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

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November 4, 2022

Ms. Judith Cash, Director
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Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

AMENDMENT REQUESTS FOR CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) SECTION 1115 DEMONSTRATION AND SECTION 1915(b) WAIVER

Dear Ms. Cash,

I am pleased to submit the enclosed requests to amend the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration (Project No.: 11-W-00193/9) and Section 1915(b) waiver (Control No. CA 17.R10) to implement county-based model changes in the Medi-Cal Managed Care program. Through the Section 1915(b) waiver amendment, DHCS also plans to add or update language on policies or programs in the approved CalAIM 1915(b) waiver, including to reflect proposed direct contracts with the Kaiser Foundation Health Plan available for enrollment of certain Medi-Cal beneficiaries in select counties.

California's Medi-Cal Managed Care delivery system consists of multiple managed care models that vary by county. Each county offers one of these models: one plan operated by the county (County Organized Health System (COHS)); one local initiative plan operated by the county and one commercial plan (Two Plan); multiple commercial plans (Geographic Managed Care, Regional, and Imperial model); or one commercial plan and a Fee-for-Service option (San Benito model). Prior to the launch of the State's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model. As part of this process, DHCS conditionally approved model changes in 17 counties; 15 of these counties seek to move to a managed care model that involves one plan per county, either via expansion of an existing COHS model or establishment of a "Single Plan" model. Single Plan models will be expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority.

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in these relevant geographic regions. This authority would apply in the Metro, Large Metro, and Urban counties operating under the COHS and Single Plan models. Through a coordinated submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan.

DHCS looks forward to working with CMS to advance this request and further strengthen the goals of CalAIM, which include improving quality, access, and accountability in Medi-Cal. For any questions, please contact Ms. Susan Philip, Deputy Director of Health Care Delivery Systems, by phone at (916) 324-5870 or by email at Susan.Philip@dhcs.ca.gov.

Sincerely,

[redacted]

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State of California

Department of Health Care Services

Medicaid Section 1115 Demonstration

Amendment Request:

CalAIM Medi-Cal Managed Care Model Changes

November 4, 2022

Section 1 – Historical Narrative Description of the Demonstration

Introduction

The California State Department of Health Care Services (DHCS) is seeking an amendment to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration to implement county-based model changes in its Medi-Cal Managed Care program. This request is in conjunction with related changes to the CalAIM Section 1915(b) waiver.

Through the CalAIM Section 1115 demonstration and Section 1915(b) waiver approvals in December 2021, DHCS transitioned authority for California's managed care delivery systems — Medi-Cal Managed Care, Dental Managed Care, Specialty Mental Health Services, and Drug Medi-Cal Organized Delivery System — from the State's longstanding Section 1115 demonstration to authority under the CalAIM 1915(b) waiver to simplify and align the programs, enhance oversight, and standardize benefits and enrollment into Medi-Cal.

California's Medi-Cal Managed Care delivery system consists of multiple managed care models that vary by county. Each county offers one of these models: one plan operated by the county (County Organized Health System (COHS)); one local initiative plan operated by the county and one commercial plan (Two Plan); multiple commercial plans (Geographic Managed Care, Regional, and Imperial model); or one commercial plan and a Fee-for-Service option (San Benito model). Today, 22 counties[1] offer one plan operated by the county, all implemented through a COHS model. Prior to the launch of the State's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model. As part of this process, DHCS conditionally approved model changes in 17 counties; 15 of these counties seek to move to a managed care model that involves one plan per county, either via expansion of an existing COHS model or establishment of a "Single Plan" model. Single Plan models will be expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority effective January 1, 2024.

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in these relevant geographic regions. This authority would apply in the Metro, Large Metro, and Urban counties operating under the COHS and Single Plan models. Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area

[1] The 1915(b) waiver approved in December 2021 lists 23 counties as COHS in error. DHCS intends to include a technical correction in the 1915(b) amendment to update Stanislaus as a Two-Plan county instead of a COHS.

exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan. Implementing these models is consistent with the goals of CalAIM, including improving quality, access, and accountability.

For more information on the COHS and Single Plan models, including information on which counties are currently seeking to adopt these models, please visit the Medi-Cal Managed Care Plan (MCP) Model Change website here.

Background

The expansion of the COHS model and new Single Plan model to counties as proposed by DHCS will build on the existing COHS model in the State, which are among California's highest performing plans. Currently, DHCS has authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions[2] that exempt them from the otherwise applicable managed care choice requirements set forth in or derived from Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are health insuring organizations (HIOs) under federal law; their statutory exemption from 1903(m)(2)(A) and associated Medicaid requirements is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is seeking expenditure authority through this Demonstration Amendment to limit plan choice in non-rural areas for all COHS.

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[2] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986, so long as a choice between at least two providers;
- HIOs as described in Sec. 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by Section 4734 of the Omnibus Budget Reconciliation of 1990, Section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Section 205 of the Medicare Improvements for Patients and Providers Act of 2008, subject to certain conditions including that total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

The proposed Single Plans are not subject to federal statutory exemption from plan choice requirements as existing COHS/HIOs are. Therefore, expenditure authority through this Demonstration Amendment is also needed to limit plan choice in Single Plan model counties in non-rural areas.

Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS and rural counties intending to operate a Single Plan, and to include language memorializing the model changes and plans operating in each county following re-procurement.

Summary of Current CalAIM Section 1115 Demonstration

On December 29, 2021, CMS approved the CalAIM demonstration. This five-year demonstration authorized the renewal of components of the State's prior Medi-Cal 2020 Section 1115 demonstration, in addition to new authorities, to continue advancing the State's goal of improving health outcomes and reducing health disparities for Medicaid and other low-income populations in the State. Building on the successes of the Medi-Cal 2020 demonstration, California has moved to implement whole person care strategies statewide through the State's CalAIM 1915(b) managed care delivery system (with some aspects authorized through Section 1115 demonstration authority) and moved other aspects of the Medi-Cal 2020 demonstration into the Medi-Cal State Plan. The CalAIM Section 1115 demonstration initiatives include:

- Renewing the Global Payment Program (GPP) to streamline funding sources for care for California's remaining uninsured population with a renewed focus on addressing social needs and responding to the impacts of systemic racism and inequities on the uninsured populations served by California's public hospitals.

- Authorizing Community Supports services for recuperative care and short-term post-hospitalization housing.

- Authorizing the Providing Access and Transforming Health (PATH) Supports expenditure authority to (1) sustain, transition, and expand the successful Whole Person Care (WPC) Pilot and Health Home Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports and (2) sustain justice-involved pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.

- Continuing short-term residential treatment services to eligible individuals with a

substance use disorder (SUD) in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

- Authorizing Contingency Management as a DMC-ODS benefit, to offer Medi-Cal beneficiaries this evidence-based, cost-effective treatment for SUD that combines motivational incentives with behavioral health treatments.

California also has requested authority to provide in-reach services to justice-involved populations, leverage federal funding of Designated State Health Programs (DSHPs) to support the non-federal share funding for the PATH program, and offer traditional healer and natural helper services; these requests are still pending with CMS.

On June 29, 2022, CMS approved an amendment to the CalAIM 1115 demonstration to permit the state to increase and eventually eliminate asset limits for certain low-income individuals whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods.

Section II. Proposed Amendment

This Demonstration Amendment seeks expenditure authority to allow COHS and Single Plan models to operate in select Metro, Large and Urban counties. These changes are intended to improve access to and quality of care and accountability. No other changes to the CalAIM demonstration are being requested at this time.

Summary of Proposed CalAIM Section 1115 Demonstration Amendment Features

DHCS is requesting an amendment to the CalAIM 1115 demonstration to secure expenditure authority to allow DHCS to limit choice of managed care plans in Metro, Large Metro, and Urban counties in order to allow counties to participate, or continue participating, in the COHS and Single Plan models. In order to maximize continuity of care and minimize member disruption, the expenditure authority will apply during the transition period and following the implementation of the models on January 1, 2024. DHCS will memorialize the transition policies as part of an Appendix to the CalAIM Special Terms and Conditions.

Summary of Current Demonstration Features to Be Continued Under the Section 1115 Demonstration Amendment

California is not seeking to modify any other features in the currently approved CalAIM Section 1115 demonstration. The demonstration will continue to operate pursuant to the Special Terms and Conditions (STCs) issued by CMS on December 29, 2021 and amended on June 29, 2022.

Eligibility

The State is not proposing any changes to Medi-Cal eligibility requirements through this Section 1115 demonstration amendment request. The amendment impacts approximately 1,001,400 Medi-Cal managed care enrollees residing in the select Metro, Large and Urban counties that would be limiting plan choice (based on enrollment figure as of February 2022) by adopting the COHS or Single plan models.

Medicaid Delivery System

Through this Section 1115 amendment request, the State is proposing changes to the Medi-Cal managed care delivery system to strengthen quality, access to care, and accountability as described here. While most Medi-Cal beneficiaries will not be impacted by the proposed change, the proposed model transition will limit choice of plans for the Medi-Cal enrollees living in the counties that employ the COHS or Single Plan model.

Medicaid Covered Benefits

The State is not proposing any changes to the benefits available to Medicaid enrollees in the Medi-Cal program.

Medicaid Cost-Sharing

The State is not proposing any changes to cost-sharing under the Medi-Cal program.

Section III. Implementation of Amendment

The model changes proposed in this Demonstration would take effect January 1, 2024, consistent with the corollary CalAIM Section 1915(b) waiver amendment. DHCS has been actively engaged since Fall 2020 to ensure full MCP and county readiness and member and stakeholder engagement, under the condition of CMS approval. Below is the State's general timeline for engagement and implementation:

- March – April 2021: Counties submitted letters of intent to DHCS
- August 2021: DHCS issued conditional decision letters to enable counties to progress in seeking model change
- October 2021: Counties seeking model changes submitted approved County ordinances seeking model change to DHCS, verified by DHCS
- November 2021: DHCS announced conditional approvals for county model changes

- December 2021: Affected counties and their plan partners submitted a network contracting strategy to be considered as part of operational readiness
- June 2022 through October 2023: MCP operational readiness process and related technical assistance to plan and county partners underway, including network development and adequacy evaluations
- October 2023 – January 2024: Member noticing, outreach, and continuity of care and transition activities

Model changes are advancing in parallel to the statewide procurement of commercial MCPs. With the exception of El Dorado and Alpine counties, which are conditionally approved to transition from a Regional to a Two-Plan model for which the commercial plan is being procured, the other conditionally approved model change counties are not participating in the procurement underway, nor are existing COHS and Local Initiatives in other counties. Once selection has been completed for commercial plans, the MCP operational readiness process already begun for model change plans will proceed largely in parallel with awarded commercial MCPs to ensure statewide MCP readiness across all plan types and models prior to the January 1, 2024 effective date.

DHCS is committed to ensuring a smooth transition among plans for members, with particular attention to those members most vulnerable to disruptions in care. Member noticing, outreach and continuity of care policies and procedures are being carefully considered and will be included in a Transition Plan developed with substantial input from plans, providers, counties, consumer advocates and other stakeholders.

Section IV. Requested Waivers and Expenditure Authority

DHCS is requesting 1115 demonstration expenditure authority to limit choice of managed care plans for managed care enrollees residing in the Metro, Large Metro, and Urban counties participating in the COHS and Single Plan models. In order to maximize continuity of care and minimize member disruption, the expenditure authority will apply during the transition period and following the implementation of the models on January 1, 2024.

Expenditure Authority

Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a)(3) of the Act, including as it is implemented and interpreted in 42 CFR 438.52(a)(1), to the extent necessary to allow the state to limit choice of managed care plans to a single managed care entity in Metro, Large Metro, and Urban counties that have been approved by the state to implement County Organized Health System (COHS) and Single Plan models. For Health Insuring Organizations (HIO) described in Section 1932(a)(3)(C)(i)(II) authorized under the COHS model, this expenditure authority shall apply for any time

period during the demonstration term in which aggregate enrollment in such HIOs meets or exceeds the sixteen percent threshold described in Section 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as subsequently amended.

Section V. Financial Data

The expanded COHS and Single Plan model changes proposed in this Demonstration Amendment are not expected to impact the overall number of people enrolled in the Medi-Cal program or the Medi-Cal managed care delivery system or increase the expenditures on enrollees in these counties. For that reason, the State does not anticipate this Demonstration Amendment will have any appreciable financial impact.

Section VI. Evaluation and Demonstration Hypotheses

The performance of the managed care plans operating under the expenditure authority requested in this amendment will be evaluated as part of the CalAIM Section 1115 Demonstration evaluation. These managed care plans will play an important role in testing the CalAIM Section 1115 Demonstration's existing hypotheses, including to improve quality, access, and accountability in line with the goals of the Medi-Cal program. DHCS will update the CalAIM Section 1115 Demonstration evaluation plan to incorporate this amendment and clarify the applicability of Demonstration hypotheses to these managed care plans. In addition, DHCS will continue to evaluate and monitor managed care plan performance as required under the CalAIM Section 1915(b) waiver's STCs.

Section VII. Oversight, Monitoring, and Reporting

Upon approval, California will update regular CalAIM Demonstration monitoring and reporting to reflect this amendment, consistent with the STCs and CMS policy. DHCS is committed to ensuring smooth transitions for individuals required to switch plans following as a result of implementation of the expanded COHS and Single Plan models, including through continuity of care requirements to support continued beneficiary access to providers and prevent disruptions in treatment, robust appeals and grievances processes, member communication and data sharing of member information prior to plan transition.

Section VIII. Compliance with Public Notice Process

DHCS has engaged and will continue to engage in robust stakeholder engagement around the proposed managed care model changes. Starting in mid-2021, DHCS announced the process for counties to propose model changes on its website and through its newsletter to stakeholders. Additionally, in October 2021, DHCS hosted a webinar to provide technical assistance to counties potentially interested in a model

change. DHCS required counties to submit their county ordinance to demonstrate local support for the model change. DHCS reviewed the county ordinance to determine that it meets the intent of the county proposing to change their county model type effective January 1, 2024. The conditional approvals have also been posted on the model change website, which will be updated to add other information about model changes (e.g., FAQs, timelines) as they become available. In the first half of 2022, DHCS convened meetings to discuss model changes with stakeholders representing providers, consumer and children's advocates, and county organizations. DHCS has also convened impacted MCPs and counties, as well as stakeholders in model change counties and will continue meeting with them quarterly through the end of 2022.

In August 2022, DHCS released the requisite notice for this demonstration amendment proposal, announcing the state public comment period of August 12, 2022 through September 12, 2022. In addition to the formal public comment period, starting in the second half of 2022 and continuing into 2023, DHCS will present and discuss the model change proposal and implementation, in the context of the changes associated with both model change and the procurement results, quarterly at two of its standing advisory committees – the Stakeholder Advisory Committee (SAC) and the Managed Care Advisory Group (MCAG) – in addition to quarterly discussion with Tribal and Indian Health Program partners. DHCS will also continue to meet with other stakeholders (those not represented on the SAC and MCAG) on a regular basis. Finally, DHCS is preparing a robust member outreach and stakeholder engagement plan for 2023 to inform members and stakeholders about the model change implementation and what it will mean for members.

Public Comment Period

The required 30-day public comment period ran from August 12, 2022, through September 12, 2022. At the start of the public comment period, the CalAIM 1115 Demonstration & 1915(b) Waiver webpage and DHCS Indian Health Program webpage included the State's public comment materials, a summary of the public comment period's dates and purpose, details about upcoming public hearings (i.e., dates, access information, accessibility details), and information about how stakeholders could submit public comment submissions via email, by U.S. mail, and in public hearings. The following materials were shared for public comment:

- Proposed CalAIM Section 1115 demonstration amendment application
- Proposed Section 1915(b) waiver amendment overview
- Public Notice
- Tribal Public Notice

DHCS hosted two public webinars to present the details of the demonstration amendment and to take public comments. The first hearing was held on August 22, 2022, from 10:00–11:00 am Pacific Time. The second hearing, specifically for Tribes

and Designees of Indian Health Programs, was held as part of the Tribes and Designees of Indian Health Programs Quarterly Webinar on August 31, 2022 from 2:00—3:00 pm Pacific Time.

During the 30-day public comment period, the State received 82 public comments. 58 comments were submitted via email (CalAIMWaiver@dhcs.ca.gov) or U.S. mail and 24 comments were 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. Overall, the State received a limited number of comments about the MCP model changes. Most commenters requested clarification on the MCP model change approach or impacts of MCP model changes on counties and Medi-Cal beneficiaries. Some commenters expressed concerns about DHCS contracting directly with Kaiser Foundation Health Plan. More than half of the public comments received were unrelated to the proposed MCP model change amendments. Specifically, many commenters urged the State to move expeditiously to submit an application to waive the federal Medicaid institutions for mental diseases (IMD) exclusion that prevents Medi-Cal payment for inpatient admissions in IMDs of over 16 beds for individuals with serious mental illness (SMI) or serious emotional disturbance (SED). The written comments are available here and a synthesis of the comments and responses is available in Appendix A.

Appendix A. Summary of Responses to Public Comments

Overview

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 State greatly appreciates the valuable and thoughtful comments submitted by stakeholders and is committed to continuing an open and collaborative process to strengthen the Medi-Cal program.

This Appendix summarizes key themes of the comments received and provides the State's responses. The summary primarily reflects input on the draft CalAIM Section 1115 amendment for the Medi-Cal Managed Care Plan (MCP) model changes (as required by 59 Federal Register 49249). DHCS also briefly summarizes comments related to the associated CalAIM 1915(b) waiver amendment overview. In addition to comments related to the proposed MCP model change amendments, various commenters provided input about other CalAIM and Medi-Cal topics, including the State's plan to request a separate serious mental illness (SMI) / serious emotional disturbance (SED) Section 1115 demonstration. The State appreciates those comments and will consider them as it continues to work to strengthen Medi-Cal.

Responses to Public Comments

Comments on Section 1115 and 1915(b) Requests for Authority to Implement Medi-Cal Managed Care Model Changes

DHCS received a number of comments directly related to the MCP model changes described in the Section 1115 amendment draft, as well as the Section 1915(b) amendment overview.

Comment: **Two commenters expressed support for the County Organized Health System (COHS) and Single Plan model changes. Another commenter expressed disapproval of the model changes, suggesting they could result in disruption for providers and beneficiaries.**

Response*:* DHCS appreciates comments from all stakeholders and recognizes different stakeholders may have different perspectives on the model changes. DHCS is committed to ensuring a smooth transition among MCPs for members transitioning to a new MCP as a result of the planned model changes, with particular attention to supporting providers and members vulnerable to disruptions in care. Member noticing,

outreach, data sharing, network adequacy and readiness, and continuity of care policies and procedures are being carefully considered and will be included in a Transition Plan developed with substantial input from MCPs, providers, consumer advocates and other stakeholders.

Comment: **A few commenters requested clarity on the proposed MCP model changes and the potential impact for Medi-Cal members.**

Response*:* MCP model changes are driven by counties' assessment and intent to change their MCP model type based on local stakeholder input. DHCS has conditionally approved model changes in 17 counties; 15 counties seek to move to a managed care model that involves one MCP per county, either via expansion of an existing COHS model or establishment of a Single Plan model. Medi-Cal members residing in counties undergoing model changes may be required to transition to a new MCP, and those residing in counties operating under the COHS or Single Plan models will be enrolled in a MCP operating as a county-driven local initiative or MCP otherwise operating under a county or local authority. DHCS is working with the affected MCPs and counties on transition planning. Further, DHCS is committed to working with stakeholders to ensure a smooth transition among MCPs for all members transitioning to a new MCP as a result of the planned model changes. The proposed changes will not impact eligibility for Medi-Cal or reduce benefits.

Comment: **Two commenters requested clarity on the implications of the proposed MCP model changes for delivery systems other than Medi-Cal Managed Care.**

Response: The model changes outlined in the Section 1115 demonstration amendment and 1915(b) waiver amendment do not contemplate changes to other Medi-Cal managed care delivery systems (i.e., Dental Managed Care, Specialty Mental Health Services, or the Drug Medi-Cal Organized Delivery System) or with respect to Medi-Cal fee-for-service delivery. The model changes described are specific to the scope of Medi-Cal Managed Care plans, and specifically the county MCP model changes that will take effect on January 1, 2024***.***

Comment*:* **Two commenters expressed the need for more explicit consumer protections and monitoring and oversight during the MCP model change transition**, **including related to continuity of care, network adequacy and readiness, Knox-Keene licensure, and reporting transparency.**

Response: DHCS is committed to ensuring a smooth transition among MCPs for Medi-Cal members transitioning to a new MCP as a result of the planned model changes. Member noticing, outreach, data sharing, network adequacy and readiness, and continuity of care policies and procedures are being carefully considered and will be included in a transition plan developed with substantial input from stakeholders.

In addition, MCPs are required to ensure access and member rights and DHCS will provide MCPs with monitoring and oversight standards and processes. DHCS will communicate the standards and processes through a variety of mechanisms including, but not limited to, policy guidance, All Plan Letters, and Frequently Asked Questions (FAQs), as well as provide ongoing training and technical assistance.

Throughout 2022, DHCS has engaged with stakeholder and advocacy groups, including the Department of Managed Health Care, and will continue to do so to keep them informed with timely information about the transition.

Comments on Updates to Policies and Program Descriptions to be Memorialized in the CalAIM 1915(b) Waiver

As noted above, the State public comment period on the proposed CalAIM Section 1115 amendment also provided the public with an opportunity to comment on the Section 1915(b) waiver amendment overview. In addition to authority to enable counties to implement, or continue to implement, the COHS and Single Plan models, the CalAIM 1915(b) amendment will include language to update policy and program descriptions memorialized in the 1915(b) waiver, such as for the broader MCMC model changes in select counties and direct contracts with Kaiser Foundation Health Plan available to certain Medi-Cal beneficiary populations in 32 counties. The state received several comments related to these updates.

Comment: **Several commenters expressed displeasure with the proposed direct contracting approach in select counties with Kaiser Foundation Health Plan, specifically expressing concerns about access and quality. One commenter expressed support for the direct contracting approach with Kaiser Foundation Health Plan.**

Response: DHCS is committed to ensuring quality and access under the Medi-Cal program. With the new or renewed direct contracts effective January 1, 2024, Kaiser will operate as a full-risk, full-scope Medi-Cal managed care plan in 32 California counties, subject to federal approvals, and will be held to the same access and quality standards and requirements as applied to all other MCPs. The only contractual area where Kaiser is treated different than other MCPs is with respect to enrollment, given the authorizing State legislation which expressly identifies the subset of Medi-Cal populations eligible to enroll in Kaiser (see California Welfare & Institutions Code section 14197.11(b)). Kaiser will no longer receive the delivery system exemption for alternative access standards or have specific arrangements for timely access survey calls to provider offices. Kaiser will be held to the same network adequacy and timely access requirements and processes in approved service areas as are all other contracted MCPs.

The Kaiser direct contract is consistent with California's efforts to improve quality outcomes, reduce health disparities, streamline and standardize Medi-Cal to optimize

the consumer experience, and hold plans accountable for delivering on these goals. Kaiser consistently scores as one of the highest in quality scores and is recognized as being a high performing health system. This proposal grows Medi-Cal's partnership with a high quality plan and leverages Kaiser's expertise to improve care for non-Kaiser members. Kaiser consistently scores above 90% in the Aggregated Quality Factor Score (AQFS), which is a quality score that accounts for plan performance on DHCS-selected Healthcare Effectiveness Data and Information Set (HEDIS) indicators. In comparison, the weighted average for other MCPs is 65%.

Other Public Comments

As noted above, in addition to comments related to the proposed MCP model change amendments, many commenters provided input about other CalAIM and Medi-Cal topics, including the State's Medi-Cal Managed Care procurement, Medi-Cal long-term care and home health services approach, and CalAIM Community Supports, among other topics. Notably, more than half of all commenters discussed the State's plan to request a separate Section 1115 SMI/SED demonstration, as described below. The State appreciates those comments and will consider them as it continues to work to strengthen Medi-Cal.

***Comment*: Many commenters urged the state to move expeditiously to submit the planned CalAIM Section 1115 demonstration application to waive the federal Medicaid IMD exclusion that prevents Medi-Cal payment for inpatient admissions in IMDs of over 16 beds for individuals with an SMI or SED. Commenters underscored the urgency of submitting an SMI/SED Section 1115 demonstration application.**

Response: DHCS appreciates the commenters' interest and advocacy and recognizes the critical importance of expanding access to and strengthening the continuum of mental health services for Medi-Cal beneficiaries living with SMI and SED. DHCS is actively working with its partners to advance the proposed section 1115 SMI/SED demonstration concept consistent with the comprehensive federal guidance issued in 2018. DHCS anticipates releasing a concept paper for stakeholder feedback in late 2022 and submitting a Section 1115 waiver application to CMS after a robust stakeholder engagement process for the concept paper and subsequent public comment period for the formal application.

Appendix B. Joint Section 1115 and 1915(b) Public Notice

DEPARTMENT OF HEALTH CARE SERVICES
NOTICE OF GENERAL PUBLIC INTEREST
RELEASE DATE: FRIDAY, August 12, 2022

PROPOSED CALAIM SECTION 1115 DEMONSTRATION AND SECTION 1915(B) WAIVER AMENDMENTS FOR MANAGED CARE MODEL CHANGES AND OTHER MANAGED CARE UPDATES

Overview

The California Department of Health Care Services (DHCS) is providing public notice of its intent to (1) submit amendments to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration and Section 1915(b) waiver to the federal Centers for Medicare & Medicaid Services (CMS); and (2) hold a public hearing to receive public comments on these requests.

DHCS is seeking the CalAIM Section 1115 and 1915(b) amendment approvals to implement county-based model changes in its Medi-Cal Managed Care (MCMC) program. Through the 1915(b) waiver amendment, DHCS also plans to add or update language on policies or programs in the approved CalAIM 1915(b) waiver, including to reflect the plans operating in each county following the State's MCMC commercial plan re-procurement, MCMC model change in select counties, and proposed direct contracts with the Kaiser Foundation Health Plan available for enrollment of certain Medi-Cal beneficiaries in select counties.

California's MCMC delivery system consists of multiple managed care models that vary by county. Each county offers one of these models: one plan operated by the county (County Organized Health System (COHS)); one local initiative plan operated by the county and one commercial plan (Two Plan); multiple commercial plans (Geographic Managed Care, Regional, and Imperial model); or one commercial plan and a Fee-for-Service option (San Benito model). Today, 22 counties[3] offer one plan operated by the county, all implemented through a COHS model. Prior to the launch of the State's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model. As part of this process, DHCS conditionally approved model changes in 17 counties; 15 of these counties seek to move to a managed care model that involves one plan per county, either via expansion of an existing COHS model or establishment of a "Single Plan" model. Single Plan models will be expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority.

[3] The 1915(b) waiver approved in December 2021 lists 23 counties as COHS in error. DHCS intends to include a technical correction in the 1915(b) amendment to update Stanislaus as a Two-Plan county instead of a COHS.

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in non-rural areas. This authority would apply in the Metro, Large Metro, and Urban counties proposed to participate in the COHS or Single Plan models. Through the CalAIM 1915(b) waiver amendment, DHCS is also requesting updates to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate under the Single Plan model. If approved, these county-based model changes will go into effect on January 1, 2024.

Implementing these models is consistent with the goals of CalAIM, including improving quality, access, and accountability. The proposed model transition will limit the choice of plans for the Medi-Cal enrollees living in the counties that employ the COHS or Single Plan model. For more information on the COHS and Single Plan models, including information on which counties are currently seeking to adopt these models, please visit the MCP Model Change website here.

Background

The expansion of the COHS model and new Single Plan model to counties as proposed by DHCS will build on the existing COHS model in the State. Currently, DHCS has authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions[4] that exempt them from the otherwise applicable managed care choice requirements set forth in or derived from Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are health insuring organizations (HIOs) under federal law; their statutory exemption from 1903(m)(2)(A) and associated Medicaid requirements is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice

[4] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986, so long as a choice between at least two providers;
- HIOs as described in Sec. 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by Section 4734 of the Omnibus Budget Reconciliation of 1990, Section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Section 205 of the Medicare Improvements for Patients and Providers Act of 2008, subject to certain conditions including that total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is seeking expenditure authority through an amendment to the CalAIM 1115 demonstration to limit plan choice in all non-rural areas operating under the COHS model. Additionally, because the new Single Plan model is not subject to federal statutory exemption from plan choice requirements as are existing COHS/HIOs, DHCS is also seeking expenditure authority through the CalAIM Section 1115 demonstration amendment to limit plan choice in Single Plan model counties in non-rural areas.

Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS and rural counties intending to operate under the new Single Plan model, and to include language memorializing the model changes and plans operating in each county effective January 1, 2024.

Public Review and Comment Process

The 30-day public comment period for the CalAIM Section 1115 demonstration amendment and Section 1915(b) amendment as described in the 1915(b) waiver overview is from Friday, August 12, 2022 until Monday, September 12, 2022. All comments must be received no later than midnight (Pacific Time) on **Monday, September 12, 2022.**

All information regarding the CalAIM Section 1115 demonstration application and the Section 1915(b) overview can be found on the DHCS website. DHCS will update this website throughout the public comment and amendment process.

DHCS will host a public hearing to solicit stakeholder comments. In light of the COVID-19 pandemic and to maximize opportunities for participation, all public hearings will be held via webinar.

- August 22, 2022
    - 10:00 -11:00 AM PT
    - Register HERE.

The complete version of the draft of the CalAIM Section 1115 demonstration amendment and the Section 1915(b) waiver amendment overview are available for public review on the DHCS website.

You may request a copy of the proposed CalAIM Section 1115 demonstration amendment; CalAIM Section 1915(b) waiver amendment overview; and/or a copy of submitted public comments related to the CalAIM Section 1115 demonstration

amendment and Section 1951(b) waiver amendment overview by requesting it in writing to the mailing or email addresses listed below.

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waiver Amendments" in the written message:

Department of Health Care Services
Director's Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Comments may also be emailed to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & and 1915(b) Waiver Amendments" in the subject line of the email message.

To be assured consideration prior to submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than midnight (Pacific Time) **Monday, September 12, 2022**. Please note that comments will continue to be accepted after September 12, 2022, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.

Upon submission to CMS, a copy of the proposed CalAIM Section 1115 demonstration amendment and Section 1915(b) waiver amendment will be published at the following internet address: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx.

After DHCS reviews comments submitted during this State public comment period, the CalAIM Section 1115 demonstration amendment and Section 1915(b) waiver amendment will be submitted to CMS. Interested parties will also have opportunity to officially comment on the CalAIM Section 1115 demonstration during the federal public comment period; the submitted application will be available for comment on the CMS website at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html. There is no federal public comment period for the CalAIM Section 1915(b) waiver amendment.

Appendix C. Joint Section 1115 and 1915(b) Tribal Public Notice

August 12, 2022

To: Tribal Chairpersons, Designees of Indian Health Programs, and Urban Indian Organizations

Subject: Notice of Intent to Submit Amendments of Section 1115 Demonstration and Section 1915(b) Waiver for Medi-Cal Managed Care Model Changes and Other Managed Care Updates

The purpose of this letter is to provide information regarding a proposed change to the Department of Health Care Services' (DHCS) Medi-Cal program that will be submitted to the Centers for Medicare & Medicaid Services (CMS). DHCS is forwarding this information for your review and comment.

DHCS is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on Medi-Cal matters having a direct effect on American Indians, Indian Health Programs or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009 (ARRA). DHCS must solicit the advice of designees prior to submission to CMS of any State Plan Amendments (SPAs), waiver requests or amendments, or proposals for demonstration projects in the Medi-Cal program.

Please see the enclosed summary for a detailed description of this DHCS proposal.

QUESTIONS AND COMMENTS

Tribes and Indian Health Programs may also submit written comments or questions concerning this proposal within 30 days from receipt of notice. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) on Monday, September 12, 2022. Please note that comments will continue to be accepted after Monday, September 12, 2022, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver applications to CMS. Comments may be sent by email to CalAIMWaiver@dhcs.ca.gov or by mail to the address below:

Department of Health Care Services
Director's Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Please also note that DHCS will host a CalAIM hearing for Tribes and Designees of Indian Health Programs on August 31, 2022. Registration and call-in information are listed at the end of this document.

Sincerely,

Original Signed By

Andrea Zubiate, Acting Chief
Office of Tribal Affairs
Department of Health Care Services

Enclosure

Department of Health Care Services
Tribal and Designees of Indian Health Programs Notice

PURPOSE

The California Department of Health Care Services (DHCS) is providing public notice of its intent to (1) submit amendments to the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration and Section 1915(b) waiver to the federal Centers for Medicare & Medicaid Services (CMS); and (2) hold a public hearing to receive public comments on these requests. The purpose of this notice is to request written feedback on the Section 1115 demonstration and Section 1915(b) waiver proposals described in this notice.

OVERVIEW

DHCS is seeking the CalAIM Section 1115 and 1915(b) amendment approvals to implement county-based model changes in its Medi-Cal Managed Care (MCMC) program. Through the 1915(b) waiver amendment, DHCS also plans to add or update language on policies or programs in the approved CalAIM 1915(b) waiver, including to reflect the plans operating in each county following the State's MCMC commercial plan re-procurement, MCMC model change in select counties, and proposed direct contracts with the Kaiser Foundation Health Plan available for enrollment of certain Medi-Cal beneficiaries in select counties.

California's MCMC delivery system consists of multiple managed care models that vary by county. Each county offers one of these models: one plan operated by the county (County Organized Health System (COHS)); one local initiative plan operated by the county and one commercial plan (Two Plan); multiple commercial plans (Geographic Managed Care, Regional, and Imperial model); or one commercial plan and a Fee-for-Service option (San Benito model). Today, 22 counties[5] offer one plan operated by the county, all implemented through a COHS model. Prior to the launch of the State's commercial plan re-procurement process in 2022, counties had the opportunity to request a change to their managed care model. As part of this process, DHCS conditionally approved model changes in 17 counties; 15 of these counties seek to move to a managed care model that involves one plan per county, either via expansion

[5] The 1915(b) waiver approved in December 2021 lists 23 counties as COHS in error. DHCS intends to include a technical correction in the 1915(b) amendment to update Stanislaus as a Two-Plan county instead of a COHS.

of an existing COHS model or establishment of a "Single Plan" model. Single Plan models will be expansions of plans currently operating as county-driven local initiatives or will otherwise be operating under a county or local authority.

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in non-rural areas. This authority would apply in the Metro, Large Metro, and Urban counties proposed to participate in the COHS or Single Plan models. Through the CalAIM 1915(b) waiver amendment, DHCS is also requesting updates to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate under the Single Plan model. If approved, these county-based model changes will go into effect on January 1, 2024.

Implementing these models is consistent with the goals of CalAIM, including improving quality, access, and accountability. The proposed model transition will limit choice of plans for the Medi-Cal enrollees living in the counties that employ the COHS or Single Plan model. For more information on the COHS and Single Plan models, including information on which counties are currently seeking to adopt these models, please visit the MCP Model Change website here.

BACKGROUND

The expansion of the COHS model and new Single Plan model to counties as proposed by DHCS will build on the existing COHS model in the State. Currently, DHCS has authority relating to the existing COHS to limit Medi-Cal managed care plan choice under federal law provisions[6] that exempt them from the otherwise applicable managed care choice requirements set forth in or derived from Section 1903(m)(2)(A) of the Social Security Act. Four of these COHS are health insuring organizations (HIOs) under

[6] SSA 1932(a)(3): requires choice of at least two MCOs, with specific exceptions including:

- COHS / HIOs that became operational prior to Jan 1, 1986, so long as a choice between at least two providers;
- HIOs as described in Sec. 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by Section 4734 of the Omnibus Budget Reconciliation of 1990, Section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Section 205 of the Medicare Improvements for Patients and Providers Act of 2008, subject to certain conditions including that total membership in those HIOs is under 16% of Medi-Cal beneficiaries; and
- Rural areas if >2 physicians or case managers (if available in the area) and may go out-of-network in appropriate circumstances.

federal law; their statutory exemption from 1903(m)(2)(A) and associated Medicaid requirements is conditioned on not exceeding a 16% enrollment level in those four COHS as a share of all Medi-Cal beneficiaries. Once the 16% enrollment level is exceeded, the managed care requirements in 42 CFR Part 438, including choice provisions, would apply to all HIOs currently operating under federal statute. DHCS projects that enrollment will likely be close to or exceed the aggregate 16% level following the expansion of two of those four COHS/HIOs into new counties.

Given enrollment will be close to or in excess of the aggregate 16% level following the expansion of the COHS model, DHCS is seeking expenditure authority through an amendment to the CalAIM 1115 demonstration to limit plan choice in all non-rural areas operating under the COHS model. Additionally, because the new Single Plan model is not subject to federal statutory exemption from plan choice requirements as are existing COHS/HIOs, DHCS is also seeking expenditure authority through the CalAIM Section 1115 demonstration amendment to limit plan choice in Single Plan model counties in non-rural areas.

Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for rural counties in existing and expanding COHS and rural counties intending to operate under the new Single Plan model, and to include language memorializing the model changes and plans operating in each county effective January 1, 2024.

IMPACT TO TRIBAL HEALTH PROGRAMS

There is no direct impact to Tribal health programs. DHCS is not proposing changes to Tribal health program services, eligibility, or any other related requirement authorized by this demonstration authority or the Medi-Cal State Plan.

IMPACT TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

There is no direct impact to FQHCs since DHCS is not proposing changes to FQHC services, rates, eligibility, or any other related requirement authorized by this demonstration authority or the Medi-Cal State Plan.

IMPACT TO INDIAN MEDI-CAL BENEFICIARIES

Like other members residing in counties implementing a COHS or Single Plan model, the changes DHCS is requesting will limit plan choice for American Indian and Alaska Native individuals who are enrolled in MCMC. American Indians and Alaska Natives have the option but are not required to enroll in MCMC (voluntary enrollment). DHCS is committed to ensuring a smooth transition among plans for all members transitioning to a new plan following the COHS and Single Plan model changes, with particular attention to those members most vulnerable to disruptions in care. Member noticing, outreach and continuity of care policies and procedures are being carefully considered

and will be included in a Transition Plan developed with substantial input from stakeholders. The proposed model changes will not change eligibility for Medi-Cal or reduce benefits.

RESPONSE DATE

Tribes and Indian Health Programs may also submit written comments or questions concerning this proposal within 30 days from the receipt of notice. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) on Friday, September 12, 2022. Please note that comments will continue to be accepted after September 12, 2022, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver applications to CMS.

Comments may be sent by email to CalAIMWaiver@dhcs.ca.gov or by mail to the address below.

DHCS will host the following hearing to solicit Tribal and Indian Health Program stakeholder comments. The public hearing will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meeting will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- – Tribal and Designees of Indian Health Programs Webinar for CalAIM Waivers
    - Register for conference: Registration link
        - Please register in advance to receive your unique login details and link to add to calendar
    - Call-in information
        - Phone Number: 415-655-0001 (Toll Free)
        - Webinar ID: 2598 690 1752
        - Passcode: a9Mgw2r7kch
        - Callers do not need an email address to use the phone option and do not need to register in advance

CONTACT INFORMATION

Written comments on the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver may be sent to the following address; please indicate “CalAIM Section 1115 & 1915(b) Waiver Amendments” in the written message:

Department of Health Care Services
Director’s Office
Attn: Jacey Cooper
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Addendum to Financial Data

To effectuate the expanded COHS and new Single Plan models, DHCS is requesting to amend the CalAIM Section 1115 demonstration to include expenditure authority to limit choice of managed care plans in these relevant geographic regions. This authority would apply in the Metro, Large Metro, and Urban counties operating under the COHS and Single Plan models. Through a separate submission, DHCS is also requesting an amendment to the CalAIM 1915(b) waiver to reflect use of the rural area exemption for plan choice in rural counties with existing and/or expanding COHS, and rural counties intending to operate a Single Plan. Implementing these models is consistent with the goals of CalAIM, including improving quality, access, and accountability.

For more information on the COHS and Single Plan models, including information on which counties are currently seeking to adopt these models, please visit the Medi-Cal Managed Care Plan (MCP) Model Change website at https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx.

The model changes pertain only to the following services or populations under the CalAIM demonstration, given the relation to the managed care delivery system:

1. CBAS
2. Deemed SSI Asset Test
3. OOS FFCY
4. HRSN Services

The model changes do not change the eligible populations, scope of services, or delivery systems under the CalAIM demonstration and 1915b waiver. For a given county, the proposed model changes will result in some or all managed care enrollees within the county shifting from one managed care plan to another effective January 1, 2024. DHCS anticipates a corresponding shift of costs from one plan to another, but we have no specific basis or information currently to justify projecting an increase or decrease in total costs for the affected counties due to the model changes. Any increases or decreases due to other factors, such as year-over-year cost trend, would be independent of the model change and anticipated to occur even absent the model change.

The expanded COHS and Single Plan model changes proposed in this Demonstration Amendment are not expected to impact the overall number of people enrolled in the Medi-Cal program or the Medi-Cal managed care delivery system or increase the expenditures on enrollees in these counties. For that reason, the State does not anticipate this Demonstration Amendment will have any appreciable financial impact.

Budget Neutrality Workbook

WITHOUT AMENDMENT:						
Eligibility Group	***DY 18***	***DY 19***	***DY 20***	***DY 21***	***DY 22***	***Total***
CBAS	$ 611,408,000	$ 850,830,000	$ 892,946,000	$ 937,147,000	$ 983,536,000	**$ 4,275,867,000**
OOS FFCY	$ 763,000	$ 802,000	$ 844,000	$ 888,000	$ 934,000	**$ 4,231,000**
Asset Test	$ 52,965	$ 113,233	$ 289,531	$ 309,533	$ 330,803	**$ 1,096,065**
HRSN	$ 353,702,693	$ 679,170,998	$ 1,038,111,532	$ 1,092,979,866	$ 1,149,596,222	**$ 4,313,561,311**
						$ 8,594,755,376
WITH AMENDMENT:						
Eligibility Group	***DY 18***	***DY 19***	***DY 20***	***DY 21***	***DY 22***	***Total***
CBAS	$ 611,408,000	$ 850,830,000	$ 892,946,000	$ 937,147,000	$ 983,536,000	**$ 4,275,867,000**
OOS FFCY	$ 763,000	$ 802,000	$ 844,000	$ 888,000	$ 934,000	**$ 4,231,000**
Asset Test	$ 52,965	$ 113,233	$ 289,531	$ 309,533	$ 330,803	**$ 1,096,065**
HRSN	$ 353,702,693	$ 679,170,998	$ 1,038,111,532	$ 1,092,979,866	$ 1,149,596,222	**$ 4,313,561,311**
						$ 8,594,755,376