023.

PROGRAM UPDATES:

The Program Updates Section describes key activities and data across the CalAIM 1115 demonstration. The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 18, as required in 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:

- **Global Payment Program (GPP)** (STCs 70-84)
- **Community Based Adult Services (CBAS)** (STCs 20-31)
- **Drug Medi-Cal-Organized Delivery Services (DMC-ODS)**: Residential and Inpatient Treatment for Individuals with substance use disorder (SUD) (STCs 47-53), including **Contingency Management (CM)** (STCs 54-58)
- **Providing Access & Transforming Health (PATH) Supports** (STCs 32-45)
- **Community Supports**: Recuperative Care & Short-Term Post Hospitalization (STCs 59-68)
- **Out-of-State Former Foster Youth** (STCs 10 and 19)

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 will add services that aim to address health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries.

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

While the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions (STCs) were approved by the Centers for Medicare and Medicaid Services (CMS), the accompanying attachments are still under review. DHCS submitted the initial GPP attachments to the Centers for Medicare and Medicaid Services (CMS) in DY 18 and continues to work with CMS for final approval. Once the STCs attachments are finalized and approved, they will be incorporated into the STCs.

Successes/Accomplishments:

DHCS instituted and conducted bi-weekly conference calls with the California Association of Public Hospital and Health Systems to discuss implementation activities and issues, trends in reported data on metrics, and budgets.

Program Highlights:

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 public health emergency (PHE). National public health emergencies are effective for 90 days unless extended or terminated.

On December 29, 2022, House of Representatives 2617 Consolidated Appropriations Act (2023) was enacted which amended the FFCRA by implementing a step-down of increased FMAPs until December 31, 2023. The FMAP is increased by 6.2 percentage points until March 31, 2023, 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.

Program Year (PY) final closeout activities took place for PYs 3 and 4 after CMS published the final federal fiscal year (FFY) 2018 and 2019 DSH allotments to the Federal Register. DHCS determined the amount earned by each PHCSs in accordance with the final reconciliation and redistribution process and completed a round 6 final GPP payment round for PY 3. Based on the final FFY 2019 DSH allotment, PHCSs received all PY 4 funding and did not require an additional round 6 payment.

Qualitative Findings

Nothing to report.

Quantitative Findings

Program Year 7 final reports for service period January 1, 2021, to December 31, 2021, were due to the DHCS from all participating GPP PHCS on September 30, 2022. Those reports included PY 7 final year-end aggregate and encounter level data. DHCS reviewed encounter level data for accuracy, completeness, reasonability, timeliness, and compliance using the GPP Encounter Data Manuals, and performed tests for reasonableness. Where necessary and appropriate, DHCS worked with PHCSs to correct or improve data. Once PY 7 aggregate and encounter data reviews were finalized, PHCSs were notified of the final reconciliation and redistribution process payment amounts and Intergovernmental Transfer (IGT) amounts on December 30, 2022.

During DY 18, PHCSs were impacted by low service utilization rates and were not able to claim the anticipated level of GPP total budget for PY 7. The low service utilization rate was a result of the PHE and its impact to the delivery of GPP services. Therefore, on April 22, 2022, CMS authorized a 24% reduction of GPP system thresholds for GPP PY 7, calendar year 2021. The threshold reduction assisted PHCSs by allowing them to claim more of their GPP budgets with their lower service utilization rates.

The payments table below shows the GPP payments made to the PHCSs in the order that they were paid during DY 18.

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 6 (formerly 6A) Final Reconciliation	$197,092,067.75	$153,605,561.69	DY 18	$350,697,629.44
PY 3 Final DSH (Round 6)	($3,202,665.00)	($3,202,665.00)	DY 13	($6,405,330.00)
PY 7 (formerly 6B)-Q4	$246,184,193.93	$191,865,973.20	DY 17	$438,050,167.13

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
PY 7 (formerly 6B) Q4B (Threshold Reduction Payment)	$238,241,892.40	$185,676,065.60	DY 17	$423,917,958.00
PY 8 (formerly 7)-Q1 (January 1, 2022 – March 31, 2022)	$368,091,161.24	$286,875,317.84	DY 18	$654,966,479.08
PY 8 (formerly 7)-Q2 (April 1, 2022 – June 30, 2022)	$350,973,082.56	$273,534,181.78	DY 18	$624,507,264.34
PY 8 (formerly 7)-Q3 (July 1, 2022 – Sept 30, 2022)	$333,674,768.58	$260,052,577.64	DY 18	$593,727,346.22
Total	**$1,731,054,501.46**	**$1,348,407,012.75**		**$3,079,461,514.21**

Policy/Administrative Issues and Challenges

DHCS experienced challenges early into the CalAIM demonstration, for instance, CalAIM was renewed without STCs attachments K, L, M, and Q that are required for the implementation of the GPP. DHCS worked closely with and increased the frequency of communication with the California Association of Public Hospitals (CAPH), PHCSs, and CMS to address changes to payment dates, threshold changes, services, and other details of the Program. DHCS continues to work collaboratively with CAPH, PHCSs, and CMS through iterations of the STCs attachments, while operating the program under the STC attachments that were previously approved in the Medi-Cal 2020 waiver. Once the CalAIM STC attachments are finalized, it is anticipated that the program will need to perform a reconciliation to bring any program operations during the CalAIM waiver time period into alignment with the CalAIM STC attachments.

Progress on the Evaluation and Findings

DHCS submitted a draft evaluation design for the PATH, GPP, and alignment and integration for dually eligible beneficiaries' portions of the CalAIM 1115 waiver demonstration to CMS on June 27, 2002. In December 2022, CMS provided their initial feedback, which included suggestions and recommendations to onboard a potential contractor to assist with the evaluation design, along with combining this evaluation effort with the evaluation of the Justice-Involved Initiative and the revisions to PATH (approved by CMS in January 2023). DHCS agreed with CMS' suggestions.

DHCS is working to finalize and then release a Request for Information with the ultimate goal of entering into a contract with an external evaluator to conduct the evaluation of GPP, PATH, the Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process, and the newly approved Reentry Demonstration Initiative. DHCS plans to submit this revised, expanded evaluation design to CMS no later than July 25, 2023, which is 180 calendar days after CMS' approval of the demonstration amendment.

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" (BTR) 1115 demonstration waiver to include CBAS, which was approved by 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 engagement opportunities to receive 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 includes the CBAS benefit. The following information was included in the CMS Approval Letter: "Under the 1115 demonstration, the state will also continue the CBAS program to eligible older adults and adults with disabilities in an outpatient facility-based setting while now also allowing flexibility for the provision and reimbursement of remote services under specified emergency situations, i.e., Emergency Remote Services (ERS). This flexibility will allow beneficiaries to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization."

Program Requirements:

CBAS is an outpatient, facility-based program, licensed by the California Department of Public Health (CDPH) and certified by CDA to participate in the Medi-Cal program. The CBAS benefit is provided to eligible Medi-Cal 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) through a face-to-face assessment, which is conducted by a registered nurse with level-of-care determination experience, using a standardized tool and protocol approved by DHCS. An initial face-to-face assessment is not required when an MCP determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information the MCP possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through a reauthorization process, or every 12 months for individuals determined by the MCP to be clinically appropriate. Reauthorization is the process by which CBAS providers reassess members to ensure their needs are being met by the services they are receiving.

On October 9, 2020, CMS approved DHCS' disaster 1115 amendment, which allowed flexibilities pertaining to the delivery of CBAS Temporary Alternative Services (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.

The state must ensure 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 provides CBAS coverage for CBAS eligible participants who have an approved medical exemption from enrolling into managed care. The final four rural counties

[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.

(Shasta, Humboldt, Butte, and Imperial) transitioned the CBAS benefit to managed care in December 2014.

Effective April 1, 2012, eligible participants were able to receive “unbundled services” if there is insufficient CBAS center capacity to satisfy the demand. Unbundled services refer to component parts of CBAS delivered outside of centers with a similar objective of supporting participants 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 managed care, the MCP will be responsible for facilitating the appropriate services on the member’s 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 managed care plans (MCPs) to develop and implement CBAS TAS. 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. Such services were conducted via 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 the assessed and expressed needs of CBAS participants.

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 providing 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 would 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, and 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 W 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 W and supersedes the June 9, 2021, Attachment W. Attachment W previously allowed TAS and virtual assessment activities up to six months after the end of the public health emergency. The authorities that the State requested in the Attachment W 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 was 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) during the last quarter to prepare CBAS providers and MCPs for the ending of CBAS TAS and implementation of ERS in compliance with 1115 waiver requirements and CDA CBAS ERS policy.

Successes/Accomplishments:

In DY 18, January 1, 2022, through December 31, 2022, CDA accomplished the following in collaboration with DHCS, CDPH, CBAS providers, MCPs, CAADS, and the Alliance for Education and Leadership (ALE): (1) drafted policy guidance for the unwinding and termination of CBAS TAS remote services effective September 30, 2022, and the transition of CBAS participants to in-center services for those who were able and willing to return; (2) provided guidance to CBAS providers on CDA's discharge requirements for participants who chose not to return to in-center services on October 1, 2022, requiring collaboration with participants and

the participants' MCPs to meet their needs post discharge from CBAS; (3) drafted ERS policy guidance for the provision of CBAS ERS in compliance with CalAIM 1115 waiver requirements; (4) established CBAS ERS reporting and data collection processes for tracking the implementation and provision of ERS as of October 1, 2022; (5) provided training to CBAS staff, CBAS providers, MCPs, and interested stakeholders in preparation for the changes in CBAS program operations with the termination of TAS and the provision of ERS; (6) participated in state-level EVV activities to prepare for the implementation of CBAS ERS EVV in 2023, which requires the establishment of new CBAS billing codes for the provision of CBAS ERS for CBAS ERS services provided in the home subject to EVV.

The completion of these activities prepared CBAS providers to: (1) transition their participants to in-center services who were willing and able when TAS ended, (2) discharge their participants who chose not to return to in-center services when TAS ended, and (3) implement CBAS ERS on October 1, 2022, for participants who meet ERS criteria and need ERS.

Based on inquiries submitted to CDA from CBAS providers and MCPs requesting clarification about ERS policies over the past quarter, additional training will be needed to help CBAS providers and MCPs understand and comply with the 1115 waiver requirements, along with CDA's policy directives for ERS implementation. All CDA CBAS ERS policy letters and recorded trainings for the past year providing guidance on the ending of TAS and implementation of ERS are posted on the CDA CBAS webpages. CDA in collaboration with DHCS will continue to provide training and issue policy directives on ERS implementation, as needed.

Program Highlights:

The following are highlights of several key program activities during DY 18, January 1, 2022, through December 31, 2022:

Policy Guidance Ending CBAS TAS and Implementing ERS

CDA met with CAADS/ALE, CBAS providers, and MCPs on a regular basis during this past year to draft all CBAS TAS and ERS policy documents for review by CDA and DHCS leadership to develop clear and acceptable policies for key stakeholders required to implement and oversee ERS implementation. In addition, CDA provided webinar trainings in collaboration with DHCS to review TAS and ERS policy directives and associated reporting requirements to improve the implementation of the policies as required. Although the drafting of policies was collaborative and the training opportunities were made available to all CBAS providers, MCPs, and interested stakeholders, challenges remain in the understanding and implementation of these policies by some CBAS providers and MCPs. CDA in collaboration with DHCS will continue to respond to inquiries by CBAS providers and MCPs to clarify CBAS ERS policies and reporting requirements to support consistency in implementation. In addition, ERS policy training was and will continue to be provided to CBAS staff to enable them to provide guidance and technical assistance to the staff of their assigned CBAS centers, and to determine a CBAS

center's compliance with ERS policies during a center's onsite recertification survey. This process includes a review of health records of participants who received or are currently receiving ERS.

Establishing 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. In addition, each month CDA posts the average number of participants receiving ERS per diem on its website, beginning October 2022. This data is provided statewide and for each center. CDA will continue to collect, distribute, and post ERS data on the CDA website for transparency and analysis.

Compliance with CBAS EVV Requirements

CDA has worked closely with DHCS to develop billing codes for CBAS ERS, and CBAS ERS provided in the home subject to EVV. The CBAS ERS EVV codes were published in February 2023 in the Medi-Cal Provider Manual. CDA and DHCS are developing policy guidance describing EVV, which CBAS services are subject to EVV if provided in the home, and how CBAS providers are to submit claims for the provision of CBAS ERS, and CBAS ERS subject to EVV. In addition, CDA will issue guidance and instructional information to CBAS providers to promote provider registration and provide technical assistance, to support successful EVV implementation. This process has been a time-intensive, collaborative effort and will require intense training for CBAS staff, providers, and MCPs.

Qualitative Findings:

Outreach Activities

CDA provides ongoing outreach and CBAS program updates to CBAS providers, MCPs, CAADS, ALE, and other interested stakeholders via multiple communication strategies such as the *CBAS Updates* newsletter, CBAS ACLs, CBAS News Alerts, CBAS webinars, CAADS conferences, CAADS/ALE/CDA webinar presentations, CAADS/ALE Vision Team Meetings (includes CDA, CBAS staff, and CBAS providers), CAADS/ALE MCP meetings (includes CDA, CBAS staff, and CBAS providers), CDA meetings with MCPs that contract with CBAS centers, and CDA meetings with the CBAS Quality Advisory Committee. In addition, CDA responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders.

The following are CDA's outreach activities during DY 18-Q4: CBAS ACLs (2); CBAS Updates Newsletter (1); CBAS News Alerts (23); CBAS webinars/"Office Hours" facilitated by CBAS, DHCS and CDPH staff (5); CAADS/ALE Vision Team Meetings with CBAS providers and CDA staff (12); CAADS/ALE- MCP-CDA meetings (3); DHCS-CDA-MCP meetings (1), CAADS

Annual Conference – CDA training sessions (5); and Responses to CBAS Mailbox Inquiries (600).

Outreach and educational/training activities focused on the following topics: (1) CBAS program operations and CDPH public health guidance, (2) CDA ACLs on policies and procedures for ERS implementation; (3) CBAS ERS reporting requirements, including the newly-established 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. CDA (in collaboration with DHCS) will be providing training on EVV to CBAS staff, providers, and MCPs after the state has published the CBAS ERS EVV billing codes and distributed policy guidance specific to EVV. CBAS ERS EVV reporting processes and procedures must be established and utilized when personal care and home health care services are provided in participants' homes.

CBAS Webinars

CDA presented five webinars/ "ERS Office Hours" between October 13, 2022 and December 20, 2022, to provide updates and training on the following: (1) CBAS ERS policy and reporting requirements for implementation as of October 1, 2022, which includes compliance with CBAS provider participation standards for the provision of ERS; (2) Pausing of in-center services related to COVID-19 and Influenza outbreaks; (3) Training on the completion of CEIFs when a public emergency impacts all center participants; and (4) how to report ERS data for each ERS category during a public or personal emergency. All CBAS webinar recordings and slides are posted on the CDA CBAS Training webpage.

CAADS/ALE Vision Team Meetings

CDA continues to collaborate weekly with the CAADS/ALE Vision Team (which includes CDA CBAS staff, and CBAS providers) in the planning, development, and implementation of ERS policy guidance 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.

MCP Meetings with CDA

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 did not convene the usual number of meetings with MCPs due to participation in multiple meetings with the MCPs convened by CAADS/ALE; and by DHCS related to the planning, development, and

implementation of ERS. CDA plans to schedule monthly meetings with MCPs starting February 2023.

MCP Meetings with CAADS/ALE

CDA participated in three meetings with MCPs that were convened by CAADS and ALE to discuss the implementation of ERS on October 1, 2022. Concerns about different interpretations of ERS policy by CBAS providers and by MCPs were identified. The need for collaboration to provide ERS as approved by CMS and as written in CDA and DHCS policy letters was also a concern.

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 quarter four 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 quarter four 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 600 CBAS mailbox inquiries, which included questions about: (1) the interpretation and implementation of ERS policies as of October 1, 2022; (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; and (7) MCP denials of some CEIFs preventing the implementation of ERS according to ERS policy directives requiring policy clarification by CDA and DHCS.

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 by March 17, 2023, and thereafter on an ongoing basis. CDA determines CBAS center compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS' directive in the CBAS Sections of the 1115 waiver, CDA developed the CBAS HCB Settings Transition Plan (CBAS Transition Plan/CTP), which is an attachment to California's Statewide Transition Plan (STP*)*. On February 23, 2018, CMS granted initial approval of California's STP, and the 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 certification/recertification surveys during DY 18-Q3 instead 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 the past quarter.

During this past quarter, 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.

Operational Updates:

<u>End of TAS Flexibilities on September 30, 2022, and Implementation of ERS on October 1, 2022</u>
The end of TAS flexibilities on September 30, 2022, and return of CBAS participants to in-center services, resulted in the discharge of some participants. CDA distributed a survey to CBAS providers in May 2022 to estimate the number of participants who chose not to, or were unable to, return to in-center services when TAS ended on September 30, 2022. At that time, approximately 5,816 participants were projected to not return to in-center services on October 1, 2022, for a variety of reasons including not wanting in-center services or not being able (physically/medically) to return. CDA directed CBAS providers to collaborate with participants, caregivers, and the participants' MCPs to develop discharge plans for participants not returning to in-center services. CBAS providers were required to submit discharge plans to participants' MCPs.

DHCS issued All Plan Letter (APL) 22-020 "CBAS Emergency Remote Services" on

November 2, 2022, which required MCPs to report CBAS discharges to DHCS on a monthly basis between September 2022 and December 2022, to monitor discharges during the transition from CBAS TAS to three months post implementation of CBAS ERS. DHCS required MCPs to collaborate with CBAS providers to prepare for the end of TAS to ensure each member's needs would continue to be met through in-person services provided at the CBAS center or through ERS. For members who choose to discontinue their CBAS services, the MCP is responsible for providing care coordination for their members to ensure their needs continue to be met. Members who are discharged from the CBAS program involuntarily by their MCP may file a grievance with their MCP and/or request a state fair hearing or independent medical review.

In July 2022, when CBAS providers were planning for the transition of participants to in-center services or discharge as of September 30, 2022, CDA began drafting CBAS ERS policy directives in collaboration with DHCS, CBAS providers, MCPs, and CAADS/ALE. CDA distributed the CBAS ERS Policy Summary and initial ERS policy letter, ACL 22-04 "Launch of CBAS ERS" in August 2022, followed by six additional policy letters through October 2022. These ERS policy documents were reviewed in CDA webinar trainings provided from August 2022 through December 2022. These trainings included multiple Question and Answer sessions with CDA and DHCS staff to clarify ERS policy directives.

In addition to CDA and DHCS policy letters and webinar trainings, in December 2022, DHCS, CDA and MCPs began meeting each month to address MCP questions about ERS policies and processes. One of the key issues has been the processing of Completion of the CBAS ERS Initiation Forms (CEIF) CBAS providers submit to CDA and the participant's MCP to initiate the provision of ERS. CBAS providers complete the CEIF for participants experiencing a public or personal emergency, based on an assessment by the center nurse and/or social worker (within their scope of practice) who then attest that the CBAS participant meets ERS criteria and needs ERS. There have been occurrences when a participant's MCP determines that the participant does not meet ERS criteria in opposition to the CBAS provider's assessment. CDA and DHCS policy directives require collaboration and coordination between CBAS providers and MCPs to determine if a CBAS participant meets ERS criteria. When an MCP does not agree with the provision (and payment of) ERS, a decision needs to be made in collaboration with the participant/authorized representative as to how to meet the participants' needs when they are not able, or choose not, to attend in-center services. DHCS, CDA, and MCPs will continue discussions about these types of situations, and others, to ensure CBAS ERS policies are interpreted and implemented as approved by CMS, problems are addressed quickly, and CBAS participants who meet ERS criteria receive needed services in a timely manner.

Based on the number of CBAS Mailbox Inquiries from CBAS providers and MCPs requesting clarification on ERS policies and processes, additional training and guidance is needed. CDA in collaboration with DHCS provided five webinars to CBAS providers and MCPs between August 5, 2022, and September 20, 2022, in preparation for the end of CBAS TAS and

implementation of CBAS ERS. The Departments held five more webinars between October 13, 2022, and December 20, 2022, specific to the implementation of ERS policies, procedures, and processes; and CDA will continue to provide training and guidance to promote a uniform interpretation and application of ERS policies.

Public Health Emergencies during ERS Implementation

The risk of COVID-19 and Influenza infections continued during the transition from the provision of CBAS TAS to in-center services. An increase in COVID-19 and Influenza infections in October and November 2022 resulted in personal emergencies (serious illness) for some participants and infectious disease outbreaks at some centers necessitating a temporary pause of in-center services and provision of ERS to all participants assessed as needing ERS while the center could not be accessed for health and safety reasons. The center nurse and physician determine, in alignment with local public health guidance, when it is safe to return to in-center services.

In addition to providing ERS to address infectious disease outbreaks, in the last quarter of 2022 there were statewide public emergencies caused by natural disasters including flooding, severe storms, and an earthquake in Humboldt County. These public emergencies have also necessitated temporary pauses of in-center services and provision of ERS to participants who do not have access to center services and need them.

These personal and public emergencies have reinforced the value of the CBAS ERS benefit. 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 to protect their health and safety.

Quantitative Findings:

Performance Metrics

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

Enrollment and Assessment Information

Per STC 24(a), CBAS enrollment data for both MCP and FFS participants, by county, is shown in Figure 1 below. CBAS centers’ licensed capacity is also shown in Figure 1.

Each quarter the MCPs self-report CBAS 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 the plan serves the entire population.

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

County	DY18 – Q1 Jan – March		DY18 – Q2 Apr – June 2022		DY18 – Q3 July – Sept 2022		DY18 – Q4 Oct - Dec 2022	
	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

**** 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 in DY18.

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 are within normal fluctuations, except for San Bernardino where the used capacity is 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.

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.

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 (on the next page) illustrates the number of new assessments reported by the MCPs. The FFS data for new assessments illustrated in the figure are 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-Q1 (Jan-Mar 2022)	2,760	2,680 (97.1%)	80 (2.9%)	0	0 (0%)	0 (0%)
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%)

Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
5% Negative change between last Quarter		No	No		No	No

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, ten assessments were performed for CBAS benefits, with five being eligible and five being ineligible. As demonstrated in the previous figure, 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.

CBAS Provider-Reported Data (STC 24.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 18-Q4. As of DY 18-Q4, the number of counties with CBAS centers and the ADA of each center are listed below in Figure 3. On average, the ADA at the 280 operating CBAS centers is approximately 23,326 participants, which corresponds to 54.2 percent of total capacity. Provider-reported data identified in the figure below, reflects data through December 2022.The ADA decreased 33.2 percent due to the program returning to a congregate setting, and individuals who remained on TAS were being transitioned back into a center-based service delivery model.

Figure 3: CDA – CBAS Provider Self-Reported Data

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

Consumer Issues and Interventions:

CBAS Beneficiary/Provider Call Center Complaints (FFS/MCP) (STC24.e.iv)
DHCS continues to respond to issues and questions from CBAS participants, CBAS providers, MCPs, members of the press, and members of the Legislature, on various aspects of the CBAS program. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Providers and members can submit their CBAS inquiries to CBASinfo@dhcs.ca.gov for assistance from DHCS and through CDA at CBASCDA@Aging.ca.gov.

Issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are collected via telephone or emails by MCPs and CDA for research and resolution. Complaints collected by MCPs were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current MCP. See Figures 4 and 5 on the next page for complaint data received by CDA and MCPs from CBAS beneficiaries and providers. During DY18, there were a total of three CBAS provider complaints.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary 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	3	3
CDA Data – Complaints 12/2022			

For complaints received by MCPs, Figure 5 illustrates there were 21 beneficiary complaints and no provider complaints submitted in DY 18. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports.

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary 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			

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

Grievance and appeals data are provided to DHCS by the MCPs. The data provided in Figure 6 reflects a total of 41 grievances were filed with MCPs during DY18. 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.

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					

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 – Q1 (Jan – Mar 2022)	1	0	0	0	1
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
		MCP Data - Appeals 12/2022			

During DY18, Figure 7 shows there were fourteen CBAS appeals filed with an MCP. The appeals were all related to “denial of services or limited services”.

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. For DY 18-Q4, there was one request for a hearing related to CBAS, which is pending.

Quality Control/Assurance Activity:

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

CDA established the CBAS Quality Advisory Committee, comprised of CBAS providers, 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 ones 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 CBAS Quality Advisory 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 such as collecting more participant characteristic data to post on the CDA website, collecting more center characteristic information to develop a consumer guide which would help participants, their families, managed care plans, and others find centers that meet their needs—medical, social, linguistic, cultural; (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 CBAS Quality Advisory 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 CBAS Quality Advisory Committee will be helpful in determining how to collect and report performance measures identified in the CalAIM 1115 waiver.

DHCS and CDA continue to monitor CBAS center locations, accessibility, and capacity for monitoring access as required under CalAIM. Figure 8 indicates the number of each county's licensed capacity since the CBAS program was approved as a waiver benefit in April 2012. The figure below also illustrates overall utilization of licensed capacity by CBAS participants statewide for DY 16-Q4 through DY 18-Q2.

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%
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%

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

Figure 8 reflects that the average licensed capacity used by CBAS participants is 51 percent statewide. Overall, most CBAS centers have not operated at full or near-to-full capacity except for Alameda County (76%). Licensing capacity allows the CBAS centers to enroll more managed care and FFS members should the need arise. Data for the total sum of license capacity for previous quarters has been updated to reflect current capacity.

STCs 24(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter-to-quarter in CBAS provider licensed capacity per county, and an analysis that addresses such variance. During DY 18-Q3, Los Angeles, San Bernardino, and Orange County all experienced an increase in licensing capacity due to the opening of new centers.

This causes capacity utilization to reflect lower percentage figures. DY 18-Q4 had no changes in licensing capacity.

Access Monitoring (STC 24.e.)
DHCS and CDA continue to monitor CBAS center access, average utilization rate, and available capacity. According to Figure 1, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS centers.

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

Prior to closing, a CBAS center is required to notify CDA and their contracted MCPs of their planned closure date and to conduct discharge planning for each of the CBAS participants to which they provide services. CBAS participants affected by a center closure and who are unable to attend another local CBAS center can receive unbundled services in counties with CBAS centers. The majority of CBAS participants in most counties can choose an alternate CBAS center within their local area. Three beneficiaries received unbundled CBAS in DY 18-Q4.

CBAS Center Utilization (Newly Opened/Closed Centers)

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

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
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 the centers' capacity to date, and adequate networks remain for this population.

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

Policy/Administrative Issues and Challenges:

The primary challenges over the past year have been preparing CBAS providers and their participants for the end of CBAS TAS, the return to in-center services, and the implementation of CBAS ERS. These transitions required the development of a significant number of policy letters, provision of multiple webinar trainings for CBAS providers and MCPs, and an increasing number of responses to CBAS mailbox inquiries. These time-intensive activities have been necessary to educate CDA staff, CBAS providers, and MCPs about CBAS ERS including new ERS reporting requirements.

As a result of the COVID-19 PHE and the provision of CBAS TAS remote services, CDA, CBAS providers, CBAS participants and their caregivers, and MCPs learned the benefit of the flexible remote services available to address participants' assessed and expressed needs, preferences, and choices during the PHE. This experience informed how CDA, in collaboration

with DHCS, CBAS providers, and MCPs, drafted and implemented CBAS ERS policy directives within the parameters of the CalAIM 1115 waiver.

CBAS TAS was available during the PHE with fewer restrictions than are permitted with CBAS ERS. For example, TAS allowed participants more flexibility in receiving a combination of remote and in-center services based on their needs until TAS ended on September 30, 2022. Under TAS, participants had flexibility in the length of time they would attend the center based on their functional abilities and tolerance levels (e.g., less than a four-hour day).

Unlike TAS, ERS is to be provided remotely under the following specified circumstances: (1) public health emergencies (state or local disasters such as wildfires and power outages), and (2) personal emergencies (time-limited illness/injury, crises, or care transitions). Participants receiving ERS may not receive a combination of remote and in-center services before returning to the center on a full-time basis.

Participants who may be experiencing a personal emergency, such as a serious illness or hospitalization, may lose function after a hospitalization or illness. As a result, they may benefit from returning to the center for short periods of time during one of their authorized days per week to receive physical therapy or occupational therapy services, but still require remote services on other days until their stamina and function improves enough to be able to return to the center for a full four-hour day and for the number of days authorized by their MCP. However, CBAS ERS as described in the 1115 waiver does not allow for the provision of a combination of ERS and in-center days. Therefore, CDA CBAS policy letters do not reflect this flexibility.

During the past quarter, some CBAS providers including CAADS and ALE have requested more flexibility in ERS policy to enable participants who are receiving ERS to be able to return to in-center services for a short period of time (less than a four-hour day) while still receiving ERS as they build endurance to remain at the center for a full four-hour day and for the number of days authorized per week. These CBAS providers and advocates believe this flexibility for time-limited “transitional” days in the center would still maintain CBAS as a facility-based program and be more responsive to participants’ needs while recovering from an emergency.

Access to remote services, such as ERS, during specified emergency situations enables HCBS programs, such as CBAS, to be responsive to participant needs, which aligns with the intent of the HCBS Settings Final Rule. The request for transitional days to support a recuperative process is an issue that some advocates and providers have proposed for more discussion within the context of evaluating CBAS ERS and improving CBAS ERS policy. CDA will continue these discussions with CAADS, ALE, and CBAS providers.

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

The DMC-ODS is a program for the organized delivery of 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, some components of DMC-ODS services are authorized under California's Section 1115 CalAIM demonstration approved through December 31, 2026 [for expenditure authority for services provided to DMC-ODS beneficiaries receiving short-term SUD treatment in IMDs; for expenditure authority for contingency management (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 Criteria.

Successes/Accomplishments:

On October 14, 2022, DHCS issued Behavioral Health Information Notice (BHIN) 22-056 to provide policy guidance for the Recovery Incentives Program: California's Contingency Management Benefit (Recovery Incentives Program). On December 8, 2022, DHCS executed a contract with Pear Therapeutics as the Incentive Manager vendor for the Recovery Incentives Program, and on December 19, 2022, CMS approved the section 1115 CalAIM post-approval protocol for CM.

In addition, DHCS began the DMC-ODS opt-in processes for two California counties, Lake and Mariposa. Per BHIN 21-075, both Lake and Mariposa Counties have successfully submitted the Implementation Plan. Pending CMS, DHCS, and counties' board approvals, both counties are tentatively scheduled to "go-live" with implementing DMC-ODS services effective July 1, 2023.

Program Highlights:

DHCS provided support and guidance to the DMC-ODS counties through BHIN communication and implementation of various initiatives. Major accomplishments in DY 18 include, but are not limited to: No Wrong Door for Mental Health Services, CalAIM Behavioral

Health policies and protocols updates for the counties, streamlining clinical documentation requirements, implementation of Peer Support Services, updated the DMC-ODS Beneficiary Handbook templates to align with CalAIM behavioral health initiatives, guidance on Mobile Crisis Services Benefit implementation, and the submission of the Behavioral Health Medi-Cal Managed Care Program Annual Report (MCPAR) to CMS.

Qualitative Findings:

In Quarter Four of 2022, an updated DMC-ODS Beneficiary Handbook template was provided to the counties. The template has been updated to align with the CalAIM behavioral health initiatives. Additionally, DHCS provided guidance to DMC-ODS counties regarding the implementation of the Medi-Cal Community-Based Mobile Crisis Intervention Services benefit. Counties will complete the required training and phase in the mobile crisis services benefits by December 31, 2023.

Outreach Activities:

- DHCS held monthly calls with each participating DMC-ODS county to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including status updates on Corrective Action Plans (CAPs) and reports.
- DHCS hosted All County Behavioral Health monthly meetings with counties and stakeholders to address various upcoming and published Behavioral Health Informational Notices. Additional assistance and guidance are provided during these meetings.
- 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.
- For counties that express interest in opting in to offer DMC-ODS, DHCS provides technical assistance to address any barriers they may have raised related to opting into DMC-ODS.

Recent activities including CalAIM demonstration guidance are listed below:

- October 19, 2022 – October All County Call
- October 31, 2022 – Annual Compliance Advisory Committee Meeting
- December 21, 2022 – December All County Call

Quality Control/Assurance Activity:

DHCS conducts annual monitoring reviews of each county that participates in the provision of DMC-ODS services. The annual monitoring reviews of all counties during DHCS' FY 2021-22 were completed on June 30, 2022, the end of DY 18-Q2. Once a review is completed a Findings Report is issued to the county. The county is then required to submit a CAP for each

area of non-compliance within 60 business days of receipt of the report for review, acceptance, and follow-up. DHCS follows up with each county to periodically check on the status of the CAP and provide technical assistance for resolution of CAP items until resolved. The Findings Reports are posted to the DHCS website on the County Performance Reports webpage.

DHCS FY 2022-23 and DY 18-Q3 began on July 1, 2022. During DY 18-Q3, DHCS was actively updating the monitoring protocols, providing input related to the contract, as requested, and contacting counties to schedule compliance reviews.

During DY 18-Q4, DHCS began sending counties the FY 2022-23 monitoring protocols requesting supporting documentation demonstrating compliance with federal and state regulations, requirements, and contractual obligations. DHCS began reviewing documentation received from the counties in preparation for DMC-ODS compliance monitoring reviews scheduled to begin in DY 19-Q1.

The following table demonstrates when County DMC-ODS monitoring reviews were completed during DY 18.

Figure 10: DY 18 Monitoring Reviews

County	Dates
Contra Costa	January 2022
Stanislaus	January 2022
San Diego	January 2022
San Mateo	January 2022
Napa	February 2022
Imperial	February 2022
Marin	February 2022
Santa Clara	February 2022
San Benito	March 2022
San Joaquin	March 2022
Placer	March 2022
Merced	March 2022
Los Angeles	April 2022
Nevada	April 2022
Orange	April 2022
Riverside	April 2022
Sacramento	April 2022
San Bernardino	April 2022
San Luis Obispo	April 2022
Ventura	April 2022

County	Dates
Alameda	May 2022
El Dorado	May 2022
Monterey	May 2022
Fresno	June 2022
Humboldt	June 2022
Kern	June 2022
Lassen	June 2022
Mendocino	June 2022
Modoc	June 2022
Santa Barbara	June 2022
Santa Cruz	June 2022
Shasta	June 2022
Siskiyou	June 2022
Solano	June 2022
Tulare	June 2022
Yolo	June 2022

Sacramento County Access to Care CAP:

Sacramento County's Access to Care CAP, which was issued on June 3, 2022, is continuously being monitored until the residential SUD treatment services and residential SUD withdrawal management services waitlist is eliminated. DHCS holds weekly meetings with Sacramento County to provide oversight and technical assistance to address the progress of the CAP. In addition, DHCS received weekly and monthly reports from Sacramento County, which include status updates for each adult beneficiary that are on the waitlist.

DHCS continued to monitor the CAP to ensure the county is providing evidence that they are striving to resolve the CAP. For Quarter 4 of 2022, DHCS received evidence from the county to close out the CAP for Notice of Adverse Benefit Determination. The county has made progress in reducing its beneficiary waitlist, and DHCS will continue to monitor the waitlist reduction and CAP.

Operational Updates:

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access SMHS, implementation of standardized statewide screening and transition tools, behavioral health payment and documentation reform, and streamlining and standardizing clinical documentation requirements. DMC-ODS counties are utilizing policy guidance released from December 2021

through December 2022 related to these items to update and implement policies and procedures.

Behavioral Health Information Notices requiring updates to policies and procedures released in DY 18-Q4 are listed below:

- **BHIN 22-055** – provides guidance for Mental Health Plans (MHPs), DMC-ODS, and DMC State Plan counties regarding funding sources for peer services.
- **BHIN 22-056** – provides guidance for the Recovery Incentives Program, which provides incentives as a Medi-Cal benefit to beneficiaries with stimulant use disorder.
- **BHIN 22-060** - informs MHPs and DMC-ODS counties of the updated requirements related to the beneficiary handbooks. The MHP and DMC-ODS beneficiary handbook templates are included as enclosures.
- **BHIN 22-061** - provides guidance regarding the process for Medi-Cal Peer Support Specialist Certification Programs to add supplemental areas of specialization.
- **BHIN 22-062** - provides information regarding DHCS oversight of Peer Support Specialist Certification Programs.
- **BHIN 22-064** - provides guidance regarding implementation of the Medi-Cal Community-Based Mobile Crisis Intervention Services benefit by MHPs, DMC State Plan, and DMC-ODS counties.
- **BHIN 22-066** - extends the deadline to apply for Medi-Cal Peer Support Specialist certification via grand parenting and extend the deadline for implementation of the Crisis Services, Forensic (Justice Involved), and Homelessness areas of specialization.
- **BHIN 22-067** - provides the annual reporting requirements for Medi-Cal Peer Support Specialist Certification Programs.
- **BHIN 22-068** - notifies all MHPs and DMC-ODS counties about the CMS Interoperability and Patient Access final rule requirements.

Policy/Administrative Issues and Challenges:

With the submission of MCPAR, DHCS identified and resolved different areas of the required reporting indicators, as well as identifying other indicators as needing improvement. DHCS is reviewing existing contractual language and protocols to address in future MCPAR reporting. This includes amending the contract and identifying different divisions within DHCS to oversee these indicators. This was the first MCPAR submission by DHCS.

Consumer Issues and Interventions:

DHCS continues to respond to issues, complaints, or grievances related to DMC-ODS counties delivering DMC-ODS services from beneficiaries. In Quarter 4 of 2022, DHCS received three incidents regarding an issue, complaint, and grievance from a beneficiary.

These incidents were addressed and resolved. Issues received by DHCS are prioritized to ensure timely responses to the beneficiaries.

Quantitative Findings:

While some reduction in values in Q4 may be attributed to the time lag in county reporting, the values for DMC-ODS residential remain generally consistent across DY 18. This may be partially attributed to the residential average length of stay of beneficiaries at 37 days (per criteria used in provider network adequacy compliance). Such duration of stays may span months or quarters in instances, lending a relative consistency to values for both enrollees and expenditures.

Performance Metrics:

The following performance metrics depict preliminary data for DMC-ODS residential services authorized by the demonstration. Prior quarters have been updated based on new claims data. For DY 18-Q3 and DY 18-Q4, only partial data is available since counties have up to six months to submit claims after the month of service.

Figure 11: Beneficiaries with FFP Funding in Authorized Residential Services

Quarter	ACA*	Non-ACA	Total
DY 18-Q1	8,479	3,219	11,698
DY 18-Q2	8,965	3,379	12,344
DY 18-Q3	8,556	3,158	11,714
DY 18-Q4	6,365	2,396	8,761

**Affordable Care Act*

Figure 12: Member Enrollment in Authorized Residential Services

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	16,271	16,523	16,815	DY 18-Q1	17,047
ACA	16,987	17,151	17,338	DY 18-Q2	17,631
ACA	17,405	17,507	17,499	DY 18-Q3	17,833
ACA	17,481	17,464	17,440	DY 18-Q4	17,674
Non-ACA	7,304	7,247	7,147	DY 18-Q1	7,634
Non-ACA	7,120	7,074	7,001	DY 18-Q2	7,438
Non-ACA	6,984	6,923	6,911	DY 18-Q3	7,255
Non-ACA	6,876	6,834	6,809	DY 18-Q4	7,034

Figure 13: Aggregate Expenditures for Authorized Residential Services, ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	375,987	$52,251,096.65	$46,407,389.73	$5,044,895.82	$798,811.10	DY 18-Q1
Non-ACA	132,066	$17,306,631.30	$9,728,153.00	$6,107,437.71	$1,471,040.59	DY 18-Q1
ACA	382,304	$58,060,600.23	$51,463,183.07	$5,746,202.03	$851,215.13	DY 18-Q2
Non-ACA	128,526	$19,197,128.29	$10,797,966.63	$6,814,052.79	$1,585,108.87	DY 18-Q2
ACA	338,513	$56,439,754.45	$50,060,915.15	$5,537,148.43	$841,690.87	DY 18-Q3
Non-ACA	115,158	$18,848,846.80	$10,582,583.27	$6,755,087.47	$1,511,176.06	DY 18-Q3
ACA	209,550	$34,192,717.75	$30,245,042.74	$3,402,341.87	$545,333.14	DY 18-Q4
Non-ACA	70,192	$11,172,533.53	$6,280,783.02	$3,986,232.79	$905,517.72	DY 18-Q4

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 18 as of December 31, 2022.

CalAIM 1115 Waiver Progress Report DY18-Annual_ODS-RES V1.xlsx

DMC-ODS Evaluation Activities and Interim Findings:

DMC-ODS Evaluation Design: DHCS submitted two separate Evaluation Designs for the Recovery Incentives Program, and the broader DMC-ODS system, in the spring of 2022. After receiving CMS feedback to combine these two evaluations into a single unified evaluation design, DHCS responded to CMS' comments and submitted a revised DMC-ODS Evaluation Design, incorporating the evaluation of the Recovery Incentives program, to CMS on February 23, 2023.

Development/Status of Activities:
Throughout 2022, the University of California Los Angeles (UCLA) evaluation team actively engaged with DHCS in the planning and writing of the evaluation designs. UCLA worked with DHCS to make revisions to the designs as requested. UCLA also began considerations for data collection strategies to address the hypothesis and research questions posed in the Evaluation Design. UCLA continued to receive administrative datasets and collect data through an annual county administrator survey (November 2022), and an annual Treatment

Perceptions Survey (TPS) (October 2022), obtaining preliminary perceptions from stakeholders of and within the SUD service system.
Additional TPS information is available on the Treatment Perceptions Survey webpage.

Challenges encountered and how they are being addressed: The primary challenge for the evaluation is that it cannot fully begin until after 1) the evaluation design is approved by CMS and 2) evaluation of the Recovery Incentives Program cannot begin until implementation begins. However, planning and preparations are underway, and the Recovery Incentives Program will begin in Q1 2023.

Recovery Incentives Program:

DHCS' implementation of the Recovery Incentives Program was delayed to Q1 2023, due to challenges in procuring an Incentive Manager vendor. Implementation of the new CM benefit is for eligible DMC-ODS beneficiaries with an SUD in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit.

DHCS plans to pilot Medi-Cal coverage of CM in 24 DMC-ODS counties between the first quarter of calendar year 2023 and March 2024. Across the 24 counties, there are over 100 sites who plan to offer CM services through the Recovery Incentives Program. Training for the Recovery Incentives Program will commence during the first calendar quarter of 2023, and participating sites will be able to provide services after completing the two-part training and readiness assessment. As such, DHCS does not yet have programmatic implementation data to report. .

Recovery Incentives: California's Contingency Management (CM) Program – Training and Technical Assistance Activities, DY 18, Quarters 1-4

DY 18-Q1 (January-March 2022)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities were focused on the development of the two-hour CM Overview Training on-demand course, sample beneficiary consent form, CM Policy Paper, subject matter expert consultant set-up, point-of-care urine drug test (UDT) protocol development, county selection/request for application (RFA) review, and project management and stakeholder engagement. Development of the Readiness Assessment and Fidelity Monitoring Tool has not started.

DY 18-Q2 (April-June 2022)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities were focused on finalization of the two-hour CM Overview Training on-demand course, sample beneficiary consent form, Recovery Incentives

Program Manual, CM Policy Paper, point-of-care UDT protocol development, county selection/RFA review, Readiness Assessment development, and project management and stakeholder engagement. Development of the Fidelity Monitoring Tool has not started.

CM Overview and Nuts and Bolts Training progress: Key activities were focused on the launch of the two-hour CM Overview Training on-demand course in May 2022. A total of 135 individuals completed the CM Overview Training on-demand course between May 16, 2022, and June 30, 2022.

DY 18-Q3 (July-September 2022)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities were focused on development of the six-hour, two-part Implementation Training, sample beneficiary consent form, Recovery Incentives Program Manual, CM Policy Paper, finalization of the point-of-care UDT protocol, determination of the Clinical Laboratory Improvement Amendments (CLIA) Certificate and State Lab Registration status of proposed sites, Readiness Assessment development, development of a Recovery Incentives Program Overview PowerPoint presentation, and project management and stakeholder engagement. Development of the Fidelity Monitoring Tool has not started.

CM Overview and Nuts and Bolts Training progress: Key activities were focused on the continued marketing of the two-hour CM Overview Training on-demand course launched in May 2022. A total of 76 individuals completed the CM Overview Training on-demand course between July 1, 2022, and September 30, 2022.

DY 18-Q4 (October-December 2022)

Statewide CM pilot training curriculum and readiness review and fidelity assessment tool development activities: Key activities were focused on further development of the six-hour, two-part Implementation Training, sample beneficiary consent form, Recovery Incentives Program Manual, BHIN review, UDT product review, determination of the CLIA Certificate and State Lab Registration status of proposed sites, determination of Narcotic Treatment Program representation in the Recovery Incentives Program, Recovery Incentives Warmline Website development, Readiness Assessment development, delivery of the Recovery Incentives Program Overview PowerPoint presentation, and project management and stakeholder engagement. Development of the Fidelity Monitoring Tool has not started.

CM Overview and Nuts and Bolts Training progress: Key activities were focused on the continued marketing of the two-hour CM Overview Training on-demand course launched in May 2022. A total of 104 individuals completed the CM Overview Training on-demand course between October 1, 2022, and December 31, 2022.

SUD Health Information Technology Plan (STC 49 and Attachment E):

The SUD monitoring protocol was submitted to CMS for review on November 1, 2022. As part of the SUD monitoring protocol, DHCS plans to report data on three different Health IT metrics as part of the "Other Annual Metrics" for DY 18 (January 2022 – December 2022). Reporting of performance metric data, as described below, will begin per the approved protocol and reporting schedule.

- Metric Q1 will address how information technology is being used to slow down the rate of growth of individuals identified with SUD. DHCS will report data on the total number of Controlled Substance Utilization Review and Evaluation System (CURES) Patient Activity Report searches/checks done by prescribers to review the patient's controlled substance history.
- Metric Q2 will address how IT is being used effectively to treat individuals identified with SUD. The state will report on the frequency of online CURES resource information updates, by providing the number of CURES updates that the Department of Justice publishes during the reporting period (i.e. informational bulletins and updates to the CURES public webpage).
- Metric Q3 will address how IT is being used to effectively monitor recovery supports and services for individuals identified with SUD. The state will report on the number of live connections each health information organization has with a correctional facility/system for incarcerated individuals with SUD, before being released to the community.

SUD Monitoring Protocol (STC 51)**:**

DHCS originally submitted a draft of its SUD Monitoring Protocol on July 8, 2022. CMS reviewed the draft and requested clarification on some of the content by November 1, 2022. On November 1, 2022, DHCS submitted responses to CMS' request for further clarification and additional information on the SUD Monitoring Protocol and also provided supporting documents. On January 10, 2023, CMS' Division of Demonstration Monitoring and Evaluation communicated that it had reviewed the revised submission. On February 10, 2023, CMS approved the SUD Monitoring Protocol.

PROVIDING ACCESS & 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; county, city, and local government agencies; former Whole Person Care (WPC) Lead Entities (LEs), community-based organizations (CBOs), public hospitals, Medi-Cal Tribal and Designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

- Justice-Involved (JI) Capacity Building, to maintain and build pre-release services to support implementation of a full suite of statewide CalAIM JI initiatives in 2023, and;
- Support for implementation of 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.

The 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 (Mitigation Initiative) – PATH funding will directly support former WPC Pilot Lead Entities (LEs) to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal managed care health 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.

JI Capacity Building Program will provide funding to support collaborative planning as well as Information Technology (IT) system modifications necessary to implement pre-release Medi-Cal application and suspension processes. Funding will be structured in multiple rounds:

- Round one is a planning grant funding opportunity that will provide small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support collaborative planning with county departments of social services and other enrollment implementation partners to identify processes, protocols, and IT modifications that are necessary to support implementation of pre-release enrollment and suspension processes.
- Round two is an implementation grant funding opportunity that will provide larger application-based grants to support entities as they implement the processes, protocols, and IT system modifications that were identified during the Round one planning phase. While entities do not need to participate in Round one in order to apply for funding in Round two, the Round one planning grant funds provide an opportunity to support the development of a comprehensive application for Round two funding.

DHCS contracted with Public Consulting Group LLC (PCG) to serve as the TPA to implement and administer the multiple initiatives under PATH. The TPA is serving 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 Planning and Capacity Building

The implementation timelines for the PATH Initiatives are as follows:

PATH Initiatives	2022				2023				2024				2025				2026			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
WPC Services and Transition																				
TA Initiative																				
Collaborative Planning and Implementation																				
CITED																				
JI Planning and Capacity Building																				

Successes and Accomplishments:

WPC Services and the Transition to Managed Care Mitigation Initiative were implemented on January 1, 2022. There are ten county LEs that have been awarded funding under this initiative and mitigation services are currently being provided. Seven LEs under the WPC Services and Transition to Managed Care Mitigation Initiative have submitted their utilization reports and midyear invoices. All seven LE's midyear payments were processed by December 2022.

TA Marketplace completed its initial round of the TA Vendor selection process in December 2022. The TA Recipient application and menu of services are in the process of finalization. Eligible applicants will be able to apply to receive TA services through a virtual "shopping experience" in the TA Marketplace. The TPA developed a website framework that allows eligible applicants to search for services, vendors, request for assistance, and apply directly on the site. The final testing phase launched in December 2022 to meet the go-live date of January 31, 2023.

The Collaborative Planning and Implementation participant registration form was released on August 22, 2022. The Collaborative Planning facilitator selection process was completed, and contracts were executed by December 2022. The 25 collaborative groups have been developed based on regional location, size, and preserving existing CalAIM collaboratives already commencing. All participant registration submissions received by September 30, 2022, were guaranteed an invitation to participate in the initial kickoff. Participant registration will be accepted on a rolling basis and participants will be connected with selected facilitators following the initial kickoff in DY 19 Q1. As of January 30, 2023, 683 participants were registered for collaborative planning efforts. DHCS anticipates for this number to increase as collaborative facilitators will expand outreach efforts on their end.

CITED application will be released in multiple rounds, until the end of the PATH Initiative. The first round application was released on August 1, 2022, and closed on September 30, 2022. DHCS received over 200 applications for a total request of $526 million. Funding for Round one was expanded and includes Round 1A and Round 1B. CITED Round one initially was intended to award $100 million to eligible entities. Due to the volume and complexity of applications, additional funds were awarded through the creation of two sub-rounds. Both Round 1A and Round 1B awardees were selected from the current Round one applicant pool and will be announced during the first quarter of 2023.

DHCS released Round one of the JI Planning and Capacity Building application in June 2022. DHCS reviewed submissions for approval as the application period ended July 31, 2022. The Round one total number of applications received and reviewed was 40. The total Round one awarded totals were $4,550,952.95. The Round two PATH JI Capacity Building application was released on August 9, 2022, with an initial deadline of December 31, 2022. The Round two application was temporarily made unavailable mid-December 2022 in order for DHCS to update the operational criteria to align with the requirements set forth in All County Welfare Director's Letter (ACWDL) 22-27 and include new permissible uses of funding. The Round two application reopened in January 2023 and the deadline for submissions has been extended to March 31, 2023. To date, DHCS received zero Round two applications.

On July 1, 2022, DHCS executed a contract with PCG to serve as the PATH TPA to administer the different initiatives under PATH. PCG will serve as the TPA to administer, market, facilitate, develop support tools, and implement the following PATH initiatives:

- TA Marketplace
- Collaborative Planning and Implementation Program
- CITED Program
- JI Planning and Capacity Building Round two

In September, 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. As of DY 18 Q4, PCG has been fully on boarded and has begun completing their contract deliverables.

Program Highlights:

- In March 2022, DHCS released the WPC Services and Transition to Managed Care Mitigation Registration Form. Former WPC LEs were required to fill out this form within 30 days of release to receive PATH reimbursement for eligible services. Applications closed in April 2022 and DHCS awarded ten LEs with PATH Mitigation funds to continue providing eligible mitigation services to Medi-Cal beneficiaries until the MCP begins to cover them.

- TA Marketplace released the vendor application on the PATH website as of October 4, 2022 and closed on November 4, 2022. Forty-seven TA vendors were approved to provide 183 off-the-shelf and hands-on TA projects. DHCS and PCG had weekly development meetings to develop seven technical assistance domains that focused on different aspects of ECM and Community Supports implementation challenges. These domains 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.

- In July 2022, PCG developed and launched the CA-PATH.com website to host all PATH Initiative content and applications in a one-stop location. The website framework allows entities to complete applications for each PATH initiative. This streamlines all program announcements, contact information, webinar documents, and guidance memos to a single location. PCG will continue to develop and relaunch the website in DY 19 Q1 to improve the user experience and interactive TA Marketplace.

- On August 1, 2022, DHCS released the online application for Round one of the CITED Initiative. CITED will provide funding to enable the transition, expansion, and development of capacity and infrastructure to support the delivery of ECM and Community Supports services. DHCS had weekly workgroup meetings with PCG to ensure incoming questions from potential applicants were addressed. A frequently asked question list and impermissible use list was created to provide CITED applicants further guidance.

- To support eligible entities with their CITED application, DHCS hosted two informational webinars in August and September 2022, which provided detailed information on CITED funds and the application process and allowed participants to ask questions.

- DHCS and PCG formed the 24 regional/county collaborative groups based on regional location, size, MCPs in that area, and preserving the existing CalAIM roundtables that had formed. DHCS has taken this strategy to align timelines and assist the transition of

participants to the Collaborative Planning Groups once the CalAIM Roundtable sunsets. Each regional/county collaborative group was assigned a facilitator but participants in the collaborative group were able to request a different facilitator assignment. The San Diego collaborative group requested a different facilitator that is more familiar with their county's provider landscape, population, and local needs. With DHCS' approval, PCG made the speedy change for that collaborative group.

- In September 2022, the TPA's contract was amended to provide finalization of the pass-through payment process whereby funds are transferred from DHCS to the TPA, and the TPA administers distribution of funds. Payment parameters were solidified through this process to ensure DHCS accounting standards and timeframes for speedy delivery of payment to PATH grantees were met and monitored.

- JI Planning and Capacity Building Round one applications closed on July 31, 2022. A total of 40 applications were approved and a total of $4,550,952.95 of funding was awarded. JI Planning and Capacity Building Round two applications were released on August 9, 2022, with an original submission deadline of December 31, 2022. The Round two applications were temporarily made unavailable mid-December 2022. The Round two application is expected to reopen in January 2023 and the deadline for submission has been extended to March 31, 2023.

Qualitative Findings:

In DY 18, following the PCG's contract execution in July 2022, DHCS and PCG held weekly meetings for each PATH initiative to develop program outlines, public facing documents, applications, review processes, outreach strategies, and quality assurance and monitoring activities. PCG develops weekly presentations that outline all outstanding deliverables, implementation accomplishments and identified risks that impact implementation timelines. PCG also provides a weekly dashboard of updates on PATH grantee activities such as the number of registered participants for Collaborative Planning, number of applicants received for PATH JI, tracking log for CITED Round one awardee funding, and all communication releases for the week.

Through the CITED application review process, DHCS was able to identify populations of focus that were not represented in the applicant pool. DHCS was proactive in ensuring equitable distribution of funds through multiple outreach avenues, listservs, social media, monthly MCP calls, DHCS stakeholder newsletters, and working with other DHCS divisional and departmental partners to share PATH application news. For CITED Round one, DHCS identified that Medi-Cal Tribal and Designees of Indian Health Programs, who are eligible for CITED funding were not a part of the applicant submission pool. Thus, a discussion began for DHCS to begin targeted outreach for Tribal partners through collaborative meeting to foster engagement beginning DY 19 Q1.

In DY 18, DHCS drafted additional protocols in response to the comments received from CMS on the 1115 waiver demonstration Special Terms and Conditions (STCs) for PATH. The additional documents include Attachment N, which outlines the Funding and Mechanics Protocol, and Attachment O, which outlines the Operational and Monitoring. DHCS met with stakeholders and associations to gather feedback and comments. DHCS submitted the operational protocols for the PATH program to CMS at the end of April 2022.

DHCS hosted multiple webinars during this reporting year to engage and solicit feedback from stakeholders on CalAIM ECM and Community Supports, PATH, JI implementation, program timelines, initiative specific applications and program designs. Many of the informational webinars provided updates and TA to potential applicants interested in applying for the various PATH initiatives. Webinars that took place in DY 18 are listed below:

- January 28, 2022, DHCS hosted a PATH All-Comer Webinar to discuss updates on the TA and CITED initiatives.
- March 9, 2022, DHCS hosted a close out call with former WPC Pilot programs to discuss the sunset of the pilot program and use of PATH funds to support the transition process of former WPC enrollees into ECM and Community Supports.
- March 22, 2022, DHCS hosted a CalAIM Monthly ECM and Community Supports MCP Meeting.
- May 26, 2022, DHCS hosted a CalAIM JI Advisory Group meeting to discuss ECM, auto-assignment into MCPs, and proposed pre-release and post-release JI care management models.
- June 29, 2022, DHCS hosted a public webinar to provide updated details on the PATH Program Design. The presentation included updates on the revised timelines for the TA Marketplace, Collaborative Planning and Implementation Initiative, and CITED initiative.
- August 23, 2022, DHCS hosted a public informational session to provide an overview of the CITED funding, application, and address frequently asked questions to over 200 attendees. Most of the meeting was focused on the walk through of the process of completing the application on the online platform and what to expect once the application is submitted.
- September 8, 2022, DHCS hosted a second public information session to provide the same CITED funding and application information presented in August. There were over 550 attendees on this second session.
- October 18, 2022, DHCS hosted a TA Marketplace Informational for organizations interested in becoming a TA Marketplace vendor. The webinar provided detailed information on the TA Marketplace and the TA Vendor application process.
- November 17, 2022, DHCS hosted a Collaborative Planning and Implementation Group Facilitator Orientation Call.
- November 24, 2022, DHCS hosted CalAIM JI Advisory Group.

DHCS developed and released a draft guidance memo for all PATH Initiatives. The guidance memos provide a policy outline of the different PATH initiatives, eligibility criteria, application

process and approach, sample uses of funding, allocation methodology, and role of the TPA, oversight, next steps, and anticipated timeline. The draft guidance allows DHCS flexibility to revise and re-release as identified needs arise and refinement of the program continues. The PATH JI Round one draft guidance was released April 2022. The PATH WPC Mitigation draft guidance was released June 2022. The Collaborative Planning draft guidance was released June 2022. The CITED draft guidance was released July 2022. The TA Marketplace draft guidance was released November 2022.

Quantitative Findings:

In DY 18, DHCS awarded approximately 60 PATH awards to eligible entities across all PATH Initiatives.

- Mitigation Initiative awarded ten LEs to provide mitigation services until the MCP(s) begins to cover those services. The awarded budget of $137,115,330.22 may change as MCPs may choose to transition eligible services earlier than anticipated, later than anticipated, or no longer choose to provide the services at all. DHCS anticipates that by DY 19, half of the LEs will no longer be eligible to participate in the Mitigation Initiative as the MCPs will have begun to provide ECM and optional Community Supports services.
- The Collaborative Planning and Implementation Initiative awarded ten facilitators to oversee 25 collaborative planning groups of a total of $14,750,000.00. Some facilitators will be overseeing multiple groups across different counties/regions.
- CITED awards will be finalized and reported in DY 19 Q1.
- TA Marketplace will be implemented, and awards will be finalized in DY 19 Q1.
- JI Initiative awarded 40 entities comprised of County Sheriff's Offices to support county jails, county probation offices to support youth correctional facilities, and the California Department of Corrections and Rehabilitation (CDCR) to support state prisons. Total awards amount is $4,550,953.00.

The table below provides a summary of the total PATH awards finalized in DY 18.

PATH Initiative	Awarded	Total Funding Awarded
Mitigation*	10 LEs	$137,115,330.22
Collaborative **	10 Facilitators	$14,750,000.00
CITED	*Pending*	*Pending*
TA Marketplace	*Pending*	*Pending*
JI	40 Entities	$4,550,952.95

Payments and Expenditures:

For DY 18, DHCS processed a total of $22,674,454.00 in payments across multiple PATH initiatives and to the TPA.

The Mitigation Initiative payment is made through an Intergovernmental Transfer (IGT) process. Once an invoice has been approved, the LE sends 50% of its approved invoice amount to DHCS. Then DHCS provides the matching 50% of federal funds and the full amount is sent back to the LE. During DY 18, LEs submitted their midyear invoices for expenditures from January 1, 2022, to June 30, 2022. Expenditures for July 1, 2022 – December 31, 2022, will be reported on the annual invoice due 90 days after December 31 of the program year. Total payment for midyear invoice payment of $15,891,622 was made by December 2022, while an additional $423,021 was processed in January 2023.

PATH JI Capacity Building Round one awards were disbursed to grantees within 60 days of application approval. DHCS processed payments from July 2022 through the end of December 2022, for a payment of $4,530,953.00. Additional payments were made in January 2023.

While the Mitigation Initiative IGTs and PATH JI Round one was paid directly by DHCS, the remaining PATH JI funding rounds, and all other PATH initiatives will be paid through a pass-through invoices process with the TPA. The TPA will be the fiscal administrator for all of PATH funding rounds going forward. Once a PATH award has been approved by DHCS, the TPA will invoice DHCS for payment. Payment is made of the pass-through payment process whereby funds are transferred from DHCS to the TPA and the TPA administers distribution of funds. During DY 18, the TPA processed $23,670,818, which included payment of $1,450,000.00 to the Collaborative Planning group facilitators that were awarded in DY 18 Q4.

Figure 14: DY 18 Total PATH Payments

PATH Initiative	DY 18 Jan – Dec 2022
Mitigation	$15,891,622
TA Marketplace	$0
Collaborative Planning	$1,450,000
CITED	$0
JI	$4,550,953
Third Party Administrator	
PCG LLC	$1,778,243
Total	**$23,670,818**

Figure 15: DY 18 Total PATH Payments by Quarter

PATH Initiative	DY 18 Q 1 Jan – March 2022	DY 18 Q 2 Apr – June 2022	DY 18 Q 3 Jul – Oct 2022	DY 18 Q 4 Sep– Dec 2022
Mitigation	$0	$0	$0	$15,891,622
TA Marketplace	$0	$0	$0	$0
Collaborative Planning	$0	$0	$0	$1,450,000
CITED	$0	$0	$0	$0
JI	$0	$0	$775,000	$3,775,953
Third Party Administrator				
PCG LLC	$0	$0	$221,364	$1,556,879
Total	**$0**	**$0**	**$996,364**	**$22,674,454**

Service Utilization:

The Mitigation initiative is the only PATH initiative that captures member utilization data. LEs provide mitigation services directly to Medi-Cal beneficiaries until MCPs initiate coverage on these services as ECM and Community Supports implementation ramp up. The data reported in the table below reflects the mitigation services provided from DY 18 Q1 through DY 18 Q3. The data is extracted from the LE's self-reported quarterly utilization reports. Utilization counts were updated during each reporting period to reflect retroactive changes and, as a result, may not match prior reports. The utilization data reported is point in time as of December 19, 2022.

Figure 16: Mitigation Services Provided by DY 18 Q1-Q3

Lead Entity	DY 18 Q 1 Jan – March 2022	DY 18 Q 2 Apr – June 2022	DY 18 Q 3 July – Sept 2022
Alameda	572	690	780
Contra Costa	0	9	N/A**
Kern	0	0	0
Los Angeles	0	0	3,823.50
Orange	0	0	N/A**
Placer	0	1	N/A**
Riverside	226	162	630
San Francisco	11,710	12,822	13,745
Santa Clara	962	1092	N/A**
Shasta	61	28	45.75
Total*	**13,531**	**14,804**	**19,024.25**

**Due to delay in the availability of data, DY 18 Q4 data will be reported in the next quarterly report.*

***N/A indicates LEs no longer providing mitigation services since the service has started to be provided under the MCP.*

Policy/Administrative Issues and Challenges:

The CITED Round one initiative application was released on August 1 and closed on September 30, 2022. The awards have been pushed back to DY 19 Q1 as DHCS received more applications and higher total request amounts than originally anticipated. DHCS and the TPA reviewed all 237 applications, interviewed over 50 organizations, and requested budget follow up from all applications in order to make awards equitable. Different variables were accounted for as part of the review such as entity type, county of service, population of focus, eligible/ineligible request, and measurable impact to the implementation of ECM and Community Supports. DHCS is currently in the finalization phase of the awards and announcements will be released in DY 19 Q1.

The JI Initiative Round one application closed July 2022. The Round two application window opened in August 2022, but due to the lower than anticipated application response, DHCS and the TPA proactively began outreach and provided TA to eligible entities. In DY 19 Q1, a series of informational webinars to garner stakeholder interest will begin. One on one meetings were scheduled with different entities to discuss their hesitancy, and any barriers they are facing. The TPA hosted weekly office hours for all eligible entities to seek TA on the application process and any other challenges that they are facing. Round two applications were temporarily made unavailable mid-December 2022 in order for DHCS to update the operational criteria to align with the requirements set forth in ACWDL 22-27 in implementing a pre-release Medi-Cal application process. The application was also updated to include new permissible uses of funding to provide additional salary support for correctional agencies. Correctional agencies may request funding to support the salaries for correctional facility staff, or their delegates, who administer the pre-release Medi-Cal application process for a limited time period until Medicaid Administrative Activity (MAA) funding becomes available. Additionally, correctional agencies may request funding to support the setting up of infrastructure/processes for correctional facilities, or their delegates, to draw down MAA funding to support salaries of staff who administer the pre-release Medi-Cal application process. On January 30, 2023, DHCS reopened the PATH JI Round 2 application window. The deadline for submissions was extended to March 31, 2023, to allow additional time for Round two applications to be completed and submitted to DHCS.

Evaluation Activities and Interim Findings:

DHCS submitted a draft evaluation design for the PATH, GPP, and alignment and integration for dually eligible beneficiaries' portions of the CalAIM 1115 waiver demonstration to CMS on June 27, 2002. In October 2022, CMS provided their initial feedback, which included suggestions and recommendations to onboard a potential contractor to assist with the

evaluation design, along with expanding certain data methodologies for PATH and combining this effort with the evaluation of the Justice-Involved Initiative and the revisions to PATH (approved by CMS in January 2023). DHCS agreed with CMS' suggestions. A revised evaluation design was submitted back to CMS in November 2022 for CMS review. DHCS will address any additional comments and edits once received from CMS.

DHCS is working to finalize and then release a Request for Information with the ultimate goal of entering into a contract with an external evaluator to conduct the evaluation of GPP, PATH, the Dually Eligible Beneficiary Satisfaction in the Medi-Cal Matching Process, and the newly-approved Reentry Demonstration Initiative. DHCS plans to submit this revised, expanded evaluation design to CMS no later than July 25, 2023, which is 180 calendar days after CMS' approval of the demonstration amendment.

COMMUNITY SUPPORTS: RECUPERATIVE CARE & SHORT-TERM POST HOSPITALIZATION

On December 29, 2021, CMS approved California's request for a section 1115(a) demonstration five-year extension titled, "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) in accordance with section 1115(a) of the Social Security Act. The approval of the "CalAIM" 1115 demonstration 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 focuses on a person-centered approach, first authorized as WPC pilots by the Medi-Cal 2020 demonstration, in order to meet the physical, behavioral, developmental, long-term care, oral health, and other health-related social needs of all beneficiaries.

One component of CalAIM is a new menu of state-approved Community Supports available for MCPs to implement through their managed care contracts with DHCS. MCPs are able to cover alternative services or settings that are in lieu of services covered under the state plan to more effectively and efficiently address their enrollees' health-related social needs. Examples of Community Supports include assistance with medically tailored meals, transitioning from nursing home care to the community to improve health and lower health care costs, and assistance with housing navigation and tenancy support.

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 them and demonstrating all of 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 is added to the MCP's contract and posted on the DHCS website as a state-approved Community Support offered by that MCP.

DHCS recognizes the work California MCPs and local communities statewide are undertaking to operationalize these new initiatives and to smoothly transition services provided under the WPC Pilots and the Health Homes Program (HHP).

While 12 of the Community Supports available under managed care authority were approved in the renewal of the 1915(b) waiver, subject to specified conditions, two additional Community Supports – Recuperative Care and Short-Term Post-Hospitalization Services – are authorized through the 1115 CalAIM Demonstration in a manner that assures consistent implementation. These two services both play an important role in California's care continuum as settings that are cost-effective and medically appropriate alternatives to hospitalization or institutionalization for individuals who otherwise would not have a safe or stable place to receive treatment. These alternative settings can provide appropriate medical and behavioral health supports following an inpatient or institutional stay for electing individuals who are homeless, at risk of

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

By authorizing Recuperative Care and Short-Term Post-Hospitalization Housing under the CalAIM demonstration, California is subject to the requirements detailed in the 1115 demonstration and must include these requirements in contracts between the state and MCPs as the operational construct for these two services.

STC 65 communicates that, while Recuperative Care and Short-Term Post-Hospitalization Services are not ILOS authorized under the 1915(b) waiver authority, in order to reduce administrative burden, the state may report on Recuperative Care and Short-Term Post-Hospitalization, including but not limited to evaluations, assessments, and work plans, through the process designated for 1915(b) authorities rather than through deliverables under the section 1115 demonstration. DHCS affirms that reporting through the 1915(b) authorities does not absolve the state from any reporting requirements outlined in the STCs that cannot be captured through the 1915(b). These requirements are included within all of the state's contracts with its MCPs.

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

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

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

Successes/Accomplishments:

DHCS actively tracks, monitors, and reviews Model of Care (MOC) updates submitted by MCPs, which can be updated semi-annually. DHCS is ensuring policies and procedures are in alignment with department guidance and members are not experiencing gaps of care. DHCS has monitored for trends in MOC reviews and reached out to MCPs for clarification, as appropriate. When trends are identified, DHCS develops additional TA and surveys for MCP response.

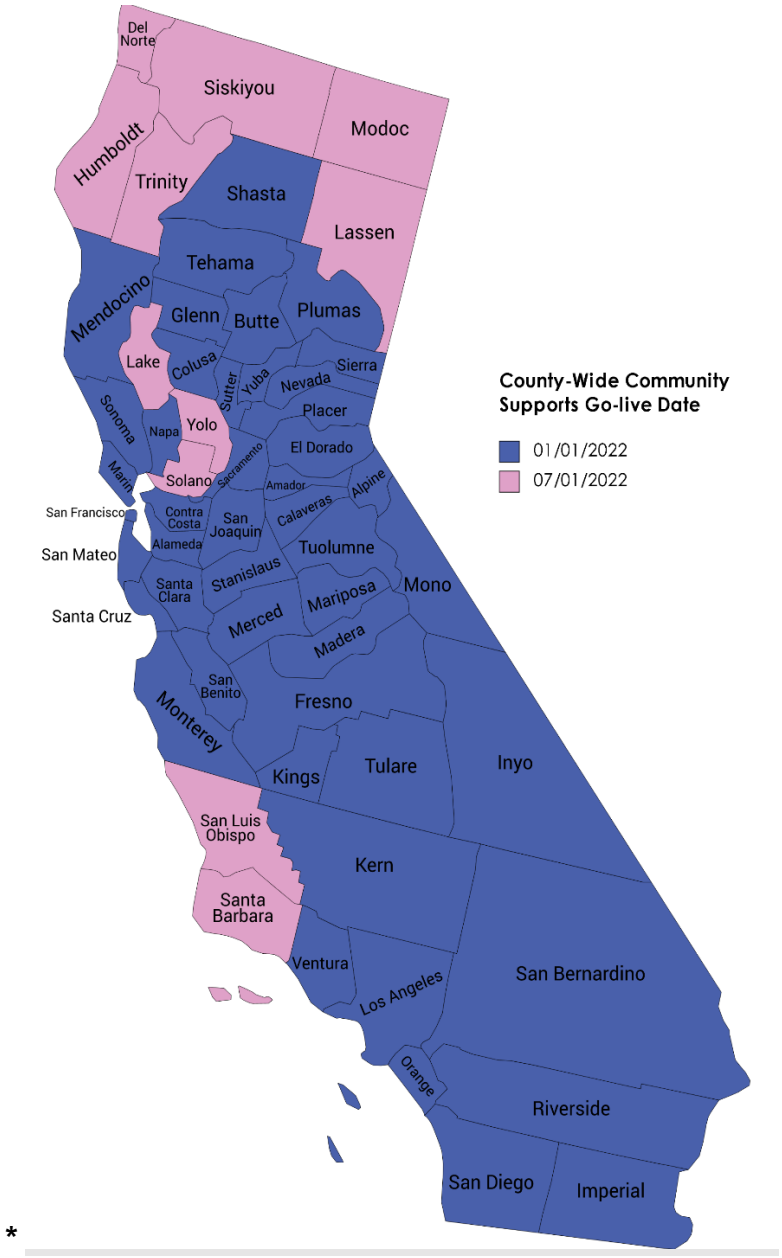
DHCS is also ensuring the MOC submissions align with the MCPs' approaches to increase delivery service infrastructure, ECM and Community Supports provider capacity, and uptake of Community Supports, as described in the MCP's Invoice Processing Platform (IPP) Payment one submissions. DHCS will continue to evaluate the MCPs' implementation progress based on their IPP Payment two submissions.

DHCS is also leveraging existing encounter data reporting mechanisms in accordance with the MCP contract for MCPs to report on ECM and Community Supports. DHCS released Billing and Invoicing Guidance and Community Supports Coding Guidance to provide further instructions for MCP reporting. In December 2022, DHCS released new Community Supports Data Sharing Guidance for stakeholder comment, which clarifies requirements and allowances in the Budget Trailer Bill, Welfare and Institutions Code, and Penal Code. DHCS will continue to develop and disseminate Community Supports guidance to MCPs and Providers.

Figure 17: Number of Pre-Approved Community Supports Live as of January 2023 by County and Implementation Date

County:	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Total CS Live (out of 14)
Alameda	8	2	2	12
Alpine	4	4	2	10
Amador	8	2	2	12
Butte	6	2	2	10
Calaveras	4	4	2	10
Colusa	6	3	2	11
Contra Costa	7	4	2	13
Del Norte	0	6	2	8
El Dorado	7	2	2	11
Fresno	7	3	2	12
Glenn	6	3	2	11
Humboldt	0	6	2	8
Imperial	4	5	5	14
Inyo	4	4	2	10
Kern	7	1	6	14
Kings	9	2	3	14
Lake	0	6	2	8
Lassen	0	6	2	8
Los Angeles	9	2	3	14
Madera	8	2	3	13
Marin	6	0	2	8
Mariposa	6	2	2	10

County:	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Total CS Live (out of 14)
Mendocino	6	0	2	8
Merced	1	6	1	8
Modoc	0	6	2	8
Mono	4	4	2	10
Monterey	5	2	1	8
Napa	6	0	2	8
Nevada	8	2	2	12
Orange	4	5	5	14
Placer	9	2	3	14
Plumas	6	2	2	10
Riverside	12	2	0	14
Sacramento	14	0	0	14
San Benito	6	2	2	10
San Bernardino	11	2	1	14
San Diego	14	0	0	14
San Francisco	8	3	2	13
San Joaquin	8	1	5	14
San Luis Obispo	0	2	4	6
San Mateo	9	0	0	9
Santa Barbara	0	2	4	6
Santa Clara	9	4	0	13
Santa Cruz	4	2	1	7
Shasta	6	0	2	8
Sierra	6	2	2	10
Siskiyou	0	6	2	8
Solano	0	6	2	8
Sonoma	6	0	2	8
Stanislaus	4	5	5	14
Sutter	6	2	4	12
Tehama	6	2	2	10
Trinity	0	6	2	8
Tulare	8	3	3	14
Tuolumne	4	4	2	10
Ventura	5	1	5	11
Yolo	0	6	2	8
Yuba	6	2	4	12



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Program Highlights:

DHCS continues to strategize with leadership to discuss the development of Community Supports initiative work plans and drafted responses to questions, which were submitted by various stakeholders. DHCS continues to accept stakeholder feedback and intends on continuing to provide guidance on this unique set of services. Webinars and meetings hosted by DHCS for this quarter included:

- Bi-weekly CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through implementation 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.
- DHCS also hosted eight Community Supports Spotlight Series webinars throughout 2022 to review and reinforce policy guidance on individual Community Supports, identify and amplify best practices and lessons learned from community providers, WPC Care pilots, and MCPs, and respond to emerging questions from the field:
    - **May 18, 2022** – DHCS held its first CalAIM Community Supports Spotlight webinar featuring **Medically Tailored Meals** which included presentations by Project Angel Food and **San Francisco Bay Area Planning and Urban Research Association (**SPUR)
    - **June 15, 2022** – **Sobering Centers** and **Day Habilitation Programs**, including eligibility requirements, program impact, and pathways to provider enrollment, as well as best practices from the field.
    - **July 20, 2022** – **Asthma Remediation** and **Environmental Accessibility Adaptations (Home Modifications)**, including eligibility requirements, program impact, and pathways to provider enrollment, as well as best practices from the field.
    - **August 18, 2022** – **Recuperative Care (Medical Respite)** and **Short-Term Post-Hospitalization Housing**, including service definitions, eligibility requirements, and program impact, as well as best practices from the field. Speakers included presenters from WellSpace Health, People Assisting the Homeless San Diego, and the National Health Care for the Homeless Council.
    - **September 15, 2022** – **Nursing Facility Transition/Diversion to Assisted Living Facilities** and **Community Transition Services/Nursing Facility Transition to a Home**, including service definitions, eligibility requirements, and program impact, as well as best practices from the field shared by guest speakers including People Assisting the Homeless, the National Health Care for the Homeless Council, WellSpace Health, and Contra Costa Health Plan.

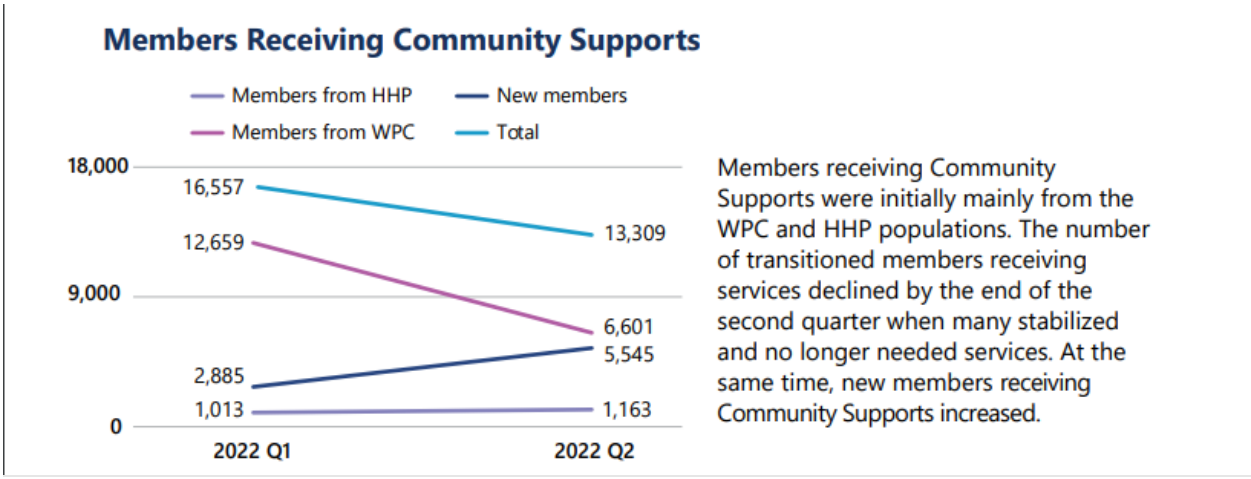
- **October 20, 2022** – **Housing Transition Navigation Services**, **Housing Deposits**, and **Housing Tenancy and Sustaining Services**, including service definitions, eligibility requirements, and program impact, as well as best practices from the field shared by guest speakers including the Corporation for Supportive Housing, LA County DHS, National Health Care for the Homeless Council, St. John's Well Child and Family Center, and Inland Empire Health Plan.
- **November 3, 2022** – **Personal Care and Homemaker Services** and **Caregiver Respite**, including service definitions, eligibility requirements, and program impact, as well as best practices from the field shared by guest speakers including Molina Health Care, Partners in Care Foundation, and 24 Hour Home Care.
- **December 8, 2022** – This final webinar focused on **services for children and youth** and included an overview of the impact of Community Supports on children and youth and the intersection between Community Supports and related child and youth program and services, as well as best practices from the field shared by guest speakers.

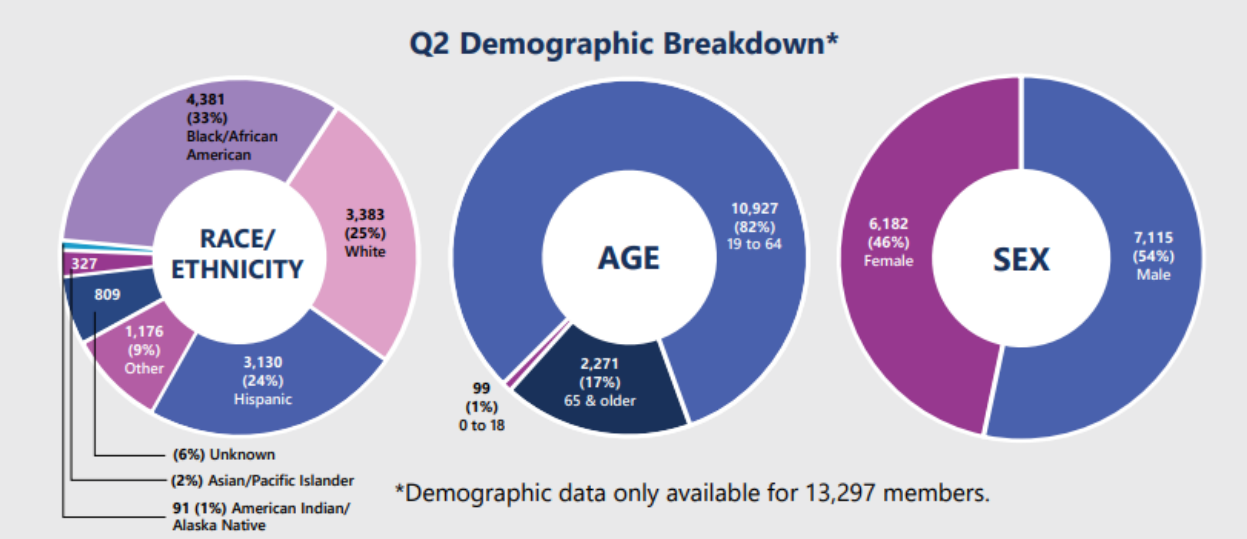
On average, nearly 300 attendees joined DHCS on each of the Community Supports Spotlight Series webinars, with some events hosting over 400 unique attendees. Significant audience participation fostered spirited and dynamic Q&A sessions with relevant questions asked, helping DHCS to fine-tune its future TA and guidance provided to the market.

Qualitative Findings:

For counties where members received WPC and/or HHP services, DHCS tracked, reviewed, and monitored data submitted by MCPs through the CalAIM Post Transition Monitoring (PTM) Survey Monkey. For the first 30 days of implementation, MCPs were required to report on any issues with providers, members, complaints, grievances, technical issues, and other concerns. Daily data submitted to DHCS included responses to questions regarding challenges related to the transition and member level issues of HHP and WPC Members. DHCS requested information on any additional issues MCPs were experiencing and provided opportunities for the MCPs to report on their concerns and needs. Some MCPs experienced minor transition issues that DHCS worked in-step to resolve through TA calls. DHCS did not identify any critical issues with implementation of Community Supports.

Example of Demographic Data available through DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:





Quantitative Findings:

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 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. Dashboards in Power BI are developed

and being continuously refined to better help accurately visualize data for the program and capture.

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 three 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.

Several of the available 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 December 2022 indicates the following number of providers, beneficiaries, and counties throughout California for the following available Community Supports:

Figure 18: Number of Providers and Number of Counties offering Community Supports Services

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

Current available data indicates the following number of unique individuals served across the first three quarters of 2022 for DHCS' available Community Supports:

Figure 19: Number of Unique Individuals served across Community Supports

Community Supports	2022 Q1	2022 Q2	2022 Q3	Grand Total
Housing Tenancy and Sustaining Services	11,468	6,451	3,251	13,556
Housing Transition/ Navigation Services	4,718	5,566	6,813	10,824
Medically-Supportive Food	327	1,092	1,711	2,303

Community Supports	2022 Q1	2022 Q2	2022 Q3	Grand Total
Recuperative Care	777	646	686	1,686
Housing Deposits	132	232	382	588
Nursing Facility(NF) Transition to Assisted Living Facility	146	156	155	219
Short-Term Post-Hospitalization Housing	7	72	96	155
Asthma Remediation	14	42	86	137
Sobering Centers	7	10	87	104
Personal Care and Homemaker Services	5	17	29	44
Day Habilitation Programs	0	1	34	35
Environmental Accessibility Adaptations	3	17	13	33
NF Transition to a Home	13	17	22	31
Respite Services	0	27	1	27
Grand Total	**16,862**	**13,492**	**12,438**	**26,828**

DHCS affirms it will submit timely, accurate, and validated encounter data to Transformed Medicaid Statistical Information System, in accordance with STC #67, Community Supports On-Going Monitoring & Oversight.

Policy/Administrative Issues and Challenges:

Nothing to report.

Community Supports Policy Guide:

Over the course of DY 18, DHCS and its stakeholders identified several key areas of the Policy Guide for which additional TA and guidance were requested. DHCS refreshes its Community Supports Policy Guide when necessary to incorporate new language and/or developments in policy, including on:

- Prime/Subcontractor Authorization Policy
- Homelessness Determinations
- Eligibility for Services
- Member Handbooks and Website Update Requirements
- Provider Network Allowances
- Continuum of Care Requirements
- Other technical corrections

Development of Additional Guidance:

In DY 18, DHCS released the following written guidance documents to assist MCPs and prospective providers acclimate to new Community Supports policy and assist with contracting and onboarding:

- ECM & Community Supports Billing & Invoicing Guidance

Through the first year of Community Supports implementation, DHCS performed regular surveys of the market which indicated that Community Supports providers and MCPs were experiencing challenges with the variation in how 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 creating administrative burden and limiting overall uptake of Community Supports.
DHCS is responding by developing guidance to define standards for member information exchange between MCPs and Community Supports providers for two exchanges:

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

The guidance defines a set of standard “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 was informed by extensive stakeholder engagement, including with MCPs, Community Supports Providers, and Health Information Organizations (HIOs).

Increased statewide standardization, as requested by the market, will ultimately support bi-directional data sharing between MCPs and Community Supports providers to:

- Enable efficient information exchange and batch reporting from MCPs to Community Supports providers about member-level information, including the status of authorizations, which reduces administrative burden, and facilitates outreach and action to engage members; and
- Establish key information that should flow back from Community Supports providers to MCPs about the delivery of Community Supports to track the status and progress of service delivery.

Although the guidance sets common minimum standards for information exchange, MCPs and Community Supports providers may adopt changes by mutual consent. DHCS is strongly recommending to MCPs, especially those operating in the same county that they work collaboratively to establish common templates for the communication of this information.

Progress on the Evaluation and Findings:

As of March 14, 2023, DHCS is still awaiting guidance from CMS regarding requirements for the ILOS Evaluation.

Opportunities for Improvement:

DHCS tracks stakeholder feedback and indicators in the marketplace, including comments received from providers and members of the public, to effectively gauge the amount and severity of any challenges presented. Over the course of 2022, DHCS also created provider feedback loops and kicked off a Statewide Listening Tour.

An important theme of stakeholder feedback has been around administrative burden. For context, beyond a wide-ranging set of program requirements, MCPs were otherwise allowed a degree of flexibility in determining details for program implementation in a manner that would allow for consideration of how to best optimize operations for the MCP and their local partners. Stakeholder feedback has indicated that, in practice, subsequent variation of implementation requirements on providers has led to increased administrative burden and other barriers to becoming or continuing as a provider. Examples of areas of lack of standardization include variations in eligibility criteria applied; authorization and referral processes; payment structures; and disparate MCP portals and documentation systems. Community-based organizations and other non-traditional providers that operate on a smaller scale with limited administrative resources and expertise are particularly impacted by such challenges. DHCS is engaging this stakeholder feedback by actively identifying and addressing areas for immediate improved standardization and will be relaying updated policies as well as reinforcing existing policies with MCPs in Quarter 3 through a focused Action Plan.

Another area of feedback relates to member eligibility for ECM. MCPs have indicated that the transition from WPC/HHP to ECM has led to some individuals no longer being eligible for services due to more limited eligibility criteria under ECM's Populations of Focus. Many of these individuals should receive complex care management through the MCP. DHCS is not able to quantitatively track Medi-Cal members who specifically lose access to ECM due to limited eligibility criteria. In the Quarterly Implementation Monitoring Report, MCPs provide accounting of member-level discontinuation of ECM and certain reasons for discontinuation, such as the member having met care plan goals, the member being ready to transition to a lower level of care, the member no longer wishing to receive ECM, and the ECM provider not being able to connect with the member despite multiple attempts. Among the reasons for discontinuation, there is an "Other" category, which could serve as a proxy "ceiling" for the number of members affected by the narrower definition.

For Community Supports, while many of the services did transition from WPC there were some that did with modifications to standardize the service based on principles of medical appropriateness and cost-effectiveness. DHCS has heard from providers in the field that some Community Supports do not mirror what was offered in WPC. However, the suite of Community Supports offered by MCPs is based on a wide range of stakeholder feedback including engagement, listening tours, advisory group meetings and other forums to build out the services in a way that could be implemented statewide. Further, while the Community Supports Policy Guide does provide service descriptions and certain eligibility criteria, there are opportunities within the policy where DHCS built in flexibility for MCPs to work with their contracted providers to offer the services in way that benefits the Medi-Cal member through the principles of medical appropriateness and cost effectiveness. DHCS will be updating guidance documents to clarify that cost effectiveness for Community Supports has been

determined and will be evaluated at the state level by DHCS, thus MCPs do not need to actively demonstrate cost effectiveness for Community Supports at the plan or individual level. DHCS will also be releasing guidance in Quarter 3 to MCPs informing them of the requirement to come into full compliance and alignment with the Community Supports service definitions as of January 1, 2024 without any further allowances regarding restrictions or limitations for the services.

DHCS continues to monitor data quality and has begun analyzing the differences between the plan-submitted data on the Quarterly Implementation Monitoring Reports and the Encounters/Claims to start visualizing how accurate the data received via the Quarterly Implementation Monitoring Report process relative to Post Adjudicated Claims & Encounters Systems.

DHCS continues to invest in Community Supports Provider Education, expanding opportunities to connect with prospective Community Supports providers and utilizing the experience of current Community Supports providers to knowledge-share and orient non-traditional Providers to Medi-Cal and Community Supports.

COVERAGE OF FORMER FOSTER YOUTH WHO WERE IN FOSTER CARE AND MEDICAID IN A DIFFERENT STATE

When the Affordable Care Act (ACA) was implemented in 2014, California selected the option under the authority of a State Plan Amendment (SPA) to provide Medicaid to Former Foster Youth (FFY) who exited foster care in another state at age 18 or older and were under age 26. A subsequent interpretation of the ACA resulted in the withdrawal of authority under the SPA to provide eligibility to Medicaid to youth who exited from foster care in a different state. The Centers for Medicare and Medicaid Services (CMS) requested California submit a waiver to provide eligibility to Out of State (OOS) FFY due to the withdrawal of authority under the SPA.

California submitted an amendment to the Medi-Cal 2020 waiver to allow California to continue providing full scope Medicaid coverage for OOS FFY under age 26, consistent with federal requirements for coverage of this population. CMS approved the amendment to the Medi-Cal 2020 waiver making California the first state to have CMS approval. With the Medi-Cal 2020 waiver amendment, eligibility and enrollment processes were not interrupted for individuals eligible under this coverage category. The Medi-Cal 2020 waiver ended on December 31, 2021.

The five-year renewal of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115(a) Demonstration waiver (originally the Medi-Cal 2020 waiver) began on January 1, 2022 and includes Medi-Cal eligibility for OOS FFY. The goal of the demonstration is to continue to provide eligibility to Medi-Cal services for the OOS FFY. The FFY may have experienced significant trauma in their lives and have high risk of negative health outcomes in adulthood. California seeks to enroll the OOS FFY in Medi-Cal to ensure they have access to care.

Eligibility and Enrollment Information, including member month reporting (See attached Exhibit 1 for complete data)

Topic	Measure	Narrative
Total Enrollment	Annual Count OOS FFY - 329	The number of OOS FFY enrollees for 2020 was 337. The number of OOS FFY enrollees for 2021 was 329 which is a 2.4% decrease in the number of OOS FFY enrolled. The number of enrollees is less than DHCS' expectation with the continuous coverage requirement of the Public Health Emergency (PHE). However, during the PHE, many individuals may have chosen to move back to their original home state, didn't access health

Topic	Measure	Narrative
		care due to concerns about COVID exposure, or weren't aware of their continuing health care eligibility. Up until 2021, the growth of the number of OOS FFY has been historically consistent.
New Enrollment	Annual Count OOS FFY - 169	This is the first annual report for this demonstration that collects new enrollment data. The data numbers are higher than expected. All FFY, including OOS FFY, who apply for Medi-Cal are immediately enrolled in Medi-Cal. Under the PHE, the FFY must have continuous coverage once they are enrolled in Medi-Cal unless they request to be disenrolled, pass away, or move out of state. The OOS FFY remain in the FFY Program until the continuous coverage ends even if they are not verified as a former foster child. California, its partners, and stakeholders work together to identify and enroll the population in the Medi-Cal FFY Program. Regardless of where an individual applies for Medi-Cal in California, one of the first questions in the application is whether the individual exited foster care on or after their 18th birthday. This ensures all FFY applicant are identified early in the application process so they can be appropriately processed.
Re-Enrollment	Annual Count OOS FFY - ** suppressed	This is the first annual report for this demonstration that collects re-enrollment data. The numbers are as expected since FFY move between programs that offer cash benefits and the FFY Program. When the FFY aren't eligible for the cash benefit aid code, they are re-enrolled in the FFY Program to provide continuous coverage.
Disenrollment	Annual Count OOS FFY - 60	This is the first annual report for this demonstration that collects disenrollment data.

Topic	Measure	Narrative
		"No reason given" is the primary reason given for disenrollment. Disenrollment may result from losing eligibility for a Medi-Cal program with cash aid benefits, moving out of state, aging out of the FFY program, or verified not eligible for the program. Under the continuous coverage requirement period, disenrollment circumstances can only result from the individual moving out of state, requesting to be removed from the program or the individual dying. The number of disenrollees aligns with the state's expectations. California enrolls FFY into Medi-Cal immediately upon application and then verifies the FFY applicants' eligibility. Due to the Public Health Emergency (PHE) FFY enrolled in Medi-Cal remain in Medi-Cal until the end of the PHE. The number of disenrollees during the PHE was limited to those individuals who requested disenrollment, those individuals who moved out of California and those who passed away. It is anticipated that with the ending of the PHE, the number of FFY disenrollees will rise since it's likely that many of the individuals in the FFY program do not have verified eligibility or they have aged out of the program.

Utilization Monitoring (See attached Exhibit 2 for complete data)

Topic	Measure: Annual Numbers and Percentage of OOS FFY Population Receiving Health Services
Utilization Monitoring	Total number of beneficiaries with any claim – 215 claims
	Total number of beneficiaries with primary care appointments – 138 appointments
	Total number of beneficiaries with behavioral health appointments – 64 appointments
	Total number of beneficiaries with emergency department visits – 133 visits
	Total number of beneficiaries with inpatient visits – 29 visits

DHCS gathered the data for 2021 Utilization Monitoring differently from the data gathered in 2020. The data in 2020 was gathered on OOS FFY who were enrolled for 11 months in the

FFY Program. The 2021 data was collected for all individuals enrolled in the FFY Program regardless of how long or short they were enrolled in the FFY Program. Due to the low number of beneficiaries with inpatient visits, de-certification has required suppression of cell information on the inpatient visit numbers.

During 2021, 65 percent of the OOS FFY population received Medi-Cal services. Of the services received, 42 percent of the OOS FFY population received services with a primary care appointment, 40 percent of the OOS FFY had primary care appointments, 19 percent of the OOS FFY population received behavioral health appointments and 9 percent of the OOS FFY had inpatient visits.

The numbers of OOS FFY utilization over the 2021 year have very slowly increased despite the PHE.

Program Integrity:

When a youth applies for Medi-Cal in California self-attesting to having exited from foster care at age 18 or older, regardless of state, the youth is immediately enrolled into the FFY Program with aid code 4M. The youth's foster care status is then verified by the county. If the youth is not eligible for the FFY Program, they are fully reassessed to determine eligibility in any other Medi-Cal program. If they are not eligible for another aid code, they are discontinued from Medi-Cal.

If the youth is eligible for aid code 4M and another aid code that offers cash benefits in addition to Medi-Cal eligibility, the youth is moved into the cash aid code. If the youth loses eligibility for the cash aid code, the youth is moved into aid code 4M for the FFY Program so there is no loss of health care coverage. If the youth is not eligible for a cash aid code, then they remain in aid code 4M.

Under the FFY Program, OOS FFY under age 26 who qualify consistent with the federal requirements receive full scope benefits in Medi-Cal until they turn 26. These youth do not need to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

Due to the small size of the OOS FFY population, no audits have been conducted. DHCS looks at high-level patterns to determine if there are any trends to identify.

Grievances and Appeals:

Due to the small population for the OOS FFY, de-identification requirements prevent disclosure of the number of grievances and appeals. However, the small number of filings is insufficient to identify a trend.

Operational/Policy/Systems/Fiscal Developments/Issues and Action Plans:

The waiver has revealed the challenge of tracking FFY once they leave foster care to ensure they continue to receive Medi-Cal up to age 26. Since many FFY have eligibility for programs that offer cash aid in addition to Medi-Cal, the OOS FFY are usually placed in the cash aid programs. When the youth lose their eligibility for the cash aid programs, they are not always placed back into the FFY Program, potentially creating a gap in their Medi-Cal coverage. In response to this possibility, DHCS developed and implemented a data field in the Medi-Cal Eligibility Data System (MEDS) for counties to track youth eligible for the FFY Program to prevent any gaps in Medi-Cal coverage. This data field shows the youth's verified eligibility and is visible to all county workers. The data collected for this field also identifies the location where the youth was in foster care, whether in California or out-of-state. Having this field removes the necessity of re-verifying the eligibility when a youth moves to a new county, thus reducing the possibility of a gap in coverage for the FFY. The MEDS field is being populated by our county partners on a prospective basis.

Later this year, DHCS will begin working on creating Alerts in MEDS to notify the county eligibility worker when a youth loses eligibility in a cash benefit so upon reassessment, they are enrolled in the FFY Program to retain eligibility to Medi-Cal health benefits.

With the passage of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Section 1002, OOS FFY will be eligible for Medicaid coverage from 18 to 26 in any state regardless of the state in which they reside and the state where they were in foster care. The SUPPORT Act, Section 1002 is effective for all OOS FFY who were in foster care and on Medicaid at 18 years of age on or after January 1, 2023. California has submitted SPA 23-0009 to CMS for review to implement OOS FFY eligibility under the SUPPORT Act, Section 1002.

To remedy the potential gap in coverage for the OOS FFY who exited foster care before January 1, 2023, California included the OOS FFY population in its request for the five-year renewal of the CalAIM 1115 demonstration waiver that was approved on December 29, 2021. Since OOS FFY were included in the new CalAIM Section 1115 Demonstration request, those OOS FFY who exited foster care before January 1, 2023, will have their Medi-Cal eligibility maintained for the next five years under the CalAIM waiver. It is anticipated that the OOS FFY eligibility for Medi-Cal under the CalAIM waiver will begin to decline since any OOS FFY exiting foster care on or after January 1, 2023, will be eligible for Medi-Cal under SPA 23-0009.

California enrolls FFY immediately into Medi-Cal based upon their self-attestation to being a FFY upon application, and then verifies their eligibility for the FFY Program after enrollment

into the program. Due to the continuous coverage requirement, individuals who were verified after enrollment as ineligible for the FFY Program remain in Medi-Cal until the continuous coverage requirement is lifted. Commencing April 1, 2023, California begins the continuous coverage unwinding period and counties will begin fully reassessing youth in the FFY Program at their next regularly scheduled annual renewal. Those who have been determined not eligible to continue in the program will be assessed for ongoing eligibility for any other Medi-Cal program. Once the FFY are fully reassessed, the number of eligible youths remaining in the FFY Program is expected to decrease.

DHCS is currently exploring the possibility of placing the FFY population in managed care plans instead of fee for service.

Budget Neutrality:

When Medi-Cal was expanded in 2014 under the ACA, California opted to cover the OOS FFY under SPA 13-0021. The OOS FFY remained eligible under the SPA until a re-interpretation of the language in 2016 removed eligibility. California continued to offer eligibility to the OOS FFY under the Medi-Cal 2020 waiver, so the OOS FFY did not lose eligibility with the re-interpretation of the language. The OOS FFY is considered part of the Mega Mandatory population and must be enrolled in Medi-Cal whenever feasible. There is no impact to the budget since the majority of FFY is usually eligible for Medi-Cal based upon income or is enrolled in an aid code with cash aid benefits. Additionally, less than 500 OOS FFY applicants are enrolled in the FFY Program every month.

Although the number of OOS FFY applicants has been artificially impacted during the PHE, it is expected to decrease further once the continuous coverage requirement ends, and a Medi-Cal redetermination is resumed. The number of OOS FFY covered under this waiver would also begin to decrease beginning on January 1, 2023, with the implementation of the SUPPORT Act, Section 1002. A new SPA 23-0009 was submitted to CMS to cover the requirements of the SUPPORT Act. SPA 23-0009 will provide eligibility to all youth exiting foster care at age 18 or older on or after January 1, 2023.

Demonstration Evaluation Activities and Interim Findings:

Under the FFY Program, the OOS FFY under age 26 who qualify consistent with the federal requirements receive full scope benefits in Medi-Cal until they turn 26. These youths do not have to re-apply for Medi-Cal until they age out of the program. At age 26, they are fully reassessed to determine if they are eligible for any other Medi-Cal programs.

During the continuous coverage requirement period, the FFY must be continuously enrolled in Medi-Cal unless 1) they request to be disenrolled, 2) they pass away, or 3) they move out of state. California enrolls FFY immediately into Medi-Cal based on their self-attestation of being a FFY at application, and then verifies their eligibility for the FFY Program after enrollment into

the program. The OOS FFY remain in the FFY Program until they are reassessed during the continuous coverage unwinding period, and the county verifies they are not eligible for the FFY Program.

Despite the additional protection given to the OOS FFY during the continuous coverage period, the numbers of OOS FFY enrolled in the FFY Program 2021 decreased when compared to OOS FFY enrolled in the FFY program in 2020.

The FFY continue to actively utilize the full scope Medi-Cal benefits available to them whether it is primary care appointments, behavioral health appointments, emergency department visits, or inpatient visits.

When the continuous coverage requirement ends, counties will fully reassess youth in the FFY Program who have been determined ineligible for the program to determine if they are eligible for any other Medi-Cal program. Once the FFY are fully reassessed, the number of eligible youths remaining in the FFY Program is expected to decrease.

Community-Based Adult Services (CBAS)
Annual Monitoring Report Attachment
Demonstration Year 18

STC#26 (HCBS Electronic Visit Verification System (EVVS)): *In absence of an annual or quarterly reporting requirement for this HCBS item, CMS recommends that CA provide EVVS information in the annual monitoring report.*

CA Response: Prior to the approval of CBAS Emergency Remote Services (ERS), CBAS did not contain EVV related services. With the end of CBAS Temporary Alternative Services (TAS) and in an effort to return to providing services in a congregate setting, ERS was implemented on October 1, 2022. At this time, systems changes are being implemented for billing in February 2023, and the Department of health Care Services (DHCS) is conducting provider outreach and disseminating instructions on how to submit ERS claims for billing. Once claims are submitted, DHCS will be able to provide EVVS information.

STC#27 (Quality Improvement (QI) Strategy for 1915c/i approval HCBS services): *Per STC#26, CA "will report on the initial series [of performance measures] within one year of finalization and from that point will report annually."*

CA Response: As indicated in the previously submitted quarterly reports, DHCS is collaborating with internal divisions and sister departments to develop meaningful performance measures. DHCS will continue to keep the Centers for Medicare and Medicaid Services (CMS) apprised of our progress and questions as we work through this process.

STC#27(f), (Financial Accountability): *CA "must demonstrate it has implemented an adequate system for ensuring financial accountability of the HCBS program…and demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438." This should be reported annually in the same way that all relevant HCBS quality assurances are reported for the 1115 demonstration.*

CA Response:

<u>Financial Accountability</u>

Regarding the financial accountability of HCBS as it pertains to managed care, each Managed Care Plan (MCP) is contracted with the state and are required to meet specific financial viability requirements which are spelled out in Exhibit A, Attachment 2 of their existing contract, this includes HCBS programs represented through CBAS. To monitor MCPs compliance to the contractual solvency obligations, MCPs are required to submit monthly (if applicable), quarterly, and annual financial reports. These financial reports that MCPs are required to submit consist of items such as balance sheets,

income statements, cash flow statements, claims schedules, and other schedules as needed. The state analyzes the plans reported data to ensure financial viability requirements are being met and the following metrics below assist in making that determination;

1. Administrative Cost Ratio (ACR)
2. Working Capital Ratio (WCR)
3. Tangible Net Equity (TNE)
4. Medical Loss Ratio (MLR)

Actuarial Soundness

The state demonstrates actuarial soundness through its rate submission to CMS. This rate submission includes various exhibits, one of which is the rate certification report that describes the rate development and provides the certification of actuarial soundness required by 42 CFR §438.4. HCBS, as applicable, would be a subset of the covered services submitted to CMS, and that are subject to actuarial soundness.

Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA	Non-ACA	Total
DY18-Q1	8,479	3,219	11,698
DY18-Q2	8,965	3,379	12,344
DY18-Q3	8,556	3,158	11,714
DY18-Q4	6,365	2,396	8,761

Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	16,271	16,523	16,815	DY18-Q1	17,047
	16,987	17,151	17,338	DY18-Q2	17,631
	17,405	17,507	17,499	DY18-Q3	17,833
	17,481	17,464	17,440	DY18-Q4	17,674
Non-ACA	7,304	7,247	7,147	DY18-Q1	7,634
	7,120	7,074	7,001	DY18-Q2	7,438
	6,984	6,923	6,911	DY18-Q3	7,255
	6,876	6,834	6,809	DY18-Q4	7,034

Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY18-Q1					
ACA	375,987	$ 52,251,096.65	$ 46,407,389.73	$ 5,044,895.82	$ 798,811.10
Non ACA	132,066	$ 17,306,631.30	$ 9,728,153.00	$ 6,107,437.71	$ 1,471,040.59
DY18-Q2					
ACA	382,304	$ 58,060,600.23	$ 51,463,183.07	$ 5,746,202.03	$ 851,215.13
Non ACA	128,526	$ 19,197,128.29	$ 10,797,966.63	$ 6,814,052.79	$ 1,585,108.87
DY18-Q3					
ACA	338,513	$ 56,439,754.45	$ 50,060,915.15	$ 5,537,148.43	$ 841,690.87
Non ACA	115,158	$ 18,848,846.80	$ 10,582,583.27	$ 6,755,087.47	$ 1,511,176.06
DY18-Q4					
ACA	209,550	$ 34,192,717.75	$ 30,245,042.74	$ 3,402,341.87	$ 545,333.14
Non ACA	70,192	$ 11,172,533.53	$ 6,280,783.02	$ 3,986,232.79	$ 905,517.72

ACA Expenditures by Level of Care for DY18-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	175,936	$ 24,160,497.61	$ 21,459,904.05	$ 2,520,165.85	$ 180,427.71
3.3 Residential	904	$ 165,841.71	$ 149,258.44	$ 16,223.27	$ 360.00
3.5 Residential	158,044	$ 23,464,506.49	$ 20,828,546.11	$ 2,496,041.72	$ 139,918.66
RES 3.2-WM	41,104	$ 4,460,250.84	$ 3,969,681.13	$ 12,464.98	$ 478,104.73

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	190,458	$ 27,486,661.06	$ 24,270,669.90	$ 3,027,071.98	$ 188,919.18
3.3 Residential	3,847	$ 386,634.63	$ 343,629.43	$ 41,393.86	$ 1,611.34
3.5 Residential	153,673	$ 25,349,611.01	$ 22,557,760.80	$ 2,666,037.49	$ 125,812.72
RES 3.2-WM	34,326	$ 4,837,693.53	$ 4,291,122.94	$ 11,698.70	$ 534,871.89

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	176,146	$ 26,867,055.00	$ 23,789,737.48	$ 2,882,303.60	$ 195,013.92
3.3 Residential	2,540	$ 384,501.60	$ 343,737.66	$ 39,969.77	$ 794.17
3.5 Residential	130,706	$ 24,408,307.58	$ 21,682,173.62	$ 2,600,485.64	$ 125,648.32
RES 3.2-WM	29,122	$ 4,779,890.27	$ 4,245,266.39	$ 14,389.42	$ 520,234.46

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	111,160	$ 16,628,138.13	$ 14,757,027.06	$ 1,760,100.36	$ 111,010.71
3.3 Residential	800	$ 187,661.47	$ 168,895.17	$ 18,587.95	$ 178.35
3.5 Residential	78,788	$ 14,360,934.35	$ 12,669,969.59	$ 1,616,582.43	$ 74,382.33
RES 3.2-WM	18,803	$ 3,015,983.80	$ 2,649,150.92	$ 7,071.13	$ 359,761.75

Non-ACA Expenditures by Level of Care for DY18-Q1					
Level of Care	**Units of Service**	**Approved Amount**	**FFP Amount**	**SGF Amount**	**County Amount**
3.1 Residential	60,942	$ 7,261,410.32	$ 4,079,316.12	$ 2,680,189.61	$ 501,904.59
3.3 Residential	2,858	$ 147,901.68	$ 83,120.96	$ 57,166.62	$ 7,614.10
3.5 Residential	55,146	$ 8,480,621.72	$ 4,767,623.68	$ 3,358,597.98	$ 354,400.06
RES 3.2-WM	13,120	$ 1,416,697.58	$ 798,092.24	$ 11,483.50	$ 607,121.84

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	59,693	$ 8,047,123.53	$ 4,523,341.53	$ 3,042,967.78	$ 480,814.22
3.3 Residential	1,968	$ 269,246.15	$ 151,316.47	$ 114,609.31	$ 3,320.37
3.5 Residential	56,200	$ 9,316,804.26	$ 5,243,299.38	$ 3,646,575.44	$ 426,929.44
RES 3.2-WM	10,666	$ 1,563,954.35	$ 880,009.25	$ 9,900.26	$ 674,044.84

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	55,200	$ 7,706,204.44	$ 4,321,866.80	$ 2,908,959.76	$ 475,377.88
3.3 Residential	605	$ 146,818.46	$ 82,511.80	$ 63,668.02	$ 638.64
3.5 Residential	50,689	$ 9,487,002.17	$ 5,328,496.80	$ 3,771,585.63	$ 386,919.74
RES 3.2-WM	8,664	$ 1,508,821.73	$ 849,707.87	$ 10,874.06	$ 648,239.80

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	33,347	$ 4,791,222.48	$ 2,699,502.85	$ 1,821,915.55	$ 269,804.08
3.3 Residential	293	$ 75,489.60	$ 42,425.06	$ 32,591.46	$ 473.08
3.5 Residential	30,102	$ 5,357,683.86	$ 3,005,130.05	$ 2,126,718.15	$ 225,835.66
RES 3.2-WM	6,449	$ 948,137.59	$ 533,725.06	$ 5,007.63	$ 409,404.90

While some reduction in values in Q4 may be attributed to the time lag in county reporting, the values for ODS residential remain generally consistent across DY18. This may be partially attributed to the residential average length of stay of beneficiaries at 37 days (per criteria used in provider network adequacy compliance). Such duration of stays may span months or quarters in instances, lending a relative consistency to values for both enrollees and expenditures.

California Department of Health Care Services

Out-of-State (OOS) Former Foster Youth (FFY) - Medi-Cal CalAIM 1115 Waiver Report

Exhibit 1

Part B. Eligibility and Enrollment Information, including member month reporting - by month for calendar year (CY) 2021

New Enrollment: Total number of beneficiaries with enrollment in the current month

Disenrolled: Total number of beneficiaries with enrollment in the previous month; with no enrollment in current month of eligibility

Reenrolled: Total number of beneficiaries who disenrolled at some point in the last 19 years and re-enrolled in current month of eligibility

** Indicates cells suppressed due to low counts

Out-of-State Former Foster Youth

Topic	Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Distinct CY2021 Count
Total Enrollment	Total number unduplicated enrolled	185	203	212	225	237	246	254	265	267	272	280	285	329
New Enrollment	Total number of new enrollees	23	19	15	17	13	11	12	19	**	**	**	11	169
Re-Enrollment	Total number of beneficiaries who disenrolled and later reenrolled	**	**	**	**	**	**	**	**	**	**	**	**	**
Disenrollment	Total number of beneficiaries who disenrolled	**	**	**	**	**	**	**	**	**	**	**	**	60

California Department of Health Care Services

Out-of-State (OOS) Former Foster Youth (FFY) - Medi-Cal CalAIM 1115 Waiver Report

Exhibit 2

Part C. Utilization Monitoring - by month for calendar year (CY) 2021

** Indicates cells suppressed due to low cell counts

Topic	Measure [Reported for each month included in the CY2021 annual report]	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Distinct CY2021	Percent of Population
														Count	Percent
Out-Of-State Former Foster Youth	Total number of beneficiaries with any claim	62	60	74	74	85	88	90	84	86	80	83	95	215	65%
	Total number of beneficiaries with primary care appointments	26	27	37	33	36	40	37	36	39	38	36	39	138	42%
	Total number of beneficiaries with behavioral health appointments	13	16	18	20	19	18	18	20	21	25	24	21	64	19%
	Total number of beneficiaries with emergency department visits	17	18	23	20	25	23	34	25	24	22	25	30	133	40%
	Total number of beneficiaries with inpatient visits	**	**	**	**	**	**	**	**	**	**	**	**	29	9%