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

Section 1115(a) Waiver Quarterly Report

Demonstration/Quarter Reporting Periods:

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

Third Quarter Reporting Period: July 1, 2022 – September 30, 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 Care Youth** to continue Medi-Cal coverage for this population during the renewal period, up to age 26.
    - **Community Based Adult Services (CBAS)** to continue to authorize CBAS for eligible adults receiving outpatient skilled nursing care, social

services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.
    - **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.
- **CalAIM Initiatives Newly Authorized in the CalAIM Section 1115 Demonstration:**
    - **Community Supports** to authorize recuperative care and short-term post-hospitalization housing services via the CalAIM Section 1115 demonstration; twelve other Community Supports were authorized via managed care authority and outlined in the CalAIM Section 1915(b) waiver.
    - **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and (2) support justice-involved pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
    - **Contingency Management** to offer Medi-Cal beneficiaries, as a DMC-ODS benefit, this evidence-based, cost-effective treatment for individuals with a SUD that combines motivational incentives with behavioral health treatments.
    - **Peer Support Specialists** authority via the CalAIM Section 1115 demonstration, as well as CalAIM Section 1915(b) waiver and Medi-Cal State Plan, in order to provide this service in DMC-ODS and Drug Medi-Cal (DMC) counties and county mental health plans (MHPs).
- **Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Continued Under Other Authorities:**
    - **Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS Delivery System Authorities** transitioned to the CalAIM Section 1915(b) waiver; the SMHS managed care program was already authorized under Section 1915(b) authority.
    - **Medi-Cal Coverage for Low-Income Pregnant Women** with incomes from up to 109 to 138% of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan.
    - **Dental Transformation Initiative (DTI)** authority as outlined under the Med-Cal 2020 Section 1115 demonstration transitioned into a new, statewide dental benefit for children and certain adults and an expanded pay-for-performance initiative to the Medi-Cal State Plan; DTI, as outlined

under the Medi-Cal 2020 demonstration, was formally sunset at the conclusion of the Medi-Cal 2020 Section 1115 demonstration.

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

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

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

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

GENERAL REPORTING REQUIREMENTS:

STCs Item 90: Monitoring Calls

CMS and DHCS mutually agreed to hold joint monthly CalAIM 1115/1915(b) waiver monitoring calls. During DY 18-Q3, monitoring calls took place on July 11, 2022, August 8, 2022, and September 12, 2022. Discussions regarding CalAIM 1115 specific-items included: Medi-Cal 2020 DY 17 Closeout Report; DY 18-Q1 and Q2 Reports; draft Evaluation Design and Budget; Contingency Management Implementation; CBAS Operational Protocol; GPP Protocols; Budget Neutrality Notebook; Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Summative Evaluation Report; DMC-ODS Draft Summative Evaluation Report; and draft DMC-ODS SUD Monitoring Protocol.

STCs Item 91: Post Award Forum

In DY 18-Q3, various meetings were held to garner valuable input from the stakeholder community on relevant health care policy issues impacting DHCS. On July 21, 2022, DHCS hosted a joint Stakeholder Advisory Committee (SAC) and Behavioral Health Stakeholder Advisory Committee (BH-SAC) Meeting. The purpose of the SAC and BH-SAC is for stakeholders to provide DHCS with input on ongoing implementation efforts for CalAIM and the state's Section 1115 waiver and behavioral health activities. DHCS provided updates on: Approved DHCS Budget for FY 2022-2023; Consumer Advisory Committee Development; Status of CARE Court Legislation; Medi-Cal COVID-19 Vaccination Incentive Program; New Community Health Worker Provider Classification; Medi-Cal Expansion to Eligible Adults Ages 50+, Regardless of Immigration Status; Children and Youth Behavioral Health Initiative; CalAIM, including the Justice-Involved Initiative; Medical Loss Ratio (MLR) Policy Update and Overview of MLR Workplans Submitted to CMS. Past meeting materials are available on the DHCS website: SACMeetingMaterials (ca.gov).

During this quarter, DHCS Consumer-Focused Stakeholder Working groups (CFSW) meetings also took place on July 1, 2022, August 5, 2022, and September 2, 2022. The meeting included discussion of DHCS programmatic implementation updates, such as: Monkeypox Vaccine and Testing; Medi-Cal Communication Project; Medicare Part B Process; Share of Cost (SOC) and Continuous Eligibility for Children; and ACWDL Quarterly Reports. The following implementation updates were discussed in multiple meetings this quarter: COVID-19 Public Health Emergency Unwinding; Older Adult Expansion Premium Reduction; Asset Limits Increase; Compact of Free Association (COFA); and Hearing Aid Coverage for Children Program (HACCP). The purpose of the CFSW was to provide stakeholders an opportunity to review and provide feedback on a variety of consumer messaging materials. The forum focused on eligibility and enrollment related activities and strived to offer an open discussion on Medi-Cal policies and functionality. Past meeting materials are available on the DHCS website: CFSW Meeting Archive (ca.gov).

Further, DHCS held a Managed Care Advisory Group (MCAG) meeting on September 8, 2022. DHCS discussed the following topics: Housing and Homelessness Incentive Program; Model Changes and Re-Procurement; Children's Outreach; PATH Updates; and Managed Care updates including ECM and Community Supports. The purpose of the MCAG is to facilitate active communication between the Managed Care program and all interested parties and stakeholders. The MCAG meets quarterly to discuss an array of issues relevant to managed care and is attended by stakeholders and advocates, legislative staff, health plan representatives, medical associations, and providers. Past meeting materials are available on the DHCS website: MCAG archives.

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

PROGRAM UPDATES:

The program updates section describes key activities and data across CalAIM 1115 program initiatives for DY 18-Q3, as required in STC 87c and STC 109 of the CalAIM 1115 demonstration STCs. For each program area, this section describes program highlights, performance metrics, outreach activities, operational updates, consumer issues and interventions, quality control/assurance activity, budget neutrality and financial updates, and progress on evaluation interim findings. Key program areas described in this section include:

- Community Based Adult Services (CBAS)
- Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Global Payment Program (GPP)
- Providing Access and Transforming Health (PATH) Supports
- Community Supports: Recuperative Care and Short-Term Post Hospitalization

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 CalAIM due to the COVID-19 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 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 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 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 with the services they are receiving.

On October 9, 2020, CMS granted approval of DHCS' disaster 1115 amendment, which allows flexibilities pertaining to the delivery of CBAS Temporary Alternative Services (TAS) and permits CBAS TAS to be provided telephonically, via telehealth, via live virtual video conferencing, or in the participant's home (if proper safety precautions are implemented). These flexibilities are described in greater detail below.

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

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

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 residing in a Coordinated Care Initiative (CCI) County and 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 Temporary Alternative Services (TAS). CBAS TAS is a short-term, modified service delivery approach that grants CBAS providers time-limited flexibility to reduce day-center activities and to provide services, as appropriate, via telehealth, live virtual video conferencing, or in the home, if proper safety precautions are taken, and if no other option for providing services is available to meet the participant’s needs. Due to the ongoing COVID-19 PHE, CBAS TAS continues to be provided, 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 California Department of Public Health (CDPH All Facility Letter (AFL) 20-34.7, issued on June 30, 2022, all licensed ADHCs are 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, 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 is not altering or reducing 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 provided confirmation to DHCS that it 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, which had previously allowed TAS and virtual assessment activities through six months after the end of the public health emergency. The authorities that the state requested in the Attachment W are effective from March 13, 2020, through September 30, 2022. These authorities apply in all locations served by the demonstration for anyone impacted by COVID-19 who receives home and community-based services 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. The provision of ERS is to ensure continuity of care and provide immediate assistance to participants experiencing state or local disasters such as wildfires and power outages, or personal emergencies due to 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 ensure 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 Program as a congregate facility-based service while providing the ERS flexibility when specific criteria are met. ERS enables 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 continual 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.

Performance Metrics:

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

Enrollment and Assessment Information:

Per STC 24(a), CBAS enrollment data for both MCP and FFS participants per county is shown in Figure 1 below. The CBAS Center's licensed capacity by county is also incorporated into the same figure.

CBAS enrollment data is self-reported quarterly by the MCPs, which sometimes results in data lags. As such, DHCS will report CBAS MCP data for DY 18-Q3 in the next quarterly report. Some MCPs report enrollment data based on the geographical areas they cover, which may include multiple counties. For example, data for Marin, Napa, and Solano counties are combined, as these are smaller counties, and they share the same population.

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

See next page.

County	DY17 – Q1 July – Sept 2021		DY17– Q2 Oct - Dec 2021		DY18 – Q1 Jan – March		DY18 – Q2 Apr – June 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	454	72%	464	74%	462	74%	479	76%
Butte	28	28%	24	24%	22	22%	24	24%
Contra Costa	140	38%	134	36%	131	35%	142	38%
Fresno	856	45%	867	39%	880	40%	960	44%
Humboldt	84	14%	90	15%	96	16%	85	14%
Imperial	276	46%	270	45%	267	44%	269	45%
Kern	187	18%	171	17%	217	21%	224	22%
Los Angeles	25,029	61%	24,545	59%	25,048	58%	24,391	55%
Merced	125	60%	111	53%	113	54%	112	53%
Monterey	112	60%	100	54%	77	41%	110	59%
Orange	2,545	56%	2,672	61%	2,748	62%	2,796	61%
Riverside	526	33%	523	30%	513	30%	520	30%
Sacramento	498	43%	525	46%	508	44%	504	57%
San Bernardino	663	66%	690	69%	734	73%	789	79%
San Diego	2,006	66%	1,842	57%	1,869	58%	1,731	54%
San Francisco	857	55%	841	54%	854	54%	875	56%
San Joaquin	38	16%	25	11%	36	15%	33	14%
San Mateo	68	67%	68	67%	67	66%	69	68%
Santa Barbara	*	*	*	*	*	*	*	*
Santa Clara	607	46%	585	44%	622	45%	615	44%
Santa Cruz	75	49%	75	49%	98	64%	85	56%
Shasta	*	*	*	*	*	*	*	*
Stanislaus	*	*	*	*	*	*	*	*
Ventura	921	61%	819	55%	809	54%	832	55%
Yolo	241	64%	235	62%	232	61%	227	60%
Marin, Napa, Solano	83	17%	79	16%	82	16%	78	16%
Total	**36,432**	**57%**	**35,766**	**55%**	**36,502**	**54%**	**35,968**	**53%**

***Note: Information is not available for DY 18-Q3 due to a delay in the availability of data and will be presented in the next quarterly report.*

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

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

The data provided in the previous figure demonstrates a slight decrease in enrollment for the previous 12 months, with the exception being DY 17-Q1 having an increase in enrollment. The data reflects ample capacity for participant enrollment into all CBAS Centers.

Monterey, Sacramento, and San Bernardino Counties experienced an increased capacity utilization in DY 18-Q2 of greater than five percent. The increase in percentages of utilization are all within normal fluctuations, except for Sacramento where the use capacity is higher due to a closure of a center.

A majority of counties maintained consistent enrollment and capacity utilization that did not experience fluctuations greater than five percent. Santa Cruz County experienced a greater than five percent decrease due to regular attendance fluctuations, which is not uncommon for counties with a low CBAS population to move more than five percent in either direction.

DHCS will report CBAS Enrollment data for DY 18-Q3 in the next quarterly report.

Assessments for MCPs and FFS Participants

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

Figure 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

CBAS Assessments Data for MCPs and FFS						
Demonstration Year	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
DY17-Q2 (Oct-Dec 2021)	2,779	2,688 (96.7%)	91 (3.3%)	0	0 (0%)	0 (0%)
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	2765 (96.2%)	109 (3.8%)	5	4 (80%)	1 (20%)
DY18-Q3 (Jul – Sept 2022)	*	*	*	0	0 (0%)	0 (0%)
5% Negative change between last Quarter		No	No		No	No

*Note: *MCP assessment information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Requests for CBAS are collected and assessed by the MCPs and DHCS. According to the previous figure, for DY 18-Q2, 2,874 assessments were completed by the MCPs, of which 2,765 were determined to be eligible, and 109 were determined to be ineligible. For DHCS, no assessments were performed for CBAS benefits under FFS. As indicated in the previous figure, the number of CBAS FFS participants is low, given that most participants are in a managed care plan, although there are occasional requests for CBAS FFS. DHCS will report CBAS MCP Assessment Data for DY 18-Q3 in the next quarterly report.

CBAS Provider-Reported Data (STC 24.b)

The opening or closing of a CBAS Center affects the CBAS enrollment and CBAS Center licensed capacity. The closing of a CBAS Center decreases licensed and enrollment capacity while conversely new CBAS Center openings increase licensed and enrollment capacity. 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-Q2. As of DY 18-Q2, the number of counties with CBAS Centers and the ADA of each center are listed below in Figure 3. On average, the ADA at the 277 operating CBAS Centers is approximately 35,137 participants, which corresponds to 87.4 percent of total capacity. Provider-reported data identified in the figure below, reflects data through June 2022.

Figure 3: CDA – CBAS Provider Self-Reported Data

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	28
Total CA Counties	58
Number of CBAS Centers	277
Non-Profit Centers	48
For-Profit Centers	229
ADA @ 276 Centers	35,137
Total Licensed Capacity	40,200
Statewide ADA per Center	87.4%
CDA - MSSR Data 06/2022	

*Note: *CDA CBAS Provider Self-Reported information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Outreach Activities:

CDA provides ongoing outreach and CBAS program updates to CBAS providers, MCPs, CAADS, the Alliance for Education and Leadership (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 triannual meetings with MCPs that contract with CBAS Centers, and CDA triannual meetings with the CBAS Quality Advisory Committee. In addition, CDA responds to ongoing written and telephone inquiries from CBAS providers, MCPs and other interested stakeholders.

The following are CDA's outreach activities during DY 18-Q3: CBAS ACLs (7); CBAS Updates Newsletter (1); CBAS News Alerts (35); CBAS webinars (5); CAADS/ALE Vision Team meetings (11); CDA MCP meetings (1); CAADS/ALE MCP meetings (three); CBAS Quality Advisory Committee Workgroup meeting (1); and Responses to CBAS Mailbox Inquiries (428).

These outreach and educational/training activities focused on the following topics: (1) CBAS program operations and CDPH public health guidance, such as COVID-19 infection prevention and mitigation, state vaccination, testing, and masking requirements; (2) Guidance per CDA ACLs on transitioning from CBAS TAS to in-center congregate services and preparation for ERS implementation; (3) Guidance per CDA ACLs on newly-established ERS policies and procedures; (4) CBAS reporting

requirements, including the newly-established CBAS ERS Initiation Form (CEIF) and the CBAS Incident Report form, which requires reporting of adverse events or unusual occurrences as defined in regulation that occur in the center or in transit to the center (e.g. epidemic outbreaks reportable to local or state public health officials, which could trigger the provision of ERS); (5) Education and training opportunities to promote quality of care and to comply with CBAS program requirements; and (6) Guidance on ordering Personal Protective Equipment (PPE) and COVID-19 testing supplies from the state to support CBAS provider compliance with public health guidance and state testing requirements. CDA (in collaboration with DHCS) will be providing training on EVV once the state has completed establishing the ERS EVV billing codes. In addition, reporting processes and procedures must be established when personal care and home health care services are provided in CBAS participants' homes.

CBAS Webinars

During this quarter, CDA presented five webinars from August 5, 2022 through September 29, 2022 to provide updates on the following: (1) CDPH policy directives in AFL 20-34.7, notifying ADHC licensees of the suspension of specified ADHC regulatory licensing flexibilities (in effect during the COVID-19 pandemic) and requiring all CBAS providers to be staffed and providing basic services in their centers (effective September 30, 2022 when TAS flexibilities end); (2) CDA ACL policy directives and existing flexibilities for remote services as needed by participants through September 30, 2022; (3) Requirement for CBAS providers to identify and report to CDA and CBAS participants' MCPs, the participants who will choose not to return or are unable to return to in-center services by September 30, 2022, due to medical/functional reasons or due to a center's operational constraints, and to assist those participants in collaboration with the participant's managed care plan to identify alternative services to address their needs; and (4) 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. 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 development of ERS policy guidance and the planning of webinars for CBAS providers, MCPs and other interested stakeholders to support the transition of CBAS participants to full in-center services in preparation for when CBAS licensing and TAS flexibilities end on September 30, 2022. These meetings have included opportunities for CBAS providers to describe their efforts, experiences, and challenges in preparing participants and participants' families for the transition to in-center services when TAS ends.

MCP Meetings with CDA

CDA convenes triannual 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 any CBAS provider issues requiring CDA assistance.

During this quarter, CDA convened one meeting on September 1, 2022 to: (1) review the CDPH requirement for CBAS providers to transition their participants to full in-center services in preparation for the end of TAS flexibilities on September 30, 2022; (2) discuss the need for CBAS providers in collaboration with their contracted MCPs to identify participants (i.e. who choose not to return or are unable to return to in-center services), which would require collaboration with the provider, the participant, and the participant's managed care plan to identify alternative services that address their needs; (3) receive feedback from the MCPs on the readiness of their contracted CBAS providers to implement ERS as of October 1, 2022; and (4) facilitate an in-depth discussion of ERS policy drafts and the CEIF to be completed by CBAS providers and submitted to the participant's MCP for review and coordination of care when an emergency occurs. CDA discussed and received feedback from the MCPs on the draft ERS policies and reporting requirements before finalizing ERS policies in collaboration with DHCS. The next meeting with MCPs convened by CDA will be scheduled sometime in early December.

MCP Meetings with CAADS/ALE

CDA participated in three meetings convened by CAADS and ALE with MCPs on July 6, 2022, August 3, 2022, and September 7, 2022, for collaborative discussions about the transitioning of CBAS participants to full in-center services by September 30, 2022, in preparation for when state ADHC licensing flexibilities and TAS flexibilities end, and to provide updates on planning for the implementation of ERS as of October 1, 2022. MCPs are concerned about the potential number of participants who may not be returning to in-center congregate services and the need to find alternative services that may not be available. MCPs and CBAS providers agree for the need to collaborate on discharge planning options with their members and on ERS implementation.

CBAS Quality Strategy Advisory Committee Meetings

CDA convenes triannual meetings with the CBAS Quality Strategy Advisory Committee comprised of CBAS providers, MCPs, DHCS staff, and representatives from CAADS and ALE in order to provide updates and receive guidance on program activities and to accomplish the goals and objectives identified in the CBAS Quality Strategy. During this quarter, CDA convened a workgroup meeting on July 22, 2022, with interested members of the CBAS Quality Advisory Committee to discuss additional data fields to be collected from the CBAS IPC and reported to CDA by CBAS providers when submitting their biannual Participant Characteristics Report (PCR). Additional details about the CBAS Quality and Improvement Strategy and the CBAS Quality Advisory Committee are provided in the "Quality Control/Assurance Activity" section of this report.

CBAS Mailbox Inquiries

During this quarter, CDA responded to 428 CBAS mailbox inquiries, which included questions about: (1) CBAS program operations during the transition from TAS to full in-center congregate services and the implementation of ERS policies as of October 1, 2022; (2) public health guidance that addresses COVID-19 infection risk and mitigation by including testing, vaccinations/boosters, masking, six-foot distancing requirements, and isolation and quarantine requirements in preparation for TAS ending and return to in-center services; (3) provision of CBAS in-center services and staffing requirements; (4) staffing shortages and the challenge of meeting staffing requirements for the provision of in-center services as of October 1, 2022; (5) challenges with the transition to full in-center operations amidst uncertainties of infection risks; (6) participants who are fearful of returning to congregate services due to infection risk, and concerns about the availability of alternative services when CBAS TAS ends; (7) CDA reporting requirements for ERS and submission of the CEIF in the Peach Portal to initiate ERS; (8) steps to take if CBAS participants do not want to return to in-center services as of October 1, 2022, for whatever reason, when TAS is no longer available and if there are no alternative services in the community to meet their needs; and (9) what to do with COVID-19 infection outbreaks resulting in the temporary pausing of in-center services as participants are returning to in-center services after TAS ends on September 30, 2022.

Home and Community-Based (HCB) Settings and Person-Centered Planning Requirement Activities

CDA, in collaboration with DHCS, continues to implement the activities and commitments to CMS for compliance of CBAS Centers with the federal HCB Settings Requirements by March 17, 2023, and thereafter on an ongoing basis. CDA determines CBAS Center compliance with the federal requirements during each center's onsite certification renewal survey process every two years. As background, per CMS' directive in the CBAS Sections of the 1115 waiver, CDA developed the CBAS HCB Settings Transition Plan which is an attachment to California's Statewide Transition Plan (STP*)*. On February 23, 2018, CMS granted initial approval of California's STP and the Draft CBAS Transition Plan based on the state's revised systemic assessment and proposed remediation strategies. CMS is requesting additional revisions of the STP and Draft CBAS Transition Plan before granting final approval.

The state continues to implement the activities and commitments identified in the *Milestones and Timelines* in the STP and Draft CBAS Transition Plan to comply with the federal HCB Settings Requirements. CDA continues to evaluate each CBAS Center for compliance with the federal requirements during each center's certification renewal survey process every two years for compliance with the federal requirements during each center's certification renewal survey process every two years.

Due to the COVID-19 pandemic and implementation of CBAS TAS requirements through September 30, 2022, CDA continued to conduct telephonic 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 are continuing 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.

DHCS submitted the STP and Draft CBAS Transition Plan 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 Draft CBAS Transition Plan to CMS for final approval following the public comment period and incorporation of STP actions taken in response to comments. CDA will address any questions related to the Draft CBAS Transition Plan submitted to DHCS or to CDA during the public comment period.

Operational Updates:

<u>COVID-19 Pandemic and Public Health Emergency</u>
In response to the COVID-19 pandemic and subsequent PHE declaration, DHCS and CDA developed a new CBAS service delivery model, known as TAS, beginning in March 2020. Under this model, CBAS Centers provided limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants. To authorize this CBAS TAS model, DHCS requested flexibility under a Section 1135 waiver on March 19, 2020, and a Section 1115 waiver on April 3, 2020. On October 9, 2020, CMS sent a letter to DHCS approving CBAS program modifications effective from March 13, 2020 through March 12, 2021.On June 9, 2021, CMS approved California's request to extend the duration of the previously approved Emergency Preparedness and Response Attachment K, which is an attachment to California's Section 1115(a) demonstration titled, "Medi-Cal 2020" (Project No. 11-W-00193/9), to respond to the COVID-19 PHE. The Attachment K flexibilities are effective, and available to be applied by the state, from March 13, 2021, through six months after the PHE ends. As stated previously, on September 8, 2022, CMS provided confirmation to DHCS that it approved California's request to revise the end date of CalAIM (project no. 11-W-00193/9) demonstration authorities in the state's Attachment W, which allowed the state to resume normal operations for the CBAS beginning on October 1, 2022.

CDA continued to require CBAS providers to staff their centers with a full CBAS multidisciplinary team, conduct participant evaluations and assessments to determine a participant's willingness and ability to return to in-center congregate services. In addition, CBAS providers were required to develop an IPC every six months (or more frequently if the participant's needs/conditions change) that were person-centered,

address participants' needs via remote and/or in-center services, and support the transition to in-center services based on conditions in their individual communities and their centers while adhering to public health guidance and risk mitigation requirements.

As a result of the fluctuations in COVID-19 infections and hospitalizations in the state, the Governor issued multiple Executive Orders between February 8, 2022, and June 30, 2022, which resulted in the CDPH issuing AFLs extending the temporary waiver of specified regulatory ADHC licensing requirements as follows: (1) AFL 20-34.5 (issued February 8, 2022) extended ADHC licensing flexibilities to March 31, 2022; (2) AFL 20-34.6 (issued March 16, 2022) extended ADHC licensing flexibilities to June 30, 2022; and (3) AFL 20-34.7 (issued June 30, 2022) extended ADHC licensing flexibilities to September 30, 2022, when CBAS TAS ended.

Summary of Challenges and Actions Taken

There have been many challenges and uncertainties during this past quarter that CDA in collaboration with DHCS, CBAS providers, their staff, participants and their families, and MCPs have been navigating while preparing for the end of ADHC licensing flexibilities and the unwinding of CBAS TAS. Examples of these challenges and uncertainties include some participants' fears of COVID-19 infections in a congregate setting, a decline in participant functional abilities during the COVID-19 pandemic despite receiving CBAS TAS, and limited ability of some participants to attend in-center services for a full four-hour day per program requirements and at the frequency authorized by their MCP due to a decline in their functional ability and stamina. Other challenges expressed by CBAS providers include, insufficient community resources to provide alternative services for participants, particularly if remote services similar to CBAS TAS are not available and they do not meet ERS criteria.

To address some of these challenges, MCPs can change the frequency of authorized days of in-center services to meet the needs of their CBAS participants due to their decline in their functional ability and stamina. In addition, MCPs continue to implement ECM and Community Supports to address the needs of some CBAS participants who are unable to return to in-center services, but continue to require community services and supports.

In preparation for the end of TAS, CDA requested that CBAS providers submit a Discharge Projections Report to CDA in July 2022 to begin the process of identifying participants who will not return to in-center services by October 1, 2022. CDA shared the projected discharge information with CBAS participants' MCPs. MCPs informed CDA that they were following up with their members who previously indicated they may not return to their CBAS Center.

The planned ending of ADHC licensing flexibilities on September 30, 2022, required the return of participants to full in-center services by October 1, 2022, which resulted in the

discharge of some participants who were too frail, not ready to return, or did not qualify for ERS. The number of discharges is yet to be determined by CBAS providers and MCPs in collaboration with their participants/members.

Over this past quarter, CDA has issued extensive policy guidance, provided multiple CBAS webinars, and addressed over 400 CBAS mailbox inquiries to assist CBAS providers and MCPs in this process. CDA will determine the impact of the end of CBAS TAS on participant in-center attendance through the submission of required Monthly Statistical Summary Reports (MSSR) and request for CBAS Discharge Summary Reports for all Medi-Cal and Fee-for-Service participants discharged from their centers due to the TAS ending.

CDA in collaboration with DHCS will continue to promote collaboration and coordination between CBAS providers, and their contracted MCPs after October 1, 2022, with the objective of ensuring ERS policies are interpreted and implemented as intended, problems are addressed quickly, and CBAS participants who meet ERS criteria, for a public or personal emergency, receive needed services. After October 1, 2022, CDA will determine how many CBAS participants were assessed by CBAS providers as needing ERS based on the number of CEIFs submitted by CBAS providers into the CDA Peach Portal. CBAS providers are required to submit CEIFs to their participants' MCPs as well. CDA will continue to provide guidance to CBAS providers and MCPs on ERS implementation during ongoing webinars, via responses to CBAS mailbox inquiries, and during the ongoing meetings with CBAS providers and MCPs described in the Outreach Activities section of this report.

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 Partner. See Figures 4 and 5 below for complaint data received by CDA and MCPs from CBAS beneficiaries and providers. DHCS will report CBAS MCP complaint data for DY 18-Q3 in the next quarterly report.

Figure 4: Data on CBAS Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY17-Q1 (Jul - Sep 2021)	0	0	0
DY17-Q2 (Oct – Dec 2021)	0	0	0
DY18-Q1 (Jan – Mar 2022)	0	0	0
DY18-Q2 (Apr – Jun 2022)	0	0	0
CDA Data – Complaints 6/2022			

Note: CDA information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.

For complaints received by MCPs, Figure 5 illustrates there were 7 beneficiary complaints and no provider complaints submitted in DY 18-Q2. DHCS continues to work with health plans to uncover and resolve sources of increased complaints identified within these reports. DHCS will report CBAS MCP data for DY 18-Q3 in the next quarterly report.

Figure 5: Data on CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Beneficiary Complaints	Provider Complaints	Total Complaints
DY17-Q1 (Jul - Sept 2021)	0	0	0
DY17-Q2 (Oct – Dec 2021)	0	0	0
DY18-Q1 (Jan - Mar 2022)	9	0	9
DY18-Q2 (Apr - Jun 2022)	7	0	7
Phone Data – Phone Center Complaints 06/2022			

*Note: *MCP assessment information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.*

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

Grievance and appeals data are provided to DHCS by the MCPs. The data provided in Figure 6 reflects a total of four grievances were filed with MCPs during DY18-Q2. Three of the grievances were solely regarding CBAS providers, and one grievance was designated as "other". Overall, total grievances decreased by six from the prior quarter. DHCS continues to work with health plans to uncover and resolve sources of increased grievances identified within these reports. DHCS will report CBAS MCP grievance data for DY 18-Q3 in the next quarterly report.

Figure 6: Data on CBAS Managed Care Plan Grievances

Demonstration Year and Quarter	Grievances:				
	CBAS Providers	Contractor Assessment or Reassessment	Excessive Travel Times to Access CBAS	Other CBAS Grievances	Total Grievances
DY17-Q1 (Jul - Sept 2021)	6	0	0	4	10
DY17-Q2(Oct – Dec 2021)	6	0	0	5	11
DY18-Q1 (Jan – Mar 2022)	2	1	1	6	10
DY18-Q2 (Apr – Jun 2022)	3	0	0	1	4
MCP Data - Grievances 06/2022					

Note: CDA assessment information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.

Figure 7: Data on CBAS Managed Care Plan Appeals

Demonstration Year and Quarter	Appeals:				
	Denials or Limited Services	Denial to See Requested Provider	Excessive Travel Times to Access CABS	Other CBAS Appeals	Total Appeals
DY17 – Q1 (Jul – Sept 2021)	2	0	0	0	2
DY17 – Q2 (Oct – Dec 2021)	3	0	1	0	4
DY18 – Q1 (Jan – Mar 2022)	1	0	0	0	1
DY18 – Q2 (Apr – Jun 2022)	4	0	0	0	4
		MCP Data - Grievances 06/2022			

Note: MCP appeals information is not available for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.

During DY18-Q2, Figure 7 shows there were four CBAS appeals filed with an MCP. The appeals were related to "denial of services or limited services". DHCS will report CBAS MCP appeals data for DY18-Q3 in the next quarterly report.

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-Q3, there were no requests for hearings related to CBAS which are pending.

Quality Control/Assurance Activity:

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

CDA established the CBAS Quality Advisory Committee, comprised of CBAS providers, 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.

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

During the April 18, 2022 meeting, the CBAS Quality Advisory Committee continued the discussion about the collection of participant characteristic data from the IPC including diagnoses. CDA convened a separate work group on July 22, 2022, with members of the Quality Advisory Committee to discuss what diagnoses should be collected in addition to the ones currently collected that may correlate with a greater risk of hospitalization/adverse events. The CBAS Quality Advisory Committee Work Group decided it wanted to collect all participant diagnoses and risk factor data on a participant's IPC. CDA in collaboration with the CBAS Advisory Committee will determine what information to post on the CDA PCR webpage that might be useful for different audiences and various purposes. The CDA CBAS team will be determining CDA's capacity to collect and store this data as part of the CBAS PCR biannual reporting requirements.

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	CBAS Centers Licensed Capacity					
	DY17-Q1 Jul-Sept 2021	DY17-Q2 Oct-Dec 2021	DY18-Q1 Jan-Mar 2022	DY18-Q2 Apr-Jun 2022	Percent Change Between Last Two Quarters	Capacity Used ***
Alameda	370	370	370	**370**	0.0%	76%
Butte	60	60	60	**60**	0.0%	24%
Contra Costa	220	220	220	**220**	0.0%	38%
Fresno	1,132	1,297	1,297	**1,297**	0.0%	44%
Humboldt	349	349	349	**349**	0.0%	14%
Imperial	355	355	355	**355**	0.0%	45%
Kern	610	610	610	**610**	0.0%	22%
Los Angeles	24,371	24,371	25,531	**25,958**	**+1.6%**	55%
Merced	124	124	124	**124**	0.0%	53%
Monterey	110	110	110	**110**	0.0%	59%
Orange	2,678	2,603	2,603	**2,723**	**+4.6%**	61%
Riverside	935	1,025	1,025	**1,025**	0.0%	30%
Sacramento	680	680	680	**520**	**-23.5%**	57%
San Bernardino	590	590	590	**590**	0.0%	79%
San Diego	1,903	1,903	1,903	**1,903**	0.0%	44%
San Francisco	926	926	926	**926**	0.0%	56%
San Joaquin	140	140	140	**140**	0.0%	14%
San Mateo	60	60	60	**60**	0.0%	68%
Santa Barbara	100	100	100	**100**	0.0%	5%
Santa Clara	780	780	820	**820**	0.0%	44%
Santa Cruz	90	90	90	**90**	0.0%	56%
Shasta	85	85	85	**85**	0.0%	1%
Stanislaus	0	0	360	**360**	0.0%	1%
Ventura	886	886	886	**886**	0.0%	55%
Yolo	224	224	224	**224**	0.0%	60%
Marin, Napa, Solano	295	295	295	**295**	0.0%	16%
SUM	**38,073**	**38,253**	**39,813**	**40,200**	**+0.9%**	53%

***Capacity used information is not available for DY 18-Q3 due to the delay in the availability of the data.*

**** 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 53 percent statewide. Overall, most CBAS Centers have not operated at full or near-to-full capacity except for Alameda and San Bernardino. These counties operated between 76 and 79 percent capacity. Licensing capacity allows the CBAS Centers to enroll more managed care and FFS members should the need arise for these counties. Data for the total sum of license capacity for previous quarters has been updated to reflect current data.

STCs 24(e)(v) requires DHCS to provide probable cause upon a negative five percent change from quarter-to-quarter in CBAS provider licensed capacity per county and an analysis that addresses such variance. During DY 18-Q2, Sacramento County experienced a closure of a CBAS Center, which caused the percentage of licensing capacity to reduce by 23 percent. Los Angeles County experienced two centers opening and one closure. Orange County also opened a new CBAS Center. DHCS will report CBAS licensing capacity data for DY 18-Q3 in the next quarterly report.

Access Monitoring (STC 24.e.)

DHCS and CDA continue to monitor CBAS Center access, average utilization rate, and available capacity. According to Figure 1, CBAS capacity is adequate to serve Medi-Cal members in all counties with CBAS Centers. Data for DY 18-Q3 is not reflected in those figures due to a lack of availability but will be presented in the next quarterly report.

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 are able to choose an alternate CBAS Center within their local area. Six beneficiaries received CBAS unbundled in DY 18-Q2.

CBAS Center Utilization (Newly Opened/Closed Centers)
DHCS and CDA continue to monitor the opening and closing of CBAS Centers since April 2012 when CBAS became operational. For DY 18-Q2, CDA had 277 CBAS Center providers operating in California. According to Figure 9, two CBAS Centers closed and three centers opened in DY 18-Q2. DY 18-Q3 will be presented in the next quarterly report due to a delay in the availability of the data.

Figure 9: CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
June 2022	275	0	2	2	277
May 2022	276	2	1	-1	275
April 2022	276	0	0	0	276
March 2022	274	0	2	2	276
February 2022	272	0	2	2	274
January 2022	270	0	2	2	272
December 2021	270	0	0	0	270
November 2021	270	0	0	0	270
October 2021	270	1	1	0	270
September 2021	270	0	0	0	270
August 2021	270	0	0	0	270
July 2021	269	0	1	1	270

*Note: *CDA assessment information is not reported for DY 18-Q3 due to a delay in the availability of the data and will be presented in the next quarterly report.*

Figure 9 shows there was no negative change of more than five percent in DY 18-Q2, so no analysis is needed to address such variances.

Budget Neutrality and Financial Updates:

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

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

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

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

Originally authorized by the Medi-Cal 2020 demonstration, most of the components of DMCODS 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 (ASAM) Criteria.

Contingency Management Updates:

DHCS' implementation of the CM Pilot 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 a SUD in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilots will allow California to evaluate and assess the effectiveness of a CM benefit before determining whether it should be available statewide. Under the pilot, the CM benefit will be available in participating DMC-ODS counties that opt in, and are approved by DHCS to provide this benefit, to qualified beneficiaries who meet the eligibility requirements, and receive services from a non-residential DMC-ODS provider.

In July, DHCS met regularly with its implementation team and initiated planning in collaboration with the CDPH, to provide training to provider sites to help them comply with the requirements of the Clinical Laboratory Improvement Amendments (CLIA) during program implementation. CLIA trainings were held the second week in October with over 250 registered individuals.

In August, DHCS issued a new procurement for an incentive manager vendor to support the calculation and delivery of incentives to beneficiaries participating in the Recovery Incentives Program. Additionally, throughout August, the team continued to respond to

questions from participating counties and provider sites, supported the development of training materials for counties and providers, and revised program FAQs. The University of California, Los Angeles (UCLA) also conducted a presentation on the CM evaluation design and received feedback from stakeholders at the statewide DHCS SUD Integrated Care Conference on August 24, 2022.

In September, DHCS received proposals for an incentive manager. DHCS also continued to respond to questions from participating counties and provider sites and posted revised program FAQs on the DHCS website. In addition, DHCS released a Behavioral Health Information Notice (BHIN) with Recovery Incentives Program implementation guidance for stakeholder review; stakeholder comments were minor and largely positive. DHCS revised the program's procedures and protocols for accuracy, based on changes the project implementation team determined necessary, and submitted these changes to CMS as draft Attachment V. DHCS received CMS approval for the 1115 protocol in December 2022.

Performance Metrics:

Prior quarters have been updated based on new claims data. For DY 18-Q2 and DY 18Q3, only partial data is available since counties have up to six months to submit claims after the month of service.

Figure 10: Demonstration Quarterly Report Beneficiaries with FFP Funding

Quarter	ACA*	Non-ACA	Total
DY18-Q1	8,448	3,203	11,651
DY18-Q2	8,219	3,084	11,303
DY18-Q3	3,501	1,171	4,672

**Affordable Care Act*

Figure 11: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (to date)
ACA	12,936	13,054	13,159	DY18-Q1	13,622
	12,399	12,469	12,527	DY18-Q2	12,956
	7,848	7,843	7,822	DY18-Q3	8,077
Non-ACA	5,357	5,321	5,255	DY18-Q1	6,029
	4,843	4,817	4,770	DY18-Q2	5,514
	2,875	2,852	2,843	DY18-Q3	3,178

Figure 12: Aggregate Expenditures: ACA and Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount
DY18-Q1					
ACA	372,575	$51,691,852.67	$45,930,384.64	$4,970,286.50	$791,181.53
Non-ACA	130,823	$17,122,190.62	$9,624,987.37	$6,033,891.06	$1,463,312.19
DY18-Q2					
ACA	346,014	$51,993,427.09	$46,105,061.18	$5,100,854.77	$787,511.14
Non-ACA	117,426	$17,367,297.39	$9,769,105.63	$6,102,442.11	$1,495,749.65
DY18-Q3					
ACA	83,510	$15,296,837.36	$13,569,213.71	$1,530,898.70	$196,724.95
Non-ACA	25,757	$4,785,770.37	$2,680,824.61	$1,685,170.13	$419,775.63

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.

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 is 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.

Recent activities including CalAIM demonstration guidance are listed below:

- July 20, 2022 – All County Behavioral Health Meeting

Operational Updates:

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including: 1) updates to the criteria to access SMHS; 2) implementation of standardized statewide screening and

transition tools; 3) behavioral health payment reform; and 4) streamlining and standardizing clinical documentation requirements through documentation reform. DMC-ODS counties are utilizing policy guidance that was released from December 2021 through September 2022 (related to these items) to update and implement policies and procedures.

Behavioral Health Information Notices requiring updates to policies and procedures released in this quarter are listed below:

- **BHIN 22-034** – County Submission Deadlines for CalAIM Behavioral Health Policies and Procedures
- **BHIN 22-043** – Annual County Monitoring Activities (ACMA) for MHPs, DMC-ODS for Fiscal Year (FY) 2022/23
- **BHIN 22-045** – Clarification for MHPs and DMC-ODS counties regarding the imposition of administrative and monetary sanctions and contract terminations
- **BHIN 22-050** – Updated Guidance for CalAIM Behavioral Health Quality Improvement Program
- **BHIN 22-053** – Obligations Related to Indian Health Care Providers in DMC-ODS counties

Consumer Issues and Interventions:

DHCS continues to respond to issues, complaints, or grievances related to DMC-ODS counties delivering DMC-ODS services from beneficiaries. Issues that generate complaints or grievances related to DMC-ODS are minimal. In Q3, we received one (1) incident regarding an issue, complaint, and grievance from a beneficiary. This incident was addressed and resolved. Issues received by DHCS are prioritized to ensure timely response to the beneficiaries.

Quality Control/Assurance Activity:

The Audits and Investigations Division conducts annual monitoring reviews of each county that participates in the provision of DMC-ODS services. The annual monitoring reviews of all counties during the DHCS FY 2021-22 were completed on June 30, 2022, the end of DY 18-Q2.

DHCS FY 2022-23 and DY 18-Q3 monitoring reviews 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. The initial reviews for FY 2022-23 are being scheduled during DY 18-Q4.

Update from Last Quarter:
DHCS continues to provide support to Sacramento County Behavioral Health Services to ensure resolution of the DHCS imposed CAP. The CAP was issued to Sacramento County on June 3, 2022. DHCS continues to hold weekly meetings with Sacramento County to provide oversight and technical assistance to address the progress of the

CAP. In addition, DHCS continues to receive weekly and monthly reports from Sacramento County, which include status updates for each adult beneficiary that are on a waitlist for residential SUD treatment services and residential SUD withdrawal management services. Additionally, DHCS is continuing to monitor the DMC-ODS services they are currently receiving, evidence that they are providing the required Notice of Adverse Benefit Determination (NOABD) to impacted beneficiaries, and the steps the county is taking to eliminate the waitlist and ensure compliance in the future. For this quarter, Sacramento County has met their waitlist reduction target and is on track for resolution of their CAP.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Within this reporting period, UCLA continued activities on the 1115 waiver evaluation as described below:

- UCLA made presentations on recent DMC-ODS health disparity findings for the County Behavioral Health Directors Association (CBHDA) “SAPT+” committee meetings held July 14, 2022, and August 3, 2022, and is in the process of following up on feedback and suggestions received from the administrators. This has led to a continuing conversation, and CBHDA invited UCLA to provide a follow-up presentation on October 27, 2022. Also, as part of a separately funded DHCS Tribal Medication Assisted Treatment (MAT) analytics project, UCLA developed and refined performance projects that will be applicable to measuring DMC-ODS performance in future reports.

- UCLA continued considerations for data collection strategies to address the hypothesis and research questions posed in both the Recovery Incentives Program and DMC-ODS evaluation designs. These include county administrator surveys, provider surveys, as well as provider and consumer interviews. At this time, UCLA is working with DHCS to complete a contract amendment that will guide continued data collection efforts and deliverables. In this next quarter, an online survey for behavioral health/SUD county administrators of waiver counties will be finalized and disseminated in November 2022.

- UCLA is finalizing a recorded webinar to support the implementation of the publicly available ASAM Criteria Assessment Interview Guide. It is intended to be publicly available in October 2022. The evaluation team is coordinating with UCLA’s training department (who is using the Interview Guide as the primary tool in their current ASAM trainings) to incorporate a feedback survey into post-training data collection from training attendees.

- UCLA completed the 2022 Treatment Perception Survey (TPS) data collection

period from October 17-21, 2022. This included preparation of the data collection forms (paper and online), as well as, supportive materials and accurate provider contact information to enhance provider engagement and patient response. UCLA provided training and technical assistance to counties, as needed, and utilizes the TPS website (which is updated frequently) as a hub for all participating counties to access information.

- UCLA continued efforts on activities from the statewide spring 2022 Consumer Perceptions Survey (CPS) which occurred May 16-20, 2022. In this reporting period, all paper surveys were submitted to UCLA, scanned, cleaned, and stored. All submitted online surveys were merged with the paper surveys to prepare a final dataset ready for analysis. At this time, UCLA confirmed that all counties participated in the spring 2022 CPS data collection which provided over 12,000 online surveys and over 39,000 paper surveys. The total number of surveys received in the 2022 data collection period is 39,860, slightly less than 2021. In this next quarter, UCLA plans to further analyze this data with reporting milestones due by November and December 2022.

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 will incorporate services that are otherwise available to the state's Medi-Cal beneficiaries under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. Under the CalAIM waiver, GPP continues the work accomplished under the Medi-Cal 2020 waiver and will add services that aim to address health disparities for the uninsured population, as well as align GPP service offerings with those available to Medicaid beneficiaries.

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

Performance Metrics:

Nothing to report.

Outreach Activities:

Nothing to report.

Operational Updates:

The Families First Coronavirus Response Act (FFCRA) provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA-increased FMAP was effective January 1, 2020 and extends through the last day of the calendar quarter of the PHE. During DY 18-Q3, the Secretary of Health and Human Services extended the COVID-19 PHE, effective July 15, 2022 through October 13, 2022. National public health emergencies are effective for 90 days unless extended or terminated.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

DY 17 final reports for service period January 1, 2021, to December 31, 2021 were due to DHCS from all participating GPP PHCS on September 30, 2022. Those reports were for Program Year (PY) 7 final year-end aggregate and encounter level data reports. DHCS received all reports on time and is conducting a thorough evaluation. DHCS will

complete the final reconciliation and redistribution process and notify PHCS of final reconciliation payment and Intergovernmental Transfer (IGT) amounts.

Figure 14: Budget Neutrality and Financial Updates

Payment	FFP Payment	IGT Payment	Service Period	Total Funds Payment
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
Total	**$350,973,082.56**	**$273,534,181.78**		**$624,507,264.34**

DY 18-Q3 GPP reporting activity includes payments made in July 2022. Payments made in this time period were for PY 8 (formerly 7)-Q2.
In the GPP PY 8 (formerly 7)-Q2, the PHCS received $350,973,082.56 in federal-funded payments and $273,534,181.78 in IGT-funded payments.

Evaluation Activities and Interim Findings:

Nothing to report.

PROVIDING ACCESS AND TRANSFORMING HEALTH (PATH) SUPPORTS

California's Section 1115 waiver renewal includes expenditure authority for the PATH initiative to maintain, build, and scale services, capacity, and infrastructure necessary to ensure successful implementation of the CalAIM initiative. PATH funding aims to support community level service delivery networks by ensuring access to health care services and improving health outcomes, with particular attention to communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors. PATH funding is available for various entities such as providers, counties, cities, local government agencies, former Whole Person Care (WPC) Lead Entities (LEs), community-based organizations (COBs), public hospitals, Medi-Cal Tribal and designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

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

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

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

of ECM and Community Supports capacity and infrastructure. The TPA will administer and facilitate this initiative.

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

- Technical Assistance Marketplace
- Collaborative Planning and Implementation
- CITED
- Justice Involved Initiatives - Planning and Capacity Building

The anticipated 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																				

Performance Metrics:

Enrollment and Utilization data is collected for the WPC Services and Transition to Managed Care Mitigation Initiative, which will be reported in DY 18 – Quarter Four (Q4).

Operational Updates:

During this quarter, approved grantees of the PATH WPC Services and Transition and Mitigation submitted their semi-annual invoices to DHCS for expenditures from January 1, 2022 to June 30, 2022. The first payment for this initiative will be processed by DY 18-Q4. TA Marketplace released the facilitator application on the PATH website on October 4, 2022. During this quarter, DHCS and PCG had weekly development meetings to develop seven technical assistant 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.
The Collaborative Planning and Implementation facilitator selection process has been completed, and the participant registration form was released on August 22, 2022. Collaborative groups have been developed based on regional location, size, and preserving existing collaboratives already commencing. Participants whose registration submissions were received by September 30, 2022, were in turn invited to participate in the initial kickoff. Following the initial kickoff, participant registrations are accepted on a continual basis and participants are connected with selected facilitators.

CITED applications will be released in multiple rounds, until the end of the PATH Initiative. Round one of the applications launched August 1, 2022, and closed on September 30, 2022. DHCS is in the process of reviewing applications and will report awarded details by DY 18-Q4.

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 applications received and reviewed was 42. The total round one awarded totals were $4,476,053. The PATH JI Capacity Building Guidance round two application were released August 9, 2022 and the application period closes on December 31, 2022.

TPA Procurement Activity:

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

- Technical Assistance Marketplace
- Collaborative Planning and Implementation Program
- CITED
- Justice Involved Initiatives - Planning and Capacity Building Round 2

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

During this quarter, DHCS completed the TPA onboarding process with PCG. PCG has been actively working with DHCS as the TPA to ensure the various PATH initiatives are implemented in a timely manner.

Stakeholder Engagement:

DHCS hosted monthly JI Advisory Group meetings to solicit stakeholder input on policy and implementation. Advisory Group leaders and representatives are diverse, and include counties, prisons, jails, providers, consumers, health plans, and policy organizers. Slides from past meetings are posted on the CalAIM JI Initiative webpage. DHCS has created several workgroups to discuss concerns, issues, and barriers facing the correctional facilities, county Social Services Department (SSD) and other stakeholders, advocates and system representatives.

- DHCS and the California Department of Corrections and Rehabilitation (CDCR) meet on a weekly basis to discuss the pre-release application process, policy and technical issues, concerns, and barriers to the implementation of mandatory pre-release processes that will be effective on January 1, 2023.
- The JI Pre-Release Application Sub-Workgroup meets monthly as of September 2022. The workgroup participants include county agencies, advocates, and stakeholders. Topics discussed in these meetings range from suspension processes and funding guidance, to pre-release processes and data-sharing guidance.
- The Inmate Workgroup consists of county sheriffs from all 58 counties, representatives from the California Statewide Automated Welfare System, California Work Opportunity and Responsibility to Kids Information Network (CalWIN[2]), and the Chief Probation Officers of California.
- The Data Sharing Workgroup meets with county SSDs throughout the state and all Medi-Cal providers in an effort to gain knowledge on issues relating to data sharing among agencies. The feedback from these agencies is assisting in the drafting of a new data-sharing agreement in compliance and alignment with the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

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

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[2] CalWIN is an online system that administers public assistance programs which include but are not limited to Medi-Cal, employment services, childcare, in-home support services, general assistance, foster care, and food stamps.

Entities interested in participating in the TA Marketplace, as a TA vendor or a potential recipient of TA (i.e., CBOs), have contacted DHCS to participate in PATH initiatives and have been shared with the TPA. The TPA has developed a PATH website that provides program information, applications for each PATH initiative, and specific contact information for those seeking assistance. The TPA has conducted outreach to potential participants and vendors for the TA Marketplace, CITED, and Collaborative Planning and Implementation initiatives that have launched.

DHCS continued development of PATH initiative work plans and design elements of each PATH initiative and drafted responses to questions from various stakeholders. DHCS incorporates feedback from stakeholders and provides guidance on the different methods to apply the PATH initiative across each initiative. A few of the webinars and meetings hosted by DHCS for this quarter included the following:

- On May 26, 2022, DHCS hosted a CalAIM JI Advisory Group meeting to discuss ECM, auto-assignment into MCPs, and the proposed pre-release and post-release JI care management models.
- On August 23, 2022, DHCS hosted a public informational session to provide an overview of the CITED funding, application, and to address frequently asked questions with over 200 attendees. The majority 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.
- On September 8, 2022, DHCS hosted a second public information session to provide the same CITED funding and application information presented in August 2022. There were over 550 attendees for the second session.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

DHCS released round one of the JI Planning and Capacity Building application in June 2022 and closed the application window on July 31, 2022. The round one total applications received and reviewed were 42. The round one award totals to $4,476,053; of this amount, $3,939,000 was paid this quarter, and the remaining funds are in process to be paid by DY 18-Q4.

Figure 15: JI Planning and Capacity Building Application Amounts

PATH Initiative	Approved Amount	Federal Financial Participation	State	Intergovernmental Transfer
DY 18 - Q1				
n/a	$0	$0	$0	$0
DY 18 - Q2				
n/a	$0	$0	$0	$0
DY 18 - Q3				
JI Capacity Building (Round 1)	$3,939,000	$1,969,500	$1,969,500	

Figure 16: Total Approved Amounts by PATH Initiative

PATH Initiative	Total Payment
JI Capacity Building	$3,939,000.00
WPC Mitigation Initiative	$0
TA Marketplace	$0
Collaborative Planning and Implementation	$0
CITED	$0
TPA	$0
TOTAL	$3,939,000.00

Evaluation Activities and Interim Findings:

During this quarter, DHCS submitted an evaluation design for the CalAIM 1115 waiver demonstration to CMS, which includes the design for the PATH program. DHCS will address any comments and edits once received from CMS.

COMMUNITY SUPPORTS: RECUPERATIVE CARE AND SHORT-TERM POST HOSPITALIZATION

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

Community Supports are optional for MCPs to offer and for members to utilize. MCPs cannot require members to use Community Supports instead of a service or setting listed in the Medicaid State Plan.

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

Community Supports include, but are not limited to, providing nutritional assistance with medically tailored meals, personal care and homemaker services in the home, and transitioning from nursing home care to the community to improve health and lower health care costs. These services benefit Medi-Cal enrollees with complex health needs and unmet social needs who are at high risk of hospitalization, institutionalization, and other higher cost services. Several Community Supports, such as Short-Term Post-Hospitalization Housing, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services have a built-in Housing First approach, recognizing that people experiencing homelessness have higher rates of diabetes, hypertension, human immunodeficiency virus, and mortality resulting in longer hospital stays and higher readmission rates than the general public. Community Supports are authorized through the CalAIM demonstration in a manner that assures consistent implementation.

Community Supports are a significant change and a high priority for DHCS. DHCS recognizes the work California MCPs and communities are undertaking to operationalize these new initiatives and to smoothly transition services provided under the WPC Pilots and the Health Homes Program.

In conjunction with the authority to provide the state-approved Community Supports

under 42 CFR 438.3(e)(2), the demonstration provides separate authority for Short-Term Post-Hospitalization Housing and Recuperative Care services delivered by MCPs consistent with the other Community Supports. These two services both play an important role in California's care continuum to provide cost-effective and medically appropriate alternatives to hospitalization or institutionalization for individuals who otherwise would not have a safe or stable place to receive treatment. These alternative settings can provide appropriate medical and behavioral health supports following an inpatient or institutional stay for electing individuals, who are homeless or at risk of homelessness and who may otherwise require additional inpatient care in the absence of recuperative care.

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

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

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

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

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

DHCS is working with MCPs to better understand the initial data submission and is targeting to make the Q1-2022 and Q2-2022 data publicly available in Q4-2022 (by December 2022). Dashboards in Microsoft Power Business Intelligence (BI) are in final development, which will help accurately visualize data for the program.

Outreach Activities:

During this reporting period, DHCS held 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.

As part of the Quarterly Implementation Monitoring Report, DHCS requires MCPs to report on identifying eligible members and outreach attempts. DHCS will make Q1-2022 and Q2-2022 data publicly available in Q4-2022 (by December 2022). Q32022 data will be submitted by plans in mid-November and will become available in Q1-2023. During this reporting period, DHCS hosted monthly TA and guidance webinars geared towards health plan executives and personnel, who have a significant role in the implementation of ECM and Community Supports. Details on the content of these meetings are included in the section below.

Operational Updates:

During this reporting period, DHCS continued to strategize with leadership to discuss the implementation of Community Supports and drafted responses to questions pertaining to the suite of benefits, which were submitted by various stakeholders. DHCS continues to accept stakeholder feedback and intends on continuing to refine guidance on this unique set of services. A few of the webinars and meetings hosted by DHCS for this quarter included:

- Bi-weekly CalAIM Implementation Advisory Group – This group, composed of a select group of MCPs and counties participating in ECM and Community Supports, plays a critical role in ensuring that DHCS maintains visibility into the rollout of newly launched benefits. In addition, this group helps DHCS identify and work through transition challenges, provides critical review of decisions and documents before 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
- On July 20, 2022, DHCS virtually hosted the first public webinar of the quarter and the third webinar overall for the “CalAIM Community Supports Spotlight” series. The goal of the series is to review and reinforce policy guidance on individual Community Supports, identify and amplify best practices and lessons learned from community providers, WPC pilots, and MCPs, and to answer emerging questions from the field. Agenda items included background on CalAIM

Community Supports and information about Asthma Remediation and Environmentally Accessibility Adaptations (Home Modifications), including eligibility requirements, program impact, and pathways to provider enrollment as well as best practices from the field.

- On July 21, 2022, DHCS hosted an "Office Hours" discussion of CalAIM ECM and Community Supports implementation in rural counties. This event was the first in a new "Office Hours" series focused on answering implementation questions from the field. Throughout the series, DHCS leaders are joined by panelists from MCPs, provider groups, and community organizations implementing CalAIM, who help answer questions posed by participants during the "Office Hours" session, received in previous webinars, and submitted via email prior to the meeting.
- On July 26, 2022, DHCS hosted its first Monthly CalAIM: ECM & Community Support MCP Technical Assistance meeting of the quarter. Part of this meeting served as "Office Hours" for the CalAIM Incentive Payment Program, Payment 2 materials and submission process. During this meeting, DHCS communicated its new requirements for expedited authorizations for time-sensitive Community Supports, along with its expectations regarding prime and subcontractor authorization alignment.
- On August 4, 2022, DHCS hosted a webinar on the data exchange necessary for ECM and Community Supports, intended especially for plans and providers in counties where ECM launched in July 2022, but open to all as a refresher. DHCS provided an overview of the guidance documents that were released last year and corresponding data flows, with a focus on the exchange of information that occurs between MCPs and ECM and Community Supports providers. The webinar was targeted towards ECM and Community Supports providers, MCPs, and others engaged in the implementation of ECM and Community Supports.
- On August 11, 2022, DHCS hosted its second "Office Hours" discussion of CalAIM ECM and Community Supports implementation focused on Data Exchange. Topics included data flows between MCPs and ECM and Community Supports providers, MCP reporting requirements to DHCS, and DHCS' expectations and supports for implementing data and reporting requirements.
- On August 18, 2022, DHCS hosted the fourth webinar in the "CalAIM Community Supports Spotlight" series, focusing on Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing. Agenda items included background on CalAIM Community Supports and information about Short-Term Post-Hospitalization Housing and Recuperative Care (Medical Respite), including service definitions, eligibility requirements, and program impact, as well as best practices from the field. Speakers included presenters from WellSpace Health, PATH (San Diego), and the National Health Care for the Homeless Council.
- On August 25, 2022, DHCS hosted an all-comers webinar on CalAIM ECM and Community Supports Member Engagement. Topics for this session included provider and member communications, referrals, outreach, and enrollment. This event is part of a series of technical assistance and informational sessions focused on supporting implementation of ECM and Community Supports.

Throughout the series, DHCS leaders are joined by presenters from MCPs, providers, and CBOs implementing CalAIM.

- On September 1, 2022, DHCS hosted an "Office Hours" discussion on CalAIM ECM and Community Supports Member Engagement. A follow-up to the August 25th webinar on this topic, this Q&A session covered provider and member communications, referrals, outreach, and enrollment.
- On September 15, 2022, DHCS hosted the fifth webinar in the "CalAIM Community Supports Spotlight" series, focusing on 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.
- On September 28, 2022, DHCS hosted a CalAIM: Monthly MCP TA meeting. This forum is intended for health plan executives and personnel who have a significant role in the implementation of CalAIM Population Health Management initiatives.
  On September 29, 2022**,** DHCS hosted an "Office Hours" discussion on CalAIM ECM and Community Supports implementation in rural counties**.** This event is part of a series of "Office Hours" events focused on answering implementation questions from the field.

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

In August 2022, DHCS updated its Community Supports Policy Guide and All Plan Letter language to accommodate minor adjustments necessary to highlight the following: 1) a new requirement for prime and subcontractor authorization policy alignment; 2) a new requirement for expedited authorization timeframes for certain Community Supports for urgent needs, as appropriate, which includes the Short-Term Post-Hospitalization Housing and Recuperative Care Community Supports.

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

On September 1, 2022, DHCS received final updated Models of Care (MOCs) from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services. Revised Community Supports elections are planned to be posted on the DHCS website in mid-December, once DHCS issues its final approval for all outstanding MCP MOCs. DHCS will continue to update Community Supports elections semi-annually.

Technical assistance and guidance webinars are recorded and hosted on the DHCS website and are updated regularly. DHCS also maintains a regularly updated "frequently asked questions" (FAQ) document on its ECM and Community Supports

webpage. The document highlights several FAQs from MCPs, providers, and stakeholders and include answers provided by DHCS.

Consumer Issues and Interventions:

Nothing to report.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

Nothing to report.

Enclosures/Attachments:

Community Supports Elections (by MCP and County) – PDF Chart showing the Community Support Elections MCPs have elected to offer, current as of July 2022.

Community Supports Policy Guide – The operational document for CalAIM's Community Supports, which builds on the contractual requirements for Community Supports, and outlines Community Supports policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines. DHCS updates the Community Supports Policy Guide to reflect the latest requirements and guidelines.

DUALLY-ELIGIBLE ENROLLEES IN MEDI-CAL MANAGED CARE

California's Section 1115 waiver includes flexibilities to support the state's effort to integrate dually eligible populations statewide into Medi-Cal managed care through the 1915(b) waiver prospectively as well as support integrated care by allowing the state, in specific counties with multiple Medicaid plans, to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage (MA) plan. Beneficiaries impacted by this expenditure authority will be able to change Medicaid plans by picking a new MA plan or original Medicare once a quarter. A dually eligible beneficiary's Medicaid plan will be aligned with their MA plan choice, to the extent the MA plan has an affiliated Medicaid plan. In the counties where the state is authorizing the exclusively aligned enrollment (EAE) Dual-Eligible Special Needs Plan (D-SNP) model, 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, available 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) will transition 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 will be mandatorily enrolled in Medi-Cal managed care, with the exception of those with a SOC who are not in a LTC facility. All dually eligible beneficiaries residing in LTC facilities will be mandatorily enrolled in Medi-Cal managed care. As of 2022, most dually eligible beneficiaries in COHS 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 help meet the statewide goals of improving care integration and person-centered care for dually eligible beneficiaries, under both CalAIM and the California Master Plan for Aging.

DHCS developed a webpage to provide stakeholders with more detailed information about the Medi-Cal matching plan policy. In addition, DHCS is updating the beneficiary notice regarding this policy, to take effect January 1, 2023. In some of the counties with the Medi-Cal matching plan policy, Medi-Cal managed care enrollment for dual eligible

beneficiaries has been optional. However, starting January 2023, all dual eligible beneficiaries, except those with a SOC and not in a LTC facility, will enroll in a Medi-Cal plan. 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.

DHCS developed beneficiary notices for these transitions, in coordination with CMS and stakeholders.

For example, for the CMC to EAE D-SNP transition, members began receiving notices and outbound calls from their CMC plan about the transition in fall 2022:

- September 2022: CMC members received an Annual Notice of Change (ANOC).
- October 2022: Noticing aligned with Medicare Annual Enrollment Period:
    - CMC Transition to Medicare-Medicaid Plan (MMP) 90-Day Notice and Notice of Additional Information (NOAI)
    - Outbound calls to CMC members by CMC plans
- November 2022: Noticing aligned with Medicare Annual Enrollment Period:
    - CMC Transition to MMP 45-Day Notice and NOAI

For the transition from Medi-Cal FFS to Medi-Cal managed care, and LTC carve-in, DHCS developed 60- and 30-day beneficiary notices in coordination with stakeholders. These notices also reference the Medi-Cal matching plan policy, for beneficiaries in the 12 Medi-Cal matching plan counties listed above.

Additionally, DHCS continues to conduct various stakeholder meetings to discuss all aspects of these transitions related to beneficiary communication, TA impacts on any system changes, continuity of care, and provider network adequacy and reporting requirements.

Performance Metrics:

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

Outreach Activities:

There are a variety of stakeholder and workgroup meetings that are occurring to engage with stakeholders about the current matching plan policy ahead of the 2023 transitions. Examples of these stakeholder meetings include but are not limited to the following: EAE CMC Transition and EAE Technical Call Meetings and MLTSS & Duals Stakeholder Workgroup. DHCS also meets with California's State Health Insurance

Assistance programs, known as Health Insurance Counseling and Advocacy Program (HICAP) in California, as well as Medicare agents and brokers, to provide information about the Medi-Cal matching plan policy. There are a variety of workgroup meetings that are formed as needs arise to discuss various D-SNP transition policy decisions needing to be made.

Operational Updates:

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

Consumer Issues and Interventions:

There are no reported consumer issues at this time. Following the beneficiary testing of the D-SNP transition, notices were finalized and mailings began around September 30, 2022. Other notices for the Medi-Cal managed care enrollment have been sent to impacted members. DHCS is also providing information to consumers and stakeholders on balance billing.

Quality Control/Assurance Activity:

Nothing to report.

Budget Neutrality and Financial Updates:

Nothing to report.

Evaluation Activities and Interim Findings:

DHCS is currently developing the Request for Information to hire a contractor for the evaluation of this component of the waiver.

Enclosures/Attachments:

Nothing to report.