CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM) DEMONSTRATION

(PROJECT NUMBERS 11-W-00193/9 AND 21-W-00077/0)

SECTION 1115(A) WAIVER

DEMONSTRATION YEAR (DY) 20

FINAL REPORT

DEMONSTRATION YEAR: TWENTY (JANUARY 1, 2024 - DECEMBER 31, 2024)

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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EXECUTIVE SUMMARY

On December 29, 2021, CMS approved the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration, effective through December 31, 2026. The demonstration aims to assist the state in improving health outcomes for Medi-Cal members across the state.

This Annual Monitoring Report for Demonstration Year 20 includes operational updates, performance metrics, budget neutrality and financial reporting, and evaluation activities and interim findings for the period from January 1, 2024, through December 31, 2024, in compliance with CalAIM STC 16.5.

Key Demonstration Year (DY) 20 Accomplishments:

Key CalAIM demonstration accomplishments for the period from January 1, 2024, through December 31, 2024 include the following:

- **Pre-Release Services.** California has authority to partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility. In 2024, California became the first state in the nation to implement its Section 1115 authority to cover Medicaid services in correctional settings. As of October 1, 2024, three California counties—Inyo, Santa Clara, and Yuba—began delivering a targeted set of Medi-Cal services to people returning to communities after incarceration. The California Department of Corrections and Rehabilitation (CDCR) and one additional county, San Joaquin, intensively (and successfully) prepared to go live on February 1, 2025. All California counties are required to implement this initiative before October 1, 2026.
- **Community Supports.** Through the CalAIM demonstration, California has authority to implement Short-Term Recuperative Care and Short-Term Post-Transition Housing services. (Twelve other Community Supports were authorized via managed care in-lieu-of services authority and outlined in the CalAIM Section 1915(b) waiver.) Recuperative Care and Short-Term Post-Transition Housing services provide medically appropriate and cost-effective alternatives to hospitalization or institutionalization for individuals without stable housing. Both provide a setting for safe recovery and continuity of care for individuals experiencing homelessness or at risk of homelessness, including essential medical and behavioral health support post-hospitalization. In DY 20, Medi-Cal managed care plans (MCPs) in 55 out of 58

counties offered Short-Term Post-Transition Housing, and MCPs in 57 counties offered Recuperative Care. The provider networks for both Short-Term Post-Transition Housing and Recuperative Care have also expanded significantly. The Short-Term Post-Transition Housing provider network grew from 34 providers in Q1 2022 to 235 in Q2 2024, reflecting steady quarterly increases. The Recuperative Care provider network also saw notable growth, increasing from 97 providers in Q1 2022 to 224 in Q2 2024.

- **Providing Access and Transforming Health (PATH) Supports.** California has expenditure authority for critical transition and capacity-building activities. In 2024, the PATH initiative continued to play a transformative role in improving the lives of vulnerable populations by enabling organizations to implement and scale essential ECM and Community Supports, particularly Short-Term-Post-Hospitalization and Recuperative Care. In rural areas, PATH funding has been instrumental in expanding service capacity, providing case management for the unhoused, and establishing vital recuperative care programs that allow people to recover in stable housing, instead of returning to emergency rooms. PATH's investment in technology and staff has facilitated the growth of ECM and Community Supports programs. These services have been critical in reaching individuals who otherwise would have faced barriers due to their geographic, social, or health-related challenges. PATH also successfully supported planning for and implementation of pre-release Medi-Cal applications for the Reentry Initiative through grant awards to the California Department of Corrections and Rehabilitation, county probation agencies, county sheriff offices, county behavioral health agencies, and other implementation partners. These grants supported capacity development, one-time infrastructure and IT investments, collaborative planning, and technical assistance to support implementation of pre-releases services.
- **Contingency Management**. Through the CalAIM Section 1115 demonstration, California has authority to offer Medi-Cal members, as a Drug Medi-Cal Organized Delivery System (DMC-ODS) benefit, this evidence-based, cost-effective treatment for individuals with a substance use disorder (SUD) that combines motivational incentives with behavioral health treatments. As of December 31, 2024, 20 counties are actively providing the CM service across 105 provider sites, three counties are in the readiness process to launch. Collectively, these counties serve 80 percent of the Medi-Cal population.
- In 2024, DHCS issued updated policy guidance for the Recovery Incentives Program. The revised guidance allows the 16 remaining DMC-ODS counties to opt-in to the program by submitting a streamlined Implementation Plan and receiving DHCS

approval. The expansion will result in the benefit being available to 97 percent of the State's Medi-Cal members.

- **SUD Institutions for Mental Disease (IMD) Authority**. This CalAIM demonstration continues to provide the state with the ability to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS members 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, placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria, evidence-based practices in SUD treatment, and increased coordination with other systems of care.
- **Traditional Health Care Practices.** On October 16, 2024, CMS approved DHCS' Traditional Health Care Practices demonstration amendment, marking the culmination of nearly a decade of collaboration between DHCS, Tribes, and Tribal partners. This approval marks the first time Medi-Cal will cover traditional health care practices that are deeply rooted in cultural practices and have been shown to improve health outcomes, particularly for individuals with SUDs. DHCS, in consultation with Tribes and Tribal partners, issued policy guidance that includes practitioner descriptions, member eligibility, participation requirements, practitioner qualifications, service documentation requirements, and claiming and payment requirements. The BHIN (25-007) was published on March 21, 2025 and Traditional Health Care Practices can be provided and covered following publication of final guidance. In addition, DHCS is making system updates to enable claiming and published DMC-ODS plan rates with public notice. Technical assistance will also be available to Tribes and Tribal partners throughout the demonstration period.
- **Dually Eligible Enrollees in Medi-Cal Managed Care.** The CalAIM demonstration authorizes expenditure authority to allow the state to keep a member in an affiliated Medicaid plan once the member has selected a Medicare Advantage (MA) plan unless and until the member changes MA plans or selects Original Medicare. As part of CalAIM, DHCS has implemented policies to promote integrated care for members dually eligible for Medicare and Medi-Cal. California has implemented this "Medi-Cal matching plan policy" in 17 counties, effective January 1, 2024. On January 1, 2023, members of the federal financial alignment initiative known as Cal MediConnect (CMC) transitioned into Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) and matching Medi-Cal Managed Care Plans (MCPs), in the seven Coordinated Care Initiative (CCI) counties. Under EAE D-SNPs, members 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 members

statewide that were not already enrolled in Medi-Cal managed care were mandatorily enrolled in Medi-Cal managed care, except for those with a Share of Cost who are not in a Long-Term Care (LTC) facility.

- **Global Payment Program (GPP).** Under the CalAIM demonstration, GPP continues the work accomplished under the Medi-Cal 2020 waiver and has added services that aim to improve health outcomes for the uninsured population, as well as to align GPP service offerings with those available to Medicaid members. Throughout DY 20, DHCS worked collaboratively with the California Association of Public Hospitals (CAPH), public health care systems, and CMS. DHCS continues to conduct bi-weekly conference calls with CAPH to discuss programmatic activities, budgets, and trends in reported data.
- **Community Based Adult Services (CBAS).** Under the CalAIM demonstration, California continues 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. In DY 20, the number of CBAS centers increased from 293 to 302 (a three percent increase from DY 19).
- **Other Policies.** DHCS also continued several longstanding policies under the CalAIM demonstration, including continue authority to pay Tribal providers for chiropractic services and continuing coverage for out-of-state former foster youth up to age 26. DHCS also implemented its authority to no longer apply the asset limits for individuals in Deemed Supplemental Security Income (SSI) populations beginning January 1, 2024.

INTRODUCTION

On June 30, 2021, California submitted a renewal request for the CalAIM Section 1115 demonstration to the Centers for Medicare & Medicaid Services (CMS). This Section 1115 demonstration requested a five-year renewal of components of the Medi-Cal 2020 Section 1115 demonstration to continue improving health outcomes and reducing health disparities for individuals enrolled in Medi-Cal and other low-income populations in the state. In tandem, the Department of Health Care Services (DHCS or the Department) requested authority through a renewal of the state's longstanding Specialty Mental Health Services (SMHS) Section 1915(b) waiver. This request would transition nearly all Medi-Cal managed care delivery systems to a single authority, streamlining California's managed care programs and applying statewide lessons learned from previous Section 1115 demonstrations, as described below.

On December 29, 2021, CMS approved California's 1115(a) "CalAIM" demonstration, effective through December 31, 2026. The approval is part of the state's larger CalAIM initiative, which includes transitioning 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 members and other low-income people in the state.

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

The overview below outlines: (1) Medi-Cal 2020 Section 1115 demonstration initiatives continued via the Medi-Cal State Plan or CalAIM Section 1915(b) waiver, (2) Medi-Cal 2020 Section 1115 demonstration initiatives renewed in the CalAIM Section 1115 demonstration; (3) current CalAIM Section 1115 demonstration initiatives.

- **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 percent to 138 percent of the federal poverty level (FPL) transitioned from Section 1115 authority to the Medi-Cal State Plan. The sunset date for this authority was on December 31, 2021.
- **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.

» **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.
- **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 DMC-ODS.
- **Coverage for Out-Of-State Former Foster Youth** to continue Medi-Cal coverage for this population during the renewal period, up to age 26.
- **Community Based Adult Services (CBAS)** to continue to authorize CBAS for eligible adults receiving outpatient skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation, with modest changes to allow flexibility for the provision and reimbursement of remote services under specified emergency situations.
- **Tribal Uncompensated Care (UCC) for Chiropractic Services** to continue authority to pay Tribal providers for these services, which were eliminated as a Medi-Cal covered benefit in 2009.
- **Designated State Health Programs (DSHP)** Expenditures for DSHPs, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in the CalAIM Standard Terms and Conditions (STCs).

» **CalAIM Initiatives Currently Authorized in the CalAIM Section 1115 Demonstration:**

- **Deemed SSI** expenditure authority to extend eligibility for individuals in Deemed SSI populations (the Pickle Group, Disabled Adult Child group, and Disabled Widow/Widower group) who are eligible based on (1) applying a targeted asset disregard of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of ten household members as of July 1, 2022, and (2) no longer applying the asset test as of January 1, 2024.
- **Community Supports** to authorize Short-Term Recuperative Care and Short-Term Post-Transition Housing services via the CalAIM Section 1115 demonstration. Twelve other Community Supports were authorized via managed care in-lieu-of services authority and outlined in the CalAIM Section 1915(b) waiver.
- **Dually Eligible Enrollees in Medi-Cal Managed Care** expenditure authority allows the state to keep a member in an affiliated Medicaid plan once the member has selected a Medicare Advantage plan unless and until the member changes Medicare Advantage plans or selects Original Medicare. As part of CalAIM, DHCS is implementing policies to promote integrated care for members dually eligible for Medicare and Medi-Cal.
- **Providing Access and Transforming Health (PATH) Supports** expenditure authority to: (1) sustain, transition, and expand the successful Whole Person Care (WPC) pilots and Health Homes Program (HHP) services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports; and, mostly recently approved in January 26, 2023, (2) support justice-involved pre-release and post-release services and support Medi-Cal pre-release application planning and Information Technology (IT) investments.
- **Contingency Management (CM)** to offer Medi-Cal members, 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, to provide this service in DMC-ODS and Drug Medi- Cal (DMC) counties and county mental health plans (MHPs).
- **Pre-Release Services** authority via the CalAIM Section 1115 demonstration waiver for DHCS to partner with state agencies, counties, and community-based

organizations to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

- **Traditional Health Care Practices** expenditure authority to provide coverage for traditional health care practices, granting eligible Medi-Cal and CHIP members access to culturally based care provided by Indian Health Service (IHS) facilities, Tribal health clinics, and Urban Indian organization facilities through the Drug Medi-Cal Organized Delivery System (DMC-ODS).

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.

Since the initial approval of the CalAIM Section 1115 demonstration, CMS has approved several amendments which can be viewed on DHCS' website. On October 16, 2024, CMS approved an amendment to the CalAIM Demonstration to permit the state to cover culturally centered substance use disorder (SUD) treatment services provided by traditional healers and natural helpers. This approval grants eligible Medi-Cal members access to culturally based care provided by Indian Health Services Facilities, Tribal Health Clinics, and Urban Indian Organizations through the DMC-ODS.

On December 16, 2024, CMS approved another amendment to the CalAIM Demonstration. The amendment provides waiver authority related to the approved reentry demonstration initiative for a limited purpose, adds Title XXI expenditure authority for health-related social needs (HRSN) services, includes updates to the special terms and conditions (STCs) for already approved HRSN services in alignment with CMS's housing duration and frequency policy, and makes other technical changes.

Further, DHCS continued to finalize on protocols and attachments with CMS related to CalAIM Section 1115 demonstration initiatives. On March 6, 2024, CMS issued approvals for the Reentry Demonstration Initiative Implementation Plan (IP) and for the DSHP Related Provider Payment Increase Assessment Attestation Table, which were incorporated in the STCs as Attachment CC and Attachment BB respectively. On October 2, 2024, CMS approved new updates to the Reentry Demonstration Initiative

Implementation Plan (IP), which was incorporated into the STCs as an updated version of Attachment CC. Additionally, CMS approved the CalAIM DSHP List, Attachment Y, and the DSHP Claiming Protocol, Attachment Z on December 12, 2024.

GENERAL REPORTING REQUIREMENTS

Amendment Process (STCs 3.8 and 3.13)[1]

During the reporting period of January 1, 2024, through December 31, 2024, DHCS received approval for two CalAIM 1115 waiver amendments, which are detailed below:

Traditional Health Care Practices Amendment

On June 30, 2021, DHCS submitted a request to CMS as part of the CalAIM 1115 renewal application, requesting coverage of Traditional Healer and Natural Helper Services under the DMC-ODS. On October 16, 2024, CMS approved DHCS's Traditional Health Care Practices demonstration amendment, marking the culmination of nearly a decade of collaboration between DHCS, Tribes, and Tribal partners. This approval marks the first time Medi-Cal will cover traditional health care practices that are deeply rooted in cultural practices and have been shown to improve health outcomes, particularly for individuals with substance use disorders (SUDs).

CalAIM Reentry and HRSN Amendment

On December 16, 2024, CMS approved a CalAIM Section 1115 Demonstration amendment related to the Reentry Demonstration Initiative and HRSN. Specifically, CMS provided authority for the state to extend pre-release services to all individuals in an adult facility who are under the age of 21 or a former foster care youth, without meeting any health-related criteria. CMS also updated the housing duration limits for two currently approved HRSN housing services, now referred to as short-term recuperative care and short-term post-transition housing, along with other technical changes.

Out-of-State Former Foster Youth (STC 4.1a)

On August 29, 2024, DHCS submitted to CMS the CalAIM - Out of State Former Foster Youth (OOS FFY) 2021 Extension Period Report, which is currently under CMS review.

Supplemental Payments for Chiropractic Services (STCs 3.15 and 18.12)

Supplemental payments are Certified Public Expenditure (CPE)-based payments for uncompensated care to support participating Indian Health Service (IHS) and Tribal 638 facilities that incur costs associated with providing chiropractic services. Under this program, DHCS makes encounter-based payments at a flat rate to the California Rural

[1] The December 16, 2024, version of the STC's are referenced throughout this report: CalAIM STCs.

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

The IHS global encounter rate is updated on the Federal Register for each CY. The IHS global encounter rate for CY 2024 is $719. Figure 1 below shows IHS and tribal 638 payment activity in the order of occurrence during DY 20.

Figure 1: IHS and Tribal 638 Payment Activity During DY 20

Service Month/Year	FFP	Number of Encounters
July-September 2023	$96,792.00	148
October-December 2023	$75,210.00	115
January-December 2023 Reconciliation	$8,502.00	13
January-March 2024	$64,710.00	90
April-June 2024	$56,801.00	79
Total	**$302,015.00**	**445**

Applicable encounter claims are paid on a quarterly basis. July-September 2024 and October-December 2024 encounters were paid in February and March 2025, respectively, and any remaining encounters not already paid for January-December 2024, are expected to be reconciled and paid in May 2025.

Designated State Health Programs (STCs 10-10.6)

On January 26, 2023, CMS approved California's request to claim federal matching funds for state-funded DSHP to "free-up" state funding for Medicaid coverage initiatives.

California will use DSHP claiming to support portions of the PATH program. DSHP is effective January 1, 2023, to December 31, 2026. The total claimable federal financial participation (FFP) for the four-year period is $646,425,000.

DSHP consist of State Only Medical Programs and Workforce Development Programs. Allowable DSHP expenditures will be applied against each DY using the date of service information from each claim paid through the approved DSHP listed below.

State Only Medical Programs
California Children's Services Program
Genetically Handicapped Persons Program
Medically Indigent Long-Term Care
Lanterman Development Disabilities Act
Prostate Cancer Treatment Program
Workforce Development Programs
Department of Health Care Access and Information · Song-Brown Health Care Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program

CMS approved the DSHP List, Attachment Y, and the DSHP Claiming Protocol, Attachment Z, on December 12, 2024, and the first DSHP claims for the period of January-March 2023 were processed in December 2024. DHCS will continue to process claims from 2023 and 2024 during DY 21. Figure 2 below shows claiming during DY 20.

Figure 2: Claiming During DY 20

Service Month/Year	FFP
January-March 2023	$40,401,562.50
Total	**$40,401,562.50**

Provider Rate Increase Requirement (STCs 11.1-11.13)

Pursuant to Welfare & Institutions Code section 14105.201, DHCS implemented Targeted Rate Increases for primary care, obstetric care, and non-specialty mental health

services effective for dates of service on or after January 1, 2024. These rate increases apply to eligible providers in the Fee-For-Service delivery system, as well as eligible network providers contracted with Medi-Cal managed care plans. DHCS increased rates for targeted services to no less than 87.5 percent of Medicare rates, inclusive of incorporating applicable Proposition 56 supplemental payments for physician services into base rates. DHCS calculated an equivalent rate increase for services that do not have a rate established by Medicare. DHCS received federal approval of these targeted rate increases for the Fee-For-Service delivery system in State Plan Amendment (SPA) 23-0035. For the Managed Care delivery system, DHCS adopted a minimum fee schedule for applicable procedure codes using State plan approved rates in accordance with Title 42, Code of Federal Regulations, Part 438.6(c)(1)(iii)(A), publishing guidance in All Plan Letter (APL) 24-007[2] and incorporating relevant provisions in Medi-Cal managed care plan contracts and rate certifications for the rating period beginning January 1, 2024.

DHCS attests that, for DY 20, the Medi-Cal program met the requirements in STC 11.2 relating to the ratio of Medi-Cal to Medicare provider rates for each of the services that comprise the state's definition of primary care, obstetric care, or behavioral health care, as relevant, in the Fee-For-Service and Managed Care delivery systems, by setting Medi-Cal rates for the applicable services at no less than 87.5 percent of Medicare rates. For this purpose, DHCS defined primary care, obstetric care, and non-specialty mental health services to include applicable procedure codes and provider types consistent with coverage of these services in the Fee-For-Service and Managed Care delivery systems, except that inpatient behavioral health services were excluded. The list of applicable procedure codes is currently available at the following location: https://www.dhcs.ca.gov/services/medi-cal/Documents/LTCRU/CY-2024-TRI-Fee-Schedule-Feb.xlsx.

California voters approved Proposition 35 at the November 5, 2024, general election. Among other changes, Proposition 35 dedicates the revenues derived from California's approved Managed Care Organization (MCO) provider tax to specified Medi-Cal program purposes beginning in 2025 (DY 21), including continued investments in primary care, obstetric care, and non-specialty mental health services.

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[2] APL 24-007 is available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-007.pdf.

Dually-Eligible Enrollees in Medi-Cal Managed Care (STC 5.26)

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 member in an affiliated Medicaid plan once the member has selected a Medicare Advantage (MA) plan. Members impacted by this expenditure authority can change Medicaid plans by selecting a new MA plan or original Medicare once a quarter. A dually eligible member'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 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 member in an affiliated Medicaid plan once they have selected a MA plan, known as the Medi-Cal matching plan policy, in 17 counties, effective January 1, 2024: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Stanislaus, and Tulare. On January 1, 2023, members of the federal financial alignment initiative known as Cal MediConnect (CMC) transitioned into EAE D-SNPs (Medicare Medi-Cal plans) and matching MCPs, in the seven Coordinated Care Initiative (CCI) counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Under EAE D-SNPs, members 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 members statewide that were not already enrolled in Medi-Cal managed care were mandatorily enrolled in Medi-Cal managed care, except for those with a Share of Cost who are not in a Long-Term Care (LTC) facility.

Figure 3, on the next page, provides the total number of members, broken out by DY quarter, enrolled in MA plans (including D-SNPs) that request to change Medi-Cal managed care plans (MCPs) and are referred to the MA plan or 1-800-MEDICARE in the 17 counties in 2024 where DHCS aligned Medi-Cal plan enrollment with Medicare plan choice: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Orange,

Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Stanislaus and Tulare.

Figure 3: DY 20 Matched Members Requesting Transfer into an Unmatched Plan and Referred to Medicare

Month	Matched Members Requesting Transfer into an Unmatched Plan and Referred to Medicare
1/1/2024	146
2/1/2024	160
3/1/2024	141
Q1 Total	**447**
4/1/2024	144
5/1/2024	144
6/1/2024	140
Q2 Total	**428**
7/1/2024	112
8/1/2024	57
9/1/2024	51
Q3 Total	**220**
10/1/2024	63
11/1/2024	32
12/1/2024	57
Q4 Total	**152**
2024 Grand Total	**1,247**

Deemed SSI Population (STCs 4.1, 11, and 18.7)

California State Assembly Bill 133 directed DHCS to seek federal approval to implement a two-phased approach to increase and eliminate the asset limits for Non-Modified Adjusted Gross Income (Non-MAGI) coverage groups. On November 24, 2021, DHCS received approval for State Plan Amendment (SPA) 21-0053 that gave DHCS the authority to implement the resource disregard to increase the asset limits for most Non-MAGI coverage groups. Since the authority to apply disregards under section 1902(r)(2) of the Social Security Act is limited to certain enumerated coverage groups, the

approved SPA did not apply to the Deemed SSI groups, specifically those mandatory Medi-Cal eligibility groups comprised of individuals who would be eligible for Medicaid if they were receiving Supplemental Security Income (SSI) and/or State Supplementary Payments (SSP), but are no longer receiving such payments and are thus "deemed" eligible for Medi-Cal. On April 6, 2022, the state submitted an amendment to the CalAIM demonstration to assure access to and provide parity with the asset disregard policy for the populations under the approved SPA.

On June 29, 2022, DHCS received federal approval of California's two-phased approach to increase, and eventually eliminate, asset limits for the Deemed SSI groups through the CalAIM Section 1115 Demonstration waiver amendment. This subgroup of the Non-MAGI Medi-Cal member population has historically been limited in the amount of property they can own and retain, and still be eligible for Medi-Cal.

Effective July 1, 2022, asset limits for Non-MAGI Medi-Cal programs increased to $130,000 for one person and $65,000 for each additional household member. The prior asset limits were $2,000 for one person and $3,000 for two persons. Members were able to keep additional resources, resulting in increased financial stability and improved quality of life. This increase in asset limits made Medi-Cal coverage accessible to a larger number of potentially vulnerable Californians, including elderly and disabled individuals. The elimination of asset limits implemented on January 1, 2024, significantly improves access to Medi-Cal coverage for these vulnerable populations as well.

The CalAIM Asset Test approval letter can be viewed on the DHCS website.

Figure 4 outlines the expenditure information for individuals in the Deemed SSI groups during DY 20.

Figure 4: Deemed SSI Groups DY20 Expenditures

Reporting Period	Total Expenditures	Federal Funding	Total Federal Expenditures for DY 20
Quarter 1 **1/1/2024-3/31/2024**	$54,091.85	50%	$27,045.93
Quarter 2 **4/1/2024-6/30/2024**	$54,351.88	50%	$27,175.94

Reporting Period	Total Expenditures	Federal Funding	Total Federal Expenditures for DY 20
Quarter 3 **7/1/2024-9/30/2024**	$52,486.03	50%	$26,243.01
Quarter 4 **10/1/2024-12/31/2024**	$39,571.84	50%	$19,785.92
DY 20 Totals	**$200,501.60**	**N/A**	**$100,250.80**

Reentry Demonstration & Pre-Release Services (STCs 5.13, 5.15, and 9.1-9.11)

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities (YCFs) for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by CMS, DHCS will partner with state agencies, counties, providers, and community-based organizations (CBOs) to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release and reentering their communities. The initiative will help California address the unique and considerable health care needs of justice-involved (JI) individuals, improve health outcomes, deliver care more efficiently, and advance health equity across the state.

Providing Access and Transforming Health (PATH) Justice-Involved (JI) Capacity Building Program

To support planning for and implementation of pre-release Medi-Cal applications, DHCS awarded $561 million in grant awards to the California Department of Corrections and Rehabilitation, county probation agencies, county sheriff offices, county behavioral health agencies, and other implementation partners to support with capacity development, one-time infrastructure and IT investments, collaborative planning, and technical assistance to support implementation of pre-releases services under the Waiver. These grants were authorized under the CalAIM waiver, as part of the Providing Access and Transforming

Health, or PATH, funding.

DHCS provided three rounds of JI capacity building PATH grant funding. Round one grants supported collaborative planning activities (e.g., collaborative planning sessions, identification of operational gaps, and hiring processes for staff to support pre-release application processing) and round two grants supported implementation and administrative activities related to pre-release Medi-Cal applications (e.g., IT systems upgrades, physical infrastructure modification, development of protocols and procedures, and staff training to coordinate pre-release applications). Round three provides implementation grants to correctional facilities (or an entity applying on behalf of a facility) and county behavioral health agencies to support the planning and implementation of pre-release reentry services under the 1115 Waiver.

Pre-Release Enrollment

Effective January 1, 2023, all California county social services agencies/offices were required to suspend, rather than terminate, Medicaid coverage for both adults and youth during the duration of an individual's incarceration. State guidance, published in November 2022, provides information related to implementing DHCS' Medicaid benefit suspension and unsuspension (activation) policies, including guidance on suspension timelines for individuals with short-term stays.

The following summarizes the State's policy and operational approach:

- Through the benefit suspension process, the correctional facility reports the member's incarceration status to the county; the social services agency/office will change an individual's Medi-Cal status from "active" to "suspended." While in the suspension period, the individual will be eligible to receive inpatient hospitalization and pre-release services (for no more than 90 days) only. Individuals receive a notice of action when their Medi-Cal coverage is suspended and again upon reactivation.
- If inpatient hospital services are required during an individual's incarceration, the correctional facility can apply for the county or State Medi-Cal Incarceration Eligibility Program (MCIEP). MCIEP occurs at both a state and county level and allows Medi-Cal reimbursement for inpatient hospital stays of 24 or more hours for incarcerated individuals who are determined eligible for Medi-Cal.
- All individuals found eligible for pre-release services, including individuals who were incarcerated for 28 days or less, will be assigned a specific aid code that will ensure the only services that will be provided and paid for are Reentry Demonstration Initiative services. DHCS required social services agencies/offices, County Sheriff's Departments and County Probation Departments to complete and submit readiness assessments

beginning in November 2022, through which they attested to their readiness to implement pre-release Medi-Cal application processes. DHCS also implemented a monitoring plan to assess compliance with the mandate, including suspension and unsuspension processes, and ongoing implementation of the mandate.

Policy and Operational Planning

On October 20, 2023, DHCS released a final Policy and Operational Guide to implement reentry services. This guidance memorializes policy and operational requirements for implementing the Medi-Cal JI Reentry Initiative. The draft guidance is intended to lay out to implementing stakeholders – correctional facilities, behavioral health agencies, providers, CBOs, and Medi-Cal managed care plans (MCPs), among others – the policy design and operational processes that will serve as the foundation for implementing this important initiative.

Throughout 2023, DHCS worked with CMS to finalize the Reentry Demonstration Implementation Plan and Reinvestment Plan. The Implementation Plan describes (1) a summary of how the State already meets any expectation and specific activities related to each milestone, and (2) any actions needed to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions and the timelines and activities the State will undertake to achieve the milestone. The Implementation Plan was approved in 2024. In 2023, CMS approved DHCS' Reentry Reinvestment Plan, which defines the total amount of reinvestment required and types of reinvestments that will be made over the term of the Demonstration.

DHCS System Readiness – JI Screening Portal

In conjunction with the county correctional facility go-live in October 2024, DHCS launched a new JI Screening Portal which was developed specifically for the purpose of collecting and sharing pre-release service eligibility data between correctional facilities and DHCS. The Portal allows the correctional facility to activate the JI pre-release aid code and communicate, in real-time, with DHCS their determination about whether and by what criteria an individual is eligible for pre-release services[3], in accordance with the Waiver STCs.

Correctional Facilities (CFs) and/or their delegates will also be able to pause, reset, and

[3] For more information on how to use the JI Screening Portal, please see the JI Screening Portal User guide available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3F4685CF-F9E5-4B7D-B5D1-DC174B0463E9/ji_screening_portal_user_guide.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

restart pre-release services via the JI Screening Portal. Individuals who qualify for pre-release services will receive an initial 90-day period of benefits per incarceration. For individuals with a known release date, services should begin no more than 90-days prior to the expected day of release. For individuals with an unknown release date, services should start as close to intake as possible. An individual's 90-day pre-release benefits can be paused if they experience a qualifying event. CFs and/or their delegates will pause the JI aid code via the JI Screening Portal to ensure that pre-release services are unable to be reimbursed using Medi-Cal funding during this time. Qualifying events include the following scenarios:

- Individual is found to be incompetent to stand trial and transferred to a state hospital and then returns to the jail.
- Individual's release date is unexpectedly extended or delayed.

Note: When an individual is transferred from a county jail to a state prison, from a state prison to a county jail, or from one county to another this is considered a new incarceration period. This does not include transfers between prisons or between jails within the same county.

After pre-release services are paused, CFs will either **reset or restart** pre-release benefits, depending on the circumstances. An individual's pre-release services can only be reset one time per incarceration. If the individual has multiple qualifying events and has already had their services reset, their 90-day period can be **paused** and then the CF can then **restart the individual's 90-day period** to provide them any available remaining days from their second 90-day period of benefits as described below.

Stakeholder Engagement

Over the past three years, DHCS has collaborated intensively with a wide array of stakeholders to prepare for this massive system transformation. To support successful implementation, the state has provided deep technical assistance and critical funding opportunities for implementation partners to prepare to succeed in this groundbreaking initiative.

In October 2023, DHCS released its Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Reentry Initiative[4]. Since then, DHCS has worked closely with JI stakeholders, consultants, and internal teams to enhance the 2023 guidance, offering additional support to implementing counties. DHCS employs a multi-faceted

[4] Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Reentry Initiative

strategy to boost stakeholder awareness and correctional facility participation in the JI Reentry Waiver program. Since September 2024, DHCS launched a statewide learning collaborative series to provide vital information on key policy, milestones, systems, and processes for the effective implementation of pre-release services. Each of the first seven session had an average attendance of 300 participants, including representatives from CFs, behavioral health, managed care plans, pharmacy providers, community-based organizations, and county social service departments. The sessions focused on distinct components of the JI program such as the screening portal, behavioral health services, non-behavioral health services, Enhanced Care Management, pharmacy, and the Consolidated Appropriations Act of 2023. Following each collaborative session, DHCS facilitated office-hours meetings to debrief and gather feedback from stakeholders and implementation partners.

Successes and Barriers

In 2024, California became the first state in the nation to implement its section 1115 waiver to cover Medicaid services in JI settings. As of October 1, 2024, three California counties—Inyo, Santa Clara, and Yuba—were approved to begin delivering a targeted set of Medi-Cal services to people returning to communities after incarceration. The California Department of Corrections and Rehabilitation (CDCR) and one additional county, San Joaquin, went live on February 1, 2025. All California counties are required to implement this initiative before October 1, 2026.

- PATH JI Round 3: DHCS approved 148 applications and awarded $424,125,638.73.

DHCS has identified the following barriers through the implementation of the JI Initiative:

- **Unknown Release Dates:** Given the prevalence of short-term stays and unpredictable release dates, particularly in county jails and county youth correctional facilities, correctional facilities will likely face operational challenges in screening all individuals who are incarcerated for only a short period of time and providing them with reentry services.
- **Supporting CFs in building systems to bill/claim Medicaid:** Implementation partners that have not traditionally billed Medi-Cal (e.g., correctional facilities and community-based providers that will be providing in-reach and post-release care management services) will be enrolling in Medi-Cal and setting up new billing and claiming processes for the first time and may face challenges navigating related requirements (e.g., need for EHR/system updates, intensive technical assistance on provider enrollment and billing processes).

- **Workforce Capacity:** Managing workforce shortages for in-reach providers (especially behavioral health providers and case managers) with relevant experience; capacity of correctional facility staff needed to move people to appointments as well as provide healthcare.
- **Warm-Hand Offs/Care Management and Medications in hand:** One of the challenges reported regarding the warm hand off to care management and ensuring medications are in hand is the difficulty in providing medications to individuals who have short-term stays or are being released overnight. This is especially problematic when medications are not available before release, leading to gaps in care. This is also a challenge for individuals with an unknown release date, as it becomes difficult to coordinate medication handoff.

SUD Health IT Plan (STC 6.3 or Attachment E)

The SUD monitoring protocol was submitted to CMS for review on November 1, 2022, and was approved on February 10, 2023. As part of the SUD monitoring protocol, DHCS reports data on three different Health IT metrics as part of the "Other Annual Metrics" for each demonstration year.

The state reported its first annual reporting for these metrics along with the DY18 (January 2022 – December 2022) annual report. The following represents the State's second annual reporting for these metrics as submitted to CMS in August of 2024.

- **Health IT Q1 - Number of checks**: For January 1, 2023 – December 31, 2023, the total number of Controlled Substances Utilization Review and Evaluation System (CURES) Patient Activity Report searched was 98,159,799.
- **Health IT Q2 - Number of web updates**: For January 1, 2023 – December 31, 2023, the total number of online CURES resources information updates published was 10.
- **Health IT Q3 - Number of corrections live:** For January 1, 2023 – December 31, 2023, the total number of connection corrections systems to the SUD delivery system for incarcerated individuals released to the community was three.

DHCS plans to report data on three different Health IT metrics as part of the Other Annual Metrics for DY 20 (January 2024 – December 2024).

Managed Care in County Organized Health Systems (STC 12.2-12.6)

DHCS provided the "1115a STC 12.1-12.6_Comprehensive Report" to CMS on December 29, 2023, that outlined DHCS' compliance activities and monitoring with STC 12.1 – 12.6. In accordance with STC 12.2c requirements, DHCS submitted monthly reports on

Primary Care Physician (PCP) retention to CMS. DHCS submitted its first monthly PCP retention report to CMS on February 29, 2024 and the last PCP retention report on July 17, 2024

DHCS deployed a multi-pronged monitoring approach including a bi-weekly data submission from all MCPs involved in the transition. The monitoring data includes data on PCP retention, Continuity of Care (CoC) requests, and special populations provider outreach, among other data points. Data collected via monitoring processes indicated MCPs were demonstrating compliance with DHCS transition requirements. DHCS analyzed monitoring data for trends that indicate the potential for concern, including high CoC request denial rates, low PCP retention, low provider outreach, or low network provider agreement/CoC for provider agreement totals. When a potential concern was identified, DHCS alerted the MCP, and scheduled technical assistance calls to provide guidance and affirm requirements. DHCS escalated issues to MCP leadership when technical assistance calls did not achieve the desired outcome and required MCPs to submit Corrective Action Plans (CAPs) when deficiencies persisted. DHCS reviewed and approved CAPs which included actions taken to address deficiencies and timelines for remediation. DHCS required PHC to submit a CAP for non-compliance with the PCP retention requirements on February 27, 2024, as detailed in our PCP retention report submitted on February 29, 2024. Please reference the "1115a STC 12.1-12.6_Comprehensive Report" for additional information on PCP retention.

Figures 5 and 6 show cumulative totals as of June 2024, relevant to agreements subject to CoC requirements. DHCS required that special populations have enhanced CoC's protections which required MCPs to conduct outreach to out-of-network (OON) providers without the need for a member to initiate the request. This was in addition to standard CoC protections which allowed for continuity of services or providers when the member or the provider makes the request; subject to the OON provider and MCP coming to an agreement.

Figure 5: Special Populations Provider Outreach Totals

MCP Name	Reporting Unit/ County	Total Out-of-Network Providers Contacted/ Outreached	Total Provider Contracts/CoC Agreements established	Total Out-of-Network Providers who are non-responsive or declined to contract	Total CoC for provider agreements or provider contracts Pending/In-process
AAH	Alameda	338	19	319	0
CCAH	Mariposa	33	7	26	0
CCAH	San Benito	21	4	17	0
CCHP	Contra Costa	121	54	67	0
CHPIV	Imperial	10	10	0	0
PHC	Butte	1210	882	276	52
PHC	Colusa	570	458	102	10
PHC	Glenn	333	302	13	18
PHC	Nevada	1095	818	229	48
PHC	Placer	2528	1422	1038	68
PHC	Plumas	266	200	44	22
PHC	Sierra	50	35	0	15
PHC	Sutter	1293	1250	8	35
PHC	Tehama	707	636	51	20

MCP Name	Reporting Unit/ County	Total Out-of-Network Providers Contacted/ Outreached	Total Provider Contracts/CoC Agreements established	Total Out-of-Network Providers who are non-responsive or declined to contract	Total CoC for provider agreements or provider contracts Pending/In-process
PHC	Yuba	1370	1009	309	52

Figure 6: Total CoC Member Requests and Total Approved

MCP Name	Reporting Unit/County	Total Number of Member CoC Requests	Number of Agreements Established	Number Approved Because Provider is Already in Network	Number of Pending Member CoC Requests	Number of Denied Member CoC Requests	Number of Member CoC Requests Cancelled by Requestor
AAH	Alameda	3659	608	2887	45	119	0
CCAH	Mariposa	**	*	0	47	0	0
CCAH	San Benito	69	20	0	49	0	0
CCHP	Contra Costa	665	476	0	61	**	*
CHPIV	Imperial	40	30	*	**	*	*
PHC	Butte	1937	22	1785	28	71	31
PHC	Colusa	220	*	204	*	*	*
PHC	Glenn	340	*	**	0	*	*
PHC	Nevada	771	22	623	27	77	22

MCP Name	Reporting Unit/County	Total Number of Member CoC Requests	Number of Agreements Established	Number Approved Because Provider is Already in Network	Number of Pending Member CoC Requests	Number of Denied Member CoC Requests	Number of Member CoC Requests Cancelled by Requestor
PHC	Placer	3299	159	2456	99	452	133
PHC	Plumas	85	*	**	*	*	*
PHC	Sierra	17	0	17	0	0	0
PHC	Sutter	1048	12	955	24	41	16
PHC	Tehama	843	*	750	*	**	64
PHC	Yuba	787	*	688	*	46	36

**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 small counts are suppressed to protect the privacy and security of participants.*

*** Complementary cell suppression.*

In accordance with STC 12.3 and 12.4 requirements, DHCS conducted an Annual Network Certification Readiness (ANC Readiness) assessment of all COHS Expansion and Single Plan Model MCPs and submitted results to CMS using the Network Adequacy and Access Assurances Reporting template (NAAAR) and the "1115a STC 12.1-12.6_Comprehensive Report" on December 29, 2023. At the time of submission, DHCS stated it would require any MCP found non-compliant with network adequacy standards to submit a CAP effective upon launch in January of 2024.

DHCS found CCHP and PHC non-compliant with PCP provider to member ratios and both MCPs directed to submit CAPs which included specific activities to remediate deficiencies and the timelines for remediation. DHCS held two calls with each of the MCPs to address the non-compliance and determined the non-compliance was driven by a data reporting deficiency. The MCPs reported progress on correcting data deficiencies to DHCS on a monthly basis as part of the CAP. DHCS reassessed the MCPs for compliance with the PCP provider to member ratios standard using the MCPs' March 2024 provider network data submitted in April 2024 and confirmed that all deficiencies were resolved. The CAPs were formally closed by DHCS in May of 2024.

In addition to the ANC Readiness assessment described above, DHCS conducted a Subcontractor Network Certification Readiness (SNC Readiness) assessment for all COHS Expansion and Single Plan Model MCPs and submitted its results to CMS using the CMS-approved modified NAAAR template (modified NAAAR) and the "1115a STC 12.1-12.6_Comprehensive Report" on December 29, 2023. All COHS expansion and Single Plan Model MCPs were found compliant with SNC Readiness requirements, which require MCPs to assess all Subcontractors delegated risk for the provision of covered services against the same network adequacy standards that DHCS uses to certify the MCPs' aggregate Provider Networks through the ANC process. DHCS requires MCPs to place any Subcontractor found non-compliant with network adequacy standards on a CAP and report progress to DHCS on a quarterly basis.

Alameda Alliance for Health (AAH) imposed CAP submissions requirements on two Subcontractors for non-compliance with timely access standards. AAH worked with its Subcontractors to address findings from the readiness SNC. Both Subcontractors were required to provide timely access training to their network providers, provide OON access through letters of agreement, and continue efforts to recruit additional providers to improve their networks. AAH reassessed its Subcontractors in Q2 2024 confirming all deficiencies were resolved. The CAPs were formally closed by the MCP in April 2024.

Community Health Plan of Imperial Valley (CHPIV) imposed CAP submission requirements

on one Subcontractor for non-compliance with time or distance and timely access network adequacy standards. CHPIV worked with its Subcontractor to address findings from the readiness SNC. The Subcontractor was required to provide timely access training to their network providers, provide OON access through letters of agreement, and continue to conduct efforts to recruit additional providers to improve its network. CHPIV reassessed its Subcontractor in Q2 of 2024, confirming all deficiencies were resolved. The CAP was formally closed by the MCP in March of 2024.

STC 12.5 states that DHCS "must submit 60 days after of the end of each quarter, appeals and grievance data for all managed care plans that furnish services to Medicaid members enrolled in Medi-Cal managed care and impacted by this section 1115(a) demonstration launching on or after January 1, 2024." DHCS is currently submitting a Quarterly Appeals and Grievance report to CMS in response to the 1915(b) Waiver STC 14 on the template provided by CMS, which began in 2023.

Traditional Health Care Practices (STCs 13.1-13.6)

Per STC 13.3 DHCS is required to report Traditional Health Care Practices utilization in the Annual Monitoring Report. However, since the benefit was not yet being provided during this reporting period, there is no data to report. In future quarters, after the benefit has been fully implemented, DHCS will comply with the necessary reporting in accordance with STC 13.3 and STC 16.5b.

On October 16, 2024, the Centers for Medicare & Medicaid Services (CMS) approved DHCS to cover Traditional Health Care Practices provided by Indian Health Care Providers (IHCPs) for Medi-Cal and CHIP members covered by Drug Medi-Cal Organized Delivery System (DMC-ODS) counties through December 31, 2026, unless extended or amended. DHCS, in consultation with Tribes and Tribal partners, has been finalizing policy guidance in the form of a Behavioral Health Information Notice (BHIN) that includes practitioner descriptions, member eligibility, participation requirements, practitioner qualifications, service documentation requirements, and claiming and payment requirements. The BHIN was published on March 21, 2025 and Traditional Health Care Practices can be provided and covered following publication of final guidance. In addition, DHCS is making system updates to enable claiming and published DMC-ODS plan rates with public notice, consistent with STC 13.6. Technical assistance will also be available to Tribes and Tribal partners throughout the demonstration period.

Post Award Forum (STC 16.9)

DHCS' Stakeholder Advisory Committee (SAC) provides the Department with valuable input on ongoing CalAIM implementation efforts and helps further its efforts to provide

members with high-quality, accessible, and equitable care. SAC members are recognized experts in their fields, including, but not limited to, member advocacy organizations and representatives of various Medi-Cal provider groups.

DHCS' DHCS Behavioral Health Stakeholder Advisory Committee Behavioral Health Stakeholder Advisory Committee (BH-SAC) is a broad-based body of recognized behavioral health experts. Following the model of the SAC, the BH-SAC advises the DHCS Director on the behavioral health components of the Medi-Cal program as well as behavioral health policy issues more broadly.

The committees' hybrid meetings are conducted in the spirit of the Bagley-Keene Open Meeting Act, and public comment occurs at the end of each meeting. In DY 20, four joint SAC/BH-SAC meetings were convened on the following dates: February 15, 2024; May 29, 2024; July 24, 2024; and October 16, 2024. DHCS agenda items included:

- CalAIM Behavioral Health Key Findings from Preliminary Implementation Feedback Report
- Equity and Practice Transformation (EPT) Provider Directed Payment Program
- QPHM: Overview and Stakeholder Engagement for Behavioral Health Components
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH CONNECT) Update
- Children and Youth Behavioral Health Initiative Update
- Final Update: Year of Medi-Cal Redeterminations
- CalAIM Dashboard: Bold Goals, Behavioral Health, and Population Health Management
- Introduction of Medi-Cal Connect (Formerly the Population Health Management Service)
- CalAIM Waiver Update: Traditional Healers & Natural Helpers
- BH CONNECT: Incentive Programs
- CalAIM Justice Involved Reentry Initiative
- Transitional Rent Update: DHCS Proposals and Related Policy Considerations
- Enhanced Care Management and Community Supports Update
- Behavioral Health Transformation Update

To view past meeting agendas, visit DHCS' website at DHCS Stakeholder Advisory Committee Past Meeting Archive or DHCS Behavioral Health Stakeholder Advisory

Committee Past Meeting Archive.

Monitoring Reports (STC 16.5)

The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, and stakeholder outreach, as well as consumer operating issues. The quarterly reports are due to CMS sixty days following the end of each demonstration quarter. In DY 20, DHCS submitted three quarterly reports to CMS electronically on the following dates:

Quarter	Reporting Timeframe	Submitted to CMS	CMS Approval
One	January 1 – March 31, 2024	May 24, 2024	July 26, 2024
Two	April 1 – June 30, 2024	August 20, 2024	October 21, 2024
Three	July 1 – September 30, 2024	November 15, 2024	Under CMS Review

Per CMS' guidance, the fourth quarterly reporting information has been folded into the annual reports beginning in DY 15.

Monitoring Calls (STC 16.8)

CMS and DHCS held three quarterly calls for the CalAIM 1115 demonstration on February 12, 2024, May 13, 2024, and August 12, 2024 for DY 20-Q1, DY 20-Q2, and DY 20-Q3 respectively. All three calls were focused on Contingency Management (CM) and PATH – Justice Involved (JI) Initiative/Stakeholder Engagement updates. During DY 20-Q4, CMS and DHCS mutually agreed to cancel the quarterly call scheduled for November 18, 2024. As needed, separate CalAIM 1115 deliverable-specific calls also took place during the quarter.

Financial Reporting Requirements (STCs 16.5c and 18.1-18.8)

The expenditures related to CalAIM's section 1115 populations for DY 20 were claimed on the CMS-64: Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program forms. Figure 7 shows expenditures reported to CalAIM waivers for DY 20.

Figure 7: MAP Waivers

Waiver Name	DY 20	
	Total Computable	Federal Share
Asset Test MAP	0	0
Asset Test MC	248,495	124,248
CBAS	1,580,039,718	794,914,892
DMC-ODS	47,080,348	23,546,539
DMC-ODS Adult Expansion	177,305,931	159,575,338
DMC-ODS Recovery Incentive	2,723,205	2,115,902
DSH	176,398,851	88,199,426
Global	2,076,393,647	1,038,196,824
HRSN Adult Expansion	32,879,452	29,591,507
HRSN Services	56,397,264	28,198,633
IHS Chiropractic Services	121,511	121,511
OOS FFCY MC	391,224	195,614
PATH Supports MAP	0	0
Reentry Demonstration Initiative MAP	36794	31379
UC - IHS	0	0
DMC-ODS MCHIP	285597	185637
DMC-ODS Recovery Incentives	261	170
HRSN MCHIP	0	0
Reentry Demonstration Initiative MCHIP	32	21

DHCS reported administrative costs associated with this demonstration on the CMS 64.10 Waiver. Per STC 18.10, "The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS." The figure below shows expenditures reported to CalAIM waiver for DY 20.

Figure 8: ADM Waivers

Waiver Name	DY 20	
	Total Computable	Federal Share
DMC-ODS	108,160	54,082
PATH Support ADM	118,011,065	59,005,533
Reentry Demonstration Initiative ADM	0	0

Monitoring Budget Neutrality (STCs 19.1-19.13) and Medicaid Expenditure Groups (STCs 18.9-18.10)

The State has complied with all quarterly reporting requirements for monitoring budget neutrality set forth in the STCs and is providing an updated budget neutrality workbook with this report. This workbook will work serve as the annual monitoring report for DY 20 and utilizes the template most recently supplied by CMS. The following paragraphs describe key changes or caveats affecting expenditures specific to certain Medicaid Expenditure Groups (MEGs).

For most MEGs, expenditure data for DY 18 through DY 20 is now reflected on Schedule C, reducing the need for manual adjustments to expenditures.

Contingency Management: Contingency Management encounter claims started being received in August 2023, which led to an anticipated increase in expenditures from DY 19 to DY 20. While expenditures have increased in DY 20, encounter claim payouts for DY 20 were lower than anticipated. Any remaining adjustments and unpaid encounters will be addressed in the upcoming quarters.

DMC-ODS: IMD: In accordance with STC 19.7, the actual expenditures for DMC-ODS: IMD services will be included in the expenditure limit for the demonstration project.

Reentry Demonstration Initiative: The JI program went live on October 1, 2024, with a phased implementation approach until the mandatory go-live date on October 1, 2026. The first quarter includes three counties and a total of nine facilities going live. Additionally, counties are given 180 days from the date of service to submit claims. Utilization is expected to increase in DY 21 with the phase in of ten counties and CDCR.

PATH: The different initiatives under the PATH Program have undergone various program design evolutions to refine the application processes, award processes, contract structure, reporting requirements, and payment processing. Award funding is tied to milestones that are achieved by the awardees. For example, CITED awardees have up to two years to complete milestones and activities will be completed by end of DY 22.

Global Payment Program (GPP) and DSH: GPP expenditures and projections listed under the With-Waiver Total Expenditures are inclusive of both Adjusted DSH allotment and UC Pool (formerly known as Safety Net Care Pool) federal funding ($472 Million total computable annually). Projections for DSH payments also under the With-Waiver Total Expenditures include NDPH and UC DSH hospital payments, also known as Traditional DSH, funded only by the federal DSH allotment and various non-federal funding sources (IGTs, CPEs, & General Fund). DSH program years are consistent with the State Fiscal Year (July-June), rather than the Demonstration Year (January-December). Expenditures reported on Schedule C for DSH are expenditures associated with the Federal Fiscal Year (and DSH program year) beginning within the given Demonstration Year.
GPP and DSH projections for applicable payments reflect the stepdown of enhanced FMAP authorized by the Consolidated Appropriations Act (CAA 2023). GPP and DSH projections reflect updated NDPH DSH allocation estimates given changes in hospital data trends.

DSHP: CMS approved the DSHP List, Attachment Y, and the DSHP Claiming Protocol, Attachment Z, on December 12, 2024, and the first DSHP claims were processed in December 2024.

CBAS: CBAS per-capita expenditures for DY 20 are higher than the $6.90 PMPM projection in the STCs. In accordance with STC 19.7, the actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. The reported DY 19 expenditures reflect an adjustment following the correction of a system error. A similar adjustment will be made to the DY 20 expenditures and is anticipated to occur in 2025 Q1.

OOS FFCY: OOS FFCY member months and expenditures continue to align with trends observed in DY 19. Expenditures remain lower than the hypothetical budget neutrality per-capita expenditure limit.

IHS Chiropractic Services: The DY 20 Q3 and Q4 IHS encounters are calculated for claiming in February and March 2025, respectively, while any remaining IHS encounters for DY 20 are expected to be claimed in May 2025. The IHS global encounter rate is updated on the Federal Register for each calendar year (CY). The IHS global encounter rate for CY 2024 (DY 20) is $719. Total expenditures for DY 20 are below the annual limit of $1,550,000.

HRSN Services: In DY 20, HRSN Services (Recuperative Care and Short-Term Post Hospitalization Housing) actual expenditures fall below the approved capped hypothetical amount of $391,653,626.

Asset Test: Total expenditures throughout DY 20 have remained stable and are consistent with DY 19 reporting. Because of the availability of more expenditure data, the projections for DY 21 and 22 were updated based on the additional data. In accordance with STC 19.7, the actual expenditures for the Deemed SSI asset limit increase and elimination will be included in the expenditure limit for the demonstration project.

Maintenance of Effort (MOE) (STC 8.15)

The State is required to maintain a baseline level of State funding for ongoing social services related to housing transition supports, not including one-time or non-recurring spending. DHCS surveyed the Fiscal Forecasting Branch of the California Department of Social Services (CDSS) for a list of programs, and associated appropriations, that meet the definition of ongoing social services related to housing transition supports.

2024-2025 Appropriation

The figure below provides funding breakouts tied to the 2024-25 Appropriation (as of the 2025-26 Governor's Budget), and a link to the premise write-up with specific details of the program. In total, State funding for applicable programs in the 2024-2025 Appropriation equals or exceeds the baseline.

Figure 9: 2024-2025 Appropriation

Budget Item	Total	Federal	State/Other
Family Stabilization	$71,200,000	$61,612,000	$9,588,000
Housing Support Program	$95,000,000	$0	$95,000,000

Budget Item	Total	Federal	State/Other
Transitional Housing Supplement	$5,284,000	$1,329,000	$3,955,000

The State assesses the following program meets the definition of ongoing social services related to housing transition supports:

- Family Stabilization: In addition to an increased level of case management, Family Stabilization may include *transitional housing*, emergency shelter, rehabilitative services, counseling, and other services. Note, providing transitional housing is not a requirement of the program.
- Housing Support Program: Interventions are provided to CalWORKs families to help obtain and keep permanent housing by providing rent and move-in assistance, focused case management and individualized services (legal services, credit repair, etc.).
- Transitional Housing Supplement - Administration: Provides a housing supplement for youth participating in eligible Transitional Housing Placement programs. This supplement helps offset the rising cost of housing and allows youth to focus on developing self-sufficiency.

The following programs were evaluated but deemed not to meet the criteria:

- Documents for Dependent Children: Social workers are provided 15 minutes per case to document information on the results of referrals to *transitional housing* or other housing assistance efforts provided to a dependent child in the court report to be submitted at the last regularly scheduled review hearing before a dependent child attains 18 years of age. Note, funding is for administrative time for social workers.
- Domestic Abuse Homeless Assistance Program: Provides CalWORKs applicants two periods of 16 cumulative calendar days of temporary shelter assistance. Note, funding is not explicitly for transitional housing.
- Housing and Disability Advocacy Program: Housing supports (outreach, case management) and disability benefit application assistance to people likely eligible for disability benefits and experiencing homelessness or at risk of homelessness.
- Housing for Non-Minor Dependents: Social workers will require one hour per case to evaluate placement and emergency housing resources. Note, funding is for administrative time for social workers.

PROGRAM UPDATES

The Program Updates section describes key activities and data across CalAIM 1115 program initiatives for DY 20, as required in the CalAIM 1115 demonstration Special Terms and Conditions (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:

- **GPP**: (STCs 15-15.15)
- **CBAS**: (STCs 5.1-5.12)
- **DMC-ODS**: Residential and Inpatient Treatment for Individuals with substance use disorder (SUD) (STCs 6.1-6.7), including **CM** (STCs 7.1-7.5)
- **PATH**: (STCs 5.13-5.25)
- **Community Supports**: Short-Term Recuperative Care & Short-Term Post Transition Housing (STCs 8.1-8.15)

GLOBAL PAYMENT PROGRAM

The Global Payment Program (GPP) assists public health care systems (PHCS) that provide health care to the uninsured. The GPP focuses on value, rather than volume, of care provided. The purpose is to support PHCS in their key role of providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. In addition to providing value-based care, the GPP incorporates services that are otherwise available to the state's Medi-Cal members 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 has added services that aim to address health disparities for the uninsured population, as well as to align GPP service offerings with those available to Medicaid members.

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.

Successes/Accomplishments

Throughout DY 20, DHCS worked collaboratively with the California Association of Public Hospitals (CAPH), PHCS, and CMS. DHCS continues to conduct bi-weekly conference calls with CAPH to discuss programmatic activities, budgets, and trends in reported data.

Following approval of SPA 24-0029 on April 1, 2024, and SPA 24-0053 on November 12, 2024, DHCS requested a technical amendment to the GPP Participating PHCS List (Attachment C) adding three University of California Los Angeles hospitals as GPP participants. CMS approved the technical amendment on January 17, 2025.

Program Highlights

On February 23, 2024, the State revised its hospital-specific DSH limit (OBRA) calculations beginning with SFY 2021-22 to be compliant with the Consolidated Appropriations Act (CAA 2021). This change resulted in recoupments and payments for GPP program year (PY) 7 and PY 8 in June and July 2024, respectively.

On September 27, 2024, CMS released the final ARP-adjusted federal share DSH allotment for Federal Fiscal Year (FFY) 2023, and the draft unreduced preliminary DSH allotment for FFY 2025. The FFY 2023 final ARP-adjusted federal share DSH allotment did not change from the preliminary allotment previously received from CMS, therefore no associated budgetary changes were made to GPP. However, the draft unreduced

preliminary DSH allotment for FFY 2025 resulted in GPP budgetary changes for PY 10 and PY 11, in accordance with the DSH Coordination Methodology (Attachment Q).

On September 30, 2024, PHCS submitted PY 9 encounter-level data with equity-related data fields to allow for more robust stratification and improved evaluation of disparities. Reporting of the equity-related data will continue through PY 12 on an annual basis as part of the existing GPP encounter data reporting process.

On November 29, 2024, PHCS began submitting PY 9 Health Equity stratification reporting data to DHCS in alignment with the GPP Health Equity Monitoring Metrics Protocol (Attachment M) goals. DHCS will continue to collaborate with PHCS to improve the ability to stratify and evaluate disparities within the data, monitor performance and trends over time, and discuss improvement strategies.

Qualitative Findings

Nothing to report.

Quantitative Findings

DHCS received, reviewed, and approved PHCS PY 8 final year-end encounter-level data reports and completed the PY 8 final reconciliation and redistribution process on February 15, 2024. Overall, the PHCS final year-end reports indicated that two hospitals were overpaid during the program's four quarterly payments and needed to return excess payments to be redistributed to other eligible hospitals. As a result, DHCS recouped $5,794,805.55 in total funds from Alameda Health System and $5,387,552.33 from Natividad Medical Center, and redistributed those funds, along with the remaining GPP budget, to other eligible PHCS for a net final reconciliation payment of $174,539,259.92. In total, GPP paid out the maximum PY 8 total fund budget of $2,577,959,436.88.

PY 9 final reports were submitted to DHCS from all participating PHCS by September 30, 2024. The reports included PY 9 final year-end aggregate and encounter-level data. DHCS reviewed the encounter-level data for accuracy, completeness, reasonableness, timeliness, and compliance, and worked with PHCS to correct or improve data as needed. Upon completion of PY 9 aggregate and encounter-level data review, PHCS were found to have met 128 percent of the GPP budgeted point threshold which will allow GPP to expend the entire GPP budget.

Figure 10 below shows the GPP payments made to the PHCS in the order that they were paid during DY 20.

Figure 10: GPP Payments/Recoupments During DY 20

Transaction Description	FFP Payment/(Recoupment)	IGT Payment/(Recoupment)	Service Period	Total Funds Payment/(Recoupment)
PY 8 Final Reconciliation	$87,269,629.96	$87,269,629.96	DY 18	$174,539,259.92
PY 9 Q4 (October 1, 2023 – December 31, 2023)	$343,522,540.18	$343,522,540.17	DY 19	$687,045,080.35
PY 10 Q1 (January 1, 2024 – March 31, 2024)	$362,461,771.03	$362,461,771.03	DY 20	$724,923,542.06
PY 7 Final Rule	($8,199.16)	($8,199.16)	DY 17	($16,398.32)
PY 8 Final Rule	($7,472.58)	($7,472.58)	DY 18	($14,945.16)
PY 10 Q2 (April 1, 2024 – June 30, 2024)	$337,993,978.11	$337,993,978.11	DY 20	$675,987,956.22
PY 10 Q3 (July 1, 2024 – September 30, 2024)	$337,741,074.67	$337,741,074.66	DY 20	$675,482,149.33
Total	**$1,468,973,322.21**	**$1,468,973,322.19**		**$2,937,946,644.40**

Policy/Administrative Issues and Challenges

The Affordable Care Act requires a reduction in national DSH allotments, which was previously scheduled to take effect on October 1, 2013, but has been repeatedly

postponed. Currently, the DSH allotment reductions required under section 1923(f)(7) of the Act are in effect for FFYs 2025, 2026, and 2027 at a national reduction of $8 billion for each FFY. On March 9, 2024, HR 4366 eliminated the FFY 2024 reduction and postponed implementation of the FFY 2025 reduction until January 1, 2025. Most recently, on December 20, 2024, Section 3401 of Title IV of the American Relief Act, 2025, delayed the FY 2025 DSH allotment reductions until April 1, 2025.

COMMUNITY-BASED ADULT SERVICES

On December 29, 2021, CMS approved California's CalAIM Section 1115 demonstration waiver, effective through December 31, 2026, which includes the Community-Based Adult Services (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 members 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 the California Department of Aging (CDA) to participate in the Medi-Cal program. The CBAS benefit is provided to eligible Medi-Cal members 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 members place of residence and the CBAS Center when needed. CBAS participants have chronic medical, cognitive, mental health, and/or intellectual developmental disabilities and are at risk of needing institutional care. The overarching goals of the CBAS program are to support community living, promote health and well-being, and prevent hospitalization and institutionalization.

CBAS providers are required to 1) meet all applicable licensing/certification and Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed 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.

The state must maintain CBAS access and capacity in every county where ADHC services were provided prior to CBAS starting on April 1, 2012. 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.

CBAS Emergency Remote Services (ERS) is a 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, power outages, or personal emergencies due to illness/injury, crises, or care transitions. CDA collaborated with DHCS, MCPs, and CBAS providers to develop ERS policy guidance, reporting templates, and processes to ensure compliance with the CalAIM 1115 waiver, 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 used lessons learned from the implementation and operation of CBAS Temporary Alternative Services (TAS) during the COVID-19 Public Health Emergency (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 with continual access to

services.

Successes/Accomplishments

In November of 2024, two CBAS bureau chiefs presented a CBAS "Back to Basics" training at the annual California Association for Adult Day Services (CAADS) Fall conference. Presentation topics were designed to target new centers or existing providers with new staff. The presentation highlighted important areas of the Medi-Cal Provider Manual and provided center staff with key takeaways on relevant topics such as core services, care plan development, multidisciplinary team (MDT) collaboration, medication administration, and ERS usage. All centers were offered personalized walk-throughs of the training post conference.

In DY 20, the number of CBAS centers increased from 293 to 302. This constituted a three percent increase from DY 19. This year was also notable for centers learning new policies and procedures for ERS; properly initiating ERS when outbreaks occur and pausing in-center services; and safely triaging participants to home. In addition, CDA continued to assist CBAS providers with registering and successfully implementing EVV, as well as resolving ongoing challenges with staffing and transportation shortages.

EVV Program History and Recent Highlights

Effective March 23, 2023, the CalEVV system began supporting CDA and CBAS providers to ensure compliance with CBAS ERS EVV requirements. The EVV system is utilized when providing participants with professional services such as clinical nursing services, personal care services to support activities of daily living, physical and occupational therapy, and a meal when prepared in the home. The CalAIM 1115 Waiver directs the state to demonstrate compliance with the EVV requirements for the provision of in-home PCS and Home Health Care Services (HHCS) to CBAS participants utilizing the CBAS ERS benefit. To ensure continued compliance, EVV in-person training is in place. This includes several office hour sessions and in-person training at locations across California. The EVV Team held three virtual office hour events in July 2024, three in August 2024, and three in September 2024. These office-hour events hosted by DHCS are available to caregivers, providers, and Jurisdictional Entities (JE). Office hours are held to allow providers and JEs the chance to ask the EVV Team questions related to registration, capturing EVV visit data, how to navigate the CalEVV portal as well as other related topics of interest. In addition, the EVV Team continued its successful California "Training Road Show" over the course of DY 20-Q3 and traveled to Santa Barbara, Redding, Eureka, Santa Rosa, San Jose, and Los Angeles. The EVV Training Road Show offers live and in-person training and support along with tools, resources, and state guidance on provider JE compliance, roles, and responsibilities

regarding EVV. The EVV model was fully implemented in DY 20. CBAS centers were able to offer home health or personal care support to CBAS participants experiencing either a public or personal emergency as defined in the fully developed EVV policy.

Qualitative Findings

Outreach Activities

CDA's EVV Program provided ongoing outreach and program updates to CBAS providers, MCPs, and other interested stakeholders. Communication modalities included "CBAS Updates" email blasts, state-sponsored webinars, and CDA meetings with MCPs that contract with CBAS Centers. In addition, CDA responded to ongoing written and telephone inquiries from CBAS providers, MCPs, and other internal and external stakeholders.

For DY 20, CDA supported the overall statewide EVV effort as a co-sponsor of 29 virtual "Office Hour" training events that were held throughout the year. These ubiquitous online office-hour trainings were available to caregivers, providers, and JEs. In general, online office hour events are opportunities for providers and JEs to ask the state EVV Team questions related to self-registration, capturing EVV visit data, how to navigate the CalEVV Portal, as well as other related topics of interest.

In addition, CDA supported the state sponsored EVV "Training Road Show" (TRS) initiative over the course of DY 20. The TRS effort consisted of an ambitious schedule of onsite, in-person, multi-day live trainings that included the use of a mobile "computer lab" that offered attendees a hands-on, kinesthetic learning experience. State trainers traveled to over a dozen locations throughout California, including Sacramento, Fresno, Bakersfield, Santa Barbara, Chico, Santa Rosa, San Jose, San Diego, and Los Angeles. The EVV TRS initiative offered interactive support along with tools, resources, and state guidance on provider and JE roles, responsibilities, and compliance requirements for EVV.

CDA provides ongoing outreach and program updates to CBAS providers, MCPs, CAADS, and other interested stakeholders via multiple communication strategies, including the following:

- CBAS Quarterlies
- CBAS ACLs and CBAS Updates
- CBAS webinars
- CAADS conferences
- CDA meetings with MCPs that contract with CBAS centers
- CDA meetings with the CBAS Quality Advisory Committee
- CAADS Education Committee Meetings

The following are CDA's outreach activities in DY 20:

- CBAS Quarterlies **(2)**
- CBAS Updates **(42)**
- CAADS Education Committee Meetings **(9)**
- CDA-MCP Meetings **(4)**
- CBAS Quality Advisory Committee Workgroup Meetings **(10)**
- CDA DHCS Meetings **(11)**
- CDA CDPH Quarterly Meetings **(0)**
- Responses to CBAS Mailbox Inquiries **(2,334)**

Along with the outreach activities mentioned above, CDA also responds to ongoing written and telephone inquiries from CBAS providers, MCPs, and other interested stakeholders. Outreach, education, and training activities focused on the following topics: (1) An Aging Resource Guide which provided an overview of Aging programs and services and useful information about healthy aging, elder rights and abuse prevention, fraud detection and prevention, disaster preparedness, and volunteerism as well as community involvement; (2) Electronic Visit Verification (EVV) technical assistance, training opportunities, and reminders related to responsibilities for participant record-keeping under the Federal Cures Act; (3) resources for the CBAS centers to obtain personal protective equipment (PPE); (4) reminders for the centers pertaining to important ERS protocols; (5) Participant Characteristics Report deadline reminders and technical assistance; and (6) CAADS 2024 Spring and Fall Conference registration information and presentation distribution.

CBAS Webinars

CDA did not facilitate any webinars during DY 20.

CAADS Education Committee Meetings

In DY 20, CDA attended nine meetings to discuss and support the Spring and Fall CAADS conferences. These bi-annual conferences serve to bring CBAS center staff, managed care plans and other interested stakeholders together to learn critical program and regulatory information to support successful CBAS operations. The planning meetings cover hotel site selection, the selection of educational topics for attendees, procurement of speakers, conference agendas, use of volunteers, use of surveys to gauge feedback for future conference planning, among other general items. Post conferences, this committee convenes to review attendee feedback and incorporate that data to improve upon future conference planning decisions. This meeting forum is also used to collaborate and plan future educational webinars and discuss legislative activity

that could affect the centers.

MCP Meetings with CDA

MCPs are crucial partners for implementation and oversight of CBAS services, as nearly all participants receive the services through their MCPs. CDA convenes meetings with MCPs that contract with CBAS providers to (1) promote communication between CDA and MCPs on issues of concern by the MCPs; (2) update MCPs on CBAS activities, 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 DY 20, CDA convened four meetings with the MCPs. Meeting content for DY 20 was highly focused on the review of frequent and recurring ERS technical assistance requests CDA receives from the MCPs. CDA offered technical assistance to help curb common ERS related citations during the onsite recertification surveys. In Q4 of DY 20, this meeting cadence was changed from monthly to quarterly.

CBAS Quality Strategy Advisory Committee Meetings

The CBAS Quality Assurance and Improvement Strategy was developed through a year-long stakeholder process and was released for comment on September 19, 2016, beginning implementation in October 2016. This paved the way for CDA to establish the CBAS Quality Advisory Committee, to review/evaluate progress on achieving the Quality Strategy's original goals and objectives, as well as to identify new goals and objectives that will support and promote the delivery of quality services. This continuous quality improvement effort is designed to support CBAS providers in meeting program standards while continuing to develop and promote new approaches to improve service delivery.

This meeting series is comprised of various stakeholders, including members of the CBAS Executive Team, CBAS providers, MCPs, DHCS, and representatives from CAADS. 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.

CBAS Mailbox Inquiries

During DY 20, CDA responded to 2,334 CBAS mailbox inquiries. Below is a breakdown of

the email inquiries by quarter:

Quarter	Inquiries
Quarter 1	769
Quarter 2	531
Quarter 3	490
Quarter 4	544

Some commonly submitted inquiries for DY 20 included: (1) technical assistance requests from providers and MCPs regarding CBAS program operations and regulations; (2) CBAS participant and Medi-Cal enrollment, share of cost and program related questions; (3) Peach Provider Portal technical assistance requests; (4) COVID related questions including the use of ERS and EVV requirements; and (5) inquiries regarding the CBAS reimbursement rates.

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

CDA, in collaboration with DHCS, continued to implement the activities and commitments to CMS for compliance of CBAS Centers with the federal HCB Settings Requirements through 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 requested additional revisions of the STP and Draft CBAS Transition Plan before granting final approval. CDA responded to additional revisions as requested. DHCS informed CDA in June 2023 that CMS granted STP final approval.

Operational Updates

Public and Personal Emergencies Related to ERS Experience

All CBAS centers can offer clinical support to CBAS participants who may be experiencing either a public or personal emergency as defined in the fully developed CBAS ERS policies. The ERS events are broken down into two categories: public

emergencies and personal emergencies. For DY 20, CDA received a total of 5,957 ERS events related to personal emergencies which include: 300 for care transition; 323 related to crisis; and 5,334 initiated for serious illness or injury. In addition, there were 6,873 public emergencies reported by CBAS centers: 5,238 related to epidemic/infectious disease or outbreak such as COVID, TB, and Norovirus; 90 events documented for fires; 667 events for floods; 778 categorized as other; and 100 events related to power outages. The total ERS related events for DY 20 are 12,830. In DY 20-Q4, CDA received 1,435 ERS events categorized as personal emergencies: 495 in October; 409 in November; and 531 in December 2024. The majority of the personal emergencies reported by CBAS providers were for serious illness. CDA also received 892 ERS events related to public emergencies: 257 in October; 69 in November; and 566 in December 2024. The vast majority of public emergencies were initiated due to epidemic/infectious disease outbreaks. The total ERS events for DY 20-Q4 are 2,327. CDA continues to see the successful utilization, implementation, and value that the ERS component brings to the CBAS providers and participants.

New CBAS Centers by County

During DY 20 CBAS certified 13 new CBAS centers that are open, active, and operating. The number of new CBAS centers increased from 294 active centers to 302, demonstrating a three percent increase in DY 20 from 2023. The breakdown of new centers by County is represented below:

- Three in Los Angeles County
- Four in Orange County;
- One in Ventura County;
- One in Riverside County;
- One in Madera County;
- One in Tulare County and;
- Two in San Diego County.

For DY 20 there were two new centers that opened as the first in their county: Madera and Tulare. CDA continues to see tremendous interest and growth through the CBAS initial certification process. The processes continue to be reviewed, streamlined, and built out to ensure the continued success of new CBAS center openings. Newly opened CBAS centers are assigned a CBAS Registered Nurse (RN) and a Program Analyst to support them through their first year and provide technical assistance, guidance, and training. The CBAS Nursing Bureau, also newly developed, welcomed four new Nurse Evaluators in DY 20 to continue to provide a clinical perspective and support the newly opened centers.

All Center Letters (ACL)

All Center Letters (ACLs) are issued to CBAS centers to communicate operational and policy changes. In DY 20, no ACLs were issued.

Summary of Challenges and Actions Taken

Since the end of the PHE in May of 2023 and the implementation of ERS, CBAS providers face a few new challenges which include: the continuous/ongoing assessment of participants who are frail due to a decline in health during the pandemic and the decision to discharge participants who may need a higher level of care; the ongoing need to understand proper initiation of ERS during a personal or public emergency; and the occasional COVID outbreak at the centers, forcing the need to pause in-center congregate services for up to two weeks.

In DY 20, CDA incorporated a review of how CBAS providers operationalize ERS policy into the onsite re-certification process, citing areas of non-compliance and requiring corrective action by the provider to remediate any deficiencies identified. Outside of the formal onsite survey and corrective action processes, CDA continued to enforce ERS policy requirements by providing ongoing support, technical assistance, and outreach to CBAS providers, disseminating clarifying information in quarterly newsletters, and addressing common misconceptions and areas of non-compliance at the 2024 Spring and Fall CAADS Conferences. CDA will continue to provide guidance to CBAS providers and MCPs on ERS utilization and program support-through 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.

Quantitative Findings

Performance Metrics

CDA continued to facilitate the Quality Strategy Advisory Committee meetings in DY 20, which included members of the CDA Executive Team, CBAS staff, CDA providers, DHCS, MCPs, and other stakeholders. The committee meets monthly to develop performance measures required in STC 5.8. In addition, per STC 5.9, "The state will work on establishing the performance measures with CMS to ensure there is no duplication of effort and will report on the initial series within one year of finalization and from that point will report annually."

Throughout DY 20, the CBAS Quality Advisory Committee completed the development and submission of the following PM categories: Administrative Authority, Eligibility, Qualified Providers, Service Plan and Financial Accountability. In DY 20-Q4, the

committee focused on the Health and Welfare category and conducted a thorough review of how the current incident report can serve to collect the necessary data for this category. Furthermore, all PMs were reviewed again for the addition of sub assurances as required. The committee continues to move the final PMs forward, with submissions to DHCS and CMS occurring on an ongoing flow basis. The target completion date is March 1, 2025. The ongoing formal discussions and recommendations from the CBAS Quality Advisory Committee on prioritization and implementation of performance measures are to comply with the 1115 Waiver requirements.

Enrollment Information

Per STC 5.6(a), Figure 11 demonstrates the number of CBAS FFS and managed care beneficiaries, as well as the capacity of each county. Each quarter, the MCPs self-report enrollment data, which results in data lags. In addition, 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.

Refer to the next pages for Figure 11.

Figure 11: Preliminary CBAS Unduplicated Participant – FFS and MCP Enrollment Data with County Capacity of CBAS

County	DY 20–Q1		DY 20–Q2		DY 20–Q3		DY 20–Q4	
	Jan – Mar 2024		April – June 2024		July – Sept 2024		Oct – Dec 2024	
	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	382	66%	386	67%	379	70%	368	60%
Butte	21	35%	23	28%	28	37%	45	37%
Contra Costa	77	44%	76	42%	80	46%	89	45%
Fresno	1,092	66%	1,111	65%	1,113	61%	1,127	59%
Humboldt	94	18%	94	17%	90	18%	101	17%
Imperial	262	56%	260	57%	260	56%	256	52%
Kern	392	39%	419	41%	398	42%	452	40%
Los Angeles	25,662	67%	26,133	68%	27,044	70%	28,314	70%
Madera	N/A	N/A	N/A	N/A	0	0%	0	0%
Merced	115	64%	116	46%	104	42%	114	40%
Monterey	95	59%	104	64%	97	62%	97	61%
Orange	3,061	65%	2,972	62%	3,064	67%	3,510	64%
Riverside	589	40%	592	33%	570	33%	684	37%
Sacramento	390	57%	413	60%	450	62%	453	61%
San Bernardino	893	42%	1,005	47%	1,084	53%	1,155	53%
San Diego	1,916	49%	1,981	49%	1,978	51%	2,133	48%
San Francisco	730	62%	746	64%	751	65%	834	65%
San Joaquin	0	N/A	0	N/A	0	N/A	0	N/A
San Mateo	39	15%	45	15%	71	22%	112	25%
Santa Barbara	69	30%	71	31%	73	35%	86	32%
Santa Clara	632	50%	635	52%	680	55%	688	57%
Santa Cruz	92	51%	99	56%	105	56%	131	53%
Shasta	**	**	**	**	**	**	**	**
Stanislaus	*	*	*	*	*	*	*	*
Ventura	593	39%	494	33%	580	36%	668	39%
Yolo	261	75%	254	70%	254	69%	269	72%
Marin, Napa, Solano	130	39%	129	40%	124	40%	149	68%
Total	**37,657**	**61%**	**38,228**	**61%**	**39,458**	**63%**	**41,932**	**63%**

[5]CBAS capacity data by County – FFS and MCP

**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 small counts are suppressed to protect the privacy and security of participants.*

***Complementary cell suppression*

****Information is not reported for DY 20-Q4 due to a delay in the availability of the data and will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 11 data will be submitted one quarter in the rear due to the reporting delays.*

[5] According to the DY 20 Q1-Q2 data releases, 1% of the overall enrollment are FFS participants.

Figure 11 depicts a few fluctuations in the data for DY 20-Q4 as there are a few increases greater than five percent in capacity used. Of note, when the average daily attendance (ADA) of a center changes, or a new center opens, there may be an increase in overall capacity. However, most new centers take a while to build up their ADA, so a new center may also bring utilization rates or ADA down temporarily until the center builds their census. Figure 11 presents several data points that warrant explanation. For instance, three new centers opened in Orange County during DY 20-Q1 and Q3. Additional fluctuations include Butte, Marin, Napa, and Solano Counties which tend to fluctuate significantly due to the small number of participants served; San Bernardino and San Mateo had three new centers open in Q4 of 2023 which could cause utilization to fluctuate in DY 20 as the centers continue to enroll new participants; and Stanislaus and Alameda counties experienced a center closure on July 8, 2024 and December 13, 2024 respectively, which can increase utilization due to lower license capacity, especially in a small county. Overall, totals in DY 20 Q2, Q3, and Q4 show unduplicated participants increased by 4,275, creating a two percent increase overall in capacity used.

Figure 12: CBAS Participants Enrolled in Enhanced Care Management & Community Supports

Demonstration Year and Quarter	Number of CBAS Participants	Enrolled in Enhanced Care Management (ECM)	Enrolled in Community Supports	Enrolled in Enhanced Care Management (ECM) & Community Supports
DY 20 – Q1 (Jan – Mar 2024)	39,776	2,482	2,224	613
		6.24 %	5.59%	1.54%
DY 20– Q2 (Apr – Jun 2024)	41,812	3,059	2,386	812
		7.32%	5.71%	1.94%
DY 20 – Q3 (Jul – Sep 2024)	43,427	3,677	2,626	1,074
		8.47%	6.05%	2.47%
DHCS Data 09/2024				

**Information is not reported for DY 20-Q4 due to a delay in the availability of the data, and it will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 12 data will be submitted two quarters in the rear due to the reporting delays.*

Figure 12 displays the number of CBAS participants who also received Enhanced Care Management (ECM) and Community Supports (CS) through their Medi-Cal managed care plans. ECM and CS are a new statewide Medi-Cal benefit as part of CalAIM. ECM is available to select "Populations of Focus" that will address the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet members wherever they are (e.g., on the street, in a shelter, in their doctor's office, or at home). Members receiving ECM have a lead care manager who coordinates care and services among the physical, behavioral, dental, developmental, and social services delivery systems. Community Supports are designed to address social drivers of health (factors in people's lives that influence their health). All Medi-Cal managed care plans are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services. As of DY 20-Q3, there were a total of 43,427 CBAS participants – 3,677 received ECM, 2,626 received Community Supports and 1,074 received both benefits. As shown in Figure 12, enrollment for ECM, CS, and both benefits increased between quarters, therefore resulting in no negative change greater than five percent throughout the demonstration year.

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 13 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 13: 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
DY 20-Q1 (Jan-Mar 2024)	3,098	3,042 (98%)	562%	0	0 (0%)	0 (0%)
DY 20-Q2 (Apr-Jun 2024)	3,717	3,686 (99%)	311%	0	0 (0%)	(0%)
DY 20-Q3 (Jul-Sep 2024)	2986	2,940 (98%)	462%	0	0 (0%)	0 (0%)
5% Negative change between last Quarter	No	No	No	No	No	No

**Information is not reported for DY 20-Q4 due to a delay in the availability of the data and will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 13 data will be submitted one quarter in the rear due to the reporting delays.*

Per STC 5.6(a), Figure 13 presents DY 20, Q1-Q3 data for the total determined eligible and ineligible beneficiaries per county. DHCS FFS members have consistently presented zero new assessments performed for CBAS benefits throughout the demonstration year. Among the assessments conducted by MCPs, Figure 13 demonstrates no reported negative change that was greater than five percent from quarter to quarter. A majority of MCP's assessments determined participants to be eligible in DY 20. For example, DY 20-Q3 displays a total of 2,986 new assessments and of those assessments, 2,940 were eligible. Therefore, it is conclusive that 98 percent of participants were eligible and two percent of the participants were ineligible.

CBAS Provider-Reported Data

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, compliance, and oversight of the centers.

Figure 14: CDA – CBAS Provider Self-Reported Data

DY 20-Q1

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	296
Non-Profit Centers	46
For-Profit Centers	250
ADA @ 294 Centers	27,169
Total Licensed Capacity	44,853
Statewide ADA per Center	92
CDA - MSSR Data as of 03/2024	

DY 20-Q2

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	300
Non-Profit Centers	46
For-Profit Centers	254
ADA @ 294 Centers	27,840
Total Licensed Capacity	45,689
Statewide ADA per Center	93
CDA - MSSR Data as of 06/2024	

DY 20-Q3

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	27
Total CA Counties	58
Number of CBAS Centers	300
Non-Profit Centers	45
For-Profit Centers	255
ADA @ 294 Centers	28,835
Total Licensed Capacity	45,760
Statewide ADA per Center	96
CDA - MSSR Data as of 09/2024	

DY 20-Q4

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	28
Total CA Counties	58
Number of CBAS Centers	303
Non-Profit Centers	43
For-Profit Centers	260
ADA @ 294 Centers	20,197
Total Licensed Capacity	46,498
Statewide ADA per Center	96
CDA - MSSR Data as of 12/2024	

Figure 14 identifies the number of counties with CBAS centers and the ADA for DY 20.

The tables above reflect a change in methodology. The old methodology was the sum of the ADA of all CBAS centers divided by the sum of licensed center capacity of all centers. To more accurately reflect the data requested in Figure 14, the new methodology represents the sum of the ADA of all centers divided by the number of centers. The Statewide ADA per center reflects how many participants, on average, were served on any given day at an individual CBAS center. For instance, DY 20-Q1, ADA at 296 active centers was approximately 27,169 participants, indicating that, on average, 92 participants were served on any given day. For DY 20-Q2, ADA at 300 CBAS center was approximately 27,840 participants, indicating that, on average, 93 participants were served. For DY 20-Q3, ADA at 300 active centers was approximately 28,835 participants, indicating that on average, 96 participants were served. The provider self-reported data identified in Figure 14 for the previous three quarters reflects data through September of 2024. For DY 20-Q4, ADA at 303 active centers was approximately 29,197 participants, indicating that on average, 96 participants were served. The provider self-reported data identified in Figure 14 for the previous four quarters reflects data through December of 2024.

The differences DY 20- are: (1) the increase in the number of CBAS Centers from 296 to 303; (2) for-profit centers increased by four percent; (3) non-profit centers decreased by three; (4) in DY 20-Q2, the total ADA at 300 centers increased by 671 compared to DY 20-Q1. In DY 20-Q3, the total ADA also at 300 centers increased by 995 when compared to DY 20-Q2. In DY 20-Q4, the total ADA at 303 centers increased by 365 when compared to DY 20-Q3; (5) lastly, total licensed capacity increased by 836 from DY 20-Q1 to Q2, increased slightly by 71 from DY 20-Q2 to Q3, and further increased by 738 from DY 20-Q3 to Q4.

Consumer Issues and Interventions

Areas of operations were assessed, and it was determined that new applicants applying for CBAS initial certification would benefit by CDA streamlining internal initial certification processes. Process improvements are ongoing to support the initial CBAS certification application processes for applicants who desire to open a new CBAS Center. CDA also restructured the pre-screening phase of the initial certification application process. Desirable outcomes include greater efficiency and reduced timeframes to certify new centers, resulting in more CBAS participants being served more quickly and an increase in new centers being certified. In DY 20, CBAS certified thirteen new CBAS centers, including the first ever in two counties: Madera and Tulare.

During on-site recertification surveys in DY 20, CDA identified CBAS centers that were

not adhering to Emergency Remote Services (ERS) policy requirements. To ensure remediation of the deficient practices identified, specific issues were addressed with individual centers through the plan of correction process.

CBAS Member/Provider Call Center Complaints (FFS/MCP) (STC 5.6.e.iv)

DHCS and CDA continues to respond to issues and questions from CBAS participants, providers, MCPs, and members of the Legislature on various aspects of the CBAS program. Additionally, stakeholders may refer to DHCS and CDA webpages for CBAS updates and information. CBAS providers and members can submit their inquiries to CBASCDA@aging.ca.gov for assistance.

The number of issues that generate CBAS complaints are minimal and are collected from both participants and providers. Complaints are received via telephone or email by MCPs and CDA for research and resolution. Complaints collected by MCPs in DY 20 were primarily related to the authorization process, cost/billing issues, and dissatisfaction with services from a current managed care plan partner. Figures 15 and 16 present complaint data received by CDA and MCPs from CBAS members and providers.

Figure 15: Data on CBAS Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 20-Q1 (Jan – Mar 2024)	3	0	3
DY 20-Q2 (Apr – Jun 2024)	0	1	1
DY 20-Q3 (Jul – Sep 2024)	0	0	0
DY 20-Q4 (Oct – Dec 2024)	0	0	0
CDA Data – Complaints 12/2024			

Figure 16: Data On CBAS Managed Care Plan Complaints

Demonstration Year and Quarter	Member Complaints	Provider Complaints	Total Complaints
DY 20-Q1 (Jan – Mar 2024)	3	0	3
DY 20-Q2 (Apr – Jun 2024)	4	5	9
DY 20-Q3 (Jul – Sep 2024)	0	0	0
Phone Data – Phone Center Complaints 09/2024			

**Information is not reported for DY 20-Q4 due to a delay in the availability of the data and will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 16 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 15 shows complaints received by the CDA team for DY 20, Q1-Q4. In DY 20-Q1, CBAS received three member complaints and exhibited a decrease in Q2, reflecting zero member complaints. In addition, CBAS saw a decrease in total complaints in Q2, reporting one provider complaint. The Q2 provider complaint was related to payment issues with several MCPs due to the 2024 MCP transition. DY 20 continued to present a decrease in overall complaints in Q3 and Q4, both quarters displaying zero complaints in Figure 15. Figure 16 presents complaints reported by MCPs. MCPs recorded three complaints in the first quarter, followed by nine total complains in Q2 displaying a negative increase in complaints from providers and members. However, MCPs experienced a significant decrease in the total complaints, reporting nine total complaints in Q2 to zero complaints in Q3. According to the MCPs and CDA's findings, DY 20 does not present a negative change in reported complaints during the most recent quarters, i.e., Q2 and Q3.

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

Grievances and appeals data are recorded by the MCPs and reported to DHCS. Grievances data collection range from issues with access and availability of services to inconveniences of travel to access CBAS, and provider grievances. Individuals are

entitled to appeal the issues like denials for eligibility or requests for specific providers; appeals may also include issues with limited services or excessive travel to acquire CBAS services. Figures 17 and 18 display the recorded data from MCPs for grievances and appeals.

Figure 17: 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
DY 20-Q1 (Jan – Mar 2024)	10	1	0	7	18
DY 20-Q2 (Apr – Jun 2024)	5	0	0	8	13
DY 20-Q3 (Jul – Sep 2024)	3	0	0	24	27
MCP Data - Grievances 09/2024					

**Information is not reported for DY 20-Q4 due to a delay in the availability of the data and will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 17 data will be submitted one quarter in the rear due to the reporting delays.*

Figure 18: 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
DY 20–Q1 (Jan – Mar 2024)	7	0	0	1	8

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
DY 20–Q2 (Apr – Jun 2024)	11	0	0	1	12
DY 19–Q3 (Jul – Sep 2024)	16	1	0	2	19
MCP Data - Grievances 09/2024					

**Information is not reported for DY 20-Q4 due to a delay in the availability of the data and will be presented in the DY 21-Q1 Quarterly Report. For future reports, Figure 18 data will be submitted one quarter in the rear due to the reporting delays.*

As recorded in Figure 17, there were a total of 27 grievances that MCPs recorded in DY 20-Q3, which is an increase from 13 grievances reported in DY 20-Q2. Partial data included for DY 20 present a significant number of grievances that are reported from quarter to quarter. MCPs note grievances from multiple counties, including San Diego, Sacramento, Riverside, and San Bernardino. San Diego presented the most grievances among the total number of grievances. MCPs recorded other CBAS grievances that involved challenges with access and availability of services, attitudes/services, and general balance billing. As demonstrated in Figure 17, the total number of grievances have presented negative changes given there was not a significant decrease in total grievances between quarters. Figure 18 displays the CBAS appeals data for DY 20. In DY 20-Q3, 19 total appeals were recorded for CBAS by MCPs. As identified in Figure 18, MCPs reported the appeals were commonly due to denials or limited services. Additionally, the data reveals a negative increase in total appeals between quarters.

Individuals in disagreement with the outcome of their request for services or how the case was handled, may file an appeal. Upon receiving a Notice of Action (NOA), the individual may request a State Fair Hearing (SFH). The California Department of Social Services (CDSS) facilitates the hearings/appeals processes, with Administrative Law Judges hearing all cases filed. CDSS reports the fair hearings/appeals data to DHCS. As presented in Figure 19 below, a total of two SFH requests were filed in DY 20-Q2. The requests for hearings were filed in Orange County and were reported to be due to the

delay/denial of CBAS services. The final dispositions for both requests were withdrawn. DHCS continues to work with the MCPs to identify and resolve sources of increased grievances and appeals identified within these reports.

Figure 19: Total Number of State Fair Hearings

Demonstration Year and Quarter	Number of Requested State Fair Hearings
DY 20–Q1 (Jan – March 2024)	0
DY 20–Q2 (Apr – June 2024)	2
DY 20–Q3 (July – Sept 2024)	0
DY 20–Q4 (Oct – Dec 2024)	0
Total Number	**2**

CBAS FFS and Managed Care Access Monitoring

Per STC 5.6(e), CDA reported the access/capacity in every county where CBAS exists. Additionally, the data collection will demonstrate overall utilization of newly opened and closed centers throughout DY 20. Figure 20 accounts for 29 counties with CBAS centers, detailing the capacity used for CBAS centers. Figure 21 displays CBAS operating centers that experienced openings and closures for the months of DY 20, demonstrating the net losses and gains. DHCS and CDA continue to monitor the overall utilization of CBAS, including the opening and closing of CBAS centers since April 2012, when CBAS became operational.

Figure 20: CBAS Centers Licensed Capacity

County	DY 20-Q1 (Jan-Mar 2024)	DY 20-Q2 (Apr-June 2024)	DY 20-Q3 (July-Sept 2024)	DY 20-Q4 (Oct– Dec 2024)	Percent Change Between Last Two Quarters	***Capacity Used
Alameda	370	370	370	370	0.0%	60%
Butte	60	60	60	60	0.0%	37%
Contra Costa	130	130	130	130	0.0%	45%
Fresno	1,297	1,297	1,297	1,297	0.0%	59%
Humboldt	349	349	349	349	0.0%	17%
Imperial	355	355	355	355	0.0%	52%
Kern	805	805	805	805	0.0%	40%
Los Angeles	28,006	28,301	28,597	28,730	+0.5%	70%
Marin	0	0	0	0	N/A	N/A
Madera	0	0	210	210	0.0%	0%
Merced	124	175	175	175	0.0%	40%
Monterey	110	110	110	110	0.0%	61%
Napa	100	100	100	100	0.0%	45%
Orange	3,501	3,711	3,636	3,906	+7.4%	64%
Riverside	1,025	1,225	1,225	1,225	0.0%	37%
Sacramento	520	520	520	520	0.0%	61%
San Bernardino	1,446	1,446	1,446	1,446	0.0%	53%
San Diego	2,359	2,439	2,439	2,574	+5.5%	48%
San Francisco	926	926	926	931	0.5%	65%
San Joaquin	0	0	0	0	N/A	N/A
San Mateo	245	245	245	245	0.0%	25%
Santa Barbara	180	180	180	180	0.0%	32%
Santa Clara	820	820	820	820	0.0%	57%
Santa Cruz	120	120	120	120	0.0%	53%
Shasta	85	85	85	85	0.0%	40%
Solano	**	**	**	**	**	**
Stanislaus	*	*	*	*	*	*
Ventura	1,066	1,066	1,066	1,066	0.0%	39%
Yolo	224	224	224	224	0.0%	72%
SUM	**44,853**	**45,689**	**45,760**	**46,498**	**+ 1.6%**	**63%**

**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 small counts are suppressed to protect the privacy and security of participants.*

***Complementary cell suppression*

****Capacity Used measures the average number of total individuals receiving CBAS at a given CBAS center daily (average daily attendance [ADA]) versus the maximum capacity available.*

As shown in Figure 20, in DY 20-Q4, Orange County shows an increase of 7.4 percent between DY 20-Q3 and Q4 as a center opened on December 6, 2024. San Diego County shows an increase of 5.5 percent between DY 20-Q3 and Q4 as a center opened on October 29, 2024. Data reported in Figure 20 for DY 20, Q1-Q4, did not indicate any other fluctuations in capacity by county.

Unbundled Services

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. Members 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 whom 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. Unbundled services refer to parts of the CBAS benefit delivered outside of centers with a similar objective of supporting participants and allowing them to remain in the community. The majority of CBAS participants in most counties can choose an alternate CBAS center within their local area.

Figure 21: CBAS Center History

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
Dec 2024	302	1	2	1	303
Nov 2024	301	0	1	1	302
Oct 2024	300	0	1	1	301
Sept 2024	298	0	2	2	300
Aug 2024	297	0	1	1	298

CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
July 2024	299	2	0	-2	297
Jun 2024	298	1	2	1	299
May 2024	298	0	0	0	298
Apr 2024	296	0	2	2	298
Mar 2024	295	0	1	1	296
Feb 2024	295	0	0	0	295
Jan 2024	294	0	1	1	295

According to the data in Figure 21 above, two centers closed, and three centers opened in DY 20-Q3. Center openings for Q3 included two in Los Angeles County and one in Madera County. The center that opened in Madera County is the first in the county. The data shown in Figure 21 for DY 20-Q4 includes four new center openings, one in San Diego County, one in Los Angeles County, one in Orange County, and one in Tulare County. The center that opened in Tulare County is the first in the county. The data for Q4 shows one center closure in Alameda County. Figure 21 shows there was no negative change of more than five percent in DY 20-Q2 and Q3, therefore, no analysis is needed to address such variances.

Budget Neutrality and Financial Updates

The CalAIM Section 1115 demonstration waiver will have no effect on budget neutrality as actual expenditures for the CBAS benefit are included in the expenditure limit for the demonstration. As such, the program cannot quantify savings, and the extension of the program has no effect on overall waiver budget neutrality.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM AND CONTINGENCY MANAGEMENT

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal eligible individuals with a SUD who reside in a county that elects to participate in the DMC-ODS (hereafter referred to as DMC-ODS members). All California counties have the option to participate in the DMC-ODS program to provide their resident Medi-Cal members with a range of evidence-based SUD treatment services in addition to those available under the traditional Drug Medi-Cal (DMC) program.

The DMC-ODS program was originally authorized in 2015 by the Medi-Cal 2020 Section 1115(a) demonstration. However, as a part of CalAIM, on June 30, 2021, DHCS submitted a 1915(b) waiver renewal to CMS to consolidate Medi-Cal managed care delivery system programs previously authorized under California's Medi-Cal 2020 Section 1115(a) demonstration – Medi-Cal Managed Care, Dental Managed Care, and DMC-ODS – with Specialty Mental Health Services (SMHS) under the 1915(b) waiver in 2022. On December 29, 2021, CMS approved the reauthorization of DMC-ODS, shifting the managed care authority to the consolidated CalAIM 1915(b) waiver and using the Medicaid State Plan to authorize the majority of DMC-ODS services. The authority to provide reimbursable Medi-Cal services for DMC-ODS members residing in institutions for mental disease (IMDs), Medi-Cal Peer Support Services, and Contingency Management (CM) remain authorized under the Section 1115 demonstration through December 31, 2026. This CalAIM demonstration continues to provide the state with the ability to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS members 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.

Successes/Accomplishments

Expansion of the Recovery Incentives Program

In 2024, DHCS issued Behavioral Health Information Notice (BHIN) 24-031, superseding BHIN 23-040, which provided updated guidance for the Recovery Incentives Program, California's Contingency Management Benefit. To date, 24 DMC-ODS counties have opted into the benefit. The revised BHIN provided guidance to allow the 16 remaining DMC-ODS counties to opt-in to the program by submitting a streamlined Implementation Plan and receiving DHCS approval. The expansion results in the benefit now being available to 97 percent of the State's Medi-Cal members.

Enhanced Urinary Drug Testing (UDT) and Overdose Prevention Efforts

BHIN 24-031 also incorporates new UDT approval efforts, adding two UDTs that include fentanyl testing. Given that fentanyl is the leading cause of drug overdose deaths, including in stimulant-related deaths, identifying combinations of other illicit drugs with fentanyl is crucial. In addition, DHCS released updated program frequently asked questions (FAQs) and training materials that include the following topics: identifying individuals at risk for fentanyl exposure; providing appropriate counseling to Medi-Cal members with stimulant use disorder; referral for evaluation for medications for addiction treatment (MAT); and access to naloxone for overdose reversals.

Quarterly Progress Reporting (QPR) for Program Monitoring

In September 2024, DHCS delivered the QPR Template to county leads and Behavioral Health Directors to track monitoring and oversight activities. The first of four QPRs covers October 2024 through December 2024 and was due to DHCS by January 31, 2025.

Program Impact and Utilization Metrics

As of December 31, 2024, 100 sites in 19 counties were providing CM services. These counties cover 80 percent of Medi-Cal members. The program served 5,060 members, with 1,159 members successfully graduating. In 2024, 80,791 UDTs were administered, with 76,969 testing negative for stimulants. For all members, the rate of negative drug test results was 95.0 percent, whereas for members who completed 24 weeks of CM, this rate was 94.8 percent. Both figures are substantially higher than the average of 85.3 percent negative drug tests among all submitted samples drawn from the CM literature (Roll and Shoptaw, 2006; Stitzer et al. 2020; Strona 2006).

When unexcused absences are added to the count, the negative drug results percentage decrease to 74.3 percent for all members and 73.9 percent for CM-completing members. This percentage is still notably higher than the average of 53.4 percent calculated from CM reports that have handled absences similarly (Chudzynski et al. 2015; Peirce et al 2006; Petry et al 2005).

Additionally, DHCS approved seven new gift card vendors bringing the total to 32 vendor options for members to redeem gift cards The most common gift card vendors in 2024 were:

- Walmart (54 percent)
- Chevron (15 percent)

- Nike (three percent)

Members earned $1,181,341.50 in incentives with $1,078,026.50 disbursed in 2024.

Behavioral Health Documentation Redesign and ASAM Criteria Updates

In 2023, DHCS released BHIN 23-068, which provides updates to the CalAIM Behavioral Health policy initiative Documentation Redesign, inclusive of DMC-ODS services. These updates were made to update Medi-Cal behavioral health documentation requirements to improve the member experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective member care; address equity and disparities; and ensure quality and program integrity. Following the release of BHIN 23-068, the ASAM published updated criteria, the ASAM Criteria 4th Edition. The ASAM Criteria Assessment Interview Guide and ASAM CONTINUUM software are currently being updated to reflect the 4th Edition criteria.

To support DMC counties and DMC-ODS plans with implementing new assessment tools based on ASAM's 4th Edition criteria, DHCS released BHIN 24-045 in 2024. This guidance partially supersedes the previous ASAM 3rd Edition Criteria assessment included in BHIN 23-068. DHCS is actively collaborating with stakeholders regarding implementation of 4th Edition criteria and will publish updated guidance, consistent with the new criteria, in a forthcoming BHIN.

Medi-Cal Peer Support Services and NPI Guidance

Throughout 2024, DHCS continued to develop an all-inclusive Medi-Cal Peer Support Services BHIN (consolidating various previously published guidance on the benefit), as well as accompanying FAQs, which are expected to be finalized and released in early 2025. The Medi-Cal Peer Support Services BHIN will include updates and guidance on, though not limited to, the requirements and standards for implementing the Medi-Cal Peer Support Services benefit, the Medi-Cal Peer Support Specialist provider type, and Medi-Cal Peer Support Specialist certification programs. DHCS also continued to meet with internal and external stakeholders, soliciting feedback to inform DHCS' continued policy development around requiring Medi-Cal Peer Support Specialists and other unlicensed providers to obtain a National Provider Identifier (NPI) number. DHCS will continue its efforts in early 2025 to develop NPI guidance, which is expected to be published in Q1-Q2 of 2025.

DMC-ODS Program Expansion

DHCS completed the DMC-ODS opt-in processes for two additional California counties that

were newly seeking to participate in the DMC-ODS program: Lake and Sonoma Counties. Lake County began offering DMC-ODS services on July 1, 2024, and Sonoma County began offering DMC-ODS services on December 1, 2024. As of December 2024, 40 of California's 58 counties are actively providing DMC-ODS services.

Program Highlights

DHCS provided support and guidance to the DMC-ODS Plans through policy updates and the implementation of various initiatives. Program highlights in DY 20 include but are not limited to: updating the integrated member handbook template requirements (BHIN 24-034), ensuring compliance with Patient Access and Provider Directory Application Programming Interfaces (API) (BHIN 23-032), providing technical assistance to counties to help execute Memorandum of Understandings (MOUs) for DMC-ODS Plans and Medi-Cal Managed Care Plans (MCPs) (BHIN 23-054), continuing to collect 1915(b) Quarterly Appeals and Grievance reports (BHIN 23-062) and Managed Care Program Annual Report (MCPAR) (BHIN 22-036) from the DMC-ODS Plans.

DHCS provided guidance to updated requirements related to the integrated member handbooks for the 2025 calendar year. The updates require DMC-ODS Plans to develop and distribute integrated member handbooks to streamline and strengthen: the member's experience with county and county-contracted providers when seeking services, the DMC-ODS Plan's internal structures and processes regarding program administration and data management, and DHCS' oversight of DMC-ODS Plan operations. The updates include, but are not limited to, requiring an integrated member handbook for DMC-ODS Plans and Mental Health Plans (MHPs), other SUD services available from Managed Care Plans or Medi-Cal "Fee for Service" programs, "Justice Involved Reentry" services, and the availability of services by telephone or telehealth. In addition, the following sections were updated: Signs/symptom list, language regarding minor consent per Assembly Bill 665, language indicating members have the right to not pay for continued services while a State Fair Hearing is pending and if the decision is in favor of the DMC-ODS Plan's adverse benefit determination, and lastly, language was updated for grievance decisions to be made within 30 calendar days. Beginning February 2025, DHCS will review the integrated member handbooks submitted by DMC-ODS Plans to ensure compliance with applicable standards.

DHCS reviewed evidence from counties to demonstrate their compliance with the Patient Access and Provider Directory API requirements. This included the review of the DMC-ODS Plan's policy and/or procedure to ensure compliance with Patient Access API requirements.

DHCS provided guidance to the DMC-ODS Plans to address the oversight, compliance, and reporting requirements to ensure that MOUs between Medi-Cal MCPs and DMC-ODS Plans are regularly reviewed and updated. For DMC-ODS Plans that have not executed their MOUs, DHCS is providing technical assistance through regularly scheduled monthly calls, email correspondence, and requiring those DMC-ODS Plans to submit quarterly reports to provide updates regarding the status of the DMC-ODS Plans MOU execution.

DHCS continued to collect quarterly appeals and grievance data from DMC-ODS Plans and now has an adequate data set to identify trends to address with the DMC-ODS Plans. The goal is to utilize the data analysis to provide technical assistance to the DMC-ODS Plans to improve the quality of services provided to members. Additionally, DHCS submitted its third MCPAR report to CMS for State Fiscal Year 2023-24.

On October 20, 2023, DHCS submitted its application for a new Medicaid Section 1115 demonstration to increase access to and improve mental health services for Medi-Cal members statewide. The BH-CONNECT Section 1115 demonstration application, takes advantage of Centers for Medicare & Medicaid Services' (CMS') 2018 guidance and associated federal funding aimed at improving care for Medi-Cal members living with significant behavioral health needs. This demonstration builds on California's historic commitment to creating a full continuum of care for SUD treatment and recovery services through the DMC-ODS. Throughout calendar year 2024, DHCS designed the benefit and negotiated the various waiver components of the program with CMS. In December 2024, DHCS received CMS approval of its BH-CONNECT waiver and approval of its final protocol in January 2024.

This demonstration will allow DMC-ODS Plans to cover community-based services and evidence-based practices, such as Community Health Worker services and Supported Employment services on an opt-in basis. A statewide incentive program will be established to strengthen counties' quality monitoring infrastructure, and an opt-in incentive program will be established to strengthen the continuum of community-based services available to Medi-Cal members living with significant behavioral health needs, inclusive of DMC-ODS Plans.

DHCS continues to create opportunities for access to 24/7 low-barrier SUD treatment in emergency departments (EDs) through CA Bridge. As of January 2024, DHCS has invested $71.6 million in total funding for 282 hospitals to serve as primary access points for evidence-based treatment of behavioral health symptoms through:

- Expanding access to low barrier medications for addiction treatment (MAT).

- Providing navigation and support.
- Facilitating direct referrals for continued care in the community.

This project has seen great outcomes with:

- Over 300,000 patients seen for substance use and/or mental health conditions.
- Over 240,000 patients seen were identified as having an opioid use disorder.
- Over 97,000 encounters in the ED occurred where MAT was prescribed or administered.

A recent CA Bridge implementation study compared outcomes between adult patients discharged from EDs with cocaine, alcohol, and opioid use-related diagnoses who received care from a BH Navigator to those who did not. The study found that patients who had the BH Navigator intervention were three times more likely to engage in treatment within 30 days of discharge compared to those who did not.

To support the long-term sustainability of CA Bridge, DHCS has collaborated intensively with Medi-Cal managed care plans, hospitals, and the CA Bridge program to support the successful implementation of the Community Health Worker (CHW) benefit for Medicaid reimbursement for BH navigator services. In 2023, DHCS drafted requirements for the MCPs to implement a billing pathway for supervising providers, including contracted hospitals, to claim provisions of CHW services during an ED visit and as an outpatient follow-up to that ED visit. The BH-CONNECT demonstration will also expand the CHW benefit to DMC-ODS Plans.

Qualitative Findings

During the DY 20 reporting period, DHCS performed periodic reviews of counties to ensure compliance with program requirements. When counties were found out of compliance, DHCS provided technical assistance and as needed, issued Corrective Action Plans (CAPs) to address outstanding issues. These reviews include but are not limited to: Annual County Monitoring Activities (ACMA), Member Handbooks, MOUs for Medi-Cal Managed Care and DMC-ODS Plans, and CAP Resolutions from DHCS Audits.

DHCS is in the process of reviewing and providing technical assistance to the DMC-ODS Plans for non-compliance items identified through the ACMA review. For items of non-compliance that are not resolved in the specified timeframe, the county will be issued a CAP and will continue to be monitored until resolution of the CAP.

DHCS continues to monitor and oversee outstanding CAPs related to DHCS Audit Reviews. This is completed through regular communication with the county through

technical assistance calls and e-mails to follow up on the status of their CAP Resolution.

Outreach Activities

- DHCS held monthly calls with each participating DMC-ODS Plan to provide technical assistance and monitor ongoing compliance with contractual and regulatory compliance, including status updates on CAPs and reports.
- DHCS hosted All County Behavioral Health monthly meetings with counties and stakeholders to address various upcoming and published BHINs. Additional assistance and guidance are provided during these meetings.
- DHCS issues weekly Behavioral Health Stakeholder Updates and Information Notices communication via email to stakeholders. The information provided includes announcements of draft and finalized BHINs, as well as upcoming webinars and other information.
- For counties that express interest in opting in to offer DMC-ODS, DHCS provides technical assistance to address any barriers related to opting into DMC-ODS.

Q1 – Q3 Activities, Including CalAIM Demonstration Guidance

- January 17, 2024, January All County Call
  - Drug Medi-Cal Organized Delivery Systems: BHIN 24-001
  - Interoperability: Patient Access and Provider Directory APIs
- February 21, 2024, February All County Call
  - Behavioral Health Quality Improvement Program (BHQIP) Updates
  - Documentation Re-Design Updates
- March 20, 2024, April All County Call
  - BHIN Updates – 18-010E, Parity
  - Documentation Re-Design FAQ
  - Interoperability Compliance Monitoring Process
  - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration – County Assessments for the Statewide Incentive Program
  - Recovery Incentives Program
- April 17, 2024 – April All County Call
  - Recovery Incentives Program
  - CalAIM BHQIP March 2024 Reporting Period Update

- May 15, 2024 – May All County Call
  - Documentation Re-Design FAQs
  - DMC-ODS FAQs
  - Claim Submission
- June 27, 2024 – June All County Call
  - BHIN 23-032: Interoperability Compliance Monitoring Results
  - DMC-ODS FAQS
- July 17, 2024 – July All County Call
  - The Recovery Incentives Program
- August 21, 2024 – August All County Call
  - Medi-Cal Peer Support Services
- September 18, 2024, September All County Call
  - External Quality Review Organization
  - Behavioral Health Quality and Healthy Equity Framework Update
  - 2025 Integrated Member Handbook Templates
  - Medi-Cal Eligibility: Inter-County Transfer (ICT) Policy Reminder
  - CalAIM Behavioral Health Administrative Integration: Provider Integration

Recent Activities, Including CalAIM Demonstration Guidance

- October 16, 2024 – October All County Call
  - DMC-ODS FAQs
  - MOU Quarterly Progress Report
  - 1915(b) Quarter 1 Appeals and Grievance Report
  - Integrated Member Handbook
- November 20, 2024 – November All County Call
  - Plan Data Feed- Inclusion of SUD Claims Data
  - BHIN Update: Mental Health Substance Use Disorder 18-010E & BHIN 22-070
  - BHIN Update: Behavioral Health Accountability Set MY24 Sanctions
- December 18, 2024 – December All County Call
  - Senate Bill (SB) 923

- Documentation Redesign Updates
- BHIN 23-068: Updates to Documentation Requirements for SMH, DMC, and DMC-ODS Services
- ACMA Updates
- SUD Report Inbox Updates
- CARE Act Data Collection and Reporting Update
- CalAIM Section 1915(b) Waiver Appeals and Grievance (A&G) Report

Quality Control/Assurance Activity

DHCS conducts annual compliance reviews of each county that participates in the provision of DMC-ODS services. The annual compliance reviews of all counties during SFY 2023-24 were completed on June 30, 2024. Once a review is completed, a Findings Report is issued to the county. The county is then required to submit a CAP for each area of non-compliance within 60 business days of receipt of the report for review, acceptance, and follow-up. DHCS follows up with each county to periodically check on the status of the CAP and provide technical assistance for the resolution of CAP items until resolved. The Findings Reports are posted to the DHCS website on the County Performance Reports webpage.

During SFY 2023-24 and DY 20-Q2, DHCS announced to counties that compliance reviews are scheduled to begin for SFY 2024-25 in July 2024. DHCS began conducting the FY 2024-25 compliance reviews by requesting supporting documentation, demonstrating compliance with federal and state regulations, requirements, and contractual obligations. DHCS began reviewing documentation received from the counties in preparation for DMC-ODS compliance reviews scheduled to start within DY 20-Q3. DHCS completed nine compliance reviews during DY 20-Q4.

Figure 22 demonstrates when County DMC-ODS compliance reviews were completed during DY 20.

Figure 22: DY 20 Compliance Reviews

County	Month/Year
Kern	January 2024
San Diego	January 2024
Stanislaus	February 2024
Napa	February 2024

County	Month/Year
San Francisco	February 2024
Fresno	March 2024
Marin	April 2024
San Luis Obispo	April 2024
Monterey	April 2024
Riverside	April 2024
Alameda	May 2024
Yolo	May 2024
Imperial	May 2024
Sacramento	May 2024
Nevada	May 2024
San Bernardino	May 2024
Santa Clara	May 2024
Santa Cruz	May 2024
Siskiyou	May 2024
Mendocino	May 2024
Shasta	May 2024
Humboldt	May 2024
Lassen	June 2024
Solano	June 2024
Modoc	June 2024
San Benito	June 2024
Los Angeles	June 2024
El Dorado	June 2024
Santa Barbara	June 2024
Santa Clara	July 2024
Tulare	September 2024
Contra Costa	October 2024
Orange	October 2024
San Luis Obispo	October 2024
San Mateo	November 2024
Mariposa	November 2024
San Joaquin	December 2024
Merced	December 2024

County	Month/Year
Fresno	December 2024

Operational Updates

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to behavioral health payment and documentation reform, and streamlining and standardizing clinical documentation requirements. DMC-ODS Plans are utilizing policy guidance released from January 2024 through December 2024 related to these items to update and implement policies and procedures.

Behavioral Health Information Notices requiring updates to policies and procedures released in Q1 – Q3 of DY 20 are listed below:

- 24-001 - Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026.
- 24-006 - Updated guidance for the California Advancing and Innovating Medi-Cal Initiative (CalAIM) Behavioral Health Quality Improvement Program (BHQIP)
- 24-007 – Effective Communication, Including Alternative Formats, for Individuals with Disabilities
- 24-008 – County of Responsibility and Reimbursement for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- 24-010 - Drug Medi-Cal (DMC) Claiming Timelines for Short Doyle Medi-Cal (SD/MC)
- 24-020 – 2024 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans
- 24-023 – Standards for Specific Behavioral Provider Types and Services; Amends Relevant Sections within Title 9 and Title 22 of the California Coded of Regulations (CCR)
- 24-026 - Supersedes BHIN 23-024. Drug Medi-Cal Organized Delivery System (DMC-ODS) Treatment Perception Survey (TPS)
- 24-030 - 2024 CalOMS Tx Update to Demographic Reporting Requirements
- 24-031 - Updated Guidance for the Recovery Incentives Program: California's Contingency Management Benefit

- 24-032 - Update to the Servicemembers Civil Relief Act (SCRA) via Veterans Auto and Education Improvement Act of 2022 (H.R. 7939): To advise of the exemption of certain individuals from the California counselor registration or certification requirements following updates to the SCRA.

Behavioral Health Information Notices requiring updates to policies and procedures released in DY 20-Q4 are listed below:

- 24-034 - Supersedes BHIN 23-048. Integrated BH Member Handbook Requirements and Templates
- 24-045 - Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) American Society of Addiction Medicine (ASAM) Assessment Tools

Policy/Administrative Issues and Challenges

For MOU requirements, DHCS continues to provide technical assistance to counties to have executed MOUs between the county and their local managed care plans. The counties will continue to submit executed MOUs and Quarterly MOU Progress reports to DHCS until all required MOUs are executed.

Consumer Issues and Interventions

DHCS continues to respond to issues, complaints, and grievances related to DMC-ODS Plans delivering DMC-ODS services. For Q1 through Q3, all issues, complaints, or grievances reported to DHCS have been resolved. In Q4 of 2024, DHCS received one complaint from a Medi-Cal member. This incident was resolved and closed. Issues received by DHCS are prioritized to ensure timely responses to members.

Quantitative Findings

Figure 23: Quarterly Count of Unduplicated DMC-ODS Members with FFP Funding was determined by unique members with DMC-ODS residential claims from the Short-Doyle billing system. Figure 24: Member Enrollment was determined by unique members that received DMC-ODS residential claims within each month of the reporting period for the ACA and non-ACA population. Figure 25: Aggregate Expenditures represent total units of DMC-ODS residential service utilized by ACA and non-ACA population and their corresponding approved amounts.

Performance Metrics

Prior quarters have been updated based on new claims data. The performance metrics below consist of preliminary data since California counties have up to 12 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.

Figure 23: Quarterly Count of Unduplicated DMC-ODS Members with FFP Funding

Quarter	ACA	Non-ACA	Total
DY 20-Q1	11,029	3,614	14,643
DY 20-Q2	11,120	3,348	14,468
DY 20-Q3	8,566	2,422	10,988
DY 20-Q4	3,459	968	4,427

**Affordable Care Act (ACA)*

Figure 24: Member Enrollment

Population	Month 1	Month 2	Month 3	Quarter	Current Enrollees (To date)
ACA	6,217	6,250	6,404	DY 20-Q1	11,029
ACA	6,390	6,338	6,247	DY 20-Q2	11,120
ACA	5,412	4,970	3,309	DY 20-Q3	8,566
ACA	2,986	1,347	213	DY 20-Q4	3,459
Non-ACA	2,025	1,947	1,882	DY 20-Q1	3,614
Non-ACA	1,848	1,820	1,639	DY 20-Q2	3,348
Non-ACA	1,433	1,333	898	DY 20-Q3	2,422
Non-ACA	796	407	33	DY 20-Q4	968

Figure 25: Aggregate Expenditures for ACA And Non-ACA

Population	Units of Service	Approved Amount	FFP Amount	SGF Amount	County Amount	DY
ACA	425,722	$99,484,361.20	$89,436,874.19	$8,804,695.79	$1,242,791.22	DY 20-Q1
Non-ACA	119,553	$28,684,979.39	$14,382,926.87	$12,008,160.70	$2,293,891.82	DY 20-Q1
ACA	436,581	$102,360,066.41	$92,036,286.43	$9,081,234.97	$1,242,545.01	DY 20-Q2
Non-ACA	110,731	$26,214,599.63	$13,151,596.31	$10,874,496.12	$2,188,507.20	DY 20-Q2
ACA	317,670	$74,857,202.75	$67,310,271.42	$6,443,050.73	$1,103,880.60	DY 20-Q3
Non-ACA	76,323	$18,099,994.47	$9,077,861.43	$7,211,948.42	$1,810,184.62	DY 20-Q3
ACA	107,723	$25,681,507.51	$23,108,276.87	$2,156,254.70	$416,975.94	DY 20-Q4
Non-ACA	26,012	$6,308,809.17	$3,159,503.78	$2,512,589.96	$636,715.43	DY 20-Q4

Performance Metrics Enclosures/Attachments

The attachment, CalAIM 1115 Waiver Progress Report DY20-Annual_ODS-RES.xlsx, contains the Enrollment data, Member Month data, and Aggregate Expenditures data referenced in this section of the report. Additionally, the attachment contains the ACA and Non-ACA Expenditures reported for DY 20 as of December 31, 2024.

Recovery Incentives Program

In 2023, DHCS approved 24 DMC-ODS Plans for the pilot program of the Recovery Incentives Program: California's Contingency Management Benefit. As of December 31, 2024, 19 of these counties are providing Recovery Incentive Program CM services. These counties include Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Marin, Nevada, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Barbara, Santa Clara, Tulare, Ventura, and Yolo. Counties working on readiness are Sacramento, San Joaquin, Santa Cruz, and Shasta counties, and they are preparing to launch services. One county, San Luis Obispo, withdrew from the program citing staffing issues as the reason they are unable to participate. DHCS worked with the county to recoup start-up funds. Collectively, the participating counties cover 80 percent of Medi-Cal members.

As of December 31, 2024, the program has approved 100 sites, of which 94 are actively

serving members. In addition to these sites, 15 have completed the required Implementation Training and are working to complete the Readiness Assessment in order to launch the Recovery Incentives Program. Additional sites are approved on a rolling basis as they complete the Implementation Training and Readiness Assessment process. The Figure below describes each county and the number of approved active sites in each.

Figure 26: Approved Active Sites by County

County	Total Active Sites
Alameda	1
Contra Costa	2
Fresno	1
Imperial	4
Kern	6
Los Angeles	47
Marin	3
Nevada	1
Orange	6
Riverside	9
San Bernadino	3
San Diego	3
San Francisco	4
San Mateo	1
Santa Barbara	3
Santa Clara	2
Tulare	2
Ventura	1
Yolo	1

CM recognizes individual positive behavioral change, as evidenced by urinary drug tests (UDTs) that are negative for stimulants, and reinforces that behavior through motivational incentives. The Recovery Incentives Program served 5,060 members, and 1,159 members have graduated from the program. In 2024, 80,791 UDTs were administered, of which 76,969 were negative for stimulants. As a result, $1,181,341.50 in motivational incentives (gift cards) were earned by members for meeting the treatment goal of submitting a UDT negative for stimulants.

Members can receive their gift card incentive immediately when earned, or they can

choose to 'bank' the incentive amount to save up for a larger gift card to be dispersed at a later date. Of the total incentives earned, $1,078,026.50 were dispersed in 2024. When a member chooses to redeem their incentive, they can choose from a list of DHCS-approved vendors. In addition to fulfilling program requirements, vendors are selected to ensure a diverse representation of interests and locations, promoting inclusivity. In 2024, DHCS approved seven new vendors for a total of 32. The most common gift card vendors chosen in 2024 included Walmart (54 percent), Chevron (15 percent), and Nike (three percent).

DHCS Recovery Incentives Program Approved Vendor List:

- Adidas
- Apple Store
- Bath and Body Works
- Best Buy
- Burger King
- Chevron
- Cold Stone
- Columbia
- Domino's Pizza
- Foot Locker
- GameStop
- Gap
- Google Play
- Jamba
- Krispy Kreme
- Kohl's
- Lowe's
- Marshalls
- Nike
- Old Navy
- Petco
- Pete's Coffee
- PetSmart
- Subway
- The Home Depot
- The Vitamin Shoppe
- TJ Maxx

- Ulta
- Victoria's Secret
- Walmart

Following the completion of the first year of the pilot program, DHCS updated program policies, procedures, training materials, data collection points, and programmatic resources to integrate lessons learned and support program expansion. In August 2024, DHCS released BHIN 24-031, which supersedes BHIN 23-040. This revised BHIN allows any DMC-ODS county to participate in the Recovery Incentives Program after submitting a new, streamlined Implementation Plan to DHCS and upon receiving DHCS approval. The program team is working with two counties on the application and conducts outreach to counties as they are approved for DMC-ODS. The program expansion aims to include the remaining DMC-ODS Medi-Cal population and reach populations disproportionately afflicted with stimulant use disorder, such as rural and tribal communities.

The revised BHIN also incorporates new UDT approval efforts that allowed two UDTs, including fentanyl testing, to be added to the program. Fentanyl is the leading cause of drug overdose death, and it is important to identify the combination of other illicit drugs like stimulants with fentanyl, which increases the risk of overdose. The program FAQs and training materials were updated to provide information and guidance on the importance of program providers identifying individuals who are at risk for fentanyl exposure and providing appropriate counseling, referral for evaluation for MAT, and resources, including access to Naloxone to reverse an overdose.

In September 2024, DHCS delivered the Quarterly Progress Report (QPR) Template to county leads and Behavioral Health Directors to track monitoring and oversight activities. The first of four QPRs covers October through December 2024 and is due by the counties to DHCS by January 31, 2025. Per BHIN 24-031, counties participating in the Recovery Incentives Program are required to complete QPRs for a total of four consecutive quarters.

Throughout 2024, the DHCS Recovery Incentives Program team continued weekly planning meetings with the CM training and technical assistance provider, UCLA, and the Incentive Manager (IM) vendor, Q2i. Oversight and monitoring activities continued to include ongoing coaching calls, which provide support to CM providers, and fidelity reviews with sites and county leads to discuss adherence to the CM protocol.

The Recovery Incentives Program team coordinates with the California Department of Public Health (CDPH) for expedited processing of Clinical Laboratory Improvement

Amendments waivers. The program team is collaborating with CDPH to develop mobile CM methods to expand the program to reach populations of focus that have limited access to transportation or are in unhoused situations and, as such, struggle with being able to test at a specific location on a regular basis. The team intends to launch mobile CM in 2025.

Recovery Incentives: California's Contingency Management (CM) Program – Training and Technical Assistance Activities, DY 20, Quarters 1-4

DY 20-Q1 (January 1, 2024 – March 31, 2024)

Key activities accomplished during DY 20-Q1 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and then once every six months thereafter for the duration of the Recovery Incentives Program. Fidelity Monitoring Self-Study and Interview #1 is completed 2-3 months following Program launch, and Fidelity Monitoring Self-Study and Interview #2 is completed 4-6 months following Program launch. Copies of Fidelity Monitoring Self-Study #1 and #2 are on file at DHCS. The Fidelity Monitoring #3 Qualtrics Self-Study tool was finalized and approved by DHCS. This tool is intended for sites that have been implementing CM services for at least eight to ten months. Scheduling these regularly required fidelity reviews (inclusive of both the Self-Study and the Interview) ensures the Recovery Incentives Program is being delivered consistently and rigorously over time, and for the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of 13 Fidelity Monitoring #1 interviews and ten Fidelity Monitoring #2 interviews were completed.
- **Outreach Efforts:** A recruitment flyer was created in Spanish and English and approved by DHCS for sites to use to increase enrollment.
- **Site-Level CLIA Waiver/State Lab Registration:** A total of 167 State Lab Registration Applications and 167 Clinical Laboratory Improvement Amendments (CLIA) Certificate Applications have been identified as completed/approved. A total of 164 Site Lab Directors have been identified.
- **Recovery Incentives Program Website:** The Recovery Incentives website was updated as materials were refined. Website updates included the Implementation Training registration links, an editable recruitment flyer in English and Spanish, Provider Outreach Toolkit, Program Manual with Appendices, and the Incentive Manager (IM) Portal gift card list.

- **CM Overview Training (On-Demand):** A total of 76 individuals completed the CM Overview Training on-demand course between January 1, 2024 – March 31, 2024.
- **Two-Part CM Implementation Training:** UCLA Integrated Substance Use and Addiction Programs (ISAP) conducted 12 Implementation Trainings (with 127 total participants) from 20 of the 24 counties.
- **Coaching Calls:** UCLA ISAP conducted 28 interactive Zoom Coaching Calls with a total of 378 attendees.
- **Readiness Assessment:** UCLA ISAP conducted seven Readiness Assessment interviews and five outreach calls to prepare for the Assessment. Six sites initiated the two-step Readiness Assessment process using the link they received to the Qualtrics self-study.

DY 20-Q2 (April 1, 2024 – June 30, 2024)

Key activities accomplished during DY 20-Q2 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and then once every six months thereafter for the duration of the Recovery Incentives Program. Fidelity Monitoring Self-Study and Interview #1 is completed 2-3 months following Program launch, Fidelity Monitoring Self-Study and Interview #2 is completed 4-6 months following Program launch, and Fidelity Monitoring Self-Study and Interview #3 is completed 8-10 months after Program launch. Copies of Fidelity Monitoring Self-Study #1, #2, and #3 are on file at DHCS. Scheduling these regularly required fidelity reviews (inclusive of both the Self-Study and the Interview) ensures the Recovery Incentives Program is being delivered consistently and rigorously over time, and for the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of 14 Fidelity Monitoring #1 interviews, four Fidelity Monitoring #2 interviews, and ten Fidelity Monitoring #3 interviews were completed during the reporting period.
- **Outreach Efforts:** To increase enrollment, sites were encouraged to utilize Sample Messages as outlined in the Provider Outreach & Communications Toolkit on the Recovery Incentives website. These messages include website text, email newsletters, and social media posts. Additional outreach materials include the Recovery Incentives Program flyer, wallet cards, and FAQ document.

- **Site-Level CLIA Waiver/State Lab Registration:** A total of 144 State Lab Registration Applications and 134 CLIA Certificate Applications have been identified as completed/approved. A total of 159 Site Lab Directors have been identified.
- **Recovery Incentives Program Website:** The Recovery Incentives website was updated as materials were refined. Website updates included the Implementation Training registration links, IM Portal gift card informational document, CM Provider Outreach Toolkit, Program Manual with Appendices, Recovery Incentives Training Flyer updating the DHCS logo, and the California Consortium of Addiction Programs and Professionals (CCAPP) number updated to 2N-00-445-1125.
- **CM Overview Training (On-Demand):** A total of 89 individuals completed the CM Overview Training on-demand course between April 1, 2024 – June 30, 2024.
- **Two-Part CM Implementation Training:** UCLA ISAP conducted 13 Implementation Trainings (with 153 total participants) from 12 of the 24 counties.
- **Coaching Calls:** UCLA ISAP conducted 30 interactive Zoom Coaching Calls with a total of 385 attendees.
- **Readiness Assessment:** UCLA ISAP conducted ten Readiness Assessment interviews and nine outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by seven sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process).

DY 20-Q3 (July 1, 2024 – September 30, 2024)

Key activities accomplished during DY 20-Q3 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and then once every six months thereafter for the duration of the Recovery Incentives Program. Fidelity Monitoring Self-Study and Interview #1 are completed 2-3 months following Program launch, Fidelity Monitoring Self-Study and Interview #2 are completed 4-6 months following Program launch, and Fidelity Monitoring Self-Study and Interview #3 are completed 8-10 months after Program launch. Copies of Fidelity Monitoring Self-Study #1, # 2, and #3 are on file at DHCS. Scheduling these regularly required fidelity reviews (inclusive of both the Self-Study and Interview) ensures the Recovery Incentives Program is being delivered

consistently and rigorously over time and allows the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of five Fidelity Monitoring #1 interviews, 12 Fidelity Monitoring #2 interviews, and nine Fidelity Monitoring #3 interviews were completed during the reporting period.

- **Outreach Efforts:** To increase enrollment, sites were encouraged to utilize Sample Messages as outlined in the Provider Outreach & Communications Toolkit on the Recovery Incentives Program website. These messages include website text, email newsletters, and social media posts. Additional outreach materials include the Recovery Incentives Program flyer, wallet cards, and a FAQ document. Site specific recruitment strategies are discussed during the Fidelity Monitoring Interviews and during monthly coaching calls.
- **Site-Level CLIA Waiver/State Lab Registration:** A cumulative total of 133 State Lab Registration Applications and 122 CLIA Certificate Applications have been identified as completed/approved. (NOTE: The cumulative number of CLIA applications decreased from Q2 to Q3 because 16 sites indicated that they will no longer be participating in the Program). A total of 140 Site Lab Directors have been identified.
- **Recovery Incentives Program Website:** The Recovery Incentives Program website was updated as materials were refined. Website updates included the Implementation Training registration links, PowerPoint slides, and handouts. Updates were also made to the IM Portal gift card informational document, and the Program Manual with Appendices, which included BHIN 24-031 updates.
- **CM Overview Training (On-Demand):** A total of 77 individuals completed the CM Overview Training on-demand course between July 1-September 30, 2024.
- **Two-Part CM Implementation Training:** UCLA ISAP conducted 13 Implementation Trainings (with 143 total participants) from 13 of the 24 counties.
- **Coaching Calls:** UCLA ISAP conducted 30 interactive Zoom Coaching Calls with a total of 428 attendees.
- **Readiness Assessment:** UCLA ISAP conducted eight Readiness Assessment interviews and six outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by six sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process).

DY 20-Q4 (October 1, 2024 – December 31, 2024)

Key activities accomplished during DY 20-Q4 included:

- **Ongoing Fidelity Monitoring:** Fidelity Monitoring occurs for all launched sites twice in the first six months of CM service implementation, and then once every six months thereafter for the duration of the Recovery Incentives Program. Fidelity Monitoring Self-Study and Interview #1 are completed 2-3 months following Program launch, Fidelity Monitoring Self-Study and Interview #2 are completed 4-6 months following Program launch, and Fidelity Monitoring Self-Study and Interview #3 are completed 8-10 months after Program launch. The Fidelity Monitoring Part 4 Qualtrics template was finalized during DY 20-Q4. Copies of Fidelity Monitoring Self-Study #1, #2, #3, and #4 are on file at DHCS. All versions were revised to request sites to include the expiration dates for the CLIA and State Lab Registrations. Scheduling these regularly required fidelity reviews (inclusive of both the Self-Study and Interview) ensures the Recovery Incentives Program is being delivered consistently and rigorously over time and allows the UCLA Training and Implementation Team to gauge how well the site is implementing their CM program to fidelity. A total of 18 Fidelity Monitoring #1 interviews, nine Fidelity Monitoring #2 interviews, seven Fidelity Monitoring #3 interviews, and nine Fidelity Monitoring #4 interviews were completed during the reporting period.
- **Outreach Efforts:** To increase enrollment, sites were encouraged to utilize Sample Messages as outlined in the Provider Outreach & Communications Toolkit on the Recovery Incentives Program website. These messages include website text, email newsletters, and social media posts. Additional outreach materials include the Recovery Incentives Program flyer, wallet cards, and a FAQ document. Site specific recruitment strategies are discussed during the Fidelity Monitoring Interviews and during monthly coaching calls.
- **Site-Level CLIA Waiver/State Lab Registration:** A cumulative total of 135 State Lab Registration Applications and 124 CLIA Certificate Applications have been identified as completed/approved. A total of 141 Site Lab Directors have been identified as completed/approved.
- **Recovery Incentives Program Website:** The Recovery Incentives Program website was updated as materials were refined. Website updates included the Implementation Training registration links, PowerPoint slides, and handouts. The Program Manual with Appendices was also updated.
- **CM Overview Training (On-Demand):** A total of 60 individuals completed the

CM Overview Training on-demand course between October 1-December 31, 2024.

- **Two-Part CM Implementation Training:** UCLA ISAP conducted nine Implementation Trainings (with 109 total participants) from 16 of the 23 counties.
- **Coaching Calls:** UCLA ISAP conducted 26 interactive Zoom Coaching Calls with a total of 471 attendees.
- **Readiness Assessment:** UCLA ISAP conducted seven Readiness Assessment interviews and two outreach calls for Readiness Assessment preparedness. The two-step Readiness Assessment process was initiated by four sites (they received a link to the Qualtrics self-study to initiate the Readiness Assessment process).

DY 20-Q1-Q4 (January 1 – December 31, 2024)

During DY 20 (January 1-December 31, 2024, the Statewide CM pilot training program completed the following activities:

- A total of 302 individuals completed the CM Overview Training on-demand course. UCLA ISAP conducted 47 Implementation Trainings (with 532 total participants). UCLA ISAP conducted 114 interactive Zoom Coaching Calls with a total of 1,662 attendees. UCLA ISAP conducted 32 Readiness Assessment interviews. UCLA ISAP conducted 22 outreach calls for Readiness Assessment preparedness. UCLA ISAP completed 50 Part I, 35 Part II, 26 Part III, and nine Part IV Fidelity Monitoring interviews. There are 100 sites providing CM Services with approximately 1,599 members enrolled.
- During DY 20, the UCLA team continued to conduct Implementation Trainings and Fidelity Monitoring began. The UCLA team continued to engage with participating counties and sites to help prepare them for the program launch. During the course of the year, the UCLA team continued to refine training materials and the Program Manual.
- Coaching calls are intended for sites to bring up any questions, issues, or concerns that arise during implementation. Sites are also encouraged to share challenges and success stories. A major goal of the monthly Coaching Calls is to foster cross-site learning across the state.
- During Coaching Calls sites share member success stories, listed below are a few examples:
    - "I bought new clothes for my interview and got the job."

- "I bought my friend a burger; I've never been able to do that before."
- "I'm finally in a place where I can help my mom buy groceries."
- "My Coordinator believes in me, and now, I believe in myself."

Perspective from the Project Director:

- "While conducting the Fidelity Monitoring interviews, I am reinvigorated by hearing the stories and the progress members have made. The passion and commitment from the CM Staff are infectious."

Perspective for CM Staff:

- "Working in this field not only heals the members but heals me too."

Medi-Cal Peer Support Services Updates

Medi-Cal Peer Support Specialist services are an optional behavioral health Medi-Cal benefit that can be implemented within DMC-ODS, DMC, and/or SMHS delivery systems. As of December 31, 2024, 4,641 individuals are certified as Medi-Cal Peer Support Specialists Certification through the California Mental Health Services Authority (CalMHSA). CalMHSA is currently the sole DHCS-recognized certification program for Medi-Cal Peer Support Specialists (see Figure 27 for a breakdown of applicants by application/certification status). As of December 31, 2024, 52 out of 58 California counties provide Medi-Cal Peer Support Services, including 33 DMC-ODS, 52 MHP, and ten DMC programs. Approximately 98.5 percent of the Medi-Cal population is represented in the MHP counties and approximately 91.8 percent in the DMC-ODS Plans, based on enrollment data.[6] DHCS provides the opportunity for counties to opt-in to provide Medi-Cal Peer Support Services on an annual basis.

Figure 27: Medi-Cal Peer Support Specialist Applications and Certifications

NEW Applications & Certifications per Quarter	Q1	Q2	Q3	Q4
New Applications submitted	854	916	1027	1102
New Certifications	508	520	573	533

Throughout DY 20, DHCS conducted stakeholder engagement on program

[6] Medi-Cal total enrollment data as of December 2023

implementation, addressed stakeholder questions on service delivery, claiming, scholarships, plan of care documentation, scope of services, areas of specialization, and updates for Medi-Cal Peer Support Specialists in the Provider Information Management System, and coordinated regularly with CalMHSA to ensure responsiveness to stakeholders and alignment with policy. DHCS also continued to develop an all-inclusive Medi-Cal Peer Support Services BHIN, as well as accompanying FAQs, which are expected to be finalized and released in early 2025. DHCS continued to gather feedback from internal and external stakeholders to inform policy development around requiring Medi-Cal Peer Support Specialists and other unlicensed providers to obtain a National Provider Identifier (NPI) number. NPI guidance is expected to be developed by early 2025.

SUD Monitoring Protocol (STC 6.5)

On February 10, 2023, DHCS obtained CMS approval to provide data on the SUD Monitoring Protocol. DHCS will continue to present trends retrospectively in future reports as it awaits CMS to develop more refined guidance for the SUD Monitoring Protocol.

The figure below outlines the agreed-upon performance measures to depict progress on SUD monitoring activities for members with SUD diagnoses served in an SUD program for the first three months of 2024

Figure 28: Number of SUD Members Served by Performance Measure

Population	January 2024	February 2024	March 2024
#3: Medicaid Members with SUD Diagnosis	518,741	520,691	519,991
#6: Number of members enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	123,243	119,600	120,543
#7: Early Intervention; Number of members who used early intervention.	3,512	3,480	3,332
#8: Outpatient Services	76,114	72,664	72,441
#9: Intensive Outpatient and Partial	956	846	908

Population	January 2024	February 2024	March 2024
Hospitalization Services			
#10: Number of members who use residential and/or inpatient services for SUD during the reporting period.	9,039	8,951	9,318
#11: Number of members who use withdrawal management services (such as outpatient, inpatient, or residential) during the reporting period.	1,794	1,704	1,891
#12: Medication-Assisted Treatment (MAT)	56,609	56,274	56,972
#23: Total number of ED visits for SUD per 1,000 members in the measurement period.	1.87%	1.81%	1.91%
#24: Inpatient Stays for SUD per 1,000 Medicaid	1.16%	1.14%	1.17%

PROVIDING ACCESS AND TRANSFORMING HEALTH

California's Section 1115 waiver renewal includes expenditure authority for the Providing Access and Transforming Health (PATH) initiative to maintain, build, and scale services, capacity, and infrastructure necessary to ensure successful implementation of the CalAIM ECM and Community Supports initiatives. PATH funding aims to support community level service delivery networks by ensuring access to health care services and improving health outcomes. PATH funding is available for various entities such as providers; county, city, and local government agencies; former WPC Lead Entities, CBOs, public hospitals, Medi-Cal Tribal and Designees of Indian Health Programs, and others as approved by DHCS.

PATH is comprised of two aligned programs:

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

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

1. WPC Services and Transition to Managed Care Mitigation Initiative – PATH funding will directly support former WPC Pilot Lead Entities to pay for existing WPC services before those services are transitioned to be paid for by Medi-Cal MCPs under CalAIM on or before January 1, 2024. PATH funding will also directly support former WPC Lead Entities to maintain reentry services currently provided through former WPC Pilots in counties that do not implement JI pre-release services until January 1, 2024, or later. JI pre-release services will launch on a rolling basis starting October 1, 2024, based on county.
2. Collaborative Planning and Implementation Initiative (CPI) – PATH funding is available for community stakeholders to work with the PATH Third-Party Administration (TPA) to establish collaborative planning and implementation efforts that support the CalAIM launch.
3. Technical Assistance (TA) Initiative – PATH funding is available for the provision of TA through a TA Marketplace for qualified applicants that intend to provide ECM and/or Community Supports.
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.

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

   - **Round 1** is a planning grant funding opportunity that will provide small planning grants to correctional agencies (or an entity applying on behalf of a correctional agency) to support collaborative planning with county departments of social services and other enrollment implementation partners to identify processes, protocols, and IT modifications that are necessary to support implementation of pre-release enrollment and suspension processes.
   - **Round 2** is an implementation grant funding opportunity that will provide larger application-based grants to support entities as they implement the processes, protocols, and IT system modifications that were identified during the Round 1 planning phase. While entities do not need to participate in Round 1 to apply for funding in Round 2, the Round 1 planning grant funds provide an opportunity to support the development of a comprehensive application for Round 2 funding.
   - **Round 3** provides funding to support the planning and implementation of the provision of targeted pre-release Medi-Cal services to individuals in state prisons, county jails, and youth correctional facilities who meet the eligibility criteria as outlined in the CalAIM Section 1115 Re-Entry Demonstration approval. This funding will also support county behavioral health agencies to implement behavioral health linkages as required by PEN §4011.11. PATH funds will be available to support investments in personnel, capacity, and/or IT systems that are needed for collaborative planning and implementation in order to effectuate pre-release service processes. These PATH capacity building funds are available to qualified entities and will be distributed based on how entities meet certain performance milestones.

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

- TA Marketplace
- CPI

» CITED

» JI Planning and Capacity Building

The implementation timelines for the PATH Initiatives are as follows:

PATH Initiatives	2022				2023				2024				2025				2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
WPC Services and Transition																				
TA Initiative																				
Collaborative Planning and Implementation																				
CITED																				
JI Planning and Capacity Building																				

Successes and Accomplishments

WPC Services and the Transition to Managed Care Mitigation Initiative were implemented on January 1, 2022. Ten county Lead Entities were awarded funding under this initiative and mitigation services are provided until a managed care plan fulfills their commitment to add the service as a Community Support. Under the WPC Services and Transition to Managed Care Mitigation Initiative, services provided by former WPC Pilots are funded until the services transition to managed care coverage under CalAIM. This ensures members have access to services and that delivery models developed under WPC Pilots are sustained until the services are transitioned. MCPs implemented many services sooner than initially projected and only three Lead Entities have services not launched by MCPs that remain eligible to submit claims for payment. Three Lead Entities had approved budgets for activities in 2023; two of which met their original awarded budget. As Lead Entities had services implemented by MCPs sooner than expected,

several Lead Entities had unutilized dollars remaining from their allocated award. DHCS is currently reviewing utilization to adjust allocations among two (2) of the three remaining Lead Entities to maximize funding for unpaid eligible services.

The TA Marketplace launched on January 31, 2023. Eligible TA Recipients can register through the TA Marketplace website and submit TA project applications. Recipient eligibility applications and TA project application windows are continuously open, and applications are reviewed on a rolling basis. As of December 2024, there was a total of 551 approved TA Recipients. As of December 2024, eligible entities can browse 340 "Hands-On" Projects and 524 "Off-the-Shelf" Projects from 116 approved TA Vendors. At the end of DY 20, 1,768 TA project applications were submitted. Of these, 872 projects have been executed.

The CPI initiative was launched for participants to register on August 22, 2022. The initial Collaborative Planning facilitator selection process was completed, and contracts were executed with ten entities in 25 regions by December 2022. On September 1, 2023, the Statewide Indian Health Collaborative was added, for a total of 26 collaborative groups in operation. As of December 31, 2024, there are 1,391 participants registered across the collaboratives. In 2024, the CA PATH CPI collaboratives demonstrated excellent stakeholder engagement across all 26 collaboratives. MCPs attended and participated in the collaborative convenings, providing enrollment data and updates on their progress with CalAIM. There was strong representation from CBOs, County, City, or Local Government agencies, Federally Qualified Health Centers (FQHCs), Tribes and Indian Health Care Providers, hospitals, providers, and other local stakeholders attending and participating in the monthly collaborative meetings. In DY 20-Q4, CA PATH CPI collaborative convenings and office hours conducted work emphasizing on key areas such as data collection, asset mapping, the development of ECM and Community Supports job aids, community engagement, provider spotlights, CalAIM 101 education, and streamlining processes.

The CITED application for Round 3 was released on January 15, 2024, and closed on February 16, 2024. DHCS received over 470 applications for a total request of $711 million. Awards were announced on August 30, 2024, and 133 entities were awarded over $146 million in funding. Round 3 focused on addressing existing implementation gaps, including low provider capacity to serve ECM Populations of Focus (POFs), low capacity in rural counties, ECM providers serving children and youth POF, Tribal Health Care Providers, statewide and county Community Supports needs, and newly launched ECM POFs. CITED Round 4 applications will open in DY 21-Q1. Round 4 funding priorities will include county-specific and statewide ECM and Community Supports gaps,

including Birth Equity, Justice-Involved, Transitional Rent, tribal entities, entities serving tribal members, and rural counties.

Additionally, savings from unspent Whole Person Care Services and Transition to Managed Care Mitigation Initiative funds that were closed out in April of 2024 were used to support the CITED initiative in the amount of $85 million. DHCS created a specific CITED Intergovernmental Transfer (IGT) Round available for entities eligible to contribute the non-federal share of funds via IGT. This brings the total funding awarded through the CITED initiative to over $350 million. In DY 20, DHCS awarded 25 eligible entities via CITED IGT Round 3 for over $41 million. While some IGT-eligible awardees declined their award, over $23 million in CITED IGT awards were accepted. Awardees will complete first midway progress report for CITED IGT Round 3 in DY 21 Q3. CITED IGT Round 4 will run concurrently with CITED Round 4 in DY 21.

The JI Planning and Capacity Building Round 2 application window was open through March 31, 2023. A total of 97 agencies were approved for approximately $64 million to support implementation of processes, protocols, and IT modifications necessary for pre-release enrollment and suspension processes. DHCS allowed awardees to submit requests for additional funding under Round 2 through June 30, 2024. Four agencies were awarded additional funding, and one awardee requested a reduction to their award in DY 20. At the end of 2024, the Round 2 awarded funding increased to approximately $65 million across 98 awardees. DHCS received the first JI Planning and Capacity Building Round 2 Interim Progress Report from 96 awardees and continues to work with the remaining awardees on their submission. Awardees are expected to complete the Executive Progress Report 1 by the deadline of January 10, 2025. The JI Planning and Capacity Building Round 3 application window opened on May 1, 2023. While the formal application window closed on July 31, 2023, Round 3 remains open to eligible correctional and county behavioral health agencies to implement behavioral health linkages. JI Planning and Capacity Building Round 3 application window remains open to allow small counties the opportunity to apply for and access the remaining available funds, ensuring equitable distribution and support across all jurisdictions. As of December 2023, 146 eligible agencies have been awarded over $422 million to support investments in personnel capacity, and IT systems to effectuate pre-release service processes.

Program Highlights

- MCPs initiated many Community Supports aligned with mitigation services sooner than initially projected and only three Lead Entities remained with approved budgets

for activities through 2023. Additionally, one of the Lead Entities has approved budgets to provide Whole Person Care Services and Transition to Managed Care Mitigation Initiative services to JI populations until pre-release services are implemented in the county under the Re-entry Demonstration.

- During DY 20, DHCS and the TPA hosted a total of 16 progress report office hours for CITED Round 1, Round 2, and Round 3 awardees, as well as CITED IGT Round 2 awardees, both prior to and during the progress reporting periods. The office hours addressed questions raised by awardees about their specific circumstances and provide an opportunity for real-time technical assistance.
- In 2024, an On Demand Resource Library was added to the TA Marketplace. On Demand resources are resources which are available directly through the CA PATH website for organizations looking to learn more about CalAIM and PATH. On Demand resources are suitable for organizations at all levels of readiness for ECM or Community Supports implementation and can support organizations with identifying other TA needs that can be addressed through the TA Marketplace. In 2024, there were 22 On-Demand resources added, and two of these resources came from TA Vendors. These resources have received over 2,200 views since posting.
- On June 27, 2024, DHCS hosted the CPI Best Practices Webinar: Improving CalAIM Engagement for Eligible Individuals, the third Best Practices webinar in a bi-annual series. The goal of the bi-annual PATH CPI Best Practices webinars is to highlight best practices for implementation of ECM and Community Supports, increase providers' successful participation in CalAIM, and improve collaboration with MCPs, state and local government agencies, and others to build and deliver quality services for Medi-Cal members. This webinar focused on identifying clear materials for providers to enhance CalAIM implementation. The goal was to improve providers' ability to articulate services to eligible individuals and to tailor these resources for specific county needs. Additionally, it explored new opportunities to foster connections between CBOs, healthcare entities, and government agencies, aiming to enhance care coordination, discussing strategies for case finding to boost new referrals.
- On December 5, 2024, DHCS hosted the fourth CPI Best Practices Webinar, Relationship Building with Organizations in the CalAIM Environment Hospital Engagement in CalAIM: Supporting Connection to ECM Services Among Eligible Medi-Cal Members. This webinar covered the value of hospitals engaging with CalAIM providers in their region, recognized opportunities for improved collaboration on discharge planning between hospital staff and ECM or Community

Supports providers, and identified opportunities for warm handoffs and other coordination strategies between hospital staff and ECM providers to improve eligible member connection to ECM and Community Supports services.

Qualitative Findings

In DY 20, DHCS and the TPA held weekly meetings for each PATH initiative to develop program outlines, public facing documents, applications, review processes, outreach strategies, and quality assurance and monitoring activities. The TPA develops weekly presentations that outline all outstanding deliverables, implementation accomplishments and identified risks that impact implementation timelines. The TPA also provides a weekly summary of updates on PATH awardee activities, such as the number of registered participants for CPI, number of applicants received for PATH JI, tracking log for CITED awardee funding and disbursement, TA Marketplace recipient, vendor, and project approvals, as well as all communication releases for the week.

In DY 20, CITED Rounds 1, 2, and 3 awardees completed progress reports highlighting their milestone achievements to earn payments. These activities included, but are not limited to, verbal intervention and trauma training for ECM and Community Supports staff, which resulted in the reduction of patient exits, the implementation of ECM programs with multiple active MCPs, as well as expansion of physical workspaces for ECM and Community Supports staff and clients.

One CITED Round 1 awardee shared their success story upon completing their CITED project. The awardee stated that CITED funding allowed them to take foundational steps to hire the appropriate staff and secure the necessary resources for implementing ECM and Community Supports. This funding enabled them to focus on delivering comprehensive care to underserved communities in Los Angeles and San Diego. Through the CITED funding, they were able to extend the runways that community organizations need to successfully launch and deliver essential ECM and Community Supports services. A CITED Round 2 awardee also shared their success story highlighting a major achievement made possible through CITED funding. They reported a significant rise in the number of households accommodated, many of which included children. This milestone was especially remarkable for the awardee as it supported the mental, physical, and emotional well-being of families. By providing stable housing, the organization was able to ensure that children have a secure environment, which has long-term benefits for their overall development and quality of life. In DY 20, CITED IGT Round 2 awardees completed progress reports. Milestone accomplishments included building IT systems necessary for ECM and Community Support, training outreach

teams, and conducting needs assessments to support streamlining patient service provision.

DHCS hosted multiple webinars during this reporting year to engage and gather feedback from stakeholders on CalAIM ECM and Community Supports, PATH, JI implementation, program timelines, initiative specific applications, and program designs. Many of the informational webinars provided updates and TA to potential applicants interested in applying for the various PATH initiatives. Webinars that took place in DY 20 are listed below:

- In DY 20, DHCS and TPA hosted four informational webinars, six application office hour sessions, and 18 one-on-one application technical assistance sessions to support eligible entities with their CITED Round 3 application, which provided detailed information on CITED funds and the application process, including time for participants to ask questions.
- DHCS and the TPA hosted quarterly TA Marketplace Recipient Informational Webinars to assist new TA Recipients with questions related to the TA Marketplace, as well as quarterly TA Marketplace Vendor Informational Webinars to support Vendors with engaging recipients, addressing implementation issues, and sharing guidance. Additionally, in DY 20, DHCS and the TPA hosted a series of Vendor Fairs to increase awareness of TA Marketplace projects and vendors.
- On November 12, 2024, DHCS and the TPA hosted the "PATH JI Round 2 Executive Progress Report" webinar. This session provided additional information on the reporting requirements for JI Planning and Capacity Round 2 awardees, as well as best practices and resources to support awardees in completing the progress report.
- On December 9, 2024, DHCS and the TPA hosted the CITED Round 4 Informational Webinar for California Black Media. The webinar offered an overview for media partners, community organizations, and leaders regarding the PATH CITED initiative. The webinar also detailed the available grants and technical support, and described the application process for the upcoming CITED Round 4, which will open in January 2025.

DHCS developed and released updated guidance memos for the PATH Initiatives, addressing refinements as the program continues. The guidance memos provide a policy outline of the different PATH initiatives, eligibility criteria, application process and approach, sample uses of funding, allocation methodology, role of the TPA, oversight,

next steps, and anticipated timeline. The PATH JI Round 2 Guidance memo was updated November 2024 to include the Executive Progress Report as a new reporting requirement from awardees. The CITED Round 4 guidance and application preview was released in DY 20-Q4 Additional guidance for CITED and CITED IGT Progress Reports was updated in DY 20.

Quantitative Findings

In DY 20, DHCS awarded funding to multiple eligible entities across all PATH Initiatives. As of the end of DY 20 only three Lead Entities are eligible for claiming under WPC Services and Transition to Managed Care Mitigation Initiative.

- The CPI Initiative awarded nine facilitators to oversee 26 collaborative planning groups. Some facilitators oversee multiple collaborative groups across different counties/regions. Throughout DY 20, DHCS and the TPA hosted twelve CPI Monthly Facilitator Support Meetings for all PATH CPI Facilitators to discuss implementation challenges, solutions and best practices learned. A lookback analysis indicated the TPA collected and reviewed 182 Q4 deliverables, conducted 34 one-on-one coaching sessions with facilitators, and held 78 collaborative convenings across the state.
- Two CPI Best Practices Webinars were held in DY 20. Following the CalAIM Engagement for Eligible Individuals, the third of the Best Practices webinar series held on June 27, 2024, 92 percent of participants that completed the post-webinar survey agreed content was relevant, useful, engaging and satisfying. Following the webinars on Relationship Building with Organizations in the CalAIM Environment and Hospital Engagement in CalAIM: Supporting Connection to ECM Services Among Eligible Medi-Cal Members on December 5, 2024, 96 percent of participants that completed the post-webinar survey agreed content was relevant, useful, engaging and satisfying, 100 percent of respondents are likely or very likely to attend another Best Practice Webinar, and 92 percent of respondent plan to register for the CPI Collaboratives or have already joined.
- Of the 133 entities awarded in CITED Round 3, 82 awardees aimed to serve children and youth POFs to address statewide provider capacity gaps for these populations. Over 70 percent of the awardees were identified as non-profit organizations. Approximately 54 percent of the applicants were identified as first-time applicants for the CITED Round 3 funding opportunity, showcasing strong interest from new entities eager to engage and contribute.
- The TA Marketplace continued to review and approve new TA projects in 2024. A

total of 451 potential TA recipients applied for eligibility to the TA Marketplace in 2024, and 383 were approved as TA Recipients. There were 1,520 TA Project Eligibility Applications submitted in 2024, and 1,040 PEAs were approved. Lastly, 887 Scope of Work and Budgets were submitted in 2024, with 732 fully executed by the end of 2024. Of the 732 executed projects, 306 were Hands-On projects while 426 were Off-the-Shelf projects; there were executed projects in all seven TA Domains. The 732 executed projects represent $46,468,123.11 in total funding executed for TA projects in 2024.

- JI Planning and Capacity Building Initiative awarded 98 entities for Round 2 and 146 entities for Round 3. Awardees were comprised of County Sheriff's Offices to support county jails, county probation offices to support youth correctional facilities, the California Department of Corrections and Rehabilitation (CDCR) to support state prisons, and county behavior health agencies to support behavioral health linkages. Round 2 awarded $1,278,256.30 while Round 3 awarded $50,657,880 for a total award amount of $51,936,136.30 in DY 20.

Figure 29 below provides a summary of the total PATH awards finalized in DY 20.

Figure 29: PATH Awards Finalized in DY 19

PATH Initiative	Awarded	Total Funding Awarded
Collaborative **	10 Facilitators	$16,200,000.00
CITED	134 Entities	$146,576,173.67
TA Marketplace	118 Projects	6,600,182.80
JI	33 Entities	$51,936,136.30

Payments and Expenditures

For DY 2019, DHCS processed a total of $363,414,823.20 in payments across multiple PATH initiatives and to the TPA.

The WPC Services and Transition to Managed Care Mitigation Initative payment is made through an IGT process. Once an invoice has been approved, the Lead Entity sends the non-federal share of its approved invoice amount to DHCS. DHCS then provides the matching federal funds, and the full amount is sent back to the Lead Entity. During DY 20, one Lead Entity submitted invoices for expenditures from January 2022 to June 2023. A total of $29,955,755.94 was paid between June and July 2024. The invoice for the period January to June 2023 was received at the end of DY 20 and will be paid during

DY 21 Q1. To receive grant funds through CITED IGT, the awardee must contribute the non-federal share through the IGT process. Payment is made on completion of milestones following the progress report measurement period. Upon approval of the awardee's CITED IGT progress report, DHCS will issue a request to the awardee for the necessary IGT amount, provided the awardee has submitted all required information, forms, and documentation, including the awardee's signature acknowledging the CITED IGT Terms and Conditions, required to facilitate payment. The awardee shall make IGT of funds to DHCS in the amount specified within seven days of receiving the State's request. If the IGTs are made within the requested timeframe, DHCS will issue the payment within 14 days after the transfers are made. While the WPC Services and Transition to Managed Care Mitigation Initiative IGTs, CITED IGTs, and JI Planning and Capacity Building Round 1 was paid directly by DHCS, all other PATH initiative payments are paid through a pass-through invoices process with the TPA. The TPA is the fiscal administrator for all of PATH funding rounds. Once a PATH award has been approved by DHCS, the TPA will invoice DHCS for payment. Payment is made in the pass-through payment process whereby funds are transferred from DHCS to the TPA and the TPA administers the distribution of funds. In DY 20, the TPA processed a total of $158,815,793.64 to JI Planning and Capacity Building awardees, $123,343,440.36 to CITED awardees, $16,843,840.53 to TA Vendors for TA Marketplace projects, and $11,909,098.10 to CPI Facilitators to oversee collaboratives.

Figure 30: DY 20 Total PATH Payments

PATH Initiative	DY 20 Jan 2024 – Dec 2024
WPC Transition and Mitigation	$33,271,379.86
Technical Assistance Marketplace (TAM)	$16,843,840.53
Collaborative Planning Implementation (CPI)	$11,909,098.10
Capacity and Infrastructure Transition Expansion and Development (CITED)	$123,343,440.36
Justice-Involved Capacity Building (JI)	$158,815,793.64

PATH Initiative	DY 20 Jan 2024 – Dec 2024
Third Party Administrator	
PCG LLC	$19,231,270.71
Total	$363,414,823.20

Figure 31: DY 20 Total PATH Payments by Quarter

PATH Initiative	DY 20 Q 1 Jan – March 2024	DY 20 Q 2 Apr – June 2024	DY 20 Q 3 Jul – Sep 2024	DY 20 Q 4 Oct– Dec 2024
Mitigation	$0	$17,573,156.09	$15,698,223.77	$0
Technical Assistance Marketplace (TAM)	$1,680,501.85	$991,050.25	$6,753,260.37	$7,419,028.06
Collaborative Planning Implementation (CPI)	$3,677,251.93	$2,043,307.71	$6,188,538.46	$0
Capacity and Infrastructure Transition Expansion and Development (CITED)	$26,387,135.00	$16,628,555.78	$38,481,305.60	$41,846,443.98
Justice-Involved Capacity Building (JI)	$10,955,296.36	$4,303,541.20	$90,304,199.17	$53,252,756.91
Third Party Administrator				
PCG LLC	$5,884,133.36	$4,982,722.15	$6,210,541.50	$2,153,873.70
Total	**$48,584,319**	**$46,522,333.18**	**$163,636,068.87**	**$104,672,103**

Service Utilization

The WPC Services and Transition to Managed Care Mitigation Initiative is the only PATH initiative that captures member utilization data. Lead Entities provide mitigation services directly to Medi-Cal members until MCPs initiate coverage on these services as ECM and

Community Supports implementation ramp up. The data reported in Figure 32 reflects updated WPC Services and Transition to Managed Care Mitigation Initiative services data provided from DY 19 Q1 through DY 19 Q4. The data is extracted from the Lead Entities self-reported quarterly utilization reports. Utilization counts were updated during each reporting period to reflect retroactive changes and, as a result, may not match prior reports. The utilization data is reported as of December 31, 2023. MCPs initiated many Community Supports services aligned with mitigation services sooner than initially projected and only three Lead Entities remain with approved budgets for activities through 2023. Additionally, one of the Lead Entities has approved budgets to provide WPC Services and Transition to Managed Care Mitigation Initiative services to JI populations until pre-release services are implemented in the county under the Re-entry Demonstration.

Figure 32: Mitigation Services Provided in DY 19 Q1-Q4

Lead Entity	DY 19 Q 1 Jan – March 2023	DY 19 Q 2 Apr – June 2023	DY 19 Q 3 July – Sept 2023	DY 19 Q 4 Oct – Dec 2023
Alameda	968	1,179	N/A*	N/A*
Contra Costa	N/A**	N/A**	N/A**	N/A**
Kern	N/A**	N/A**	N/A**	N/A**
Los Angeles	1,337	1,605	1,002	1,522
Orange	N/A**	N/A**	N/A**	N/A**
Placer	N/A**	N/A**	N/A**	N/A**
Riverside	N/A**	N/A**	N/A**	N/A**
San Francisco	17,025	17,663	24,036	22,498
Santa Clara	N/A**	N/A**	N/A**	N/A**
Shasta	N/A**	N/A**	N/A**	N/A**
Total*	**4,206**	**20,447**	**25,038**	**24,020**

**Due to delay in the availability of data, DY 19 Q3 data, and DY 19 Q4 data for Alameda, will be reported in the next quarterly report.*

*** Indicates Lead Entities no longer providing mitigation services since the service has*

started to be provided under the MCP.

Policy/Administrative Issues and Challenges

In 2024, CPI efforts focused on alignment of CPI activities with DHCS oversight of ECM and Community Supports. The TPA developed a set of core measures with the goal to support DHCS policy feedback loops and observe CPI collaboratives progress. CPI Facilitators continue to utilize collaborative convenings, office hours and workgroups to bring stakeholders together to discuss, address and resolve topical implementation issues in CalAIM implementation of ECM and Community Supports with intentional attention given to the five DHCS Action Plan Levers: Standardizing Eligibility, Streamlining and Standardizing Referral/Authorization Processes, Expanding Provider Networks and Streamlining Payment, Strengthening Market Awareness, and Improving Data Exchange.[7]

The CITED Round 3 application period received a high volume of submissions, with 470 applications requestion over $711 million in funding. Processing of CITED applications remains timely and complex. DHCS leveraged multiple data sources, including encounter data, provider capacity reports from MCPs, and other assessments, to determine the highest priority gaps across the state that may be addressed through CITED funding.

DHCS received initial feedback from prospective TA recipients in 2023 that the TA marketplace shop was complicated to navigate and that there were barriers to identifying what services they may need, and which vendors were the best fit for their organization. In January 2024, TA Marketplace filters were added to the Marketplace to support TA Recipients identifying TA Vendors and projects that would meet their TA needs. Recipients shopping the marketplace will be able to apply multiple filters, including by project type, to assist with determining the project and vendor most appropriate to provide the services needed. TA Marketplace also published the "How to Apply for PATH Technical Assistance Marketplace Services" tutorial, which is aimed to support organizations interested in the TA Marketplace determine eligibility and apply to become a TA Recipient. Additionally, the TA Recipient webinar held on September 26, 2024, provided a walkthrough of the TA Marketplace, how to apply to become a TA Recipient, and tips to submit a successful application. To address requests to add additional members of TA Vendor or Recipient teams' access to the TA Marketplace

[7] ECM and Community Supports Action Plan: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Action-Plan-Updates-Fall-2024.pdf

console, delegated access was added to the Marketplace. This new functionality gives TA Vendors and Recipients more autonomy with their TA Marketplace accounts and ensures coverage should a team member go on extended leave or part with their organization.

In November 2024, DHCS added new reporting requirements to align with changes in the 1115 Waiver that requires JI Planning and Capacity Building Round 2 awardees to complete progress reports bi-annually. While the formal JI Planning and Capacity Building Round 3 continued to express barriers with completing applications and implementation of pre-release services, the TPA hosted office hours and held ad hoc TA sessions throughout DY 20 to assist eligible entities with the application process and provide technical assistance to awardees on completing required reporting to meet milestones for payment. Eligible organizations were also encouraged to participate in local CPI groups to develop connections with local CBOs for support of re-entry services.

There were seven Lead Entities with services adopted in CalAIM earlier than originally anticipated in DY 18. Three Lead Entities are still eligible to submit claims until services are transitioned to CalAIM but expressed delays with reporting utilization of all services provided in 2023. One of the three remaining Lead Entities is currently providing pre-release services that have not fully transitioned to CalAIM. DHCS worked with Lead Entities in 2024 to resolve discrepancies in utilization reporting. Additionally, DHCS is reviewing eligible claims based on utilization submissions that exceeded initial awards to determine if unclaimed awards from Lead Entities that transitioned into Managed Care can be reallocated to pay claims for the remaining eligible Lead Entities.

COMMUNITY SUPPORTS: RECUPERATIVE CARE & SHORT-TERM POST HOSPITALIZATION

Introduction

One key component of CalAIM is Community Supports, which are optional services offered in the Medi-Cal managed care delivery system and are intended to address health-related social needs (HRSN). Community Supports includes 14 services that are supported by the evidence to reduce avoidable healthcare costs and improve health outcomes.

MCPs are required to meet all federal regulatory requirements under 42 Code of Federal Regulations (CFR) 438.3 and Contractual requirements as specified in the Medi-Cal managed care plan (MCP) Contract. MCPs must obtain state approval by demonstrating compliance with all requirements before offering Community Supports. Once the MCP receives DHCS approval, the MCP is required to comply with MCP Contract requirements to arrange for and deliver covered Community Supports to members timely. The Community Support that each MCP has elected is listed publicly on the DHCS website. Members are also notified of covered services through the Member Handbook and MCPs are required to list Community Support providers in the Provider Directory.

The full list of Community Supports includes:

1. **Housing Transition Navigation Services** - Assistance and support for individuals transitioning from homelessness to stable housing.
2. **Housing Deposits** - Financial assistance for housing deposits to help individuals secure stable housing.
3. **Housing Tenancy & Sustaining Services** - Services aimed at helping individuals maintain their housing stability, such as ongoing support for rent and tenancy-related needs.
4. **Short-Term Post-Hospitalization Housing*** - Provision of temporary housing for individuals who require it after a hospitalization.
5. **Recuperative Care (Medical Respite)*** - Care services for individuals who need a safe and stable place to recover after a medical procedure or illness.
6. **Respite Services (for caregivers)** - Temporary relief and support for caregivers of individuals with disabilities or special needs.
7. **Day Habilitation Programs** - Programs that provide structured activities and support for individuals with disabilities during the day.

8. **Nursing Facility Transition/Diversion to Assisted Living Facilities or Residential Care Facilities for the Elderly** - Support for transitioning individuals from nursing facilities to assisted living facilities like Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF).
9. **Community Transition Services/Nursing Facility Transition to a Home** - Assistance for individuals transitioning from nursing facilities to community-based living arrangements.
10. **Personal Care and Homemaker Services** - Assistance with personal care and homemaking tasks for individuals who need support to remain independent in their homes.
11. **Environmental Accessibility Adaptations** - Modifications to homes to make them accessible and safe for individuals with disabilities.
12. **Medically Tailored Meals** - Provision of specialized meals or food for individuals with specific medical conditions.
13. **Sobering Centers** - Facilities that provide a safe environment for individuals under the influence of alcohol or substances to sober up and receive support.
14. **Asthma Remediation** - Services and support aimed at addressing environmental factors that contribute to asthma.

(*Services authorized under the Section 1115 Demonstration.)

These services prioritize high-need Medi-Cal members, particularly those at risk of hospitalization or institutionalization, and aim to bridge gaps caused by unmet social determinants of health. Several services, such as Short-Term Post-Hospitalization Housing, Housing Transition Navigation Services, and Housing Tenancy and Sustaining Services, recognize the strong link between housing stability and health care utilization. For example, people experiencing homelessness have higher rates of diabetes, hypertension, and human immunodeficiency virus, and thus experience more frequent hospital admissions and readmissions and longer hospital stays, than the general public. All Community Supports are authorized through the CalAIM demonstration in a manner that assures consistent implementation.

Short-Term Post-Hospitalization Housing and Recuperative Care

The Section 1115 Demonstration provides specific authority for Short-Term Post-Hospitalization Housing and Recuperative Care, both integral to California's care continuum. These services provide medically appropriate and cost-effective alternatives

to hospitalization or institutionalization for individuals without stable housing. These settings provide a setting for safe recovery and continuity of care for individuals experiencing homelessness or at risk of homelessness, including essential medical and behavioral health support post-hospitalization.

To monitor these services, the state collects metrics to evaluate implementation of Community Supports including take up of Community Supports services by MCPs, provider networks, and utilization. The Independent evaluation conducted by UCLA will focus on whether the service use is associated with utilization and cost reductions in emergency department visits, hospital admissions/readmissions, and long-term care placements. To the extent feasible, analyses will be stratified by key demographics (i.e., age/sex/race/SOGI), region, and other factors, to understand how these services address health inequities and improve member outcomes.

Future reports will include progress updates on the independent evaluation, including insights on the Short-Term Post-Hospitalization Housing and Recuperative Care services and their effects on addressing HRSN while making use of alternative, cost-effective settings

Successes/Accomplishments

DHCS actively tracks, monitors, and reviews Model of Care (MOC) updates that MCPs may submit twice every year. DHCS reviews submitted policies and procedures to assess alignment with DHCS policies and guidance.

To support continuous improvement, DHCS reviews MOC submission for trends, and engages with MCPs to obtain clarification or additional information. When significant issues or trends are identified, DHCS gathers additional information on a systematic basis (i.e., deploys surveys to gather MCP implementation activities and perspectives), develops technical assistance, and disseminates lessons learned and insights. DHCS also works across initiatives, including with PATH CPI facilitators to provide clear feedback loops on policy updates, guidance or other TA.

DHCS also reviews MOC submissions to check alignment with each MCP's stated approaches for expanding delivery service infrastructure, building provider capacity for Community Supports, and increasing the utilization of covered services. To the extent applicable, DHCS also checks for congruence with narratives submitted as part of the Incentive Payment Program (IPP). MCPs may obtain incentive payments only if they meet program benchmarks and demonstrate measurable progress against their IPP goals.

To facilitate reporting, DHCS leverages existing encounter data mechanisms as outlined in the MCP contract, requiring MCPs to submit detailed Community Supports data. DHCS has also released several key guidance documents, including Billing and Invoicing Guidance and Community Supports Coding Guidance, to standardize reporting by MCPs.

DHCS also makes available guidance to support data sharing among MCPs and providers though its Community Supports Data Sharing Guidance, which clarifies reporting requirements and provisions related to the Budget Trailer Bill, Welfare and Institutions Code, and Penal Code. DHCS continues to refine and share updated Community Supports guidance with MCPs and Providers to address evolving program needs.

Figure 33: Number Of Pre-Approved Community Supports Live as of January 2025 By County and Implementation Date

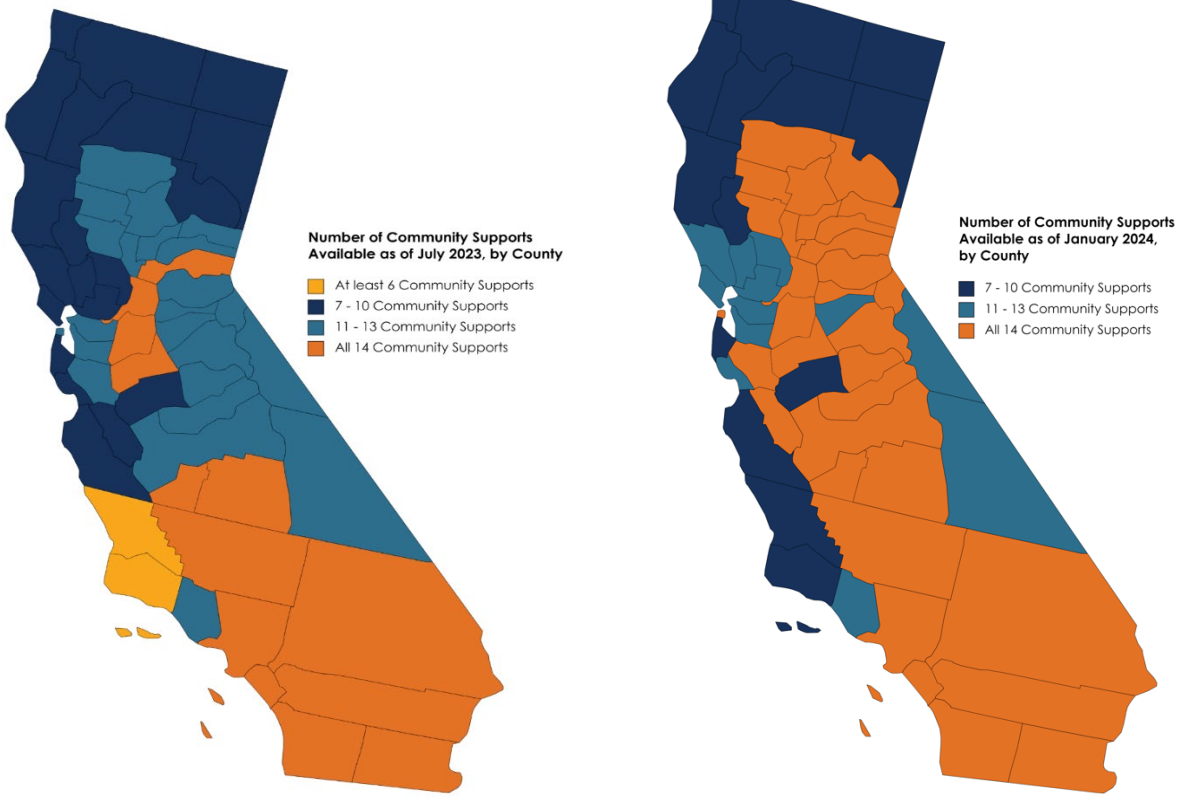
County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Start Date 7/1/2024	Start Date 1/1/2025	Total CS Live (out of 14)
Alameda	8	2	2	0	1	1	-	14
Alpine	4	4	2	2	1	-	-	13
Amador	8	2	2	1	1	-	-	14
Butte	6	2	2	0	-2	1	1	10
Calaveras	4	4	2	1	1	1	0	13
Colusa	6	3	2	0	-3	1	0	9
Contra Costa	7	4	2	0	0	0	0	13
Del Norte	0	6	2	0	0	0	0	8
El Dorado	7	2	2	0	3	-	-	14
Fresno	7	3	2	0	2	-	-	14
Glenn	6	3	2	0	-3	1	0	9
Humboldt	0	6	2	0	0	0	0	8
Imperial	4	5	5	-	-	-	-	14

County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Start Date 7/1/2024	Start Date 1/1/2025	Total CS Live (out of 14)
Inyo	4	4	2	1	-2	0	0	11
Kern	7	1	6	-	-	-	-	14
Kings	9	2	3	-	-	-	-	14
Lake	0	6	2	0	0	0	0	8
Lassen	0	6	2	0	0	0	0	8
Los Angeles	9	2	3	-	-	-	-	14
Madera	8	2	3	0	1	-	-	14
Marin	6	0	2	0	3	1	0	12
Mariposa	6	2	2	0	1	2	0	13
Mendocino	6	0	2	0	0	0	0	8
Merced	1	6	1	2	0	1	-2	9
Modoc	0	6	2	0	0	0	0	8
Mono	4	4	2	1	1	1	-2	11
Monterey	5	2	1	2	0	0	0	10
Napa	6	0	2	0	3	2	0	13
Nevada	8	2	2	0	-4	0	0	8
Orange	4	5	5	-	-	-	-	14
Placer	9	2	3	-	-1	-	-	13
Plumas	6	2	2	0	-2	0	0	8
Riverside	12	2	0	-	-	-	-	14
Sacramento	14	0	0	-	-	-	-	14
San Benito	6	2	2	0	-1	-	-	9
San Bernardino	11	2	1	-	-	-	-	14
San Diego	14	0	0	-	-	-	-	14

County	Start Date 1/1/2022	Start Date 7/1/2022	Start Date 1/1/2023	Start Date 7/1/2023	Start Date 1/1/2024	Start Date 7/1/2024	Start Date 1/1/2025	Total CS Live (out of 14)
San Francisco	8	3	2	0	1	-	-	14
San Joaquin	8	1	5	-	-	-	-	14
San Luis Obispo	0	2	4	0	4	4	-	14
San Mateo	9	0	0	0	0	3	1	13
Santa Barbara	0	2	4	0	4	4	-	14
Santa Clara	9	4	0	0	1	-	-	14
Santa Cruz	4	2	1	2	2	3	-	14
Shasta	6	0	2	0	0	0	0	8
Sierra	6	2	2	0	-2	0	0	8
Siskiyou	0	6	2	0	0	0	0	8
Solano	0	6	2	0	3	2	0	13
Sonoma	6	0	2	0	3	2	0	13
Stanislaus	4	5	5	-	-	0	-	14
Sutter	6	2	4	0	-1	2	0	13
Tehama	6	2	2	0	-2	1	0	9
Trinity	0	6	2	0	0	0	0	8
Tulare	8	3	3	-	-	-	-	14
Tuolumne	4	4	2	1	3	-	-	14
Ventura	5	1	5	1	0	1	-	13
Yolo	0	6	2	0	3	2	0	13
Yuba	6	2	4	0	2	-	-	14

Due to the 2024 MCP Transition (effective January 1, 2024), Members in several rural counties

temporarily lost access to a few services that had been available under previous MCPs no longer operating within those counties. DHCS continues to work with all entering MCPs to retain delivery infrastructure and retain access to services.



Program Highlights

Stakeholder engagement remains a cornerstone of the initiative, as DHCS is committed to maintaining open lines of communication, employing a continuous improvement strategy, and providing guidance on this unique and innovative set of services on a statewide basis. DHCS actively considers market input and continuously refines its approach to ensure effective implementation. As part of this commitment, DHCS regularly updates and shares its Action Plan[8] with MCPs, Community Supports Providers, and stakeholders, offering visibility into planned activities designed to streamline implementation and enhance service delivery.

Throughout the year, DHCS has hosted numerous webinars and meetings to facilitate dialogue, share updates, and address emerging issues. Key activities include:

- **Bi-Monthly CalAIM Implementation Advisory Group**
  This advisory group is composed of select MCPs, counties, and other

[8] The ECM and Community Supports Action Plan is available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Action-Plan-Updates-Fall-2024.pdf

stakeholders engaged in ECM and Community Supports. It plays a pivotal role in ensuring DHCS maintains real-time visibility into the rollout of newly launched benefits. The group provides:

- Critical input to address implementation challenges and inform DHCS decision-making;
- Detailed review of policy decisions, draft documents, and communications prior to broader dissemination;
- Recommendations for the development of infrastructure investments supported by performance incentives and PATH funding opportunities; and
- Guidance on technical assistance needs in the marketplace to support providers and MCPs.

Topics of discussion include:

- Implementation Experience: Feedback from MCPs and providers on the rollout of ECM and Community Supports, highlighting successes and areas for improvement.
- Member Experience: Insights into how members are accessing and benefiting from ECM and Community Supports services.
- Provider Contracting: Updates on the progress of contracting between MCPs and providers to expand service delivery networks.
- Referrals and Authorizations: Challenges and opportunities in facilitating timely and appropriate referrals and authorizations for members eligible for Community Supports.

» **Monthly MCP TA and Guidance Webinars:**

These webinars are designed specifically for health plan executives and personnel responsible for the implementation of Community Supports. They provide a vital forum for addressing operational challenges, delivering policy updates, and reinforcing best practices. Key highlights of these sessions include:

- Detailed guidance and clarifications on DHCS policies to ensure MCPs have a clear understanding of their responsibilities, as well as the standards for implementing Community Supports.
- Presentations from subject matter experts on practical implementation strategies, addressing topics such as referral workflows, data reporting

requirements, and member engagement, providing DHCS with valuable operational insights.

- Spotlights on MCPs and providers who share their experiences, challenges, and successes, enabling attendees to learn from one another and adopt proven effective practices.
- An open forum where MCP representatives can ask questions directly to DHCS staff, which helps foster transparency and real-time problem-solving.

These webinars have proven instrumental in equipping MCPs with the tools and knowledge needed to navigate the complexities of Community Supports implementation while aligning with DHCS program objectives.

» **Weekly meetings with the Local Health Plans of California (LHPC) and the California Association of Health Plans (CAHP):**
Weekly meetings with LHPC and CAHP serve as an essential touchpoint for ongoing engagement and updates regarding the implementation of ECM and Community Supports. These sessions help ensure consistent communication and collaboration between DHCS and the associations representing MCPs statewide. Key aspects of these meetings include:

- Regular reporting on the progress of ECM and Community Supports implementation, including status updates on contracting, access, member engagement, and provider onboarding.
- A platform for LHPC and CAHP to relay feedback from their member plans, helping DHCS identify and address systemic issues promptly.
- Collaborative discussions on emerging policy needs and considerations, ensuring that updates and refinements reflect real-world implementation challenges.
- Opportunities to align efforts across health plans, DHCS, and community providers, which help foster a unified approach to delivering these innovative services.

These opportunities have been crucial, allowing DHCS to remain agile in addressing implementation challenges while advancing the broader goals of the CalAIM initiative.

Throughout the year, DHCS engaged with several MCPs to address and reconcile discrepancies identified in their authorization policies for newly implemented

Community Supports services. These discussions helped in reducing policy variations across plans and counties, helping DHCS ensure greater consistency in service delivery and access for beneficiaries.

Other key activities and events over the course of CY 2024 (DY 20) include the following:

- On January 3, 2024, DHCS hosted its first monthly Managed Care Plan Call of 2024. The purpose of this meeting is to collaborate with our Medi-Cal Managed Care health plans to discuss upcoming projects and program transitions, including updates on Community Supports implementation.

- On January 5, 2024, DHCS released its updated ECM & Community Supports HCPCS Coding Guidance, which was originally released in 2021 and contains the HCPCS codes and modifiers that must be used to report ECM and Community Supports service encounters. This includes: (1) claims and encounter data that ECM and Community Supports Providers submit to MCPs and (2) encounter data Managed Care Plans (MCPs) submit to DHCS to monitor program performance and integrity. Based on feedback submitted from stakeholders throughout the first 18 months of the ECM and Community Supports implementation, DHCS made updates to this guidance with the aim of increasing the level of statewide data standardization and easing administrative burden.

- On January 11, 2024, DHCS hosted its first monthly ECM & Community Supports Implementation Advisory Group (IAG) Meeting of the year. For this meeting, DHCS was interested in learning what CalAIM-related policy or implementation issues are top of mind for IAG members to help inform identification of areas where additional policy refinement, guidance, or implementation support may be needed in the market for 2024.

- On January 23, 2024, DHCS hosted its first monthly ECM & Community Supports MCP Technical Assistance call. For Community Supports, the primary focus of this meeting was in highlighting the "Transition to JSON for QIMR Reporting" for which Phase 1 initiated in January. DHCS relayed its expectations for this reporting cycle with MCPs, reiterated the "phased-in" approach DHCS Is utilizing, answered questions, and affirmed reporting periods and due dates.

- On February 6, 2024, (Health Affairs Issue Briefing: Housing and Health) DHCS attended a virtual forum held by Health Affairs at which authors presented their work, engaged in discussion, and answered questions on these important issues. Panels included representatives from several communities and neighborhoods and

focused on issues such as health sector inventions, homelessness, and housing costs, quality, and stability.

- On February 8, 2024, DHCS hosted its Manatt Health Strategies consultant colleagues for an in-person strategy session and discussion, and to collectively look at the progress of Community Supports since implementation, what the current "State of the State" looks like, and further define the future vision, goals, and strategy for Community Supports over the coming years. After an in-depth initial look at historical data, DHCS and Manatt teams discussed the updating of several service definitions within the context of ongoing redesign work, the PATH team hosted a session highlighting awardees for Community Supports, and various payment approaches for Community Supports were analyzed and discussed.

- On February 27, 2024, DHCS hosted its second monthly ECM & Community Supports MCP Technical Assistance call, and encouraged MCPs to invite their JSON data reporting leads as the agenda included a frequently asked questions section about the transition to JSON for ECM and Community Supports. While the majority of this meeting was focused on ECM and relating requirements, DHCS provided a Q&A opportunity and fielded questions on both ECM and Community Supports.

- On March 13, 2024, DHCS met with the Health Net Community Solutions MCP team to check-in on their Community Supports implementations across the state and discuss data trends and provider capacity concerns. Other topics discussed included authorization policies, including best practices and lessons learned, utilization trends, projections, and the MCP's future vision for Community Supports in the areas they serve.

- On March 19, 2024, DHCS hosted a virtual discussion and met with the Community Supports team at Partnership Health Plan of California to review their 2024 MCP Transition coordination of care and Community Supports policies and discuss the MCP's future vision for Community Supports in the large number of counties the MCP now serves as a result of the Transition. DHCS looks forward to working with Partnership to help expand the number of available Community Supports services across the more rural parts of the state in future years.

- On March 20, 2024, DHCS presented on ECM and Community Supports to the SouthBay Collaborative Planning Group, specifically related to exclusively aligned enrollment (EAE) Dual Special Needs Plans (D-SNPs) and dual beneficiaries' eligibility to receive ECM and/or Community Supports within those care settings. For context,

SouthBay participants had conversations at the end of CY 2023 about the confusion for members and providers about the impact of enrollment into an EAE D-SNP on their ability to get ECM and/or Community Supports. They also were not clear on the enrollment process and the rules/requirements around enrollment into a D-SNP and asked DHCS to share more information, noting how much room still exists for education and resources so that the ECM and Community Supports providers can better support dual eligible members that they serve or come into contact with who need assistance and to clarify how continuity of care should be handled when someone enrolls into an EAE D-SNP.

- On March 25, 2024, DHCS hosted a virtual discussion and met with the Community Supports team at Kaiser Permanente to review their 2024 MCP Transition coordination of care and Community Supports policies and discuss the MCP's future vision for Community Supports in the large number of counties the MCP now serves as a result of the Transition.

- On April 4, 2024, DHCS hosted its fourth monthly ECM & Community Supports Implementation Advisory Group (IAG) meeting of the year. The April IAG meeting featured a discussion on proposed refinements to the Housing Deposits Community Supports service definition. DHCS encouraged attendance from all MCP organizational staff who directly work with and/or oversee the housing related Community Supports services to attend the session to encourage a robust discussion.

- On April 4, 2024 DHCS also met with Community Supports staff at two MCPs: Community Health Group and Positive Healthcare (otherwise known as AIDS HealthCare Foundation) to review and discuss low utilization over time for several of their elected services (Housing Tenancy and Sustaining Services, Short-Term Post Hospitalization Housing, Day Habilitation Programs, and Sobering Centers for Community Health Group; and Housing Tenancy and Sustaining Services for AIDS HealthCare Foundation).

- On April 8, 2024, DHCS met with staff at CalViva Health Plan to review and discuss low utilization over time for their Environmental Accessibility Adaptions, Recuperative Care, and Sobering Centers elected services.

- On April 11, 2024, DHCS met with staff at the Health Plan of San Joaquin to review and discuss low utilization over time for their Environmental Accessibility Adaptations, Sobering Centers, and Short-Term Post-Hospitalization Housing elected

services.

- On April 15, 2024, DHCS met with staff at Blue Shield Promise (BSP) as well as Santa Clara Family Health Plan (SCFHP) to review and discuss low utilization over time for several of their elected services (Day Habilitation Programs and Sobering Centers for BSP, and Recuperative Care and Sobering Centers for SCFHP).

- On April 23, 2024, DHCS hosted its fourth monthly ECM & Community Supports MCP TA call of the year. The purpose of this meeting is to collaborate with Medi-Cal MCPs to discuss upcoming projects and program transitions, including updates on Community Supports implementation. Topics for the meeting included a look at ECM & Community Supports data through Q3 2023, discussion on streamlining ECM referrals and authorizations, a review of the updated ECM/CS webpage design, a note on updated Community Supports Elections, discussion on expanding networks and streamlining payments through the CPI group, and a detailed look at how to engage MCPs in PATH Outreach, Engagement, and Marketing (OEM) efforts.

- On May 2, 2024, DHCS hosted its first of two May IAG monthly webinars, which featured a discussion on ECM referrals and authorizations, and requested feedback from the IAG on streamlining access to ECM through ECM referral and authorization standards.

- On May 15, 2024, DHCS confirmed having received all final QIMR submissions for the reporting period of Q1 2024 (January 1 – March 31, 2024).

- On May 21, 2024, DHCS hosted its fifth monthly ECM & Community Supports MCP TA call of the year. The main topic for this meeting was hosting a discussion and providing further information on Phase Two of the JSON Transition process, including the due dates across the planned testing/staging periods and for the Phase Two production files.

- On May 30, 2024, DHCS hosted its second of two May IAG monthly webinars (originally scheduled for June 2024). This IAG meeting featured a discussion on proposed refinements to the Medically Tailored Meals/Medically-Supportive Food (MTM/MSF) Community Supports service definition. DHCS encouraged attendance from individuals at MCP organizations who directly work with/oversee the MTM/MSF Community Supports service and hosted a robust discussion with all attendees.

- On May 31, 2024, DHCS hosted an all-comers webinar on ECM and Community

Supports for individuals and families experiencing homelessness. In this webinar, DHCS leaders were joined by panelists from providers and managed care plans delivering ECM and key housing-related Community Supports, who provided overviews of how ECM and Community Supports aim to address members' clinical and non-clinical needs, shared perspectives from providers on connecting Members to key housing-related Community Supports and braiding ECM and Community Supports services for individuals and families experiencing homelessness. The webinar also provided guidance to community partners and providers on referring individuals and families to ECM and Community Supports and engaging Members experiencing homelessness in CalAIM.

- On June 5, 2024, DHCS hosted PCG and PATH CPI Facilitators in Sacramento for an in-person meeting. The CPI initiative provides funding to support regional collaborative planning efforts among MCPs, providers, community-based organizations, county agencies, public hospitals, tribes, and others to support implementation of ECM and Community Supports. Stakeholders in a region form collaborative planning groups that work together to identify, discuss, and resolve implementation issues and identify how PATH and other CalAIM funding initiatives may be used to address gaps identified in MCP Needs Assessments and Gap Filling Plans. One objective of the meeting was to promote bi-directional communication and inputs across the facilitators and DHCS through sharing insights from the field in alignment with the ECM and Community Supports Action Plan,[9] including identification of challenges and potential solutions regarding CalAIM implementation. A second objective was for facilitators, PCG, and DHCS to discuss and come to consensus on goal-setting opportunities for the CPI initiative from June 24 – December 24 and beyond.
- On June 25, 2024, DHCS hosted its sixth monthly MCP TA Call of the year to present updates on several key policy areas, including its work towards updating and refining five service definitions (Housing Deposits, Community Transitions Home, Nursing Facility Transition/Diversion to Assisted Living Facilities, Medically Tailored Meals/Medically-Supportive Food, and Asthma Remediation). These services were chosen due to the significant volume of stakeholder feedback received on each, where stakeholders and organizational partners have highlighted substantial

[9] The ECM and Community Supports Action Plan is available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Action-Plan-Updates-Fall-2024.pdf

opportunities to clarify and address certain ambiguities implicit in the current existing service definition language. DHCS provided further information on July 1, of the MOC expectations and process, a minor HCPCS Coding Guidance refresh to provide further clarity around several included footnotes, and an additional Community Supports Elections Chart refresh that was made to align with final MCP elections planned for implementation on July 1, 2024.

- On June 27, 2024, DHCS hosted a statewide webinar titled “Tools to Better Engage Eligible Members in CalAIM." The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing ECM and Community Supports, increase providers' successful participation in CalAIM, and improve collaboration with MCPs, state and local government agencies, and others to build and deliver quality support services to Medi-Cal members.

- On July 1, 2024, DHCS received final updated MOCs and final January 2025 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services.

- On July 23, 2024, DHCS hosted its July CalAIM Monthly MCP TA meeting where staff spent time with the group reviewing policy on FFS enrollment requirements for Justice-Involved ECM Providers. This meeting also included a showcase of CPI 2024 Highlights as well as a year three strategic planning look-ahead session for that group.

- On July 25, 2024, DHCS participated in a California Wraparound Advisory Committee (CWAC) meeting to provide a briefing on Community Supports and answer any questions from participants. The CWAC collectively makes recommendations, identifies and shares solutions, and promotes best practices related to Wraparound policies and programs. All counties and service providers with Wraparound programs are invited to attend this quarterly meeting. Their work is informed by the California Wraparound Steering Committee.

- Also, on July 25, 2024, DHCS met with representatives from the National Academy for State Health Policy (NASHP) to help answer some questions they were getting from other states in the Health and Housing Institute about ensuring nonduplication of services while implementing their HRSN waivers. DHCS provided details on how possible duplications were identified, outlined the decisions regarding which services can or cannot be layered, and shared its processes with their team for preventing duplication.

- On August 5, 2024, DHCS hosted its quarterly CA PATH CPI DHCS/Facilitator meeting, which is intended for all PATH CPI Facilitators and DHCS stakeholders. DHCS staff provided program updates on both ECM and Community Supports, including a highlight of its recently released Q4 2023 Quarterly Implementation Report utilizing ArcGIS StoryMaps and updates on its ECM and Community Supports Action Plan. DHCS also heard feedback from the facilitators on Community Supports definitions and standards which it took back for consideration as it finalized planned clarifications in service definition language. Both DHCS and the PATH CPI Facilitators had opportunities to ask questions and provide answers ahead of time, which were discussed in length during the call.

- On August 15, 2024, DHCS' Quality Incentive Pool Program staff presented out on a survey to public hospitals about their challenges and successes in implementing ECM and Community Supports. Hospitals were asked to respond to questions both on referring to ECM and Community Supports and related to being ECM and Community Supports providers themselves. Results were shared back with ECM and Community Supports staff for synthesis and to have as an ongoing reference.

- On August 19, 2024, DHCS hosted the California Health Care Foundation (CHCF) for its monthly CalAIM meeting series, where CHCF discussed fostering the creation of several fact sheets and reference tables on the overlaps and gaps between the California Community Transitions, Assisted Living Waiver, and Home and Community-Based Alternative waiver services with Community Supports. The group also discussed new sobering center tools and the landscape for that service, and touched on other guidance CHCF was developing around emerging hub models.

- On August 22, 2024, DHCS hosted its monthly CalAIM Implementation Advisory Group meeting. The meeting featured an overview of closed loop referrals implementation guidance for ECM and Community Supports, as well as a preview of future Community Supports service definition refinements.

- On August 27, 2024, DHCS hosted its August CalAIM Monthly MCP TA meeting. Topics for this meeting included a release update on the Transitional Rent Concept Paper, sharing of the 2024 DHCS PHM Strategy Deliverable Template and communication of available office hours, a first look at the Community Supports service definition refinement work, JSON transition updates, ECM referrals and authorization guidance, an announcement for the release of the ECM and Community Supports Q4 2023 Quarterly Implementation Report, updates on the IPP,

and finally a summary of the recently released CPI Facilitator progress report.

- On September 12, 2024, DHCS hosted its Managed Care Advisory Group Quarterly Meeting where it presented attendees with a preview of pending updates to the Community Supports Policy Guide, including the service definition clarifications and refinements pending release for public comment. DHCS also highlighted the recently released ECM and Community Supports Quarterly Implementation Report which includes program data through Q4 2023, and covered updates on the JSON transition planned for its January 1, 2025, implementation phase.

- On September 17, 2024, DHCS provided the draft update to the Community Supports Policy Guide to Managed Care Plans, certain Community Supports providers, advocates, and other stakeholders (such as in the housing community). Stakeholders were provided the opportunity to review proposed refinements to seven Community Supports service definitions by October 7, 2024. The seven Community Supports services include Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Nursing Facility Transition/Diversion to Assisted Living Facilities, Community Transition Services/Nursing Facility Transition to a Home, Medically Tailored Meals/Medically-Supportive Food, and Asthma Remediation. The updates were based on input and questions raised by Managed Care Plans, providers, and other stakeholders over the last year. The updated Policy Guide includes proposing targeted clarifications to a select subset of definitions with the aim of improving standardization and increasing the utilization of these Community Supports. DHCS included a memo that provided the background, overview, and rationale of the refinements.

- On September 24, 2024, DHCS hosted its September CalAIM Monthly MCP TA meeting, which included sharing forward a Transitional Care Services technical assistance resource for Medi-Cal Members with LTSS needs. Other topics of discussion included looking at new ECM referral standards and presumptive authorization requirements, a review of ECM referrals standards and form templates, upcoming technical assistance opportunities, and a review of the Community Supports service definition refinement work that DHCS has been working toward. The meeting ended with an overview of PATH CITED Round 3, including award summaries and highlights from CPI facilitators involved with the statewide learning collaboratives.

- On September 25, 2024, DHCS hosted its monthly CalAIM Implementation Advisory

Group to feature a discussion on the recently released Transitional Rent Concept Paper. The concept paper summarizes the design of transitional rent, a new initiative under the CalAIM Section 1115 waiver demonstration to cover rent/temporary housing for Medi-Cal members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria.

- On October 8, 2024, DHCS met with representatives from Aurrera Health Group who performed work on behalf of the CHCF for an interview exploring the implementation of the Short-Term Post-Hospitalization Community Support. Specifically, they were interested in learning more about the implementation progress, uncovered best practices, and opportunities to improve. The discussion highlighted Short-Term Post-Hospitalization Housing as a critical component of CalAIM's Community Supports, providing immediate, safe housing post-discharge to support recovery and connect members to long-term care and housing services. Implementation progress includes innovative property conversions and integrated services, though challenges remain with funding sustainability, staffing, and streamlined referrals, which DHCS aims to address with enhanced guidance and stakeholder engagement.

- On October 9, 2024, DHCS hosted an All-Comer ECM and Community Supports Webinar focused on housing supports, highlighting DHCS policies and exploring strategies to expand capacity through initiatives like IPP/PATH and HHIP. The webinar included a detailed discussion of the five housing-related Community Supports (including Short-Term Post-Hospitalization Housing and Recuperative Care), Enhanced Care Management, and Behavioral Health Bridge Housing, with insights from LA Care and its FQHC partner. Additionally, the event connected broader state and federal efforts to address viral hepatitis services, showcasing California's work in leveraging Medicaid flexibilities like In Lieu of Services to inspire other entities considering similar approaches.

- On October 13, 2024, DHCS hosted an All-Comer ECM and Community Supports Webinar focused on housing supports, highlighting DHCS policies and exploring strategies to expand capacity through initiatives like IPP/PATH and HHIP. The webinar included a detailed discussion of the five housing-related Community Supports (including Short-Term Post-Hospitalization Housing and Recuperative Care), Enhanced Care Management, and Behavioral Health Bridge Housing, with insights from LA Care and its FQHC partner. Additionally, the event connected broader state and federal efforts to address viral hepatitis services, showcasing

California's work in leveraging Medicaid flexibilities like In Lieu of Services to inspire other entities considering similar approaches.

- On October 17, 2024, DHCS met with the Child and Family Policy Institute of California (CFPIC) for a roundtable discussion around Community Supports. The meeting began with introductions and a review of the CalAIM 301 PowerPoint presentation, establishing a shared understanding of the discussion framework. Participants explored criteria for determining whether foster youth benefit most from Basic Population Health Management, Complex Care Management, or Enhanced Care Management, emphasizing the importance of tailoring services to individual needs. Clarification was also sought on respite care eligibility for foster youth enrolled in Medi-Cal Managed Care Plans, with discussions underscoring its role in preventing caregiver burnout, placement disruptions, and higher health care costs while addressing gaps in existing mandates.

- On October 18, 2024, DHCS joined CHCS for their Medicaid HRSN Implementation Learning Series Session, where participants dove deeper into specific implementation topics that they identified as high priority. Many of these sessions involve peer-to-peer learning and sharing, with some opportunities to learn from other subject matter experts. This session with CHCS focused on strategies for addressing nutrition insecurity, a prevalent challenge among Medicaid members, in alignment with CMS guidance on HRSN interventions. Discussions highlighted three key approaches for state policymakers: refining benefits to meet diverse member needs, designing culturally appropriate interventions centered on member experiences, and defining eligibility criteria to maximize impact and streamline access. These insights, informed by participating states, emphasized the importance of thoughtful service design to address health equity and improve outcomes for Medicaid populations.

- On October 22, 2024, DHCS hosted its October CalAIM Monthly MCP TA meeting. During the meeting, DHCS provided updates on key CalAIM initiatives, including a preview of the Birthing Care Pathway public report, which aims to improve maternal health outcomes and address disparities. DHCS also discussed the revised implementation timeline for Closed-Loop Referrals, now set for July 2025, and highlighted progress on Community Supports monitoring and ECM referral standards. Additionally, the meeting celebrated achievements through the PATH initiative, showcasing provider success stories in advancing ECM and Community Supports statewide.

- On October 23, 2024, the DHCS Director participated on a panel with other health and human services departments to discuss topics related to seniors. DHCS provided an overview of CalAIM's Community Supports, highlighting their critical role in preventing homelessness, food insecurity, and health crises among California's most vulnerable older adults. Services are tailored to local needs and designed to stabilize seniors facing housing and food insecurity. By aligning with the Master Plan for Aging, these efforts promote health equity and long-term well-being for older adults, enabling them to remain healthy, independent, and connected to their communities.

- On October 29, 2024, DHCS joined the CHCF for their Preview of CHCF CalAIM Implementer Survey Findings webinar. The presentation explored key insights from a recent survey of ECM and Community Supports implementers, highlighting progress, challenges, and opportunities for improvement. The findings emphasized successes like expanded access to Medically Supportive Foods and housing supports, while also addressing barriers such as insufficient MCP payment rates, variability in requirements, and workforce shortages. The session underscored the importance of refining processes, supporting smaller providers, and leveraging data solutions to enhance implementation and drive better outcomes for Medi-Cal populations.

- On November 6, 2024, DHCS joined The Office of Infectious Disease and HIV/AIDS Policy (OIDP) on their "Financing Integrated Viral Hepatitis Services – Recommendations for State and Federal Entities" webinar, where OIDP introduced an upcoming report outlining strategies to optimize viral hepatitis service provision through innovative financing models in both clinical and non-clinical settings. The webinar highlighted recommendations developed over two years of research and collaborative discussions with community, state, and federal partners, focusing on payment and reimbursement strategies. California's presentation provided a high-level overview of Community Supports, zooming in on eligibility and the role of providers partnering with managed care health plans, aligning with broader efforts to implement innovative approaches featured in the report.

- On November 7, 2024, DHCS hosted the PATH CPI group for an onsite session focused on enhancing CalAIM implementation through updates, collaborative problem-solving, and planning for Year 3 of the CPI initiative. DHCS provided key policy and action plan updates, including developments in Enhanced Care Management, Closed Loop Referrals, and JI services, while also addressing Community Supports service definition changes and forthcoming developments.

Facilitated discussions and breakout groups explored critical topics like community referrals, hospital engagement, and hub models, identifying innovative solutions and next steps to refine and scale promising practices. The meeting emphasized alignment between DHCS and CPI facilitators to advance the program's strategic vision for 2025.

- On November 14, 2024, DHCS participated and presented on the CalAIM Managed Long Term Services and Supports (MLTSS) and Duals Integration Workgroup. During this meeting, DHCS provided a Spotlight on the Medically Tailored Meals/Medically-Supportive Food service with representatives from Health Net and Roots Food Group. The managed care plan and provider (Roots Food Group) shared details on their implementations and progress. DHCS additionally provided an ECM and Community Supports Data Update, a brief overview of ECM with an accompanying Population of Focus Q1 2024 update and highlighted for the group the number of dual-eligible beneficiaries who have received Community Supports to date, including a demographics breakdown.

- On November 15, 2024, DHCS joined Aurrera Health Group for their presentation and webinar Exploring Emerging Medi-Cal Community Care Hubs, offering a learning forum for Medi-Cal Community Care Hubs (MCCH), or hub organizations that centralize administrative functions for Medi-Cal providers within California. This collaborative was created in response to stakeholder recommendations outlined in the report, "Exploring Emerging Medi-Cal Community Care Hubs," authored by Aurrera Health Group in October 2024. Its primary aim was to foster discussion, promote collaboration, and explore shared learnings between MCCHs in an effort to enable community-based providers to meaningfully and sustainably participate in Medi-Cal. The focus was on MCCH development and operationalization, technical assistance, and opportunities for MCCHs and hubs to engage with each other.

- Also, on November 15, 2024, DHCS joined CHCS for their November Medicaid HRSN Implementation Learning Series Session, where participants dove deeper into specific implementation topics that they identified as high priority. In this meeting, the group of state representatives, along with CHCS staff, discussed how other states have handled the potential overlap of medically tailored meals with SNAP and how to deconflict these services.

- On November 19, 2024, DHCS participated in the Local Health Plan of California's (LHPC) "Local Plans, Local Impacts: Partnering to Build Healthier Communities"

webinar. DHCS offered its support and presented on details about the upcoming DHCS community reinvestment requirements for MCPs and the substantial community investments LHPC member plans already make in their communities to align with CalAIM's transformative goals to achieve lasting, positive community health outcomes. Included as a part of the presentation was a copy of LHPC's Community Reinvestment Report which captures additional community investment examples, collective reinvestment totals for LHPC member plans over the last five years, and offers principles for implementing this new DHCS contract requirement.

- On November 21, 2024, DHCS hosted its November CalAIM Monthly MCP Technical Assistance meeting. During the meeting, DHCS announced its ECM and Community Supports monitoring measures and approaches planned for 2025, provided an overview of the service definition updates it is working towards, and updates around the CPI workgroup as well as further details on the ECM & Community Supports (and Complex Care Management) JSON exchange. The meeting ended with a spotlight focus on ECM Continuity of Care for D-SNP members in 2025.

- On December 2, 2024, DHCS met with the Los Angeles Food as Medicine Task Force, which began with some general updates from the County and transitioned into a presentation from DHCS on the PATH initiative and associated TA opportunities as well as Community Supports. DHCS heard from LA County updates from the Office of Food Equity, reviewed the funding application for their planned 2025 summit, and discussed details and lessons learned from their recent presentations and meetings. DHCS then had an opportunity to present to the group on the PATH TA Marketplace for CalAIM and helped answer questions about California's Community Supports.

- On December 12, 2024, DHCS met with County Behavioral Health Directors and MCP CEOs for a "DHCS-County BH & MCP Summit." The meeting focused on enhancing data sharing, quality improvement, and equity in behavioral health, with sessions on MCP-County Behavioral Health data collaboration, DHCS initiatives addressing homelessness, and housing interventions such as Transitional Rent and Flex Pools. Participants engaged in panel discussions, breakout sessions, and stakeholder updates to strengthen partnerships and inform future actions.

- On December 16, 2024, DHCS met with the CDSS and CFPIC to collaborate on supporting county child welfare agencies with the implementation of CalAIM and BH-CONNECT. The meeting afforded participants an opportunity to share and discuss information, including challenges from the field, strategies to address

barriers, and meeting spaces to hear from stakeholders. DHCS staff helped answer outstanding questions they had about Foster Youth and caregiver eligibility for Community Supports.

- On December 19, 2024, DHCS hosted its December CalAIM Monthly MCP TA meeting. The December MCP TA meeting covered key updates on Community Supports service definitions, provider responsibilities for Recuperative Care, and best practices for QIMR reporting. Discussions included ECM and Community Supports monitoring, guidance for Closed-Loop Referral implementation, and JSON Phase 4 reporting. The session concluded with the release of updated Quarterly Implementation Reports for Q1-Q2 2024 and ECM updates.
- On January 1, 2025, DHCS received final updated MOCs and final July 2025 Elections from MCPs implementing Community Supports in all 58 California counties, including proposed networks and estimated capacities for services.

DHCS regularly updates its ECM and Community Supports webpage with guidance materials and program documents, in timely response to stakeholder and consumer feedback. DHCS restructured the page in April 2024 to ensure key policy and guidance documents are highlighted while at the same time archiving some of the older, more outdated guidance. All program documentation, including historic documentation, remains, and will continue to remain accessible to the general public.

Revised Community Supports elections are posted on the DHCS website 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 FAQs document on its ECM and Community Supports webpage, which highlights several FAQs from MCPs, providers, and stakeholders. The FAQs document also includes answers and policy clarifications provided by DHCS.

2024 MCP Transition

DHCS worked to monitor activities related to the transition of Medi-Cal managed care plans which were leaving and newly operating as a Prime MCP in certain counties, effective January 1, 2024. A particular focus was for continuity of care for Community

Supports. Specifically, DHCS monitored active service authorizations[10] for Community Supports to support continuity of providers and services. The Transition Policy for Community Supports was built on and aligned with the Community Supports Policy Guide and the Continuity of Care (CoC) provisions contained therein, as well as Section V, Continuity of Care of the Transition Policy Guide.[11]

Receiving MCPs were to honor existing authorizations and maintain continuity of care for Community Support services. The Receiving MCP must maintain all authorizations for no less than the length of time originally authorized by the Previous MCP; however, the Receiving MCP was not required to maintain the authorization for more than 12 months beyond January 1, 2024, unless it chose to do so. These, and related expectations were outlined in Section V, Continuity of Care of the Transition Policy Guide. In some instances, the Transition Policy for Community Supports offered enhanced protections beyond those for other services.

DHCS closely monitored MCP adherence to this Transition Policy for Community Supports to prevent disruptions in Community Supports authorizations, provider relationships, and/or services in affected counties. As of the end of Q4 2024, MCPs have fulfilled their obligations under this policy and have confirmed automatically authorizing services for eligible members and contracting with all eligible out-of-network providers who had already previously been providing the same services within the county under a previous MCP.

Qualitative Findings

Community Supports Policy Guide

Over the course of DY 19 and DY 20, DHCS and its stakeholders identified several key areas of the Community Supports Policy Guide for which additional TA, guidance, and/or further clarification were requested. DHCS refreshes its Community Supports Policy Guide when necessary to incorporate new language and/or developments in policy, including on:

- Prime/Subcontractor Authorization Policy
- Homelessness Determinations

[10] Members did not have to be actively receiving Community Supports on December 31, 2023 to qualify.

[11] Transition Policy Guide available at: https://www.dhcs.ca.gov/Documents/Managed-Care-Plan-Transition-Policy-Guide.pdf

- Eligibility for Services
- Member Handbooks and Website Update Requirements
- Provider Network Allowances
- Continuum of Care Requirements
- Other technical corrections

DHCS last updated its Community Supports Policy Guide in July 2023 to provide several key program updates. The Policy Guide will be updated again in Spring 2025 to accommodate revised service. In alignment with the Community Supports Action Plan, DHCS conducted extensive stakeholder engagement on opportunities to clarify Community Supports service definitions throughout 2024. In Spring 2025, DHCS will release a clarified, standardized set of service definitions for a subset of Community Supports. The refinements will also include updates needed to align the Recuperative Care and Short-term Post Hospitalization Housing service definitions with the time limits outlined in CMS's December 2024 CIB on coverage of services that address HRSN.

Development of Additional Guidance

DHCS has always envisioned modifying the Community Supports program over time and is committed to continuous improvement based on data and stakeholder feedback. DHCS has rolled out several policy changes and/or clarifications and provides TA to MCPs, including through the TA Marketplace. The TA Marketplace allows funding for the provision of TA for entities that intend to provide ECM and/or Community Supports. Entities may register for hands-on technical assistance support from vendors and access off-the-shelf TA resources in pre-defined TA domains. Organizations at all levels of readiness for ECM and Community Supports including JI initiatives may also access On-Demand TA resources. On-Demand resources are static resources and made available directly through the CA PATH website for organizations looking to learn more about CalAIM and CA PATH.

In 2023, DHCS updated the following core data guidance documents which were originally published in 2021:

- **ECM and Community Supports Billing and Invoicing Guidance**: Standard, "minimum necessary" data elements MCPs will need to collect from ECM or Community Supports Providers unable to submit ANSI ASC X12N 837P claims to MCPs.
- **Quarterly Implementation Monitoring Report (QIMR) Guidance**: Quarterly MCP reporting requirements and Excel template related to ECM and Community

Supports implementation across multiple domains; the QIMR fulfills AB 133 reporting requirements.

- **Community Supports Member Information Sharing Guidance**: Standards for the exchange of Member information between MCPs and Community Supports Providers to initiate, support, and track the delivery of Community Supports
- **ECM & Community Supports Coding Options Guidance**: Contains the DHCS-established HCPCS codes and associated modifiers for ECM and Community Supports services.

DHCS identified the following priority areas and has implemented several key program design refinements, discussed in further detail below, to increase the total number of Members served[12]:

- Standardizing Eligibility
- Streamlining and Standardizing Referral/Authorization Processes
- Expanding Provider Networks and Streamlining Payment
- Strengthening Market Awareness
- Improving Data Exchange

The goal of the efforts is to increase the availability and uptake of Community Supports for Medi-Cal Members who need them.

Standardizing Eligibility

Towards increasing standardization, DHCS required that MCPs remove any previously approved restrictions or limitations and adhere with the full Community Supports service definitions by January 1, 2024. MCPs no longer have the option to narrow the eligibility criteria or impose additional limitations on the service definitions (which include eligibility criteria), geographic or otherwise. DHCS is finalizing work on refining several Community Supports service definitions in response to market and stakeholder feedback and looks forward to continued work with its stakeholders to provide these needed inputs.

DHCS has clarified that any previously approved modifications and/or restrictions to service definitions must be included in Member Handbooks and on the MCPs website

[12] ECM and Community Supports Action Plan: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-Action-Plan-Updates-Fall-2024.pdf

for as long as they were in effect. Now that MCPs have come into alignment with the full DHCS Community Supports service definitions, any language about approved modifications and/or restrictions must be removed from their websites and handbooks.

In response to some MCPs having narrowed Community Supports eligibility criteria relative to the DHCS service definitions, partly due to the perception that the plan is responsible for determining cost-effectiveness, DHCS has informed MCPs that they do not need to actively assess or report on cost-effectiveness for Community Supports at the MCP or individual level for the purposes of rate setting or compliance with federal requirements. The Department will be conducting statewide aggregate analyses of the cost-effectiveness of each approved Community Supports service. Nothing prohibits MCPs from using utilization management techniques as applicable and as permitted by federal managed care regulations.

Streamlining and Standardizing Referral/Authorization Processes

In response to disparate timeframes seen for initial Community Supports authorization and reauthorization decisions within and across services, which were creating administrative burden for providers who are contracted with more than one plan and a lack of parity in the delivery of similar services for Members across the state, DHCS is working on standardizing Community Supports authorization and reauthorization periods for implementation in 2025.

Another issue raised by stakeholders relates to authorization processes and the time it can take for a provider to obtain an authorization, especially for a time sensitive service. Streamlined authorization policies, especially with providers that have a track record in submitting authorization requests that are almost always authorized, can help streamline access. As such, DHCS has encouraged MCPs to implement streamline authorization policies—such as presumptive or retrospective authorizations, especially for the Recuperative Care and Short-Term Post-Hospitalization Housing services, including from inpatient settings, emergency departments, and skilled nursing facilities.

DHCS is also continuing its work developing statewide referral standards in 2025 due to the number of disparate inputs, forms, and processes for referrals and authorizations witnessed across MCPs that is creating a high administrative burden for providers. DHCS expects MCPs to source most Community Supports referrals from the community, and that the use of internal data to identify potentially eligible Members should be balanced with active community-based outreach and engagement. To help mitigate these concerns, DHCS has begun work developing statewide standards containing the information needed to evaluate authorizations for some Community Supports. The

Department has already engaged directly with MCPs and Community Supports providers in the design work, with the anticipation of rolling out the referral standards for statewide adoption in the first half of 2025.

Expanding Provider Networks and Streamlining Payment

Through the Model of Care submission and review process as well as a careful look at the data received through the QIMR, DHCS recognizes that MCPs may be missing opportunities to contract Community Supports providers that have special skills or expertise, and who know the members best. As a result, DHCS has implemented policies requiring partnerships with specific provider types that have experience serving individuals with specialized needs in each region. MCPs must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., supportive housing providers, skilled nursing facilities).

DHCS has completed its work updating and refining its ECM and Community Supports HCPCS Coding Options guidance and reinforcing standardized application of codes at the provider level. This was in response to feedback received that the original HCPCS code set was being applied differently by different MCPs, leading to increased administrative burden for providers. DHCS re-issued the HCPCS Coding Guidance with the added clarification that MCPs must use the HCPCS coding options for Community Supports, as defined by DHCS, without additional codes or modifiers. DHCS intends to update the HCPCS guidance in the second quarter of 2025.

Finally, DHCS continues to reinforce existing timely provider payment requirements with its MCPs implementing Community Supports after receiving widespread reports of non-payment or delayed invoice payments by MCPs, especially to CBOs that are new to Medi-Cal managed care. Community Supports services are timely claims payment requirements which were further reiterated and clarified through APL 23-020. DHCS has actively intervened and enforced the APL with MCPs that have had outstanding claims.

Strengthening Market Awareness

In the first few years of program implementation, DHCS noticed there was relatively low awareness among contracted providers and MCP internal staff about Community Supports and how to access them. In response, DHCS has reinforced existing guidance and worked to ensure that MCPs are proactively ensuring their contracted networks of providers are aware of Community Supports services, what the eligibility criteria are, and are encouraging or clarifying the pathway for providers to submit referrals to the MCP. MCPs must also continue to train their call centers about how to take referrals for

Community Supports.

DHCS has reiterated requirements pertaining to Member communications, specifically that MCPs must update their public-facing websites, Member Handbooks, and Provider Directories to include the most up-to-date information about the Community Supports they offer and how members can access them. DHCS monitors MCP websites, their Member Handbooks, and follows up with MCPs whenever gaps are identified. The DHCS Community Supports website also contains fact sheets and other language that MCPs may use. DHCS always welcomes and encourages additional and creative ways of distributing information and continues to work with its stakeholders, MCPs, and Community Supports providers on these efforts.

Finally, in this area, DHCS noticed that some MCPs were delivering services to address Members' HRSN that were funded through other mechanisms outside of Community Supports, such as through value-added services. Moving forward, DHCS is requiring MCPs that are delivering such services to evaluate and determine the feasibility of transitioning them into the Community Supports program. Doing so will increase the awareness of Community Supports across the communities where other similar services are currently being provided and will drive enrollment into Community Supports. This strategy also allows MCPs to take advantage of the funding DHCS has allocated for Community Supports. Evaluating the feasibility of transitioning existing services to Community Supports may involve modifying current eligibility criteria and confirming existing providers can meet the requirements to continue to serve as Community Supports providers. DHCS stands ready to assist MCP partners with focused technical assistance in this area.

Improving Data Exchange

For the first year of CalAIM implementation, DHCS issued data standards for information exchange between MCPs and ECM providers, but not between MCPs and Community Supports providers. In Spring 2023, DHCS released the new Community Supports Member Information Sharing Guidance to standardize Community Supports member information exchange. MCPs and Community Supports Providers were required to implement all standards incorporated by this guidance by September 1, 2023. All MCPs submitted attestations confirming their compliance with these new program requirements. DHCS updated this document again in December 2024 to incorporate new requirements for Closed-Loop Referral exchange.

DHCS also updated its ECM and Community Supports Billing and Invoicing Guidance and its QIMR Guidance to accommodate these program changes and policy updates.

The HCPCS Coding Guidance for ECM and Community Supports was updated and released in early Q4 2023.

Further details about these policy refinements can be found in the Community Supports Policy Guide[13] on the DHCS ECM and Community Supports webpage. DHCS has also published an "Action Plan Update"[14] to help providers and other stakeholders navigate the ECM and Community Supports policy updates that summarizes the key policies, as well as the distinction between state-standardized policies and where there is flexibility for MCPs to define their own policies and procedures.

PATH Success Stories: Recuperative Care & Short-Term Post-Hospitalization Housing

The PATH initiative has played a transformative role in improving the lives of vulnerable populations by enabling organizations to implement and scale essential ECM and Community Supports, particularly Short-Term-Post-Hospitalization and Recuperative Care. These programs address a wide range of needs, particularly for individuals experiencing homelessness or with complex medical conditions, offering both immediate and long-term support to improve their health and well-being.

In rural areas like Del Norte County, PATH funding has been instrumental in expanding service capacity, providing case management for the unhoused, and establishing vital recuperative care programs that allow people to recover in stable housing, instead of returning to emergency rooms. This is especially important for senior populations, who face unique challenges when unhoused and in need of specialized care. Similarly, Contra Costa County's Health, Housing, and Homeless Services (H3) has used PATH support to provide housing navigation and sustained care to individuals with long histories of homelessness, ultimately helping them secure stable housing while maintaining crucial support networks.

Moreover, PATH's investment in technology and staff, such as at Kings View, has facilitated the growth of ECM and Community Supports programs, offering care that is not just medical but holistic, addressing everything from housing to behavioral health. These services have been critical in reaching individuals who otherwise would have faced barriers due to their geographic, social, or health-related challenges.

The importance of Short-Term Post-Hospitalization and Recuperative Care Community

[13] DHCS Community Supports Policy Guide (ca.gov)

[14] Enhanced Care Management/Community Supports: Action Plan Updates – Fall 2024

Supports is evident across all these stories. These services provide a critical bridge for individuals discharged from hospitals, particularly for those without stable housing or support systems. By offering recuperative care, people can recover in a safe environment, ensuring that they do not slip back into a cycle of emergency care, which often leads to worse health outcomes.

PATH and Community Supports are enabling organizations to build sustainable, person-centered care systems that prioritize both immediate needs and long-term health improvements, helping to create a more equitable healthcare environment for underserved communities.

Quantitative Findings

To monitor ECM and Community Supports implementation, DHCS developed the QIMR, which MCPs are required to submit across multiple domains. For Community Supports specifically, MCPs report data on service requests, approvals, and denials, as well as provider capacity and network adequacy. These data points are critical for tracking implementation progress and identifying emerging trends or gaps in service delivery. The information collected through QIMRs is integral to informing DHCS decision-making, including the design and application of MCP performance incentives and technical assistance priorities.

Following the implementation of Community Supports, the provider networks for both Short-Term Post-Hospitalization and Recuperative Care have expanded significantly. The Short-Term Post-Hospitalization provider network grew from 34 providers in Q1 2022 to 235 in Q2 2024, reflecting steady quarterly increases.

The Recuperative Care provider network also saw notable growth, increasing from 97 providers in Q1 2022 to a peak of 245 in Q3 2023 before stabilizing at 224 in Q2 2024. These trends highlight the ongoing expansion and strengthening of provider capacity to meet the growing demand for Community Supports services.

Since the implementation of Community Supports, utilization of Short-Term Post-Hospitalization services and Recuperative Care has steadily increased. Short-Term Post-Hospitalization services grew from just seven utilizations in Q1 2022 to 944 in Q2 2024, demonstrating consistent quarterly growth.

Similarly, Recuperative Care utilization has expanded significantly, starting at 760 in Q1 2022 and reaching 3,416 by Q2 2024. While some fluctuations occurred, overall trends indicate strong and continuous growth in both services, highlighting increasing demand and adoption over time.

DHCS is committed to transparency and is working to produce and publish program data at the earliest opportunity, while adhering to strict privacy and confidentiality standards. On average, DHCS requires approximately eight weeks to validate, process, and visualize quarterly data submissions. This includes performing rigorous quality checks, reconciling discrepancies, and ensuring data completeness. Once validated, the data is visualized using Microsoft Power Business Intelligence (Power BI), which provides a dynamic and user-friendly platform for monitoring program performance.

The Power BI dashboards, currently under continuous refinement, are designed to accurately display key metrics, including service utilization, provider participation, and beneficiary access trends. These dashboards help DHCS and its stakeholders evaluate progress, identify areas for improvement, and inform both policy and operational adjustments. Efforts are underway to expand the scope of data visualization tools to capture more granular metrics, such as service-specific trends and regional variations in utilization.

Examples of how the data are visualized are included in Figure 34 and Figure 35.

Figure 34: Program History for Members Receiving Community Support Services as of September 2024: Examples of Outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:

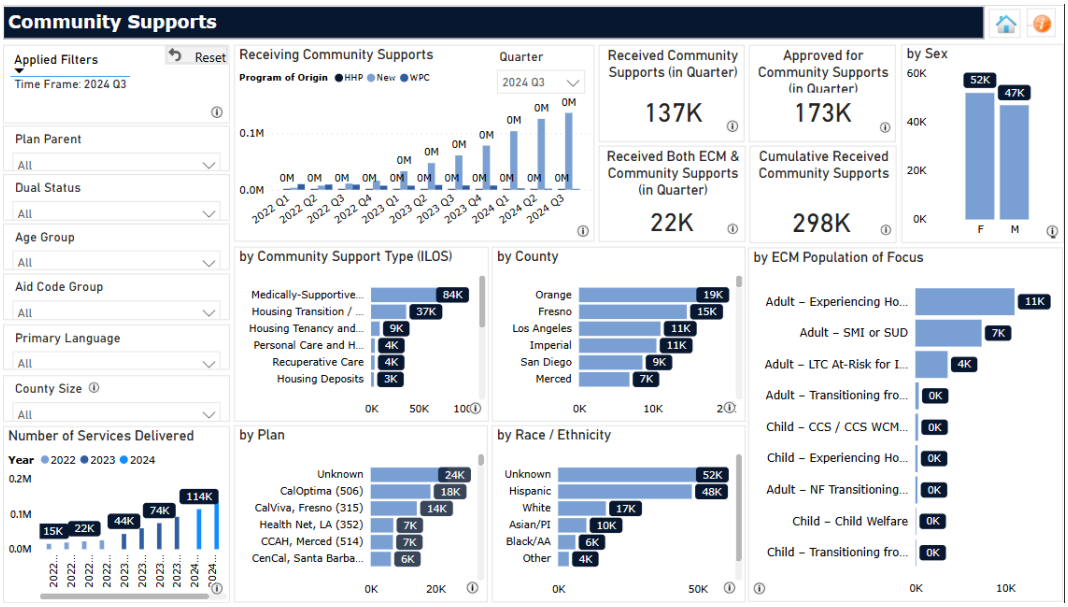
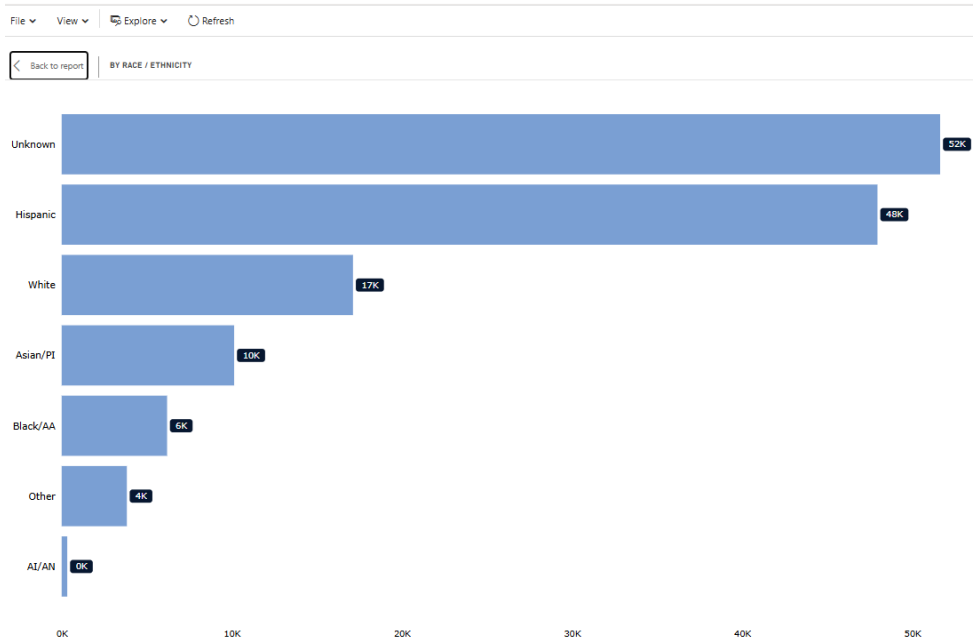


Figure 35: Demographics of Members Receiving Community Support Services as of September 2024. Examples of Outputs from DHCS' Power Business Intelligence (BI) ECM-CS Dashboard:



In addition to quarterly reporting, DHCS has initiated efforts to cross-validate QIMR data with other sources, such as encounter and claims submissions through the Post Adjudicated Claims & Encounters System (PACES). This approach provides a more comprehensive and accurate picture of program performance and ensures alignment across reporting mechanisms.

DHCS continues to work toward ensuring high data quality during the first three years of Community Supports implementation while recognizing the gaps in reporting capabilities among many new providers. MCPs face challenges in addressing significant data lag caused by providers new to Medi-Cal and/or the managed care delivery system. To date, DHCS has collected and validated 11 quarters of data for Community Supports. However, MCPs have expressed caution about interpreting trends, given the variability in provider experience and capacity.

Despite these challenges, Community Supports services have demonstrated potential for addressing critical HRSN for Medi-Cal beneficiaries. Among the most widely offered services are Housing Transition/Navigation, Housing Deposits, Housing Tenancy and Sustaining Services, Medically Tailored Meals, and Recuperative Care (Medical Respite). These services play a vital role in advancing the integration of social determinants of health into the Medi-Cal program, fostering improved health outcomes for beneficiaries

across California.

Currently available data, as of September 2024, indicates the following number of providers, members, and counties throughout California for the following available Community Supports:

Figure 36: Number of Providers Offering the Recuperative Care and Short-Term Post-Hospitalization Housing Community Supports Services

Community Supports	Number of Providers Offering Services				
	CY	Q1	Q2	Q3	Q4
Recuperative Care	2022	96	102	106	106
	2023	116	110	243	222
	2024	206	227	224	-
Short-Term Post-Hospitalization Housing	2022	34	40	53	65
	2023	87	95	176	183
	2024	198	240	245	-

MCPs in nearly all California's 58 counties have elected to offer Recuperative Care and Short-term Post-Hospitalization Housing within the first few years of the program. Recuperative Care is now available in 55 of California's 58 counties (~95%) and Short-Term Post-Hospitalization Housing is available in 56 (96.5%) counties.

Current available data indicates the following number of members served across the first three quarters of 2024 for DHCS' available Recuperative Care and Short-term Post-Hospitalization Housing Community Supports:

Figure 37: Number of Unique Individuals Served Across Community Supports

Community Supports	CY	Q1	Q2	Q3	Q4
Recuperative Care	2022	762	700	824	1,051
	2023	1,351	1,646	1,846	1,614
	2024	2,677	3,416	3,746	-
Short-Term Post-Hospitalization Housing	2022	7	91	123	193
	2023	245	306	442	521

Community Supports	CY	Q1	Q2	Q3	Q4
	2024	749	944	1,570	-

DHCS will continue to submit timely, accurate, and validated encounter data to Transformed Medicaid Statistical Information System (T-MSIS), in accordance with STC 8.13ii.

DHCS acknowledges that outstanding challenges with timely and accurate data collection remain, particularly as Community Supports represent a novel and transformative addition to Medi-Cal. These challenges are further compounded by the complexity of onboarding a diverse array of community-based providers and other non-traditional provider types who may be new to Medi-Cal's reporting and administrative requirements. Many of these providers are simultaneously navigating the operational intricacies of managed care for the first time, which necessitates ongoing technical assistance, capacity building, and support from DHCS and MCPs.

Recognizing these dynamics, DHCS is committed to actively addressing barriers to implementation and fostering a robust infrastructure for Community Supports. For example, DHCS has invested in statewide initiatives, such as the Community Supports Spotlight Series conducted in CY 2022 (DY 18), which provided targeted training on critical service areas. These sessions facilitated a shared understanding of program requirements, highlighted successful strategies and encouraged open dialogue between MCPs, providers, and DHCS. By emphasizing practical solutions and collaborative problem-solving, these forums have laid the groundwork for continued program enhancements.

In addition to technical assistance, DHCS continues to refine its approach to provider engagement by developing new tools and resources tailored to the specific needs of Community Supports providers. This includes creating step-by-step guides for navigating Medi-Cal systems, offering simplified templates for documentation and billing, and providing real-time support to address common administrative hurdles. These efforts aim to reduce burdens on providers, improve data submission accuracy, and enhance overall program efficiency.

As DHCS looks ahead, the focus remains on sustaining these initiatives and scaling up support to meet the evolving needs of the program. The challenges of data collection and operationalization are not viewed as static issues but rather as opportunities for continuous improvement and innovation. By fostering strong partnerships with MCPs and community stakeholders, DHCS seeks to build a more resilient and effective infrastructure that maximizes the potential of Community Supports to improve health outcomes and address social determinants of health for Medi-Cal beneficiaries statewide.

In CY 2025 (DY 21), DHCS will offer additional targeted technical assistance to support MCPs and providers in implementing and operationalizing upcoming refinements to select Community Supports service definitions. This effort will prioritize services such as Medically Tailored Meals, Asthma Remediation, and Community Transition Services/Nursing Facility Transition to Assisted Living Facilities. Through these efforts, DHCS aims to ensure MCPs and providers can fully align their operations with the updated definitions, enhance service delivery, and improve beneficiary outcomes. Planned activities include hosting focused webinars and training sessions, distributing updated policy guidance, and providing individualized support to address implementation challenges. Additionally, DHCS will facilitate peer-to-peer learning opportunities to share strategies, highlight promising practices, and foster collaboration across stakeholders. These initiatives are part of a broader commitment to advancing the integration of innovative, community-driven services within Medi-Cal, strengthening the program's capacity to meet the diverse HRSN of beneficiaries statewide.

JavaScript Object Notation (JSON) Transition

DHCS is committed to enhancing data availability and quality by the end of 2025 through two key strategies: (1) integrating claims and encounter data with QIMR data, and (2) accelerating the implementation data cycle by transitioning to JSON electronic file types for data collection and reporting.

The transition to JSON officially began in January 2024, marking a significant step forward in modernizing data reporting processes. MCPs were required to begin submitting additional monthly JSON files alongside their existing QIMR Excel reports. JSON, an open standard file format, is designed to facilitate streamlined data collection and transmission. This approach aligns with other mandatory reporting processes utilized by DHCS and is expected to address existing challenges with data timeliness. Currently, QIMR data lags real-time implementation by approximately four to six months. The transition to JSON is projected to significantly reduce this lag, enabling more timely monitoring and decision-making.

It is important to note that the introduction of JSON monthly reporting does not immediately replace Excel-based reporting requirements. MCPs are required to continue submitting QIMR Excel reports within 45 days of the end of each quarter. During the transition period, MCPs must adopt the JSON monthly process while maintaining Excel-based reporting for at least 12 to 18 months, or until DHCS determines that the JSON data is sufficiently robust to serve as the sole reporting mechanism. This dual-reporting period ensures data continuity and reliability as the new system is implemented.

The transition from QIMR Excel reports to JSON submissions is being executed in multiple phases, each designed to build on the previous one to ensure a smooth and effective implementation. These phases allow for iterative improvements and the resolution of any issues as they arise, supporting MCPs in adapting to the new reporting standards and requirements:

- **Phase 1 (January 2024):** Limited data elements specific to ECM and Complex Care Management (CCM) enrollment status.
    - Phase 1 was successfully adopted in January 2024 and all MCPs have been producing and submitting monthly JSON files beginning on February 10 (for the reported month of January). DHCS has worked with MCPs to identify and address technical issues and continues to provide additional technical assistance.
- **Phase 2 (July 2024):** ECM Populations of Focus, Eligibility, Outreach, Authorizations, and Provider Networks.
    - Phase 2 was successfully implemented in July 2024 and all MCPs have been producing and submitting monthly JSON files with the additional required data elements beginning on August 10 (for the reported month of July). DHCS continues to work with MCPs to identify and address technical issues and continues to provide additional technical assistance in preparation for Phase 3.
- **Phase 3 (January 2025):** ECM Care Manager & Provider Facility Details
    - Phase 3 design elements are fully developed and are undergoing validation by DHCS' internal teams. MCPs have been able to submit "practice" files for testing as of November 2024.
- **Phase 4 (July 2025):** All remaining QIMR data elements specific to Community Supports, including member-level details, utilization, authorizations, and provider networks. Closed Loop Referral (CLR) reporting will also be included for the first time, with details captured around referral and authorization decision dates, referral status, and date(s) services are received. ECM CLR Reporting & Presumptive Authorization details will also be introduced in this phase.
    - Phase 4 design elements are in final development, with teams having securing agreement on the best methods for obtaining necessary data in support of closed loop referrals.

DHCS has produced accompanying Technical Documentation through an available

Technical Assistance Companion Guide, containing all the technical information (including data dictionaries, file layouts, JSON Schemas, and details on response files) required for MCPs to be able to submit one data file to DHCS monthly. A Data Dictionary is also available, describing the required data values as well as the validation edits performed on specific data elements.

As stated above, MCPs are required to continue reporting as normal through the QIMR process within 45 days of the end of each quarter.

Other Monitoring Activities

DHCS is committed to ensuring that members and providers can easily access information about ECM and Community Supports. As such, it has established clear requirements for making information about the programs publicly available. Per the Community Supports Policy Guide, MCPs' websites must include the following easily accessible member- and provider- facing information:

- **Community Supports:** As required in A.B. 133 14184/206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021), up-to-date information about all of the Community Supports being offered by the MCP, including, at minimum:
  - A short description of each available service that is consistent with the service definitions listed in the Community Supports Policy Guide (terminology should not differ from DHCS' terminology).
  - The eligible population(s) for each service, inclusive of any DHCS approved approach to narrow or limit the eligible populations.
  - Any such limitations must meet the requirements in the CalAIM Waiver STCs, must be approved (in writing) by DHCS, and must be included in member handbooks.
  - Member and provider facing information about how to access the Community Supports offered by the MCP.
- **Community Supports Provider Networks:** MCPs are required to list all Community Supports providers in their provider directories as follows:
  - MCPs are to list all Community Support providers in the provider directories as "Other Services Providers," and should specify if a provider is an ECM, Community Supports Provider, or both.
  - MCPs must add a disclaimer in their provider directory stating that Community Supports require prior authorization and are limited to members

who meet specific eligibility criteria.

- MCPs may use symbols denoting Community Supports providers that may be listed in other sections of their provider directories in lieu of listing providers multiple times.

DHCS conducts focused reviews of MCP websites to ensure that all required information relevant to Community Supports is available and accessible to members and providers. Reviews for all MCP websites are conducted on a semiannual basis as Community Supports elections are updated. The latest reviews, completed in October 2024, confirm:

- Up-to-date member and provider facing information about Community Supports and how to request access to Community Supports.
- Up-to-date information about all Community Supports being offered by the MCP, including, at minimum: A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS' terminology.
- The eligible population(s) for each service, inclusive of any DHCS approved approach to modify or restrict the Community Supports service definitions (including eligibility). Beginning on January 1, 2024, the MCP must come into alignment with the DHCS Community Supports service definitions and must remove any language about approved modifications and/or restrictions from its website.

With the end of the third full year of Community Supports Implementation, the number of Community Supports elected by MCPs across California's 58 counties has significantly increased. Now that MCPs have had sufficient time to ramp up their processes, DHCS' primary focus is increased monitoring in addition to the following regular activities:

- Data Monitoring, Aggregation, & Analysis
- Model of Care Reviews (every six (6) months)
- Surveys/Interviews to Discuss IPP Investments
- Fact Sheets and Program Report Development
- Ad hoc Meetings with MCPs Based on Individual Plan Needs
- Oversight of IPP Earned Funding and Provider Investments
- Workgroups/Office Hours with MCPs (with a focus on sharing best practices as

well as providing support and technical assistance)

Public Reporting

On **January 29, 2024**, DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q2 2023.[15]

This report summarizes ECM and Community Supports implementation trends and data for the first 18 months of the programs, spanning January 2022 through June 2023. Similar to the 2022 Year One Implementation Report released in August 2023, this report provides insight into state-, county-, and managed care plan-level data.

In the first 18 months, 140,886 Medi-Cal MCP members across the state received the ECM benefit and 75,834 members received 167,960 Community Supports services. As California continues advancing its Medi-Cal transformation, ECM and Community Supports play a critical role in supporting whole-person care for Medi-Cal members with complex medical and health-related social needs. DHCS expects to see more enrollment growth across both programs in the coming months and years, including as additional POF become eligible for ECM and additional Community Supports services are offered in counties across the state. DHCS remains committed to supporting and sustaining this growth through program monitoring, design improvements, and standardization. Please note that the report is published via ArcGIS StoryMaps, a data visualization tool, and is best viewed on a desktop or laptop computer.

On **April 4, 2024**,[16] DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q3 2023.[17]

This report presented updated data on program utilization from January 2022 through September 2023, offering insights at the state, county, and Medi-Cal managed care plan levels. Additionally, it included demographic data such as ethnicity, primary language, age, and sex.

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[15] Report available at: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

[16] Press release available at: https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2024/24-12-ECM-CS-4-4-24.aspx

[17] Report available at: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

The report highlighted substantial growth in the availability and use of Community Supports services. As of January 2024, 23 counties offered all 14 Community Supports services, a dramatic increase from only three counties at the end of 2022. Additionally, every county in California now provides at least seven Community Supports services. In total, approximately 103,000 unique Medi-Cal members have accessed these services since the program's inception, with more than 186,000 total services delivered. Utilization has seen a sharp rise, with approximately 62,000 members using Community Supports in Q3 2023 alone – an increase of 170% from Q4 2022.

ECM and Community Supports continue to play a vital role in Medi-Cal's broader transformation by addressing both medical and social determinants of health, including housing assistance, medically tailored meals, and personal care services. State leaders reaffirmed their commitment to expanding and strengthening these initiatives, ensuring that Medi-Cal members receive person-centered care beyond traditional medical settings.

DHCS anticipates continued enrollment growth as more Populations of Focus become eligible for ECM and additional Community Supports services become available. The department remains dedicated to supporting this expansion through ongoing program monitoring, design improvements, and technical assistance. The latest report is published via ArcGIS StoryMaps, a data visualization tool optimized for desktop and laptop viewing.

On **August 2, 2024**,[18] DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q4 2023.[19]

This report provides updated data on program utilization from January 2022 through December 2023, covering state, county, and Medi-Cal managed care plan levels, along with demographic insights such as ethnicity, primary language, age, and sex.

The latest findings indicate continued growth in the availability and use of Community Supports services. As of January 2024, 19 counties now offer all 14 Community Supports services, while every county in California provides at least eight. Between Q3 and Q4 2023, the number of Medi-Cal members receiving Community Supports increased by 26 percent,

[18] Press release available at: https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2024/24-27-ECM-CS-Data.aspx

[19] Report available at: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

reaching 86,000 members. Since the program's inception, approximately 140,000 unique Medi-Cal members have utilized these services, receiving more than 350,000 total services.

ECM and Community Supports remain critical to Medi-Cal's transformation, helping members access comprehensive care that addresses both medical and social determinants of health, such as housing assistance, medically tailored meals, and personal care services. State leaders continue to prioritize these initiatives, reinforcing their commitment to equitable, person-centered health care. The report is available via ArcGIS StoryMaps, optimized for desktop and laptop viewing.

On **December 20, 2024**,[20] DHCS publicly released its ECM and Community Supports Quarterly Implementation Report for Q1 and Q2 2024, along with the following message and press release:

Latest Enhanced Care Management and Community Supports Quarterly Data Released

On December 20, DHCS released the latest Enhanced Care Management (ECM) and Community Supports quarterly report, covering data from January 2022 through June 2024. ECM provides high-touch, team-based care management for Medi-Cal members with complex needs, while Community Supports offer cost-effective, medically appropriate alternatives to traditional services, addressing social drivers of health, such as housing and nutrition. Together, these initiatives are critical to ensuring holistic, person-centered care that improves health outcomes and quality of life for Medi-Cal members. The report demonstrates sustained, quarter-over-quarter growth in both ECM and Community Supports use, as additional POF become eligible for ECM and more services are offered across the state. The report also provides the first data on ECM members in the newly introduced Birth Equity POF and the Individuals Transitioning from Incarceration POF, both of which were launched or expanded in January 2024.

Key findings included 244,750 Medi-Cal members receiving ECM benefits, with 127,024 members served from April through June 2024. This represents a more than 50 percent increase in quarterly ECM members since April through June 2023. About 239,500 members used Community Supports services, and 89 percent of Medi-Cal members had access to at least ten services. This represents a more than 120 percent increase in quarterly Community Supports members since April through June 2023. In April through June 2024, more than 59 percent of members using Community Supports accessed Medically Tailored Meals/Medically

[20] Press release available at: https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/122324-StakeholderNews.aspx

Supportive Foods, and approximately 35 percent accessed one or more services from the Housing Trio (Housing Transition Navigation Services, Housing Tenancy and Sustaining Services, and Housing Deposits).

Policy/Administrative Issues and Challenges

Nothing to report.

Opportunities for Improvement

DHCS tracks stakeholder feedback and indicators in the marketplace, including comments received from providers and members of the public, to effectively gauge the scope and severity of challenges in implementing Community Supports. Beginning in 2022, DHCS initiated a comprehensive effort to establish reliable provider feedback loops, including a Statewide Listening Tour that fostered direct engagement with a diverse array of stakeholders. These forums have been instrumental in surfacing barriers to implementation, including operational complexities, data reporting challenges, and gaps in provider readiness, while also highlighting opportunities for innovation and shared problem-solving.

To strengthen data quality and reporting, DHCS has undertaken a detailed analysis of discrepancies between plan-submitted data on the QIMRs and the Encounters System (PACES). This analysis is providing critical insights into data accuracy and completeness, allowing DHCS to identify specific areas where additional technical guidance or oversight may be warranted. The ongoing transition to JSON-based reporting, scheduled for phased implementation through 2024 and 2025, represents a significant step forward in standardizing data submission, enhancing analytical capacity, and improving the timeliness and integrity of data across reporting mechanisms.

Recognizing the importance of provider engagement, DHCS continues to invest in Community Supports provider education. Efforts include expanding opportunities to connect with prospective Community Supports providers, facilitating peer-to-peer knowledge-sharing among current and emerging providers, and developing resources to orient non-traditional providers to the operational requirements of Medi-Cal and Community Supports. These efforts aim to reduce barriers to entry for non-traditional providers, such as housing or food service organizations, and foster greater alignment with Medi-Cal's unique requirements.

Looking ahead, DHCS has identified additional areas for improvement, including optimizing the integration of HRSN services within MCP networks, refining performance monitoring frameworks to capture meaningful outcome data, and addressing ongoing

challenges in beneficiary access and service utilization. DHCS remains committed to collaboration with MCPs, providers, and stakeholders to address these opportunities and to further strengthen the delivery of Community Supports statewide.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

Providing Access and Transforming Health (PATH) Supports, Global Payment Program (GPP), Dually Eligible Enrollees in Medi-Cal Managed Care, Reentry Demonstration and Pre-Release Services, and Managed Care Plan Transition

DHCS submitted a draft evaluation design for PATH, GPP, and dually eligible members' portions of the CalAIM 1115 waiver to CMS in June 2022. CMS provided feedback in October 2022, recommending a contractor and expanded data methodologies for PATH, to be combined with the Justice-Involved Initiative evaluation. DHCS revised and resubmitted the design in November 2022. In DY 19, DHCS contracted with UCLA and RAND Corporation to assist with these evaluations.

UCLA-RAND conducted the evaluation of the Providing Access and Transforming Health (PATH), Global Payment Program (GPP), Dually Eligible Member Satisfaction in the Medi-Cal Matching Process, and the newly approved Reentry Demonstration Initiative. During DY 20, UCLA worked with DHCS to revise the designs as requested. DHCS submitted a revised, expanded Evaluation Design to CMS, including a newly drafted evaluation design for the JI initiative, on February 7, 2024.

On June 5, 2024, the Department of Health Care Services (DHCS) received feedback from CMS on the Evaluation Design for PATH, GPP, Duals, and REENTRY. Since then, DHCS worked closely with UCLA-RAND to address CMS' comments and revise the Evaluation Design accordingly.

On August 23, 2023, CMS approved DHCS' amendment request to the CalAIM Section 1115 Demonstration, which includes expenditure authority to limit the choice of managed care plans in Metro, Large Metro, and Urban counties operating under the COHS and Single Plan Models. As a result of this approval, the state was required to amend the CalAIM 1115 Evaluation Design to reflect this change.

In June 2024, DHCS selected the National Opinion Research Center (NORC) at the University of Chicago as the Independent Evaluator for the Managed Care Plans (MCP) transition. The evaluation contract with NORC was finalized in October 2024. NORC has since drafted the MCP Transition Evaluation Design, and DHCS leadership is currently in the process of revising the document. DHCS has received approval to submit a combined evaluation design document to CMS by February 28, 2025, which will include revised evaluation designs for PATH, GPP, Duals, and REENTRY, as well as a new evaluation design for the MCP transition evaluation.

Progress and Accomplishments

PATH

The UCLA PATH Team completed the cleaning of MCP interview transcripts and developed a codebook, conducting preliminary thematic coding in NVivo for qualitative analysis. They synthesized high-level findings and extracted illustrative quotes. For the MCP survey, UCLA finalized the survey instrument, incorporated DHCS feedback, programmed it into Qualtrics, and received 21 responses, following up on incomplete data. They began preliminary cleaning and coding for descriptive analysis. UCLA also finalized a provider interview protocol, began scheduling interviews, and completed 12 interviews by December 2024. For the CPI Initiative facilitator interviews, UCLA finalized the protocol, incorporated DHCS feedback, and began scheduling interviews for January 2025.

GPP

DHCS provided a range of data sets to UCLA-RAND to support the evaluation of the GPP initiative, as mandated by the CalAIM STCs. The development of the PHCS Survey protocol and logistics continued, with input from DHCS and CAPH. Items were incorporated into the survey to assess patient experiences of care from the perspective of primary care clinic staff, as an alternative to patient interviews or surveys, a strategy supported by DHCS.

Duals Matching Plan Policy

In the fourth quarter of 2024, the Duals evaluation team focused on administering the member survey. A total of 907 dual-eligible individuals participated, submitting responses online, via computer-assisted telephone interviews (CATI), or through mail. The team received 787 completed surveys: 453 web responses, 172 phone surveys, and 162 mail surveys.

Reentry Initiative

UCLA-RAND is conducting an evaluation of the CalAIM 1115 Reentry initiative, which officially launched on October 1, 2024, in Yuba County, Inyo County, and Santa Clara County. Given the recent launch of this initiative in a small number of counties, few evaluation activities had occurred prior to the end of 2024.

Community Supports

On September 11, 2024, DHCS amended the original UCLA-RAND contract to include the program evaluation of Community Supports, following a final CMS decision on the

timing and number of evaluation reports for the 12 Community Supports authorized through 1915(b) waiver authority and the evaluation requirements for the two Community Supports authorized via the 1115 waiver. DHCS submitted the Community Supports Evaluation Design for CMS review on October 17, 2024 and is currently pending CMS feedback on the Evaluation Design.

The Community Supports evaluation goals are to measure the extent to which the programmatic goals outlined below have been achieved, with first-order goals referring to service objectives that must be met before additional goals can be pursued.

First Order Goals

1. Increase uptake of Community Supports by MCPs
2. Increase awareness and offering of Community Supports by providers.
3. Increase uptake of Community Supports by eligible members

Additional Goals

1. Increase uptake of Community Supports by MCPs
2. Increase members' access to non-emergency outpatient care and reduce acute care utilization and long-term care admissions and stays
3. Improve quality and outcomes of care for eligible members
4. Reduce disparities in service utilization, quality, and outcomes of care for eligible members
5. Ensure HRSN expenditures do not exceed aggregate spending caps and Community Supports are cost-effective alternatives to State Plan services and settings

DHCS will also provide ongoing monitoring updates to CMS within the Annual Report on ILOS as required under the 1915(b)-waiver authority.

DMC-ODS, Contingency Management, and Traditional Health Care Practices (THCP)

Status of Activities/Milestones

Evaluation Design: No changes were made to the Evaluation Design during this demonstration year. Information about the Evaluation Design can be found here, and the approved Evaluation Design can be found here.

On October 16, 2024, CMS approved coverage of a new Traditional Health Care Practices

(THCP) benefit under the CalAIM demonstration and delivered through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations, or facilities operated by urban Indian organizations. DHCS and the University of California, Integrated Substance Use and Addiction Programs (UCLA-ISAP) immediately initiated discussions and reached out to stakeholders to begin developing an evaluation design appropriate to evaluate this benefit.

Regulatory Approvals: UCLA received Institutional Review Board (IRB) Research Exempt determinations from both State IRB (June 2022) and UCLA IRBs (Oct 2023) and was issued a Certificate of Confidentiality (Oct 2023) through The National Institutes of Health (NIH), protecting the identity of research participants in this project. During this demonstration year (in April 2024), an amendment was submitted to the State Institutional Review Board (IRB), Committee for the Protection of Human Subjects (CPHS) because UCLA-ISAP obtained a new data source – the CDPH death data dictionary – from which it is seeking data to utilize as part of the evaluation, if possible. While UCLA-ISAP does not yet have access to this data, it is important to have on record with the IRB the data dictionaries of all potential datasets to be involved in the project to ensure its determination. This amendment resulted in a new Exempt Approval notice from the State IRB (project number 2024-065).

Survey Data Collection: During this fiscal year, UCLA-ISAP continued the dissemination and collection of the Provider Survey as part of the evaluation of the California Recovery Incentives Program evaluation. The survey launched in September 2023, surveying programs after a minimum of five months delivering CM services as part of the Recovery Incentives Program. Data collection will continue until all programs have launched or saturation is reached. At the end of this fiscal year, 81 programs reached eligibility to receive the Provider Survey; 233 surveys were submitted with a 96 percent response rate. Survey questions include knowledge, attitudes, beliefs about contingency management, concerns about preparation and implementation procedures, and other open-ended feedback.

In addition, UCLA continued the development and implementation of the Client Survey effort, using both longitudinal and cross-sectional approaches. In February 2024, UCLA launched a cross-sectional Client Survey over a one-week period to all active members enrolled in the Recovery Incentives program among 49 launched programs. Survey questions included: self-reported substance use, associated use behaviors, perceptions about the protocol/receiving incentives, perception of its impact on treatment response and progress in recovery, and other open-ended feedback. From this effort, 546 surveys were received. To gain a better understanding of best practices and expected response

rates from a large longitudinal client survey collection effort, a sample of the respondents from the cross-sectional survey who were in week 1-2 (N = 48) during the survey period were followed up to be part of a small pilot longitudinal survey study. Follow up data collection timepoints were set at week 6, week 14, and week 28 from their baseline collection point. The follow survey questions were similar to the initial surveys. Week 6 follow-up collection initiated in late March 2024. Email and/or mobile phone numbers provided by these clients were used to disseminate the online follow up surveys at each time point. A unique survey link was provided to each individual via email and/or text with weekly contact attempts and reminders during collection windows. Response rates at each time point were as follows: Week 6 – 69 percent, Week 14 – 63 percent, and Week 28 – 56 percent. Data collection for the longitudinal client survey concluded in mid-October 2024.

Finally, from May to June 2024, UCLA distributed the annual County Administrator Survey, which aimed to continue measuring impact of the DMC-ODS waiver on SUD service delivery as well as addressing priority areas addressed under CalAIM (e.g., contingency management, peers, harm reduction efforts, etc.). Collection was completed with a 100 percent response rate.

Qualitative Interviews: As part of the Recovery Incentives Program evaluation, UCLA-ISAP conducted 16 qualitative interviews of providers delivering the Recovery Incentives Program protocol. The Evaluation team selected a subset of provider survey respondents and designed the interview sample to be representative of individuals from different parts of the state (e.g. urban, rural areas) and different points of view on the Recovery Incentives Program (as expressed in provider surveys). Interviews occurred between April and June 2024 and participants were asked questions about their experiences implementing the Recovery Incentives Program and what they believe are the strengths and weaknesses of the program, following the Interview Guide approved by DHCS in early January.

UCLA-ISAP also initiated the Program Executive/Administrator Interviews in Q4 using the interview guide approved by DHCS in June 2024. By the end of this fiscal year, seven interviews were completed with a goal of reaching approximately 20 individuals at various types of programs and counties. The purpose of these interviews is to gain a high-level perspective of the implementation of the Recovery Incentives Program, with a specific emphasis on the preparation and approval process, program protocol procedures, Incentive Manager software, financial/billing/compensation aspects, training/ongoing coaching support, client/patient reactions to the protocol and incentives, and things they would like to see change. More interviews are scheduled in

January 2025. Interviews will be transcribed and analyzed for themes that will be incorporated into future publications, reports, and conference presentation material.

Finally, client interviews initiated late in Q4, using the Interview Guide approved by DHCS in early January. The original plan to conduct these interviews was postponed while UCLA-ISAP determined best practices and preferred methods in which to contact clients who are or have participated in the Recovery Incentives Program, from the survey collection processes. By the end of this fiscal year, one interview was conducted, with more to be scheduled in the next fiscal year.

Administrative Data Analysis: UCLA continues to receive, manage, merge and analyze administrative datasets including California Outcomes Measurement System Treatment [CalOMS-Tx], Medi-Cal Claims and Managed Care Fee for Service datasets, ASAM data as well as Incentive Manager data to prepare analysis per the approved Evaluation Design.

Challenges encountered and how they are being addressed

In this fiscal year, UCLA-ISAP rolled out several data collection efforts for the CA Recovery Incentives Program. Strategies were based on feedback from providers regarding the challenges they expect the evaluators to encounter when contacting their clients over a longitudinal study. While UCLA-ISAP found survey response rates from the pilot longitudinal client survey effort to be reasonable, there is room for improvement. The sample had low representation of clients who dropped out of the intervention, effectively missing potentially important information about what is not working. When initiating qualitative interviews with clients, UCLA-ISAP experienced limited response to the outreach, encountering many phone numbers and email addresses that were no longer valid. UCLA-ISAP plans to continue reaching out to clients but are also exploring additional strategies to recruit clients outside of the pool of clients who completed surveys within this past year. UCLA-ISAP also intends to adjust the data collection strategy for the longitudinal client surveys in the upcoming year to prioritize building rapport with clients earlier in the collection period and maintaining contact more frequently to encourage response rates. Doing so will also provide more opportunities to conduct qualitative interviews earlier in the timeline. Finally, data reporting lags in administrative datasets continues to be challenging but DHCS continues to work with UCLA to address these efforts to the extent possible.

Description of Interim Findings or Reports

UCLA-ISAP provided DHCS with a Mid-Point Assessment report in Q4. DHCS is currently reviewing this report. Within this report, UCLA-ISAP discusses the progress under the

DMC-ODS Waiver toward the six milestones defined in the CalAIM STCs. Of the six milestones, only two (#4 and #6) were considered medium-risk rather than low-risk. These milestones and the progress are summarized below:

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs (Milestone 1)
    a. Goals for this milestone were met for 71.4 percent (5/7) of the monitoring metrics. Furthermore, event studies and difference-in-differences estimates suggested access is being maintained. Also, client and county administrator survey feedback was positive. Together, these findings consistently suggest a low risk of not achieving Access demonstration milestones. However, the monitoring metrics did suggest the number of beneficiaries receiving intensive outpatient treatment declined sharply, which merits further investigation.

2. Widespread use of evidence-based, SUD-specific patient placement criteria (Milestone 2)
    a. There are no CMS monitoring metrics for Milestone 2. California tracks use of ASAM screenings and assessments through ASAM Level of Care Placements data. After generating data-driven estimates to correct for missing data submissions, it is clear that the use of these screenings and assessments continues at a high level and has been maintained at the levels established in previous years.

3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications (Milestone 3)
    a. There are no CMS monitoring metrics for Milestone 3. Standards for provider qualification designations for residential treatment were established and implemented during the previous Medi-Cal 2020 waiver. These policies have been maintained in the current waiver. As of November 15, 2024, 994 facilities have received an ASAM LOC designation.

4. Sufficient provider capacity at each level of care (Milestone 4)
    a. Monitoring Metrics were inconclusive due to changes in how providers were identified. However, in the most recent available Annual Network Certification DMC-ODS Corrective Action Plan report, 11 out of 31 plans were non-compliant as of June 2023 (35.4 percent). This report and comments from stakeholders converge upon a need for more youth residential treatment specifically, though other metrics point to possible challenges in intensive

outpatient and outpatient treatment (see Milestone 1). Stakeholders also provided feedback on workforce challenges to provider capacity and provided suggestions to address them.

   b. To address these challenges, DHCS is coordinating with its partners to both explore any potential decrease in real service utilization and any potential correlation to provider availability, accessibility, and timely delivery of services. DHCS is also exploring policy changes and any other mechanisms available to the Department to address additional capacity for SUD services and expand services across geographic areas identified with insufficient capacity, with special attention to youth residential services.

5. Implementation of comprehensive treatment and prevention strategies to address opioid use and OUD (Milestone 5)
   a. Monitoring metrics were in the targeted direction for ten out of 11 measures. Administrative data suggest mostly level or slightly decreased use of MAT within DMC-ODS providers, but with a strong increase in use of MAT overall. County stakeholders offered suggestions on how to continue expanding opioid treatment and prevention strategies.

6. Improved care coordination and transitions between levels of care (Milestone 6)
   a. The sole AOD monitoring metric for this milestone was not in the expected direction. Stakeholder feedback suggests there are plausible explanations for this result as a side-effect of increased buprenorphine prescribing, but since data is not available to test these explanations at this time, this metric result is taken into account at face value. Transitions from residential treatment were stable in 2022 but dipped in 2023. Stakeholder feedback from clients was positive and stable but there is room for improvement. Stakeholder feedback from county administrators suggested a positive impact of the waiver and improving use of care coordination, but also cited additional challenges that remain.

   b. In response to these challenges, DHCS has launched several initiatives aimed at improving coordination of care, including the BH-CONNECT Demonstration, BHP Interoperability Implementation Requirements, and new Memorandums of Understanding (MOUs) between DMC-ODS counties and MCPs that further describe the data and information that can be exchanged to improve care coordination and referral processes.

A second objective of this report was to report initial evaluation results from the Recovery Incentives Program, as lessons learned from the program are critical to the contingency management efforts being developed in other states. The evaluation and thus the findings are organized around the RE-AIM framework. To summarize:

1. Reach - The number of clients participating in the Recovery Incentives Program is rapidly increasing. The program reached nearly 5,000 clients between its inception in April 2023 and October 2024.
2. Effectiveness - Urinalysis results suggest that clients in the Recovery Incentives Program are maintaining relatively high levels of abstinence that exceed levels generally found in the CM literature. These results were consistent across a variety of different methods of calculation. An overwhelming percentage of clients reported that the program had a positive impact on their response to treatment. Clients also reported that the Recovery Incentives Program helped them stop using drugs, improve their health, reduce hospital and emergency department visits, take care of personal responsibilities, and be a better member of the community. According to providers, contingency management is highly effective for clients who have long histories of substance use and who have not been able to achieve or sustain recovery in the past.
3. Adoption - A little more than half (56 percent) of the program sites that initially expressed interest in joining the Recovery Incentives Program had launched as of July 2024. Counties that decided not to participate in the program explained that their county and provider staff had to focus on keeping up with other required priorities (e.g. other CalAIM requirements) and therefore were unable to volunteer for the optional Recovery Incentives Program at this time.
4. Implementation - After providers adopt the Recovery Incentives Program and begin implementation, staffing and turnover remain the biggest barriers. Many sites did not add staffing for the program, but rather assigned new duties to existing staff, which made it difficult for these busy staff to support the program adequately.
5. Most providers (91 percent) found the Recovery Incentives Program trainings to be mostly or completely sufficient for their needs. Monthly coaching calls have been a successful mechanism to answer questions and address incentive manager software issues quickly. However, providers also reported that these calls are time-consuming for staff.

6. Providers initially identified several concerns prior to implementation, including fraudulent behavior (providers enrolling people who did not truly have a stimulant use disorder, clients attempting to cheat on drug tests), disapproval from the community, disruptions from clients upset about not being eligible for the program, or that the drug testing would undermine the staff/client relationship. However, according to providers who were surveyed after they implemented the program, these issues rarely or never actually occurred in practice.
7. Maintenance – UCLA-ISAP plans to collect data on maintenance and provide findings and recommendations in the coming years as the Recovery Incentives Program matures.

In addition to the Mid-Point Assessment report, UCLA-ISAP presented information about the implementation and early findings (as approved by DHCS) from the CA Recovery Incentives Program at 18 conferences/meetings within this fiscal year.

Out-Of-State Former Foster Youth

The eligibility and enrollment data is consistent with our expectations from 2021 to 2022. Despite a slight decrease in enrollment and retention, along with a reduction in disenrollments, there is a consistent Former Foster Youth (FFY) population.

For FFY and Out of State (OOS) FFY, the services provided are being utilized at a comparable or higher rate than the peer group from 2021 to 2022. Total number of members with any claim, primary care appointments, behavioral health appointments, emergency department visits, and inpatient visits are all measured for OOS FFY and FFY. In comparison to the peer group, some of those services are consistently used at a higher or comparable rate by OOS FFY and FFY.

Next Steps/Upcoming Evaluation Deliverables

In 2025, DHCS plans to engage in the following evaluation activities and reporting:

- A revised and combined evaluation design for the PATH, GPP, Duals Matching Plan Policy, Reentry Initiative, and MCP Transition must be submitted to CMS by February 28, 2025. As the independent evaluator, UCLA-RAND will continue data collection and analysis in preparation for the interim evaluation, which is due to CMS by December 31, 2025. For the Reentry Initiative in particular, UCLA-RAND will assess which analyses can be included in the interim report and which will need to be deferred to the final evaluation report due to limited data availability

for this new program. Additionally, UCLA-RAND will continue to submit quarterly reports to DHCS detailing its progress toward meeting these goals.

- As discussed above, UCLA-ISAP submitted a draft DMC-ODS Mid-Point Assessment to DHCS during 2024. DHCS will submit the Mid-Point Assessment to CMS by March 1, 2025. UCLA-ISAP will also submit a DMC-ODS 1115 Interim Evaluation Report by the end of 2025, per requirements outlined in STC 16.7.
- As noted in the Evaluation Design section above, UCLA-ISAP is in the process of developing an evaluation design for the THCP benefit, in consultation with Tribes and Tribal Partners.

COVID 19 Risk Mitigation Report

- Consistent with CMS requirements following the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) section 1115 demonstration application on December 29, 2021, the Department is required to develop an Evaluation Design and a Final Report, that will consolidate the demonstration's monitoring and evaluation requirements. The Managed Care Risk Mitigation COVID-19 Evaluation Design was approved on April 21, 2023, and the Final report is due to CMS June 30, 2025.