DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

January 26, 2023

Ms. Jacey Cooper
State Medicaid Director
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cooper,

The Centers for Medicare & Medicaid Services (CMS) is approving California's (the "state") request to amend the section 1115(a) demonstration titled, "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9) (the "demonstration") to provide limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the beneficiary's expected date of release, in accordance with section 1115(a) of the Social Security Act (the Act). CMS is also approving federal matching funds for Designated State Health Programs (DSHP) that California will use, going forward, to partially support the Providing Access and Transforming Health (PATH) program that was approved as part of CalAIM on December 29, 2021. As a condition for approval of DSHP, California will be required to increase and sustain Medicaid fee-for-service provider base payment rates and managed care payment rates in primary care, behavioral health, and obstetrics care, as discussed below. California's budget neutrality methodology will also be updated for consistency with current CMS policy regarding budget neutrality calculations for demonstration coverage of services to address Health-Related Social Needs (HRSN), specifically, with respect to the state's previously approved coverage of recuperative care and short-term post-hospitalization services.

This amendment approval represents a first-of-its-kind reentry section 1115 demonstration initiative, focused on certain justice-involved individuals. Section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (herein referred to as the SUPPORT Act) (Pub. L. No. 115-271) directed the Secretary of Health and Human Services, through the CMS Administrator, to issue a State Medicaid Director Letter (SMDL), based on best practices identified by stakeholders convened by the Department of Health and Human Services, regarding opportunities to design demonstrations under section 1115 of the Act to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible for Medicaid. We anticipate that this amendment approval will be consistent with the expected contents of a forthcoming SMDL setting forth such federal guidance that will encourage states to implement strategies to facilitate successful transitions into the community for justice-involved individuals released from correctional settings, such as jails, prisons, and youth correctional

facilities. California was among the first states to propose a reentry demonstration initiative for the justice-involved population. The state's proposed approach closely aligns with CMS's anticipated reentry demonstration initiative which is being developed with significant stakeholder engagement as required by section 5032 of the SUPPORT Act. The state has also undertaken a notable amount of its own stakeholder engagement, including with people with prior criminal justice system involvement, and has completed necessary preparation and coordination to prepare for implementation of its proposed reentry demonstration initiative.

Individuals recently released from jails, prisons, and other correctional settings have multi-faceted needs that must be addressed in order to ensure their successful reintegration into their communities. By improving connections and coordination between the correctional, health care, and social service systems, California's reentry demonstration initiative aims to address the needs of incarcerated beneficiaries as they near the end of their incarceration and reenter the community, with the goals of increasing and continuing coverage; improving coordination and communication between correctional systems, Medicaid systems, and community-based providers; and providing appropriate health care interventions at earlier opportunities to reduce acute services utilization and adverse health outcomes (including but not limited to decompensation, suicide-related death, overdose, overdose-related death, and all-cause death) in the period preceding their release, immediately afterward, and in the near term. As a result, the state anticipates it will increase coverage and continuity of coverage for eligible beneficiaries, improve care transitions for beneficiaries as they reenter the community, and reduce morbidity and mortality in the near-term post-release, all of which will advance public health and public safety outcomes for individuals and their communities.

This approval is effective as of the date of this letter through the end of the CalAIM demonstration approval period (December 31, 2026) upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached waiver authorities, expenditure authorities, and Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the relevant Medicaid and CHIP requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the terms of the demonstration.

Background on the CalAIM Demonstration

The CalAIM demonstration was approved on December 29, 2021, as an extension of the state's previous Medi-Cal 2020 demonstration, to help address many of the complex challenges facing California's most vulnerable residents, including individuals who are homeless and those with limited behavioral health care access, children with complex medical conditions, and the growing justice-involved population with significant clinical needs. Under the CalAIM demonstration, CMS approved the PATH program to provide one-time transitional funding to enable the state to support continuity of services, as well as efforts to maintain and support the provider and community-based organization (CBO) capacity necessary to transition from Medi-Cal 2020 to CalAIM. The approved PATH expenditures also supported planning and development activities for the pre-release eligibility education, application support, and

enrollment assistance activities under the reentry demonstration initiative we are approving today. The approved demonstration also includes expenditure authority for short-term post-hospitalization housing and recuperative care services delivered by managed care plans, and continued expenditure authority to allow federal financial participation (FFP) in expenditures for Medi-Cal services provided to beneficiaries who are short-term residents of Institutions for Mental Diseases (IMDs) receiving Drug Medi-Cal Organized Delivery System (DMC-ODS) program services for substance use disorder (SUD) treatment.

In the December 29, 2021 approval letter, we noted that CMS and California were continuing to discuss the state's pending requests related to services and supports for justice-involved adults and youth. Today's CalAIM amendment approval grants California expenditure authority for certain pre-release services that are provided to Medicaid-eligible justice-involved individuals, and individuals who would be eligible for CHIP if not for their incarceration status, who meet specific medical or institutional criteria, for a duration of up to 90 days immediately prior to the individual's expected date of release.

Additionally, in California's initial application, the state requested FFP for DSHP to support the non-federal share of costs for the PATH program. In the December 29, 2021 approval letter, CMS did not approve this request, but committed to continuing to review the proposal, which we noted remained under active CMS review. In today's amendment approval, CMS is authorizing federal matching funds under section 1115(a)(2) for state expenditures on approved DSHP. This will enable the state to use freed up state funds as the non-federal share of currently approved PATH expenditures, including transitional, non-service investments to support the delivery of pre-release services for justice-involved individuals.

This approval also modifies the budget neutrality treatment of expenditures for short-term post-hospitalization housing and recuperative care services to conform to the HRSN policy framework recently described by CMS in the section 1115 demonstration approval for Oregon dated September 28, 2022[1] and the section 1115 demonstration approval for Massachusetts dated November 7, 2022.[2]

Reentry Demonstration Initiative Background[3]

As directed by section 5032(b) of the SUPPORT Act, CMS expects to issue a SMDL on a demonstration opportunity to support community reentry and improvement in care transitions for individuals who are incarcerated and soon-to-be released (referred to as the "Reentry Demonstration Opportunity"). In the SMDL, CMS expects to include guidance related to expectations for an implementation plan and reinvestment plan, which California will be

[1] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca1.pdf
[3] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

submitting pursuant to this approval, as described further below and in the STCs. We have worked closely with California on its request to cover pre-release services for certain incarcerated individuals, and we expect that this approval will be closely aligned with the guidance concerning the Reentry Demonstration Opportunity that we anticipate releasing in the near future.

Medicaid Eligibility in Carceral Settings

Incarceration status is not relevant to status as a Medicaid eligible individual. Individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid, but absent expenditure authority under section 1115(a)(2), federal Medicaid funds may not be used to pay for services for such individuals while they are incarcerated, except when they are inpatients in a medical institution, as provided in paragraph (A) following the last paragraph of section 1905(a) of the Act, hereinafter referred to as the inmate payment exclusion. In 2016, CMS provided guidance to states regarding facilitating access to Medicaid-covered services prior to and after a stay in a correctional institution, including states' authority to suspend, rather than terminate Medicaid eligibility for individuals who are incarcerated. Suspending rather than terminating eligibility maintains enrollment for Medicaid-eligible individuals who become incarcerated, while complying with the inmate payment exclusion.[4] Since then, section 1001 of the SUPPORT Act prohibited states from terminating Medicaid eligibility for eligible juveniles[5] who are inmates in a public institution. This directly impacts when care is received and is a contributing factor for early identification of treatable medical conditions, continuity of care, reduction of medical crises, and mortality, and ensuring individuals who were incarcerated have the resources required for successful reentry into the community.[6,7]

Pre-Release Services for Justice-Involved Individuals in California

California's amendment to provide limited coverage for pre-release services for certain justice-involved individuals supports CMS's vision to serve the public as a trusted partner and steward, dedicated to expanding coverage, advancing quality and health equity, and improving health outcomes. This amendment focuses on providing high-quality coverage of certain Medicaid-covered services for certain incarcerated beneficiaries. As a group, incarcerated individuals have generally been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.

With this approval, California will cover a set of pre-release services to justice-involved adults who have significant clinical and social needs and individuals in youth correctional facilities, to improve their transitions (in particular, transitions of health coverage and care) back to the community. Coverage of the pre-release services and the activities to improve care transitions

[4] *See* April 28, 2016, State Health Official Letter # 16-007 "RE: To Facilitate successful reentry for individuals transitioning from incarceration to their communities" found at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf and January 19, 2021, State Medicaid Director Letter # 21-002 "RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act) found at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.
[5] https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.
[6] https://councilonci.org/issue-brief-1/.
[7] https://councilonci.org/harp-issue-brief-2/.

upon reentry into the community are expected to increase continuity of health coverage, prevent unnecessary disruptions in care, reduce emergency department visits and inpatient hospital admissions; reduce decompensation, suicide-related death, overdose, overdose-related death and all-cause death; and lead to improved health outcomes in general. This targeted set of pre-release services will be available to certain eligible Medicaid beneficiaries and individuals who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county jails, or youth correctional facilities, for up to 90 days immediately prior to the individual's expected release date.

For the reasons outlined below, this amendment approval provides California with the authority to cover certain pre-release services under section 1115 authority independent of the demonstration opportunity specified in section 5032(b) of the SUPPORT Act for up to 90 days immediately prior an individual's date of expected release. Covering pre-release services only in the 30 days immediately prior to an individual's date of expected release aligns with the opportunity described in section 5032(b) of the SUPPORT Act to improve care transitions for certain "soon-to-be former inmates of a public institution." However, the 30-day timeframe specified in section 5032(b) of the SUPPORT Act does not limit the Secretary's preexisting authority to approve demonstration projects and associated expenditure authorities under section 1115 of the Act, and pursuant to that authority, CMS is authorizing California to cover specified pre-release services for up to a 90-day pre-release period.

As discussed below, the state will be required to evaluate the effect of pre-release services coverage during the entire 90-day pre-release period on improving care transitions as contemplated in section 5032(b) of the SUPPORT Act. However, the extended coverage period between 30 days and up to 90 days before the individual's expected date of release is approved under section 1115(a) of the Act specifically to test whether such coverage improves the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and whether it improves uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. For example, the reentry demonstration initiative will test whether the full 90-day timeline will enable the state to support pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) which could reduce post-release acute care utilization. By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain behavioral health conditions and including stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs, California expects that it will be able to reduce decompensation, suicide-related death, overdose, and overdose-related deaths in the near-term post-release. The state will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of the extended full 90-day coverage period before the beneficiary's expected date of release on achieving these articulated goals of the initiative.

In support of improving continuity of coverage, reducing post-release acute care utilization, and reducing substance use-related health crises in the period shortly after release, the state and its demonstration partners will need to conduct other activities (including enrollment eligibility education and application assistance), and to cover services (for example, health needs screening for demonstration service qualification and case management triage) in the period up to 90 days pre-release.

Under the reentry demonstration initiative, California expects to achieve the following goals:

- **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
- **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release;
- **Improve coordination and communication** between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;
- **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
- **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health, and health-related social needs;
- **Provide intervention** for certain behavioral health conditions and using stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release; and
- **Reduce post-release acute care utilizations such as emergency department (ED) visits and inpatient hospitalizations and all-cause deaths** among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

Eligible Individuals

California will cover a set of pre-release Medicaid benefits for Medicaid beneficiaries and individuals who would be eligible for CHIP except for their incarceration status who are inmates in state prisons, county jails, and youth correctional facilities during the period up to 90 days immediately prior to the individual's expected date of release (fewer days for people who are expected to be released from incarceration in fewer than 90 days) who meet site-specific health-related criteria. This includes all beneficiaries eligible for Medicaid state plan or Medi-Cal coverage, including adults, parent-caretakers, youth under 19, pregnant or post-partum women, individuals who are aged/blind/disabled, and children in foster care and former foster care youth. Individuals residing in a state prison, or county jail not designated as a youth correctional facility, must be eligible for Medicaid (as determined pursuant to an application filed before or

during incarceration) or be eligible for CHIP except for their incarceration status, meet one or more health-related criteria, and have an expected release date not later than 90 days after initiation of demonstration-covered services to qualify for pre-release services. Health-related criteria include but are not limited to: confirmed or suspected mental health diagnosis, SUD, chronic condition or significant non-chronic clinical condition, intellectual or developmental disability, traumatic brain injury, positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), or currently pregnant or within a 12-month postpartum period. Individuals incarcerated in a youth correctional facility who are eligible for Medicaid or who would be eligible for CHIP except for their incarceration status, who have been identified as expected to be released within 90 days, qualify to receive coverage of pre-release services without any requirement to meet specific clinical criteria.

Medicaid Eligibility and Enrollment

Ensuring enrollment in health coverage is an essential component of improving care transitions between carceral settings and the community. A straightforward strategy to better ensure enrollment for newly released, Medicaid-eligible individuals is to adopt an eligibility or benefits suspension approach, instead of enrollment termination, so the individual does not have to submit a new application prior to release.

CMS is requiring, as a condition of approval of this demonstration amendment, that California make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the facilities in which the demonstration is functioning. Without outreach and support to assist all interested individuals to apply for Medicaid coverage or renewal, it is generally not possible to assess who "may be eligible" for Medicaid and limit outreach and enrollment support to a subset of inmates.

Upon an individual entering a correctional facility, California will suspend, not terminate, Medicaid eligibility. If an individual is not enrolled in Medicaid when entering a correctional facility, California will ensure that, during the period of incarceration, the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date, unless the individual voluntarily refuses such assistance.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to support the proactive identification of both physical and behavioral health needs and includes development of a plan to address health and health-related social needs for soon-to-be released incarcerated individuals who meet Medicaid eligibility criteria or CHIP eligibility criteria other than incarceration status, and demonstration criteria. The benefit package seeks to promote coverage and quality of care to improve transitions for individuals being released from jails or prisons. In addition, California expects its benefit package to support improvement in the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and it will test whether it improves uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. It also addresses the overarching demonstration

goals, while aiming to ensure that participating carceral facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

The range of covered services that CMS is authorizing California to provide to individuals who qualify for pre-release services include but are not limited to: in-reach case management services, physical and behavioral health clinical consultation services provided in-person or via telehealth, laboratory and radiology services, medications and medication administration, Medication Assisted Treatment (MAT) for all types of SUD with accompanying counseling, and services of community health workers and community navigators with lived experiences. The state will also provide covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply, as clinically appropriate, consistent with the approved Medicaid State Plan) and durable medical equipment (DME) as the individual exits the facility for reentry into the community.

CMS recognizes that many individuals exiting prisons and jails and other correctional facilities may not have received sufficient health care to address all of their physical and/or behavioral health care needs while incarcerated; however, as described above, the purpose of this demonstration opportunity is to provide short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. Therefore, CMS is approving a demonstration benefit package in California that is designed to improve identification of health and health-related social needs and facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release. Once beneficiaries are released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Implementation and Reinvestment Plans

As described in the special terms and conditions (STCs) of the demonstration, California will be required to submit for CMS approval a Reentry Initiative Implementation Plan and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing state funding for carceral health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Reentry Initiative Implementation Plan, to be submitted to and reviewed by CMS consistent with the STCs, will describe the new key policies being tested under this demonstration amendment and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the state's strategic approach to implementing the policies, including goals and milestones, as well as associated timelines for meeting them, for both program policy implementation and investments

in transitional non-service elements, as applicable. The Implementation Plan will also outline how the state will anticipate potential operational challenges and resolve the challenges the state is likely to encounter in implementing the reentry demonstration initiative.

The reentry demonstration initiative is not intended to shift current carceral health care costs to the Medicaid program. Section 5032(b) of the SUPPORT Act makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which itself includes the inmate payment exclusion in recognition that the carceral authority generally bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve carceral authorities in California of their constitutional obligation to ensure needed health care is furnished to inmates in their custody, and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program. Accordingly, with this approval, California agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration amendment into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for health-related social services that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, California will develop and submit a reinvestment plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The reinvestment plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services, as well as address HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The reinvestment plan should describe the activities and/or initiatives selected by California for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources.

Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. The 2017 SMDL explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. These approvals enabled the state to

use the "freed up" state dollars, that would otherwise have been spent on the DSHP, on demonstration expenditures. CMS has rescinded this previous guidance, effective December 23, 2022,[8] and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals.[9]

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid coverage initiatives. CMS has decided to approve section 1115 demonstrations that provide federal funding for DSHPs, with defined criteria. These approvals will limit both the size and scope of DSHP, and apply additional parameters and guardrails. Federal expenditure authority for DSHP will be provided only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded initiative will add to the state's Medicaid program, not supplant existing services or programs.

CMS's revised approach to DSHP, and the approach being approved with this CalAIM amendment, demonstrates CMS's continuing commitment to the federal-state financial partnership as a hallmark of Medicaid. As described in the STCs, California will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-supported demonstration initiative. DSHP authority will be time-limited, and the state will be required to submit a sustainability plan which describes the scope of DSHP-supported initiatives the state wants to maintain, and the strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

As described in the STCs, California is contributing non-DSHP funds (e.g., general revenue, intergovernmental transfers) as the non-federal share of the DSHP-supported initiative on an annual basis. CMS is capping the expenditures for DSHP at no more than 1.5 percent of the state's total Medicaid expenditures during the demonstration period. CMS has determined that this cap on the total amount of federal expenditure authority and the limited duration of federal funding for DSHP will appropriately balance the goals of ensuring adequate federal funding to support needed Medicaid program innovation and fiscal accountability.

With this CalAIM demonstration amendment, CMS is approving authority for federal funds for DSHP to support prospective expenditures for certain portions of the PATH program that were approved in the December 29, 2021 approval of CalAIM. CMS will generally not approve DSHP requests for expenditures associated with initiatives that are already approved. However, as stated in our December 29, 2021 approval letter, CMS pledged to continue reviewing the state's DSHP request and has now completed that review. As with other recent DSHP approvals, the state can seek federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. Because the state will be permitted to use the freed-up state funds that result from approval of the federal matching funds for its DSHP only on initiatives that improve access to covered services, approving the federal match for the

[8] https://www.hhs.gov/guidance/document/phase-out-expenditure-authority-designated-state-health-programs-section-1115

[9] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, and https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf.

state's DSHP is expected to result in an increase in overall coverage of low-income individuals in the state, improve health outcomes for Medicaid beneficiaries and other low-income populations in the state, and increase efficiency and quality of care. Additionally, because the DSHP-funded reentry demonstration initiative on which California is permitted to spend its "freed up" state funds will be treated as "hypothetical" expenditures for purposes of budget neutrality, the state will not be able to generate increased "savings" from the reentry demonstration initiative. This will also help to ensure that approving these federal expenditures will not have a significant negative impact on Medicaid fiscal integrity.

Requirements for DSHP are defined in the STCs – as are program types excluded from eligibility for DSHP funding – and the state may not claim federal financial participation (FFP) for DSHP until the specific state programs are approved by CMS. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g. bricks and mortar, animal shelters and vaccines, and revolving capital funds). The specific state programs will be limited to programs that are population- or public health-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals.

Provider Rates Requirements

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to promote coverage, access to and quality of care, and improved health outcomes for all beneficiaries, thereby helping to strengthen coverage and mitigate known health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received.[10] CMS wants to ensure that states are addressing core Medicaid program responsibilities, including access to primary care, behavioral health and obstetric care, in order to complement and support other state initiatives, such as those that address health-related social needs and/or delivery system reform. To that end, as a condition of approval for the expenditure authorities for DSHP and the HRSN services , the state will be required to increase and (at least) sustain Medicaid fee-for-service provider base payment rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care by closing the gap between Medicaid and Medicare rates by at least 2 percentage points, should the state's average Medicaid to Medicare provider rate ratio be below 80 percent in any of these categories.

For California, at this time, Medicaid fee-for-service provider base payment rates for primary care and obstetrics care, along with Medicaid managed care payment rates for obstetrics care, are below 80 percent of Medicare rates and must be increased. In addition, California will further

[10] Polsky, D., Richards, M. Basseyn, S., et al. Appointment Availability after Increases in Medicaid Payments for Primary Care. The New England Journal of Medicine; 2015; https://www.nejm.org/doi/10.1056/NEJMsa1413299; Decker, S. L., Medicaid Physician Fees and the Quality of Medical Care of Medicaid Patients in the USA. Review of Economics in the Household; 2007; https://link.springer.com/article/10.1007/s11150-007-9000-7.

increase these same services in the same delivery systems beyond the two percentage point increase minimum. The rate increases will be implemented according to the STCs, and California will not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance these required provider rate increases (i.e., cost-shifting). The state must also sustain the increases for the remaining years of the demonstration. CMS and the state have agreed to primary care and obstetrics care provider payment rate increase requirements using a methodology that will be approved by CMS and will include California's list of procedure codes, Medicaid and Medicare rates, and other data reflecting utilization for services in each benefit category that will be appended to the STCs as an attachment.

Health-Related Social Needs

With this amendment to CalAIM, CMS is also updating the budget neutrality methodology for two previously-approved community supports, short-term post-hospitalization services and recuperative care (medical respite), that address HRSN, which evidence indicates are a critical driver of an individual's access to health services that help to keep them well.[11,12] These two services play an important role in California's care continuum, as they are delivered in settings that are cost-effective and medically appropriate alternatives to hospitalization or institutionalization for individuals who otherwise would not have a safe or stable place to receive treatment. These alternative settings can provide appropriate medical and behavioral health supports following an inpatient or institutional stay for individuals who are homeless or at risk of homelessness who may otherwise require additional inpatient care in the absence of recuperative care.

Coverage of targeted services to address HRSN is expected to help individuals stay connected to coverage and access needed health care. Given that individuals experiencing homelessness are more likely to experience both physical and mental comorbidities, and that unstable housing is associated with an increase in utilization of hospital care, providing post-acute services can ensure that beneficiaries get essential healthcare when they need it most.[13,14] By addressing beneficiaries' health-related social needs at a critical time for healing, and providing a space to safely recuperate, such services have the potential to significantly improve the overall health and well-being of eligible beneficiaries. The short-term post-hospitalization and recuperative care

[11] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[12] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs-emerging-business-case-provider.

[13] "Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council (Feb. 2019), available at https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.

[14] Dan Treglia, et al., "When Crises Converge: Hospital Visits Before And After Shelter Use Among Homeless New Yorkers," Health Affairs (Sep. 2019), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05308.

services in this demonstration can be expected to stabilize the housing situations of eligible Medicaid enrollees and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

Coverage of targeted, clinically-appropriate HRSN services will also provide a regular source of needed care to meet individuals' comprehensive health needs. This is likely to directly improve their health outcomes, as well as improve their use of other clinical services. For example, individuals with medical comorbidities and/or less stable housing are likely to frequently use the emergency department for their care.[15] By providing the short-term services needed to stabilize their housing, this demonstration will test whether the individual's utilization of appropriate care (such as increased uptake of routine preventive and sub-acute ambulatory care and decreased avoidable emergency department visits) and health outcomes improve.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Act, reflects the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities). For example, medical assistance made available under a waiver authorized under section 1915(c) of the Act is provided as a home and community-based alternative to avoid the need for more intensive institutional-based care. Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services also are intended to avert a need for nursing facility care. Both provisions authorize services, including habilitation services like pre-tenancy and tenancy support services, with a goal of preventing decline in beneficiary health that would require more intensive services. Similarly, medical assistance covering interventions aimed at improving asthma management and mitigating asthma triggers, such as medical supplies, equipment and appliances authorized under the 1905(a) home health benefit, is another example of how the Medicaid statute permits states to use its authority to help reduce the beneficiary need for acute care services (e.g., emergency department visits).

Available evidence[16] suggests that there may be populations in addition to those eligible under section 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services that would benefit targeted populations, and that additional research is needed on the effects of providing coverage for those types of services to a broader group of people. This demonstration will test whether extending eligibility to a broader range of Medicaid beneficiaries and/or providing coverage for additional services will help beneficiaries maintain their coverage, preventing health-related incidents that can result from enrollment churn, such as unfilled or skipped

[15] December 18, 2020. QuickStats: Rate of Emergency Department (ED) Visits,* by Homeless Status† and Geographic Region§ — National Hospital Ambulatory Medical Care Survey, United States, 2015–2018; https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a8.htm; see also May 2002. Emergency Department Use Among the Homeless and Marginally Housed: Results From a Community-Based Study; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447161/.

[16] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

prescriptions, missed doctors' appointments and increased rates of hospitalizations and emergency department visits.[17] The demonstration will also test whether expanding eligibility for these services and/or providing coverage for additional services will support mitigating identified needs of beneficiaries, and foster appropriate utilization of services, specifically reducing potentially avoidable, high acuity health care, thereby eventually leading to improved beneficiary physical and mental health outcomes. Moreover, access to these services for individuals who currently may experience poorer health outcomes may also help to reduce health disparities that are often rooted in social and economic disadvantages.[18] Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries receive necessary and quality medical assistance. Thus, broadening the availability of coverage for certain HRSN services is expected to promote coverage and access to quality care, improve health outcomes, reduce disparities, and create long-term, cost effective alternatives or supplements to traditional medical services.

CMS expects California to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be covered without demonstration authorities.

Budget Neutrality

CMS has long required, as a condition of section 1115 demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" (WOW) costs). Historically, if a state's "with waiver" (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or "savings" rolled over into the next approval period, which meant that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 SMDL.[19] The approach described in the 2018 SMDL included certain features that limited the extent to which states could roll over unspent "savings" from one approval period to the next when CMS extended a demonstration, and which were thereby

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[17] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

[18] April, 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

[19] August 22, 2018. SMD# 18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

intended to preserve the fiscal integrity of the Medicaid program. Based on CMS's and states' experience implementing the approach described in the 2018 SMDL, it has become apparent to CMS that this approach may limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. Therefore, in this approval, CMS has reevaluated and is modifying certain aspects of the budget neutrality approach described in the 2018 SMDL, in an attempt to better support state innovation, in line with section 1115 of the Act, while maintaining its commitment to fiscal integrity. While CMS evaluates each demonstration proposal on a case-by case basis, CMS anticipates that it will apply similar updates in its approach to budget neutrality consistently to all similarly situated states, going forward.

Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMDL in two key ways. First, CMS is making several changes that are intended to give states greater access to funding, including "savings" from prior approval periods, while still maintaining fiscal integrity. These changes include an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period.

Under this approval, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs, rather than taking the approach described in the 2018 SMDL, which was to adjust WOW PMPM cost estimates to reflect only the recent actual PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state's most recent expenditures. In addition, under this approval, projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. In contrast, under the approach described in the 2018 SMDL, CMS would use the lower of the state's historical trend or the President's Budget trend rate. Using the President's Budget trend rate instead aligns the demonstration trend rate with federal budgeting principles and assumptions.

Additionally, while CMS will still limit the extent to which demonstration savings can be "rolled over" to a new approval period, the limitations will be less narrow than those that apply under the approach described in the 2018 SMDL. In the 2018 SMDL, CMS explained that it expected to permit states to roll over savings to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued savings. Applying CMS's revised approach, savings available for a state's approval period will be limited to the lower of (1) the savings available to the state in the current demonstration period plus net savings from up to ten years of the immediately prior demonstration period(s); or (2) 15 percent of the state's projected total Medicaid expenditures in aggregate for the demonstration period. Under this approval, the savings amount available in the CalAIM demonstration for the remaining approval period has been limited to the savings available to the state in the current demonstration period plus net savings from up to ten years of the immediately prior demonstration period(s). This change will permit California to access more "savings" from prior approval periods than it would otherwise be able to do under the approach described in the 2018

SMDL, and thus will better permit California to fund the program innovations described above. At the same time, CMS will limit the "savings" California can access, thereby preserving the Medicaid program's fiscal integrity. These adjustments to the 2018 approach improve the balance between the availability of expenditure authority to support program innovation and the need for fiscal restraint. CMS expects these updates will continue to ensure fiscal integrity by limiting savings rollover from one approval period to the next.

In a second key change from the approach described in the 2018 SMDL, CMS is treating certain expenditures as "hypothetical" for purposes of California's budget neutrality calculation. As described in the 2018 SMDL, CMS effectively treats a hypothetical expenditure like an expenditure that the state could have made absent the demonstration, when calculating budget neutrality. As a result, hypothetical expenditures are included in both the WOW baseline and the estimate of the WW expenditures under the demonstration. States do not have to find demonstration "savings" to offset hypothetical expenditures. Further, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS. In the 2018 SMDL, CMS explained that it has historically considered demonstration expenditures to be "hypothetical" in the following circumstances: (1) when they are for populations or services that the state could otherwise have covered under its Medicaid state plan or other title XIX authority, such as a waiver under section 1915 of the Act; or (2) when a WOW spending baseline is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates.

Under this approval, certain HRSN expenditures are considered "hypothetical" expenditures and are included in the budget neutrality WOW baseline. Some of these expenditures, as discussed above, are expenditures for services that the state could otherwise cover under other title XIX authority, such as tenancy supports for certain beneficiaries. Treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. While other approved HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915(c) and 1915(i) services for beneficiaries who would not otherwise be eligible for them under section 1915, there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures. CMS has re-assessed some of California's approved demonstration expenditures, such as recuperative care housing and short-term post-hospitalization supports, and determined these to be hypothetical.

As discussed above, based on robust academic-level research, it appears likely that services to address HRSN could improve the quality and effectiveness of other downstream services that can be provided under state plan authority.[20] And, as also discussed above, covering HRSN is expected to improve enrollees' health, reducing health disparities that are often rooted in social and economic disadvantages for these beneficiaries. Treating certain HRSN expenditures, pre-release services, and transitional non-service expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

CMS is applying a budget neutrality spending cap to the HRSN service expenditures, and is referring to these expenditures as "capped hypothetical expenditures" in the STCs. While such initiatives in section 1115 demonstrations are relatively novel, and there is no precise understanding on the budgetary effects of covering the associated services, from a fiscal integrity perspective, CMS considers that setting a maximum allowable amount, or cap, is appropriate. Under the demonstration's evaluation efforts, California will be required to conduct a comprehensive assessment of the potential uptake of HRSN services and costs of covering the services.

The caps on expenditures for HRSN services differ from the usual limit CMS places on hypothetical expenditures, including the reentry demonstration initiative expenditures discussed below, under the "supplemental test" discussed above in several respects. First, ordinarily, if a state exceeds the hypothetical expenditure limit, it can offset the additional costs with savings from the rest of the demonstration. That will not be permitted with these HRSN expenditures. Second, the expenditures subject to the cap are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects, as discussed above. Third, the upper limit on the cap is based on a range of estimates of the likely cost of these expenditures over the course of a five-year period, and set at a mid-point in that range. While this cap deviates from the traditional approach to hypothetical expenditures, it is consistent with CMS's historical approach to maintaining budget neutrality in Medicaid demonstrations insofar as, if the state projects expenditures associated with HRSN to exceed the pre-determined budget neutrality cap at the outset of the demonstration, or if actual spending exceeds the cap, the state will not be permitted to use savings to offset the additional expenditures.

As noted above, individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid, but absent expenditure authority under section 1115(a)(2), federal Medicaid funds may not be used to pay for services for such individuals while they are incarcerated, except when they are inpatients in a medical institution as provided in paragraph (A) following the last paragraph of section 1905(a) of the Act, herein after referred to as the

[20] Lipson, D. J. Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States. National Academy of Social Insurance; 2017; https://www nasi.org/wp-content/uploads/2017/06/Opportunities-for States web.pdf; Whitman, A., De Lew, N., Chappel, A., et al. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Assistant Secretary for Planning and Evaluation; 2022; https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOHEvidence-Review.pdf.

inmate payment exclusion. The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative includes coverage of services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority, and does cover for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the related pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD or serious mental illness (SMI) and serious emotional disturbance (SED) under the SUD and SMI/SED section 1115 demonstration opportunities. For these hypothetical expenditures, CMS currently adjusts the budget neutrality test to effectively treat these expenditures as if they were approved Medicaid state plan services. At this time, CMS is applying the traditional hypothetical approach to the state's reentry demonstration initiative.

Finally, CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which expenditure data indicate a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted, based on actual expenditure data, to accommodate circumstances that are either out of the state's control, (e.g., expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration, (e.g., unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (e.g., a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with CMS requirements for section 1115 demonstrations, and as outlined in the CalAIM demonstration STCs, the state is required to conduct systematic monitoring and robust evaluation of the demonstration, including the policies and initiatives approved through this amendment, per applicable CMS guidance and technical assistance.

The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Specifically, with this amendment, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary

participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives, as applicable for all key demonstration initiatives and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of reporting metrics data on quality of care and health outcomes that are known to be important for closing key equity gaps in Medicaid and CHIP (e.g. the National Quality Forum (NQF) "disparities sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to demonstration initiatives and populations.

Under the amended STCs, for the approved HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, in addition to reporting on the metrics described above, the state must track beneficiary participation in applicable services over time, as well as narratively report annually on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and contracted providers of applicable services (e.g., the managed care plan and their contracted HRSN providers). Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

The state's selection and reporting of quality of care and health outcomes metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in ECM case management post-release, and take-up of data system enhancements among participating carceral settings. In addition, the state is also expected to monitor the number of beneficiaries served by types of services rendered under the demonstration.

Also, in alignment with the state's Reentry Demonstration Initiative Implementation Plan, the state must provide in its Monitoring Reports narrative details outlining its progress with

implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional non-service expenditures, including enhancements in the data infrastructure and information technology. In addition, the state must have an independent entity conduct a mid-point assessment of the reentry demonstration initiative to be completed by the end of the third year of the initiative's implementation. The assessment will support understanding the state's progress toward—and risks of not meeting—its initiative-specific milestones and goals, and outline any necessary mitigation strategies.

The state must demonstrate through its Annual Monitoring Reports to CMS improvements in Medicaid fee-for-service base provider payment rates and payment rates for providers enrolled in managed care to the extent required by the DSHP-related STCs. As applicable, the state must also track the number and characteristics of contracted or participating organizations, specifically under the demonstration's HRSN, reentry and DSHP-funded initiatives, and corresponding payment-related metrics.

CMS and the state will work collaboratively to develop a Monitoring Protocol that includes the new demonstration components under the amendment. Once approved, this protocol will drive the monitoring activities outlined above. In addition, the state is required to continue reporting metrics data and pertinent information on the other demonstration components, as was established in the STCs during the December 2021 approval of the CalAIM demonstration.

With respect to the demonstration evaluation requirements, as was underscored with the initial CalAIM demonstration approval STCs and consistent with current CMS guidance, California must undertake a comprehensive and rigorous evaluation of its demonstration, which now includes the new amendment components. In compliance with the STCs, California submitted to CMS draft Evaluation Designs for the policies approved in December 2021, which CMS and the state are working toward finalizing. With this amendment approval, the state can choose either to amend its existing draft Evaluation Design(s) or submit a separate Evaluation Design to address only the demonstration components newly approved with this amendment. Overall, the state's Evaluation Design must support a thorough and robust assessment of whether the demonstration components, including any components added to the demonstration through this amendment, are effective in producing the desired outcomes for its beneficiaries and providers, and the state's overall Medicaid program. It must also support causal impact evaluation of the demonstration programs on beneficiary coverage, access to and quality of care, and health outcomes. Furthermore, to the best extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

With this amendment specifically, hypotheses for the HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, must focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and beneficiary physical and behavioral health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a

representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys). Given the populations of focus and the program designs of the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual and/or community level.

The state is required to examine whether and how state and local investments in housing and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of covering such services. The state is also required to include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications, related to the provision of upstream HRSN services.

Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient provision of high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination, connections between carceral and community services, access to and quality of care in carceral and community settings; preventive and routine physical and behavioral health care utilization, non-emergent emergency department visits and inpatient hospitalizations and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of the 90-day coverage period before the beneficiary's expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, decompensation, suicide-related death, overdose, and overdose-related deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of clinical, physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services. The demonstration's evaluation efforts will be expected to include an examination of carceral

provider qualifications and standards as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the state's HRSN initiative, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

Additionally, as applicable, the state must integrate the evaluation efforts for its DSHP-funded initiatives within its PATH evaluation to help demonstrate how these programs support, in conjunction with related CalAIM initiatives, for example, to improve access to and utilization of services, and enhance home-and-community-based services or services to address HRSN or behavioral health, with particular attention to historically under-resourced or marginalized populations.

In alignment with the applicable demonstration STCs, the state must continue its evaluation efforts to conduct a comprehensive demonstration cost assessment, including for the new initiatives approved through this amendment. Specifically, the state must analyze the budgetary effects of the HRSN and reentry demonstration initiatives.

The state is strongly encouraged to evaluate the implementation of the demonstration programs to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Finally, CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of the various demonstration policy components and beneficiary experiences with access to and quality of care.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Social Security Act (the Act) direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, services, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

As enacted by the Affordable Care Act (ACA), and incorporated under section 1115(d)(2)(A) and (C) of the Act, comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposed no additional requirement on the states or the Secretary to provide an individualized response to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide individualized written responses to public comments (42 CFR 431.416(d)(2)).

The state proposed the reentry demonstration initiative as part of the its original "CalAIM" section 1115(a) demonstration renewal application on June 30, 2021. Therefore, the public comment requirements were met during the federal comment period open from July 15, 2021 through August 14, 2021. A total of 173 comments were received on the demonstration as a whole, the vast majority of which were supportive of the demonstration. Specifically, 17 commenters addressed the authorities granted by this amendment and were all supportive. These commenters noted the importance of in-reach services for justice-involved populations to ease reentry and reduce barriers to Medicaid-covered services, as well as the need for 90 days of coverage of pre-release services to effectively coordinate care.

With this approval, funding is also expanded for PATH to support healthcare infrastructure and capacity building during the implementation or continuation of CalAIM initiatives. As noted in CMS's December 2021 approval of CalAIM, a portion of PATH funds were approved to support justice-involved adults and youth by sustaining the pre-release and post-release services provided through the WPC pilots, and by supporting Medi-Cal pre-release application planning and information technology investments. Many commenters expressed support for the use of PATH funding for these purposes.

All 17 comments discussing pre-release services were supportive of the state's request, with several commenters noting the importance of addressing health disparities that impact justice-involved populations, including higher rates of mental health concerns and substance use conditions. Commenters wrote that coverage of pre-release services would promote continuity of care and timely access of care for justice-involved populations, help address social needs through care coordination with community-based supports, and have the potential to enhance health outcomes and reduce recidivism.

More specifically, one commenter in favor of the initiative spoke to the challenges of forging new partnerships that will be necessary to implement an effective pre-release services program, and the likely need for significant technical assistance. CMS and the state recognize the significant coordination and collaboration that implementation will require between state health and correctional authorities, health providers, community-based organizations, and others. California has ongoing partnerships with many of these entities, and will continue soliciting feedback and emphasizing coordination as this demonstration initiative is implemented. As detailed in this letter and in the STCs, CMS will assess the state's implementation of the reentry demonstration initiative as part of ongoing demonstration monitoring and evaluation.

Another commenter was supportive of the request for the reentry demonstration initiative, but wrote that eligibility for pre-release services should be further broadened to incorporate all individuals transitioning out of incarceration. With this amendment, California has received approval to provide targeted pre-release services for qualifying justice-involved adults who meet specific health-related criteria and all individuals who are incarcerated in a youth correctional facility. The pre-releases services are targeted to these individuals because they are most at-risk for adverse outcomes upon reentry into the community. These targeting standards also help ensure the fiscal integrity of the Medicaid program.

Additionally, a commenter noted that while supportive of the state's request, they believe that section 1115 authority is not needed to implement pre-release policies, highlighting that several states without specific section 1115 authority to cover pre-release services contract managed care plans to engage with incarcerated individuals prior to release. CMS has specified particular expenditure authorities being approved and believes that these authorities are necessary to authorize the full scope of pre-release services intended to be covered under CalAIM for this reentry demonstration initiative.

After carefully reviewing the demonstration request and the public comments submitted during the federal comment period that are relevant to this amendment, and all other relevant materials provided by the state, CMS has concluded that the approval of this amendment to the CalAIM demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this amendment is conditioned upon compliance with the enclosed amended set of expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Katherine Friedman. She is available to answer any questions concerning this amendment. Ms. Friedman's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Katherine.Friedman@cms.hhs.gov

If you have any questions regarding this approval, please contact Ms. Mehreen Rashid, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Cheryl Young, Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX and XXI plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter, or as otherwise indicated herein or in the Special Terms and Conditions (STCs), through December 31, 2026.

The following expenditure authorities shall enable California to implement the CalAIM Demonstration. All Medicaid requirements apply to expenditure authority 3, 4, 5, 7, 8, 9, 10, 11 and 13 (except as inconsistent with those authorities or except as provided herein or as set forth in the STCs).

1. **Global Payments Program for Public Health Care Systems**. Expenditures for payments to eligible Public Health Care Systems, subject to the annual expenditure limits set forth in the STCs, to support participating Public Health Care systems providers that incur costs for uninsured care under the value-based global budget structure set forth in the STCs.

2. **Chiropractic Services Provided by Indian Health Service (IHS) and Tribal Facilities.** Expenditures for supplemental payments to support participating IHS and tribal facilities that incur costs associated with chiropractic services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by these providers to individuals enrolled in the Medi-Cal program.

3. **Expenditures Related to Community Based Adult Services (CBAS).** Expenditures for CBAS services furnished to individuals who meet the level of care or other qualifying criteria.

4. **Expenditures Related to Low Income Pregnant Women.** Expenditures to provide post-partum benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the Federal Poverty Level (FPL), that includes all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL. This authority will sunset on December 31, 2021.

5. **Expenditures Related to the Drug Medi-Cal Organized Delivery System (DMC- ODS) for Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered Medicaid services furnished to qualified DMC-ODS beneficiaries who are primarily receiving treatment and withdrawal management services for

substance use disorder as short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

6. **Expenditures Related to Providing Access and Transforming Health (PATH).** Expenditures for payments to Qualified Applicants approved under one or more PATH initiatives. Such expenditures may include payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of an approved PATH program.

7. **Expenditures Related to Contingency Management.** Expenditures for Contingency Management services provided to qualifying DMC-ODS beneficiaries who reside in a DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit, beginning July 1, 2022 through December 31, 2026.

8. **Expenditures Related to Health-Related Social Needs (HRSN) Services Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.** Expenditures for HRSN services, specifically recuperative care and short-term post hospitalization housing services, as detailed in the service description in the STCs, for Medi-Cal managed care enrollees who meet the eligibility criteria specified in the STCs and any related requirements.

9. **Expenditures Related to Dually Eligible Enrollees in Medi-Cal Managed Care.** Expenditures under contracts with Medicaid plans that do not meet the requirements under section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4)(A)(ii)(I) of the Act and 42 CFR 438.56(c)(2)(i) to the extent necessary to allow the state to keep a beneficiary in an affiliated Medicaid plan once the beneficiary has selected a Medicare Advantage plan unless and until the beneficiary changes Medicare Advantage plans or selects Original Medicare. Beneficiaries impacted by this expenditure authority will be able to change Medicaid plans by picking a new Medicare Advantage Plan or Original Medicare once a quarter between January through September pursuant to 42 CFR 423.38(c)(4)(i) and following the annual coordination election period from October through December pursuant to 42 CFR 423.38(b)(3). A dually eligible beneficiary's Medicaid plan will be aligned with the new Medicare Advantage Plan, to the extent the Medicare Advantage Plan has an affiliated Medicaid plan. Pursuant to 438.56(e)(1) which requires a state to approve disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment, the state will be allowed to align approval of disenrollment from a Medicaid plan with disenrollment from a Medicare Advantage plan.

10. **Expenditures Related to Out-of-State Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date.

11. **Expenditures for Deemed SSI Populations.** Expenditures to extend eligibility for individuals in the following Deemed SSI populations 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 10 household members as of July 1, 2022, and (2) no longer applying the asset test as of January 1, 2024:

    i. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
    ii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
    iii. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

12. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, identified in these STCs, 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 these STCs.

13. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible for Children's Health Insurance Program (CHIP) if not for their incarceration status for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

Title XXI Expenditure Authority:

1. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for the CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

Requirements for Providers under the State Plan
Section 1902(a)(27) and 1902(a)(78)

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above
Requirements for Providers under the State Plan **Section 2107(e)(1)(D)**

To enable the state to not require carceral providers to enroll in Medi-Cal, in order to provide, order, refer, or prescribe pre-release services as authorized under this demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the approval date, through December 31, 2026, unless otherwise specified.

Under the authority of section 1115(a) (1) of the Social Security Act (the Act), the following waivers shall enable California to implement the CalAIM Demonstration.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care. These authorities sunset on December 31, 2021.

To enable the State to require that individuals who elect to receive Health Home Program (HHP) services (under the state plan) are restricted to the Medi-Cal Managed Care Plan offered by the HHP provider to receive covered services other than family planning services. These authorities sunset on December 31, 2021.

No waiver of freedom of choice is authorized for family planning providers.

2. **Disproportionate Share Hospital (DSH) requirements**
Section 1902(a)(13)(A) (insofar as it incorporates Section 1923)

To exempt the State from making DSH payments, in accordance with Section 1923, to a hospital which qualifies as a disproportionate share hospital during any year for which the Public Health Care System with which the disproportionate share hospital is affiliated receives payment pursuant to the Global Payment Program.

3. **Statewideness** **Section 1902(a)(1)**

To enable the State to operate the demonstration on a county-by-county basis.

To enable the State to provide CBAS services on a geographically limited basis.

To enable the State to provide DMC-ODS services to short-term residents on a geographically limited basis.

To enable the state to provide contingency management services to qualifying DMC-ODS beneficiaries only in participating DMC-ODS counties that elect and are approved by DHCS to provide contingency management.

To enable the State to authorize sustaining services under PATH to individuals on a geographically limited basis.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide recuperative care and short-term post-hospitalization housing services only in certain geographic areas where Medi-Cal managed care plans elect to offer these services.

4. **Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B)**

To enable the State to provide different benefits for low-income pregnant women between 109 percent up to and including 138 percent of the Federal Poverty Level, as compared to other pregnant women in the same eligibility group. This authority will sunset on December 31, 2021.

To enable the State to provide DMC-ODS treatment and withdrawal management services for substance use disorder, for short term residents, in facilities that meet the definition of an Institution for Mental Diseases (IMD) that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide contingency management in approved DMC-ODS counties, to eligible individuals with substance use disorders under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to provide peer support specialist services within electing Drug Medi-Cal State Plan counties to individuals on a geographically limited basis, no sooner than July 1, 2022.

To enable the state to provide sustaining services under PATH that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide health-related social needs services, specifically recuperative care and short-term post hospitalization housing services, that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to provide CBAS services that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the state to (1) apply targeted resource disregards of $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members as of July 1, 2022 and (2) effective January 1, 2024 no longer apply income and resource financial methodologies to the following populations, which is in a manner that is not applied consistently to all eligibility groups in the state:

i. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;
ii. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and
iii. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **California CalAIM Demonstration**

AWARDEE: **California Health and Human Services Agency**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for California's CalAIM, formerly Medi-Cal 2020, section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The periods for each Demonstration Year (DY) 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 STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through December 31, 2026.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Historical Context
3. General Program Requirements
4. State Plan and Demonstration Populations Affected by the Demonstration
5. Demonstration Programs
    a. Community Based Adult Services
    b. PATH
    c. Duals
6. Drug Medi-Cal Organized Delivery System
7. Contingency Management
8. Community Supports

9. Reentry Demonstration Initiative
10. Designated State Health Programs
11. Provider Payment Rate Increase Requirement
12. Negative Balance
13. Global Payment Program
14. General Reporting Requirements
15. Evaluation of the Demonstration
16. General Financial Requirements
17. Monitoring Budget Neutrality for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Global Payment Program Participating Public Health Care Systems
Attachment D: Funding and Reimbursement Protocol for IHS
Attachment E: SUD Health IT Plan
Attachment F: Accounting Procedures
Attachment G: Demonstration and Program Years
Attachment H: Community-Based Adult Services (CBAS) Provider Standards of Participation
Attachment I: Drug Medi-Cal Organized Delivery System (DMC-ODS) County Certified Public Expenditures (CPE) Protocol
Attachment J: SUD Monitoring Protocol (Reserved)
Attachment K: Global Payment Program Funding and Mechanics Protocol
Attachment L: Global Payment Program Valuation Methodology Protocol (Reserved)
Attachment M: Global Payment Program Health Equity Monitoring Metrics Protocol (Reserved)
Attachment N: Providing Access and Transforming Health (PATH) Funding and Mechanics Protocol
Attachment O: Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol
Attachment P: Historical Information-Budget Neutrality Test (Reserved)
Attachment Q: DSH Coordination Methodology
Attachment R: Negative Balance Payment Schedule (Reserved)
Attachment S: CBAS Program Integrity
Attachment T: Evaluation Design (Reserved)
Attachment U: Community Supports Appendix
Attachment V: Contingency Management Procedures and Protocols
Attachment W: Reentry Demonstration Initiative Qualifying Conditions and Services
Attachment X: Health-Related Social Needs (HRSN) Community Supports Protocol (Reserved)
Attachment Y: Approved Designated State Health Program (DSHP) List (Reserved)
Attachment Z: Designated State Health Program (DSHP) Claiming Protocol (Reserved)
Attachment AA: Designated State Health Program (DSHP) Sustainability Plan (Reserved)
Attachment BB: Designated State Health Program (DSHP) Related Provider Payment

Increase Assessment Attestation Table (Reserved)
Attachment CC: Reentry Demonstration Initiative Implementation Plan (Reserved)
Attachment DD: Monitoring Protocol (Reserved)
Attachment EE: Reentry Demonstration Initiative Reinvestment Plan (Reserved)

2. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

In November 2010, the Federal government approved California's five-year Medicaid section 1115 Bridge to Reform demonstration, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The Bridge to Reform demonstration achieved the goals of simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system, and reinforcing California's safety net to meet the needs of the uninsured.

In December 2015, the Federal government approved the Medi-Cal 2020 demonstration embodying the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. Bridge to Reform waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) were continued in Medi-Cal 2020, and with the foundation of the successes of the Bridge to Reform Demonstration, Medi-Cal 2020 initiatives continued to improve the quality and value of care provided to California's Medi-Cal beneficiaries.

Medi-Cal 2020 initiatives included:

1. A Public Hospital Redesign and Incentives in Medi-Cal program (PRIME), which aimed to improve the quality and value of care provided by California's safety net hospitals and hospital systems;

2. A Global Payment Program (GPP) that aimed to streamline funding sources for care for California's remaining uninsured population and create a value-based mechanism to increase incentives to provide primary and preventive care services and other high-value services;

3. A Whole Person Care (WPC) Pilot program that aimed to support local and regional efforts to integrate the systems and improve the care provided to Medi-Cal's most high-risk beneficiaries; and

4. A Dental Transformation Initiative (DTI) aimed to improve access to dental care and reduce preventable dental conditions for Medi-Cal beneficiaries.

On June 15, 2016, California submitted an amendment to the Demonstration to expand the definition of a WPC Pilot lead entity to include federally recognized tribes and tribal health programs operated under a Public Law 93-638 contract with the Federal Indian Health Services. CMS approved this amendment on December 8, 2016.

On August 15, 2016, the state submitted an amendment to the demonstration to revise the methodology for determining the baseline metrics for purposes of receiving incentive payments for new and existing dental service office locations under the DTI. California also sought

authority to provide incentive payments for specified dental services delivered at provider service office locations at two levels: a 37.5 percent above the state's Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet at least a 1 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children served in the previous year with a preventive dental service; and a 75 percent above the state's SMA incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service, on an annual basis, above the pre-determined baseline number of children receiving a preventive dental service in the previous year. CMS approved this amendment on January 6, 2017.

On August 17, 2017, CMS approved the state's request to amend the demonstration to provide coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they "aged out" of foster at age 18 (or a higher age as elected by the state) and were enrolled at Medi-Cal at the time.

California submitted an amendment on November 10, 2016, as a companion to the Health Homes Program (HHP) State Plan Amendment (SPA) 16-007, to request a waiver of freedom of choice in the non- county organized health system (COHS) counties in order to provide the HHP services through the Medi-Cal managed care delivery system to beneficiaries enrolled in managed care. Managed care plans (MCPs) will be responsible for the overall administration of the HHP, which will be structured as a HHP network with members functioning as a team to provide care coordination. Fee-For-Service (FFS) members who meet the eligibility criteria for HHP may choose to voluntarily enroll in a MCP to receive HHP services along with other state plan services provided through MCPs. HHP services will not be provided through a FFS delivery system; therefore, beneficiaries in FFS in non-COHS counties will have to enroll in a MCP to receive HHP services. CMS approved this request on December 19, 2017.

On August 3, 2020, California received CMS approval to permit the GPP to continue from July 1, 2020 to December 31, 2020 and to permit eligible Medi-Cal beneficiaries in Orange County to elect to disenroll from CalOptima (a COHS including CalOptima Program of All-Inclusive Care for the Elderly (PACE)), to be enrolled in a PACE organization not affiliated with CalOptima.

On December 30, 2020, CMS approved a temporary extension of the state's section 1115 demonstration, in order to allow the state and CMS to continue working together on approval of a longer-term renewal of this demonstration by December 31, 2021. This temporary extension continued most elements of the Medi-Cal 2020 Section 1115 demonstration unchanged pending a full renewal and included an additional authorization for the GPP program. The extension included the removal of the authority for the State's Designated State Health Programs (DSHP).

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

- Renewing the GPP to streamline funding sources for care for California's remaining uninsured population with a renewed focus on addressing social needs and responding to the impacts of systemic racism and inequities on the uninsured populations served by California's public hospitals.
- Authorizing Community Supports services: recuperative care and short-term post-hospitalization housing.
- Authorizing the Providing Access and Transforming Health (PATH) Supports expenditure authority to (1) sustain, transition, and expand the successful WPC Pilot and HHP services initially authorized under the Medi-Cal 2020 demonstration as they transition to become Enhanced Care Management (ECM) and Community Supports, and (2) sustain reentry pre-release and post-release services provided through existing WPC pilots and support Medi-Cal pre-release application planning and IT investments.
- Continuing short-term residential treatment services to eligible individuals with a substance use disorder (SUD) in the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Authorizing Contingency Management as a DMC-ODS benefit, to offer Medi-Cal beneficiaries this evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.

On June 29, 2022, CMS approved an amendment to the demonstration to provide parity with the asset disregard policy for populations covered under SPA 21-0053. This amendment increases the asset limit and subsequently eliminates the asset test for the populations not able to be covered under state plan authority. The resources disregard will be $130,000 for a single individual and an additional $65,000 per household member, up to a maximum of 10 household members. This disregard is effective as of July 1, 2022. The elimination of the asset test for the populations covered under the demonstration will be effective January 1, 2024.

On January 26, 2023, CMS approved an amendment to the CalAIM demonstration to allow the state to provide a targeted set of pre-release services to individuals who are Medicaid eligible or individuals who would be eligible for CHIP except for their incarceration status and who are incarcerated in state prisons, county jails, or youth correctional facilities. This set of services would be provided for up to 90 days immediately prior to the expected date of release to improve transitions (in particular, transitions of health coverage and care) back to the community and for other purposes, including to reduce emergency department visits and inpatient hospital admissions; reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death; and lead to improved health outcomes in general. CMS also is approving the authority for Designated State Health Programs (DSHP), which California will use to support portions of the PATH program that was approved in the December 29, 2021 extension of CalAIM. CMS is approving additional PATH funding for planning and implementation of the reentry demonstration initiative. Lastly, in this amendment CMS is approving an adjustment to the budget neutrality methodology for two previously approved community supports, short-term post-hospitalization services and recuperative care, that address Health-Related Social Needs (HRSN), consistent with current CMS policy. Since these services are considered HRSN, CMS is adjusting the state's budget neutrality calculations to conform to current CMS policy for demonstrations that address HRSN, and will be treating these two services as "capped hypothetical expenditures."

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Laws**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

3.2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived in the waiver document (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. Nothing in this demonstration absolves California from being subject to future guidance on contingency management and the state would otherwise need to come into compliance with such guidance. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.6. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to discuss the language changes necessary to ensure compliance with Law, Regulation, and Policy. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

3.4. **Coordination with the Medicare Program.** The state must have processes in place to coordinate with the Medicare program for Medicare-Medicaid beneficiaries, including:

a. The state must provide contact information to Medicare-Medicaid beneficiaries on how they can obtain assistance with their Medicare coverage at any point of enrollment or disenrollment from Medi-Cal managed care or upon request by the beneficiary.

b. The state must provide accurate reports to CMS of the eligibility and enrollment of Medicare-Medicaid beneficiaries in the demonstration.

c. The state must comply with requirements for Medicaid payment of Medicare cost-sharing for Medicare-Medicaid enrollees, including ensuring any organization delegated with that responsibility adheres with the requirements.

d. The state must provide CMS with requested financial information and other demonstration aspects that have a specific impact on the Medicare-Medicaid

population. Requests for information will include a reasonable timeframe for responses as agreed to by CMS and the state.

3.5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 3.8 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.6. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

3.7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 3.8, except as provided in STC 3.3.

3.8. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary; and

e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.9. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 3.10.

3.10. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of

Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than fourteen (14) calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If

a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued services or benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

3.12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.8 or extension, are proposed by the state.

3.14. **Federal Financial Participation.** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Federal Financial Participation (FFP) for Indian Health Services.** Supplemental payments to participating Indian Health Services and tribal facilities are limited to the costs incurred by the certifying entity in providing chiropractic services.

3.16. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated demonstration functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved

STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5)

4. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

4.1. **Eligibility.** Certain state plan eligibles are affected by the Demonstration, as described below.

State plan eligibles derive their eligibility through the Medicaid or CHIP state plans and are subject to all applicable Medicaid and CHIP laws and regulations in accordance with the Medicaid or CHIP state plans, except as expressly waived or made inapplicable and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

The following population groups are affected by the Demonstration:

a. Out-of-State Former Foster Care Youth, defined as youth under age 26, who were in foster care under the responsibility of a state other than California or a tribe in such other state when they turned age 18 or such higher age as the state elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid at that time; and are now applying for Medicaid in California. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory Title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

b. Community Based Adult Services (CBAS) Populations are persons who are age 18 or older and meet CBAS eligibility under STC 5.1(a) and (d).

c. DMC-ODS populations are persons receiving residential services pursuant to DMC-ODS, regardless of the length of stay, as described in STC 6.1 and individuals receiving contingency management services, as described in STC 7.1.

d. Deemed SSI Populations.

i. The resource disregard described in section (ii) below, will be applied in determining eligibility for the following groups, subject to section (iii) below:

1. The Pickle Group under section 1939(a)(5)(E) of the Act and 42 CFR 435.135;

2. The Disabled Adult Child group under sections 1634(c) and 1939(a)(2)(D) of the Act; and

3. The Disabled Widow/Widower group under sections 1634(d), 1939(a)(2)(C), and 1939(a)(2)(E) of the Act and 42 CFR 435.137-138.

ii. The resource disregard to be applied to individuals described in section (i) above will be as follows:

1. Effective July 1, 2022, the resource disregard will be $130,000 for each individual and an additional $65,000 for each additional household member of the individual, up to a maximum of 10 household members; and
2. Effective January 1, 2024, all resources will be disregarded for each individual.

iii. The resource disregard described in section (ii) above, will not apply to the following individuals who are otherwise eligible under the state plan in:

1. A categorically needy eligibility group to which there is available:

a. The minimum mandatory medical assistance described in section 1902(a)(10)(A) of the Act, as implemented at 42 CFR § 441.210; or

b. Benchmark benefits described in section 1937 of the Act, as implemented at 42 CFR § 440.300 et seq; or

2. A medically needy group covered under the state plan without a spenddown.

e. Reentry Demonstration Initiative Populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarcerated status, and who are incarcerated in a state prison, county jail, or youth correctional facility and who meet the eligibility criteria under STC 9.2.

5. DEMONSTRATION PROGRAMS

A. Community-Based Adult Services (CBAS) for Medi-Cal State Plan Populations

5.1. **CBAS Eligibility and Delivery System.** CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

a. CBAS Recipients are those persons who:

i. Are age 18 years and older;

ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare;

iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care; and

iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 5.1(b), or are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 5.1(d) and STC 5.1(e).

b. Delivery System.

i. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 5.1(a) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. A Medi-Cal managed care plan shall ensure that every CBAS provider within their service area, that has been approved by the California Department of Aging as a CBAS provider, is included in the plan's network, to the extent that the CBAS provider remains licensed as an Adult Day Health Care Center, certified and enrolled as a Medi-Cal provider, and is willing to enter into a network provider agreement with the plan on mutually agreeable terms and meets the plan's credentialing and quality standards.

ii. CBAS shall be available as a Medi-Cal fee-for-service benefit delivered through licensed Adult Day Health Care Centers approved by the California Department of Aging as a CBAS provider, that are certified and enrolled as a Medi-Cal provider, for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS is provided.

iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the Department of Health Care Services must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:

    i. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the Medi-Cal managed care plan will authorize unbundled services and facilitate utilization through care coordination.

    ii. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:

        a. DHCS will work with the local CBAS Center network and beneficiary's physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS benefits that are medically necessary for the beneficiary.

        b. DHCS will work with the beneficiary's physician to arrange for needed nursing services, or referral to, or reassessment of, In-Home Supportive Services (IHSS) as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).

c. If the beneficiary needs therapeutic services, DHCS will work with the beneficiary's physician to coordinate the authorization of needed services.

d. If the beneficiary needs mental health and/or substance use disorder services, DHCS will work with the beneficiary's physician to refer the beneficiary to the local behavioral health services department or appropriate behavioral health professionals or services.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 5.1(a) and 5.1(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state engaged in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the section 1115 demonstration, to ensure complete compliance with HCBS settings by March 17, 2023.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 5.1(a) and for whom CBAS is available based on STC 5.1(b) who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v) below:

i. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations; OR

ii. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (e) Schizophrenia and Other Psychiatric Disorders, (f) Mood Disorders, (g) Anxiety Disorders, (h) Somatoform Disorders, (i) Factitious Disorders, (j) Dissociative Disorders, (k) Paraphilia, (l) Eating Disorders, (m) Impulse Control Disorders Not Elsewhere

Classified, (n) Adjustment Disorders, (o) Personality Disorders, or (p) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:

i. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

ii. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; or

iii. Have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease; or

iv. Have a mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

v. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

e. CBAS Eligibility Determination. Eligibility determinations for the CBAS benefit will be performed as follows:

i. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by the Department of Health Care Services unless criteria under STC 5.1(e)(ii) are met. The eligibility determination shall be performed by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care.

ii. An initial face-to-face review is not required when a managed care plan or the Department of Health Care Services or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses.

iii. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate.

f. Grievances and Appeals

i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.

ii. A CBAS participant may file a grievance with their Medi-Cal managed care plan as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Medi-Cal managed care plan at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the plan.

5.2. **CBAS Benefit and Individual Plan of Care (IPC).**

a. Core Services: Professional nursing care, personal care and/ or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows. CBAS benefits include the following:

i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.

ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.

iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities. The CBAS physical therapy and occupational therapy maintenance programs are considered part of Therapeutic Activities.

v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed and as specified on the person's IPC:

i. Restorative physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the Health and Safety Code (H&S Code), physical therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

ii. Restorative occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice. Pursuant to Section 1570.7(n) of the H&S Code, occupational therapy "may also be provided by an assistant or aide under the appropriate supervision of a licensed therapist, as determined by the licensed therapist. The therapy and services are provided to restore function, when there is an expectation that the condition will improve significantly in a reasonable period of time, as determined by the multidisciplinary assessment team.

iii. Speech therapy provided by a licensed, certified, or recognized speech therapist or speech therapy assistant within their scope of practice to restore function when there is an expectation that the participant's condition will improve significantly in a reasonable period of time as determined by the multidisciplinary assessment team.

iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.

v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits, nutrition assessment, and dietary counseling and education if needed.

vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).

The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

The planning process and the development and review of the IPC will comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the Department of Health Care Services.

Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports.

Person- Centered Planning includes consideration of the current and unique bio-psycho-social- cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

i. Medical diagnoses

ii. Prescribed medications.

iii. Scheduled days at the CBAS center.

iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.

v. Elements of the services that need to be linked to individual objectives, therapeutic goals, and duration of service(s).

vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.

vii. Participation in specific group activities.

viii. Transportation needs, provided or arranged, to and from CBAS participants' place of residence and the CBAS center, when needed, including special transportation.

ix. Special diet requirements, dietary counseling and education, if needed.

x. A plan for any other necessary services that the CBAS center will coordinate.

xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

5.3. **Remote CBAS Services- Emergency Remote Services (ERS).** Under certain unique circumstances, CBAS ERS may be provided in response to the individual's person-centered needs. CBAS ERS (i.e., professional nursing care; personal care services; social services; behavioral health services; speech therapy; therapeutic activities; registered dietician-nutrition counseling; physical therapy; occupational therapy; meals) shall be provided in alternative service locations (e.g., community setting or participant's home) and/or, as appropriate, telephonically, via telehealth, live virtual video conferencing, as clinically appropriate.

a. These unique circumstances are limited to the following:

i. Qualified emergencies - state or local disasters such as wildfires and power outages (to allow for services prior to the official declaration of a formal public health emergency (PHE)) as determined by the Department of Health Care Services or its contractor(s)); and,

ii. Personal emergencies - time-limited illness/injury, crises, or care transitions that temporarily, on a time-limited basis, prevent or restrict enrolled CBAS participants from receiving services, in-person, at the CBAS center (subject to approval by the beneficiary's managed care plan, or by the Department of Health Care Services or its contractor(s) for beneficiaries exempt from managed care).

b. These special circumstances are time-limited and vary based on the unique circumstances and identified needs of the participant as documented in the participant's individual care plan. Participants will be assessed at least every three months as part of the reauthorization of the individual's care plan and a review for a continued need for remote/telehealth delivery of CBAS services.

5.4. **CBAS Provider Specifications.** CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The Department of Health Care Services maintains Standards of Participation for all CBAS providers which are found in Attachment H to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

d. CBAS providers approved for provision of CBAS Emergency Remote Services must:

   i. Maintain regular communication with the participant via phone, email, other electronic device, or in-person visits in order to assess need related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

   ii. Maintain phone and email access for participant and family support, to be staffed a minimum of six hours daily, during provider-defined hours of services, Monday through Friday.

   iii. Assess participants' and caregivers' current needs related to known health status and conditions, as well as emerging needs that the participant or caregiver is reporting.

   iv. Respond to needs and outcomes through targeted interventions and evaluate outcomes.

   v. Communicate and coordinate with participants' networks of care supports based on identified and assessed need.

   vi. CBAS providers will work with individual participants to ensure they have the proper support they need in the event of equipment/technology failure including, but not limited to, arranging for alternative tools/equipment, evaluation of the existence or availability of back-up power sources, alarms, additional person(s) to assist, etc.

   vii. The CBAS provider will be required to identify back-up telehealth modality service delivery options or in-person/in-home visits in the instance that equipment/technology failure prevents the provision of services through telehealth.

   viii. Arrange for delivery or deliver supplies based on assessed need, including, but not limited to, food items, hygiene products, and medical supplies. If needs cannot be addressed, staff will document efforts and reasons why needs could not be addressed. Note: Meals are limited to no more than two meals per day.

e. Medi-Cal certification requires that a CBAS provider adhere to federal and state laws and regulations regarding the confidentiality, security, and unauthorized disclosure of protected health information. The role of the provider in remote service delivery is to:

   i. Explain privacy requirements and appropriately document in the individual's clinical records that the individual and/or the legal representative, when appropriate, has consented to receive CBAS services via telehealth.

ii. Confirm that the provider and the individual will use two-way, real-time communication technology that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that the equipment is adequately suited for the individual's needs in order for remote service delivery.

5.5. **Responsibilities of Managed Care Plans for CBAS Benefits.** The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and with these STCs and shall include that plans do the following.

a. Contract Requirements for Managed Care Plans:

i. Contract with sufficient available CBAS providers in the managed care plans covered geographic service areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in STC 5.1(d). Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.

ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on or after April 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012:

iii. Plans must ensure that telehealth delivery of the service will meet HIPAA requirements and the methodology is accepted by the HIPAA compliance officer.

iv. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic service area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.

v. Confirm that every contracted CBAS provider is licensed, certified, enrolled in Medi-Cal, operating, and meets the managed care plan's credentialing and quality standards, including required Medi-Cal enrollment of staff.

i. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing, Medi-Cal enrollment, or quality standards, is terminated pursuant to the terms of the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.

ii. The managed care plan shall provide the Department of Health Care Services a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 5.1, the processes and timelines in State law, and all of the following:

i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.

ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than 30 calendar days from the initial eligibility inquiry request.

iii. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the member in writing of his/her CBAS eligibility determination within two business days of the decision.

iv. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

i. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.

ii. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.

iii. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with STC 5.1(f).

v. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

vi. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.

vii. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.

viii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.

c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:

i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.

ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant, and significant changes in participant condition are conducted in a timely manner and facilitate care coordination.

iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.

iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

5.6. **CBAS Center Provider Oversight, Monitoring, and Reporting.** The state shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section XI, General Reporting Requirements and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

a. Enrollment Information: to include the number of CBAS FFS and managed care beneficiaries in each county, the capacity of each county, total determined eligible and ineligible beneficiaries per county quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.

b. The quarterly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.

c. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 5.9, inclusive of all amendments.

e. CBAS FFS and Managed Care Access Monitoring. The Department of Health Care Services will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.

i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

iii. Review of FFS and managed care grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or managed care plan staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the managed care plans.

v. CMS requires the state to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plan that addresses such variances.

vi. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances. Evidence of sufficient access monitoring and a corrective action plan must be provided to the regional office annually and at any other time a significant impact to the Medi-Cal managed care plan's operations are administered.

vii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

5.7. **HCBS Electronic Visit Verification System**. For any in-home services provided to CBAS beneficiaries under the CBAS Emergency Remote Services, the state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

5.8. **Quality Improvement Strategy for 1915(c) or 1915(i) Approvable HCBS Services:** For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS State plan, the state's Quality Assessment and Performance Improvement Plan must encompass long-term services and supports (LTSS) specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302. 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. The performance measures shall include the following components:

a. Administrative Authority: A performance measure should be developed and tracked for any authority that the Department of Healthcare Services delegates to another agency, unless already captured in another performance measure.

b. Level of Care or Eligibility based on 1115 Requirements: Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility, and the processes for determining level of care or eligibility for HCBS are followed as documented. While a performance measure for annual levels of care/eligibility is not required to be reported, the state is expected to be sure that annual levels of care/eligibility are determined.

c. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.

d. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

e. Health and Welfare: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

f. Financial Accountability: The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program. The state must demonstrate actuarial soundness on an annual basis pursuant to 42 CFR 438.

5.9. **Monitoring and Reporting of HCBS Quality Assurance:** The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers as an attachment to its Annual Monitoring Report described in STC 14.5.

The state must report, as an attachment to its Annual Monitoring Reports (refer to STC 14.5) identified issues and gaps found during the oversight and monitoring of the HCBS demonstration assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. 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.

5.10. **Beneficiary Protections**:

a. Person-centered planning. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.301(c)(3) or 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

b. Conflict of Interest. The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care assessment and person-centered service planning personnel will receive training on these options (for use in MLTSS programs with self-direction).

d. The state, either directly or through its managed care plan contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

5.11. **CBAS Provider Reimbursement**.

a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are not enrolled in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.

b. Managed care plans shall reimburse contracted CBAS providers pursuant to a reimbursement structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Per Welfare and Institutions Code section 14184.201(d)(4), managed care plans shall reimburse contracted CBAS providers at the rate the CBAS provider would have been paid by DHCS for CBAS services under the fee-for-service delivery system (described in 19(b)(iii) above), unless the plan and contracted CBAS provider mutually agree to a different reimbursement amount. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their reimbursement structure in paying CBAS providers.

5.12. **CBAS Program Integrity.**

a. Following a determination that a credible allegation of fraud exists involving a CBAS provider, the state shall notify managed care plans promptly of the finding. The state must require managed care plans to report, in a timeframe and manner as specified by the state, but no less frequently than quarterly, to the state all payments made to the applicable CBAS provider for CBAS services provided after the date of notification; the state must disclose this information to CMS beginning with payments made on or after April 1, 2016.

b. If the credible allegation of fraud is proven:

i. For purposes of claiming FFP, the state must adjust its claiming associated with payments to a managed care plan to account for an amount equal to what the managed care plan has paid to an applicable CBAS provider for dates of services occurring after the state has notified the managed care plan that the CBAS provider has been referred for investigation. The state shall refund the federal share associated with such payments in accordance with Attachment S.

ii. The state may recoup from its payment to a managed care plan an amount equal to what the managed care plan has paid to the applicable CBAS provider for dates of service after the state has notified the managed care plan that the CBAS provider has been referred for investigation.

iii. Additional specifications pertaining to these requirements including information about how payments and claiming will be adjusted and MCPs will be notified are set forth in Attachment S in accordance with the Medicaid Managed Care rule at 80 FR 31097 or the finalized 42 CFR 438

B. Providing Access and Transforming Health

5.13. **Providing Access and Transforming Health (PATH) Overview.** The state is authorized up to $1.85 billion (total computable) in expenditure authority for PATH, subject to the provisions in STC 5.16. PATH is one-time transitional funding that will support the state's efforts to maintain, build, and scale the capacity necessary to transition the Whole Person Care (WPC) and Health Home Pilots approved in the Medi-Cal 2020 demonstration to the CalAIM initiative. PATH funding will ensure Medi-Cal beneficiaries have continuous access to benefits and services previously covered by WPC Pilots as these activities are integrated into Medi-Cal managed care plans (MCPs). It will also support planning and information technology (IT) investments for pre-release services and reentry activities. Examples of pre-release services and reentry activities include pre-release application and suspension/unsuspension processes, assessment of qualification for reentry demonstration initiative services, the provision of pre-release services for up to 90 days immediately prior to the expected date of release, and care coordination to support reentry planning. Unless otherwise specified, this expenditure authority is authorized over the five years of the demonstration from January 1, 2022 through December 31, 2026. This funding will be administered by DHCS or a Third Party Administrator (TPA). All of PATH funding, except for sustaining services below, will be considered an administrative cost and will be paid at the 50 percent regular administrative expenditure matching rate. Funding for Sustaining Services Through the Transition to Managed Care will be matched at the medical assistance payment (MAP) matching rate.

a. The state shall select Qualified Applicants, described in STC 5.19, to receive payments under PATH, as outlined in STC 5.13(d) below, to support counties, providers, and MCPs as they sustain, transition, and expand WPC and Health Home Pilot services and interventions initially authorized under the Medi-Cal 2020 demonstration to statewide services available through the Medi-Cal managed care delivery system. PATH funding will support the development of capacity, transitional non-service expenditures, infrastructure, and systems across the state, including in those counties that did not participate in WPC.

b. The state and Qualified Applicants as defined in STC 5.19 will be subject to requirements around eligibility for funding, program integrity, and evaluation, as outlined in the PATH STCs, PATH Monitoring Protocol, CalAIM demonstration reporting, and the CalAIM demonstration evaluation approach in STC 15.4.

c. A former "WPC Lead Entity" refers to the cities, county agencies, designated public hospitals, district municipal public hospitals, or federally recognized tribes and tribal

health programs that participated in the Whole Person Care Pilots as authorized and defined under the Medi-Cal 2020 demonstration.

d. For applicable initiatives, Qualified Applicants must provide DHCS or the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System and Innovation Program to promote appropriate distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example, enrollment, access/affordability and other indicators.

e. PATH funding must not supplant funding provided by other Federal, state or local funding sources. The PATH payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or replace provider payments from MCPs. The PATH funding must not supplant funding provided for the state's Department of Corrections (DOC) for the purchase of technology for state prisons, county jails, and youth correction facilities.

5.14. **PATH Programs Description**. Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program, which is comprised of five initiatives:

a. **Support for Sustaining Services Through the Transition to Managed Care.** PATH funding is available for the Support for Sustaining Services Through the Transition to Managed Care Initiative for former WPC Pilot Lead Entities to sustain existing WPC Pilot services that will continue under CalAIM as Community Supports, as defined in Section VIII and the 1915(b) waiver. This funding is intended to ensure continuity of services for individuals when a Community Support is not adopted by the MCP on January 1, 2022, but there is a commitment from the MCP that it will elect to offer the Community Support before January 1, 2024. Funding for services will be matched at MAP for these specific services under PATH expenditures. Allowable Services may assist in the continuity of access to WPC services that are transitioning to CalAIM and may not be covered on "day one." For example:

i. Housing transition navigation services, housing tenancy and sustaining services, or asthma remediation;

ii. Sobering center services;

iii. Recuperative care services.

b. **The funding may not be used to initiate new services.** WPC services and infrastructure that will not continue under CalAIM (i.e., where there is no corresponding CalAIM Community Support) would not be eligible for this funding. Funding may not be used to fund WPC services indefinitely and may only be used to continue services until the services are picked up by MCPs no later than January 1, 2024. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

c. **Support for Sustaining Reentry Demonstration Initiative Services Through the Transition to Managed Care.** PATH will make funding available to former WPC Pilot Lead Entities to maintain reentry services currently provided through former WPC Pilots that do not transition to managed care until January 1, 2023, or later. Direct funding is available for WPC Pilot Lead Entities, as well as ECM / Community Supports providers which work with jails, prisons, and youth correctional facilities to sustain existing WPC Pilot pre-release and reentry services that map to required ECM and MCP-offered Community Supports. Funding may be used only to pay former WPC Lead Entities for services provided. Some WPC services will not be covered by MCPs until mid-2022 or 2023; this funding may be used to sustain these services until they are transitioned to and paid for by MCPs. This funding will be matched at ADM for these specific PATH expenditures. The funding may not be used to initiate new services, sustain services that were provided in WPC but are not transitioning to CalAIM, or sustain services indefinitely without a plan to transition them to the consolidated CalAIM Section 1915(b) waiver delivery system and other related authorities.

d. **Technical Assistance Marketplace.** PATH will make funding available for the provision of technical assistance (TA) to Qualified Applicants that are contracted with or that intend to contract with one or more MCPs as an ECM or Community Supports provider. This funding will be matched at ADM for these specific PATH expenditures. Qualified Applicants, as described in STC 5.19, can apply to the TPA for TA support. Allowable expenditures include, but are not limited to, the following, and once finalized will be included as an Operational Protocol at Attachment O within the STCs:

    i. Workforce training to support expansion of services to newly eligible populations or vulnerable populations (e.g., individuals who are experiencing homeless);

    ii. Technical assistance (e.g., through trainings, one-on-one consultations) mining EHR data to identify individuals newly eligible for ECM/Community Support (ILOS) services;

    iii. Developing and distributing in-depth guidance for implementing data sharing processes between providers and housing services organizations to connect members to housing community support services;

    iv. Providing specific training to support the development, coordination, and implementation for regional learning collaboratives/learning networks; and

    v. Detailed training on how to connect justice-involved individuals to housing services.

e. **Collaborative Planning and Implementation for ECM and Community Supports.** Expenditure authority will make funding available to establish and facilitate regional collaborative planning efforts to support readiness for CalAIM implementation. Regional collaborative planning efforts will be organized and facilitated by a TPA or Vendor, and should include at a minimum: MCPs, city, county, and other government

agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and Designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. As the implementers of ECM and Community Supports, MCPs will not be eligible to receive funding through this initiative but are expected to participate in Collaborative Planning and Implementation initiatives ongoing in their service areas. This funding will be matched at ADM for these specific PATH expenditures. Allowable expenditures include the following, and once finalized, will be included as an Operational Protocol at Attachment O in the STCs.

i. Support collaborative planning between MCPs and local stakeholders to identify and address gaps that may hinder implementation of ECM / Community Support services;

ii. Development of implementation plans to operationalize CalAIM and address ECM/Community Support service gaps using PATH funding;

iii. Identify and resolve ongoing ECM/Community Supports service delivery challenges through regular meetings and collaboration throughout the five-year CalAIM demonstration period; and

iv. Support development, coordination and implementation of virtual or in-person meetings to support ECM/Community Supports quality improvement efforts to ensure the delivery of high-quality services.

f. **Support for Expanding Access to Services.** Expenditure authority will make funding available to enable the transition, expansion and development of capacity and infrastructure necessary for city, county, and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers. Allowable expenditures include, but are not limited to:

i. Hiring staff that will have a direct role in the execution and expansion of ECM/Community Supports services to boost capacity to assure access to these services;

ii. Supporting implementation of a closed-loop referral system to ensure individuals referred to needed services were able to access those services;

iii. Purchasing billing systems for newly available services; and

iv. Providing up front funding needed by providers/community-based organizations to deliver ECM/Community Supports services (e.g., purchasing infrastructure that refrigerates fresh food).

g. Eligible entities include, at a minimum, city, county and other government agencies, county and community-based providers (including but not limited to public hospitals), CBOs, and Medi-Cal Tribal and designees of Indian Health Programs.

a. Qualified Applicants must provide the TPA with a specific request and justification as part of an application for funding. DHCS will determine a target amount of funding to be allocated within each county as part of the Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH Program to promote equitable distribution of funding across the state. Target funding amounts will likely be adjusted over time to meet varying demand and will be determined based on a combination of factors including, for example: MCP revenue, enrollment, access/affordability and other indicators.

5.15. **The PATH Reentry Demonstration Initiative Planning and Implementation Program** will provide expenditure authority to fund supports needed for Medi-Cal pre-release application and suspension/unsuspension planning and purchase of certified electronic health record technology to support Medi-Cal pre-release applications. PATH reentry demonstration initiative planning and implementation funds will also provide funding over the remaining four years of the demonstration (beginning January 26, 2023) to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning between DHCS, carceral facilities participating in the reentry demonstration initiative (e.g., state prisons, county jails, youth correctional facilities), county behavioral health agencies, community-based providers, probation offices, community health workers, managed care plans, sheriff's offices, local county social services departments, and others. The specific use of this funding will be proposed by the Qualified Applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the carceral facility) and must be properly cost-allocated to Medicaid or CHIP, as necessary, and once finalized will be included in the PATH Operational and Monitoring Protocol at Attachment O within the STCs. These allowable expenditures may include the following:

a. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g. for inmates who would be eligible for CHIP but for their incarceration status) and coordinating pre-release and post-release services for enrollees. This includes the development of electronic interfaces for prisons, jails, and youth correctional facilities to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with correctional facilities, local county social services departments, county behavioral health agencies, and others, such as managed care plans and community-based providers, in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

b. **Hiring of Staff and Training.** Expenditures for Qualified Applicants to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination

of Medi-Cal enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

c. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

d. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

e. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medi-Cal enrollment process and suspension/unsuspension process for eligible individuals and coordination of a period for up to 90 days immediately prior to the expected date of release and reentry planning services for individuals qualifying for reentry demonstration initiative services.

f. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration between California's correctional institutions (county jails, youth correctional facilities, and state prisons), correctional agencies (e.g. California Department of Corrections and Rehabilitation, Sheriff's Offices, Probation Offices, etc.), local county social services departments, county behavioral health agencies, managed care plans, community-based providers and others involved in supporting and planning for the reentry demonstration initiative. This may include conferences and meetings convened with the agencies, organizations, and stakeholders involved in the initiative.

g. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying uninsured who are potentially eligible for Medi-Cal; (2) assisting with the completion of an application; (3) submitting an application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

h. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-

release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry.

5.16. **PATH Funding Amounts.** PATH will be funded at the amounts described in the table below for each of the five (5) years of the CalAIM demonstration renewal, with funding phasing down over time as the CalAIM delivery system matures, totaling a maximum of $1.85 billion over five years. To the extent any of the funds associated with PATH are not fully expended or fully allocated in a given demonstration year, PATH funds may be reallocated across other PATH initiatives or years, subject to overall PATH expenditure limits. DHCS will detail within quarterly and annual reports when it reallocates PATH funding to a future DY and/or from one PATH initiative to another.

Table 1. Annual Total Computable PATH Funding by Initiative (Amounts in Millions)

Program	**PY 1 (2022)**	**PY 2 (2023)**	**PY 3 (2024)**	**PY 4 (2025)**	**PY 5 (2026)**	**Total**
Ensuring Access to Services During Transition and Delivery System Transformation and Innovation	$554	$430	$230	$70	$5	$1,289
Reentry Demonstration Initiative Planning and Implementation	$10	$350	$201	$0	$0	$561
Total	**$564**	**$780**	**$431**	**$70**	**$5**	**$1,850**

5.17. **PATH Funding Administration.** Subject to the funding limits in Table 1, DHCS will review, approve, and make payments for PATH funding in accordance with the requirements in these PATH STCs. DHCS will make payments directly to awarded Qualified Applicants or via the TPA to Qualified Applicants. DHCS will monitor payments to ensure compliance with PATH program requirements, applicable statutory and regulatory requirements, and to prevent fraud, waste and abuse. DHCS will ensure that it has appropriate mechanisms and methodologies in place to ensure the appropriate amount of FFP is claimed for each PATH program and initiative.

5.18. **Payment to Qualified Applicants and the TPA is limited to the overall PATH funding limit stipulated in Table 1.** Qualified Applicants and the TPA must attest to DHCS that they have appropriate funds controls between PATH funding and billing for Medi-Cal applicable state plan covered services.

a. DHCS will approve applicants, and administer and monitor funds for the Support for Sustaining Services Through the Transition to Managed Care, and Support for Sustaining Reentry Services Through the Transition to Managed Care initiatives. A TPA may administer and oversee funding for the other PATH initiatives, including the Reentry Demonstration Initiative Planning and Implementation Program.

b. For the Technical Assistance Marketplace, Collaborative Planning and Implementation of ECM and Community Supports, and Support for Expanding Access to Services initiatives, the TPA will be responsible for monitoring PATH payments to identify duplicate funding received by Qualified Applicants for covered Medi-Cal services or

other payment programs, such as incentives. The TPA may also administer the Reentry Demonstration Initiative Planning and Implementation Program.

c. To the extent that the intensity of needs shift, PATH funds may be reallocated across PATH initiatives or future demonstration years, subject to overall PATH expenditure limits.

5.19. **Qualified Applicants.** Criteria for Qualified Applicants will vary by PATH initiative.

a. Qualified Applicants for the PATH Ensuring Access to Services During Transition and Delivery System Transformation and Innovation Program will also vary by initiative.

i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020 demonstration, will be eligible to become a Qualified Applicant to receive Support for Sustaining Services Through the Transition to Managed Care Initiative funding. Qualified Applicants may use funding from this initiative to sustain allowable WPC services until they transition to CalAIM.

ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, former WPC Lead Entities, as defined under the Medi-Cal 2020 demonstration that have previously offered pre-release services as part of the WPC Pilots will be eligible to become a Qualified Applicant. Qualified Applicants may use funding from this initiative to sustain previously offered pre-release services until they transition to CalAIM.

iii. For the Technical Assistance Marketplace Initiative, Collaborative Planning and Implementation of ECM and Community Supports Initiative and Support for Expanding Access to Services, the following entities, at a minimum, will be eligible to become a Qualified Applicant to receive TA support: city, county, and other government agencies; county and community-based providers including but not limited to public hospitals, CBOs, and Medi-Cal Tribal and designees of Indian Health Programs contracted with or that intend to contract with MCPs as ECM or Community Supports providers; and other entities as approved by DHCS or the TPA.

b. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include correctional institutions (county jails, youth correctional facilities, and state prisons), the California Department of Corrections and Rehabilitation, Probation Offices, Sheriff's Offices, county behavioral health agencies, county departments of social services, county departments of public health, and other entities as relevant to the needs of justice-involved individuals as approved by DHCS.

5.20. **Invoice and Application Process for Qualified Applicants**. Qualified Applicants will be required to submit invoices and/or applications, to be processed and evaluated by DHCS or the TPA, in order to receive PATH dollars. Funding will vary by initiative and by Qualified Applicant. If a selected applicant fails to substantially comply with any of the terms of the approved application, DHCS will take corrective action and may terminate agreement and

redirect applicable funds to other selected applicants who qualify for additional PATH funds or to other Qualified Applicants whose programs were not previously selected for funding, in that same demonstration year or a future demonstration year, as applicable.

a. The invoice and/or application process for Qualified Applicants under the PATH "Ensuring Access to Services During Transition and Delivery System Transformation and Innovation" program will vary by initiative.

    i. For the Support for Sustaining Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

    ii. For the Support for Sustaining Reentry Services Through the Transition to Managed Care Initiative, Qualified Applicants must submit a standardized invoice for spending on permissible services.

    iii. For the Technical Assistance Marketplace Initiative, Qualified Applicants must submit a standardized application to the TPA that outlines the request for TA or supporting resources, and other relevant information to be determined by DHCS.

    iv. For the Collaborative Planning and Implementation Initiative, Qualified Applicants must submit a standardized application to the TPA outlining their interest and intent to establish and support local collaborative planning in the region and in collaboration with other entities, along with other relevant information to be determined by DHCS.

    v. For the Support for Expanding Access to Services Initiative, the Qualified Applicant must submit a standardized application to the TPA outlining the intended purpose of the PATH funds, along with other relevant information to be determined by DHCS.

b. For the Reentry Demonstration Initiative Planning and Implementation Program, Qualified Applicants must submit a standardized application for participation and/or invoices in the format specified by DHCS for spending on permissible activities.

5.21. **Treatment of PATH Funds.** PATH payments are available to Qualified Applicants. PATH Payments shall not be considered direct reimbursement for expenditures or payments for new services. PATH payments are intended to support transitional non-service expenditures, interventions and non-Medicaid covered transitional services that support the transition from WPC Pilots and Health Home Program to CalAIM, expand access to needed services, and enable community-based providers to provide Community Supports.

PATH payments are not direct reimbursement for expenditures incurred by participating entities. PATH payments shall not be considered payments for services otherwise reimbursable under the Medi-Cal program, and therefore providers may continue to bill Medi-Cal and/or the Medi-Cal managed care plan for all applicable state plan covered services. PATH payments are not reimbursement for health care services that are recognized under these STCs or under the state plan. PATH payments should not be considered patient care revenue and should not be

offset against the certified public expenditures incurred by government-operated health care systems and their affiliated government entity providers for health care services, disproportionate share hospital payments or administrative activities as defined under these STCs and/or under the state plan. The payments do not offset payment amounts otherwise payable to and by MCPs for Medi-Cal beneficiaries, or supplant provider payments from MCPs.

5.22. **PATH Progress Reports.** Qualified Applicants and the TPA receiving PATH funding shall submit progress reports in a manner and frequency specified by DHCS. Progress reports will include reporting on performance metrics that are standardized by PATH program and initiative. The state will work with the TPA to develop such performance metrics across PATH programs and initiatives. Qualified Applicants will also be responsible for determining entity-specific milestones related to their need for and use of PATH funding. These proposed milestones may be reviewed and approved by the state or the TPA, as appropriate, as a condition of funding receipt. In these cases, the Qualified Applicant will be expected to provide narrative reports in a frequency and manner established by the state and the TPA. Ongoing funding may be based on progress towards or achievement of those milestones and performance metrics, as determined by the state. Failure to adequately meet or report on milestones and performance metrics may preclude a Qualified Applicant from receiving future PATH funding.

Wherever possible, with respect to the two Support for Sustaining Services Initiatives, progress reports will seek to collect information that may be used to understand race, ethnicity, geographic location, and other characteristics of individuals who receive services associated with these two initiatives. For other PATH initiatives, the state will work to prioritize support for Qualified Applicants that have been historically underutilized and/or under-resourced, and/or that serve the diverse needs of the state's population.

5.23. **PATH Funding and Mechanics Protocol.** Within one hundred and twenty (120) days of CMS approval of the terms and conditions for the CalAIM renewal, CMS and the state will develop and finalize a PATH Funding and Mechanics Protocol that will outline additional detail on the milestones and award criteria for the Qualified Applicants. As needed, the PATH Funding and Mechanics Protocol will be updated within 180 days following approval of the reentry demonstration and DSHP initiatives to address these components outlined in these STCs.

5.24. **PATH Program Integrity.** DHCS will ensure that all PATH payments are made consistent with these STCs. Within one hundred and twenty (120) days of CMS approval of the STCs for the CalAIM renewal, CMS and the state will develop and finalize a PATH Operational and Monitoring Protocol that will outline DHCS' approach to PATH program integrity, oversight, monitoring, and performance metrics, including any required reporting to CMS. As needed, the PATH Operational and Monitoring Protocol will be updated within 180 days following approval of the reentry and DSHP initiatives to address these components outlined in these STCs. The state will ensure that PATH funding is subject to program integrity standards. Program integrity activities will include, at a minimum:

a. **Completing progress reporting on PATH-funded activities.** All PATH funding recipients will be expected to submit progress reports that document PATH-funded activities. Recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state or its contracted TPA will monitor for

funding irregularities and potential duplication across all PATH programs and initiatives.

b. **Participating in audit processes.** The state or its contracted TPA will conduct spot-audits to ensure that PATH funds are being spent on permissible uses and are being documented and reported on appropriately.

c. **Ensuring action is taken to address noncompliance.** The state or its contracted TPA will ensure that action is taken to address any identified non-compliance with PATH funding parameters. If the state determines that a funding recipient has failed to demonstrate appropriate performance, DHCS may impose corrective actions which may include caps on funding, recoupment of funding, or discontinuation of PATH funding. The state may also impose corrective actions for a Qualified Applicant if it is determined that it is out of compliance with requirements as set forth in the STCs and attachments, the agreement between the Qualified Applicant and the state, and/or policy letters or guidance set forth by the state. Prior to initiating any corrective action on Qualified Applicants, the state shall provide the Qualified Applicants notice and an opportunity to comment regarding the identified area of non-compliance. CMS reserves the right to require DHCS to return FFP associated with recoupment of funding for Qualified Applicant and TPA noncompliance.

5.25. **Sources of Non-Federal Share Funding for PATH Expenditures.** The state must have permissible sources for the non-federal share of all PATH expenditures, which may include, as applicable to a specific PATH initiative or program, permissible intergovernmental transfers (IGTs) from qualifying governmental entities, or state funds. Sources of non-federal share funding shall not include impermissible provider taxes or non-bona fide provider-related donations under Section 1903(w), impermissible IGTs from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal law to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

For PATH expenditures derived from IGTs, the qualified funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433, subpart B, and not derived from the impermissible sources listed above.

C. Dually Eligible Enrollees in Medi-Cal Managed Care

5.26. Under the expenditure authority for the Duals Eligible Program, the state will align a dually eligible beneficiary's Medicaid plan with their Medicare Advantage (MA) Plan choice, to the extent the Medicare Advantage plan has an affiliated Medicaid plan. In counties where the state is authorizing exclusively aligned enrollment Dual Eligible Special Needs Plans (D-SNPs), the state will limit enrollment into D-SNPs without Medicaid managed care plans, further simplifying the health plan market for dually eligible individuals. The state is committed to implementing valuable aspects of integration, including integrated appeals and grievances, continuation of Medicare benefits pending appeal, integrated member materials, and care

coordination that extends across Medicare and Medicaid benefits in counties where the state is authorizing the exclusively aligned enrollment D-SNP model. Aligned Medicare/Medicaid plans may also reduce inappropriate billing, improve alignment of Medicare and Medicaid networks, and improve access to care. This will include:

a. The state will develop a process by which the enrollment broker can directly facilitate immediate Medicaid plan disenrollment should the beneficiary need be urgent/medically necessary, particularly during the last quarter of the calendar year. In addition, the Cal MediConnect Ombudsman, and any successor program, can make a warm handoff to the enrollment broker to facilitate immediate Medicaid plan disenrollment in the circumstances described above.

b. With the consultation of stakeholders through the Duals & LTSS Workgroup, the state will implement continuity of care requirements to support beneficiary access to prior providers until, at a minimum, the beneficiary has the opportunity to change Medicaid plans.

c. The state will ensure that beneficiary communications from the state and from plans in counties with exclusively aligned enrollment D-SNPs explain the benefits of enrollment in integrated care, and in all counties with Medicaid plan and MA alignment the beneficiary communications explain the opportunities, process, and timing for changing Medicaid plans. Beneficiary communications will include contact information for Health Insurance Counseling and Advisory Program (HICAP) and ombudsman services.

d. DHCS will develop and implement the necessary system changes to effectuate exclusively aligned enrollment for D-SNPs aligned with the Medicaid managed care plans. The state will work collaboratively with advocates, health plans, and CMS to develop and implement a long-term system.

6. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

6.1. **Drug Medi-Cal and Organized Delivery System.** 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 SUD that reside in a county that elects to participate in the DMC-ODS (previously and hereafter referred to as DMC-ODS beneficiaries). Since the DMC-ODS pilot program began in 2015, all California counties had the option to participate in the program to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan. Originally authorized by the Medi-Cal 2020 demonstration, most components of DMC-ODS are authorized under California's Section 1915(b) waiver (for service delivery within a regional managed care environment) and California's Medicaid State Plan (for benefits coverage), as of January 1, 2022. This CalAIM demonstration will continue to provide the state with authority to claim federal financial participation (FFP) for high quality, clinically appropriate SUD treatment services for DMC-ODS beneficiaries who are short-term residents in residential and inpatient treatment settings that qualify as an IMD. The CalAIM demonstration will continue to test whether this authority will increase access to evidence-based treatment

services and improve overall health and long-term outcomes for those with SUD when a full continuum of care is provided. Critical elements of the DMC-ODS Program continue to include providing a continuum of care and patient assessment and placement tools modeled after the American Society of Addiction Medicine (ASAM) Criteria.

During the demonstration period, the state seeks to continue achieving the following goals:

a. Increased rates of identification, initiation, and engagement in treatment;

b. Increased adherence to and retention in treatment;

c. Reductions in overdose deaths, particularly those due to opioids;

d. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

e. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and

f. Improved access to care for physical health conditions among beneficiaries.

DMC-ODS Program. Under this demonstration, DMC-ODS beneficiaries will continue to have access to high-quality, evidence-based SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under section 1903 of the Act in the absence of the expenditure authority granted herein. The state will continue to be eligible to receive FFP for DMC-ODS beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. California will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 6.5 below. The ASAM Criteria assessment shall continue to be used for all DMC-ODS beneficiaries to determine placement into the appropriate level of care.

In counties that do not opt into the DMC-ODS Program, beneficiaries receive only the "Substance Use Disorder Treatment Services" covered under California's Medicaid State Plan, they are not eligible to receive the "Expanded SUD Treatment Services" covered under the State Plan which are limited to beneficiaries residing in DMC-ODS counties.

Beneficiaries under the age of 21 are eligible to receive coverable Medicaid services pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) of the Act. Nothing in the DMC-ODS overrides any EPSDT requirements. Counties remain responsible for the provision of medically necessary DMC-ODS services pursuant to the EPSDT mandate.

As outlined in Table 2 below, DMC-ODS benefits reflect a continuum of care that ensures that beneficiaries can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The ASAM Criteria Assessment shall be used for all beneficiaries to determine placement into the appropriate level of care. DMC-ODS counties must provide independent review for residential services within 24 hours of the submission of the request by the provider. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System

Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT) and Early Intervention	State plan (individual services covered) SABIRT is delivered through fee-for-service (FFS) and Managed Care Plan (MCPs) delivery systems for beneficiaries aged 11 years and older Early intervention services (excluding to SABIRT) are available in DMC-ODS and Drug Medi-Cal for beneficiaries under age 21	Required • Coordination with SABIRT delivered through FFS/MCPs • Additional early intervention services for beneficiaries under age 21
Outpatient services (also known as Outpatient Drug Free)	State plan (individual services covered)	Required
Intensive outpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Partial hospitalization services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Residential/inpatient services	State plan (individual services covered)	Required • At least one ASAM level of care initially

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
	1115 expenditure authority for services provided to individuals in IMDs	• ASAM Levels 3.5 available within two years • ASAM Levels 3.1 and 3.3 available within three years • Coordination with ASAM Levels 3.7 and 4.0 delivered through FFS/MCPs Optional • ASAM Levels 3.7 and 4.0
Withdrawal management services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • Coordination with ASAM Levels 3.7-WM and 4.0-WM delivered through FFS/MCPs • At least one level of withdrawal management (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, or 4-WM) Optional • Additional levels of withdrawal management
Narcotic Treatment Program services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Medications for Addiction Treatment for Alcohol Use Disorders and Other Non-	State plan (individual services covered)	Required

Table 2: ASAM Criteria Continuum of Care Services and the DMC-ODS System		
Benefit	**Medicaid authorities**	**Required or Optional for DMC-ODS Counties**
Opioid Substance Use Disorders	1115 expenditure authority for services provided to individuals in IMDs	
Medications for Addiction Treatment for Opioid Use Disorders	State plan (individual services covered) 1115 expenditure authorityfor services provided to individuals in IMDs	Required
Recovery Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Peer Support Services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Contingency management services	1115 expenditure authority (individual services covered)	Optional
Care Coordination services	State plan 1115 expenditure authority for services provided to individuals in IMDs	Required
Clinician consultation services	State plan (reimbursable activity; not a distinct service) 1115 expenditure authority for services provided to individuals in IMDs	Required

6.2. **DMC-ODS County Requirements.** The following requirements apply to counties that participated in DMC-ODS as part of the Medi-Cal 2020 demonstration and new DMC-ODS counties as outlined in their approved County Implementation Plan and managed care contract.

a. **Access to Critical Levels of Care.** DMC-ODS counties are required to cover all mandatory DMC-ODS benefits and optional DMC-ODS it has elected to provide, as outlined in Table 2 above.

b. **Use of Evidence-based SUD-specific Patient Placement Criteria.** DMC-ODS counties are required to ensure the ASAM Criteria is used for all beneficiaries to determine placement into the appropriate level of care.

c. **Patient Placement.** DMC-ODS counties are required to implement a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

d. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.** DMC-ODS counties are required to contract with residential SUD treatment providers that are licensed by DHCS, the California Department of Social Services (CDSS), or the California Department of Public Health (CDPH), as applicable. Residential providers licensed by DHCS offering ASAM levels 3.1, 3.3, 3.5, and 3.2-WM must also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates that the program is capable of delivering care consistent with the ASAM criteria. Residential providers are issued licenses and a DHCS LOC Designation for a two-year period that may be extended for subsequent two-year periods. During the licensure and designation period, DHCS shall conduct at least one onsite program visit for compliance and may conduct announced or unannounced site visits throughout the period. Residential providers must furnish MAT directly or facilitate access to MAT offsite. Residential providers licensed by CDPH or CDSS offering ASAM Levels of Care 3.1, 3.3, or 3.5 without a DHCS Level of Care Designation will be required to obtain an ASAM LOC Certification by January 1, 2024.

e. **Sufficient Provider Capacity.** DMC-ODS counties are required to maintain and monitor a network of contracted, DMC-certified providers and that is sufficient to provide adequate access to all covered DMC-ODS services. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, each DMC-ODS county must consider the following:

    i. Require its providers to meet State Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

    ii. The anticipated number of Medi-Cal eligible beneficiaries.

    iii. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.

iv. The expected number and types of providers in terms of training and experience needed to meet expected utilization.

v. The number of network providers who are not accepting new beneficiaries.

vi. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for beneficiaries with disabilities

f. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.** To the extent applicable, DMC-ODS counties are required to comply with opioid prescribing guidelines, overdose prevention initiative, and other interventions to prevent prescription drug misuse and coverage of and access to naloxone for overdose reversal, including but not limited to those developed by DHCS and CDPH.

g. **Improved Care Coordination and Transitions Between Levels of Care.** DMC-ODS counties are required to implement a care coordination plan to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, DMC-ODS counties will describe how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

h. **SUD Health IT Plan.** Implementation of the milestones and Metrics as detailed in STC 6.3 or Attachment E.

6.3. **SUD Health Information Technology Plan ("Health IT Plan").** The Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011 and #17-003, respectively, states must submit to CMS the applicable Health IT Plan, to be included as Attachment E to the STCs, to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type.

The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of health IT ecosystem improvement. The plan must include implementation milestones and projected dates for achieving them (see Attachment E), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

a. The state must include in its Monitoring Protocol an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

b. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report.

c. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

d. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

f. Components of the Health IT Plan include:

    i. The Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).

    ii. The Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders. · This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

    iii. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    iv. The Health IT Plan will describe how the activities described in (i), (ii) and (iii) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.

    v. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the

following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

vi. In developing the Health IT Plan, states should use the following resources:

i. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.4. **DMC-ODS Financing.** For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide the state with financial data on an annual basis in a form and manner specified by the State. This data is to be collected for the purpose of setting the rates for NTP services. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

a. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment I) must explain the process the state will use to determine costs incurred by the counties under this demonstration.

b. Only state plan DMC services will be provided prior to the DHCS approval of the State/County intergovernmental agreement (managed care contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC- ODS services.

c. SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.

d. Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

e. This STC will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology. The state will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

6.5. **SUD Monitoring Protocol.** The state must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment J. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in these STCs;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section XII of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

6.6. **SUD Mid-Point Assessment.** The state must conduct an independent Mid-Point Assessment by December 31, 2024. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of program data during the CalAIM approval period, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state will require that the independent assessor consult with key stakeholders including, but not limited to: representatives of DMC-ODS counties, SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risks, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the Mid-Point Assessment Report to CMS no later than sixty (60) days after December 31, 2024 and the state must brief CMS on the report, if requested. The state must submit a revised Mid-Point Assessment Report within sixty (60) calendar days after receipt of CMS's comments, if any.

Elements of the Mid-Point Assessment Report include:

a. A brief overview of how the state met each milestone outlined in the State Medicaid Director letter, SMD # 17-003 RE: Strategies to Address the Opioid Epidemic, dated November 1, 2017, through the implementation of California's DMC-ODC program under the Medi-Cal 2020 demonstration approval period, including any lessons learned for best practices and challenges in achieving the milestones. In addition, the Assessment must include an examination of progress toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected progress in achieving desired targets and goals in performance measures, to date;

c. A determination of factors likely to affect future performance on measure targets not yet met and an assessment about the risk of possibly missing those performance targets;

a. For measure targets at medium to high risk of not being met, recommendations for adjustments to the state's DMC-ODS implementation and operational approaches or to pertinent factors that the state can influence that will help ameliorate those risks and support improvement; and

d. An assessment of whether the state is on track to meet the budget neutrality requirements.

6.7. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Performance Measure Targets and Failure to Report Measurement Data.** Up to $5,000,000 in FFP for DMC-ODS services in IMDs may be deferred if the state is not making adequate progress in the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

7. CONTINGENCY MANAGEMENT SERVICES

7.1. Contingency Management Overview

a. Beginning no earlier than July 1, 2022, DHCS will implement a new contingency management benefit for eligible DMC-ODS beneficiaries with a substance use disorder in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilots will allow California to evaluate and assess the effectiveness of a contingency management benefit before determining whether it should be available statewide.

b. Under the pilot, the contingency management benefit will be available in participating DMC-ODS counties, that opt and are approved by DHCS to provide this benefit, to qualified beneficiaries who meet the eligibility requirements described below and receive services from a non-residential DMC-ODS provider.

7.2. **Eligibility.** To qualify for the contingency management benefit, a Medi-Cal beneficiary must meet the following conditions:

a. Be enrolled in a comprehensive treatment program that offers other services (e.g., group or individual therapy) delivered in person or via telehealth;

b. Be assessed and determined to have a substance use disorder for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving the contingency management benefit;

c. Reside in a participating DMC-ODS county that elects and is approved by DHCS to pilot the Contingency Management benefit;

a. Not be enrolled in another contingency management program for substance use disorder;

d. Receive services from a non-residential DMC-ODS provider that offers the contingency management benefit in accordance with DHCS policies and procedures; and

e. Contingency management should never be used in place of medication treatment for addiction treatment (e.g., for opioid use disorder or alcohol use).

7.3. **Service Description**

a. The contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a substance use disorder and as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

b. The contingency management benefit utilizes an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or treatment/medication adherence. The contingency management benefit provides motivational incentives for treatment/medication adherence or non-use of substances as evidenced by, for example, negative drug tests.

c. Contingency management is offered along with other therapeutic interventions, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d).

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified, recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries that meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in in the Procedures and Protocols in Attachment V, which will be submitted to CMS for review and approval before the program can be implemented.

    i. To qualify for a contingency management motivational incentive, a beneficiary must demonstrate treatment/medication adherence or non-use of substances.

    ii. The size, nature and distribution of all contingency management motivational incentives shall be determined in strict accordance with DHCS procedures and protocols, listed in Attachment V. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste or abuse associated with the motivational incentive:

        i. Providers have no discretion to determine the size or distribution of motivational incentives which will be determined by DHCS.

ii. Motivational incentives may be managed and disbursed through a mobile or web-based incentive management software program that includes strict safeguards against fraud and abuse that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

iii. To calculate and generate the motivational incentives in accordance with the schedule in Attachment V, providers shall enter the evidence of the Medi-Cal beneficiary receiving the contingency management benefit into a mobile or web-based incentive management software program.

7.4. **DMC-ODS County Participation.** To participate in the contingency management pilot, a county must participate in DMC-ODS, submit an application, and be selected by DHCS.

a. The application process shall identify counties that meet at least the following standards:

i. Participating counties shall establish a network of providers that can provide contingency management in accordance with DHCS requirements.

ii. Participating counties shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and work with DHCS to identify and support providers requiring further training or technical assistance in accordance with DHCS set standards, to be outlined in DHCS guidance.

b. DHCS will provide training, technical assistance and monitoring to counties throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by DHCS, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

c. Participating counties and providers shall comply with any billing and data reporting requirements established by DHCS to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

7.5. **Eligible Contingency Management Providers**

a. The contingency management benefit will be delivered by DMC-ODS providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with DHCS standards that will be outlined in DHCS guidance included in Attachment V and shall meet the following requirements:

i. Must serve beneficiaries residing in DMC-ODS counties that have been approved by DHCS for participation in the contingency management pilot;

ii. Must be enrolled in Medi-Cal, and certified to provide Medi-Cal and DMC-ODS services, and offer outpatient, intensive outpatient, narcotic treatment program, and/or partial hospitalization services;

iii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training developed and offered by a qualified contractor designated by DHCS;

iv. Undergo a readiness review by DHCS and a qualified contractor designated by DHCS to ensure that they are capable to offer the contingency management benefit in accordance with DHCS standards that will be detailed in DHCS guidance; and

v. Participate in ongoing training and technical assistance as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.

c. The following practitioners delivering care at qualified DMC-ODS providers can deliver the contingency management benefit through activities, such as administering point-of-care urine drug tests, informing beneficiaries of the results of the evidence/urine drug test, entering the results into the mobile or web-based application, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

i. Licensed Practitioner of the Healing Arts (LPHAs);

ii. SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;

iii. Certified peer support specialists; and

iv. Other trained staff under supervision of an LPHA.

d. SUD providers will be required to offer accompanying DMC-ODS SUD treatment services and evidence-based practices for a substance use disorder and any other co-occurring substance use disorder in addition to contingency management services. These services may include individual, group and/or family counseling using a range of applicable evidence-based modalities and techniques, including but not limited to cognitive behavioral therapy, community reinforcement, motivational interviewing, care coordination, peer support services, medications for addiction treatment, recovery supports, withdrawal management, medication services, and patient education.

e. Pilot Evaluation. In alignment with the CalAIM demonstration evaluation requirements outlined in Section XII of these STCs, CA will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost-effectiveness of these services, and its effects on

beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder and other types of SUD.

8. COMMUNITY SUPPORTS

8.1. Community Supports Overview.

The state is authorized to use expenditure authority to provide Health-Related Social Needs (HRSN) services, specifically recuperative care and short-term post-hospitalization housing, through electing Medi-Cal managed care plans as part of an array of evidence-based, cost-effective, health-related "Community Supports" under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, and must comply with the requirements of STC 8.6. Under the section 1115 demonstration, recuperative care and short-term post-hospitalization housing will be referred to as "Community Supports." The remaining other twelve (12) Community Supports are authorized, subject to the conditions enumerated in the 1915(b) waiver, via the Medi-Cal managed care plan contracts as in lieu of services (ILOS) pursuant to 42 CFR 438.3(e)(2) as part of CMS's review and consideration for approval of the managed care plan contracts for federal financial participation. By authorizing recuperative care and short-term post-hospitalization housing under the CalAIM demonstration, the state will be subject to the requirements detailed in the 1115 demonstration, outlined below, and will include such requirements in contracts between the state and managed care plans, as the operational construct for these two services. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state is required to align clinical and social risk criteria across services and with other non-Medicaid social support agencies, to the extent possible.

Recuperative care and short-term post-hospitalization housing authorized under the CalAIM demonstration must be administered in a manner that is: (1) cost effective and medically appropriate; (2) voluntary for the Medi-Cal managed care plans to offer and the beneficiary to use; and (3) offered exclusively through managed care plans and incorporated into the development of capitation rates for electing managed care plans. These services will be consistent with STC 8.6 and STC 8.8 as demonstration-authorized services regarded as qualifying for Title XIX matching funds for populations who meet the eligibility criteria described in STC 8.5 and Attachment U.

8.2. **Service Delivery.** Consistent with the Medi-Cal managed care contract and DHCS guidance applicable to all Community Supports:

a. Recuperative care and short-term post-hospitalization services authorized under the CalAIM demonstration will only be available from electing Medi-Cal managed care plans.

b. Medi-Cal managed care plans have the option to provide one or both Community Supports authorized under this demonstration on a voluntary basis through contracted network providers, as further described in STC 8.3.

c. Medi-Cal managed care plans that elect to offer these demonstration-based Community Supports do not need to offer the services or settings statewide or in all counties in which the Medi-Cal managed care plan operates.

d. The state must require that each Medi-Cal managed care plan must report to DHCS the counties in which it intends to offer the Community Supports and any sub-county limitations on the availability of the service. Managed care plans must receive state approval and provide public notice of any such limitations on each Community Support, including specifying such limitations in the enrollee handbook.

e. Medi-Cal managed care plans will have the option to newly offer these services or change their election to offer these services every six (6) months.

f. Medi-Cal managed care plans may discontinue offering Community Supports annually with notice to DHCS and beneficiaries, as described in the Medi-Cal managed care plan contract.

8.3. **Contracted Providers.** Consistent with the Medi-Cal managed care contract and DHCS guidance and applicable to all Community Supports:

a. Electing Medi-Cal plans will contract with Community Supports providers ("Contracted Providers") to deliver the elected Community Supports authorized under the demonstration.

b. Electing Medi-Cal plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the Community Supports being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

c. The Medi-Cal managed care plan and Contracted Provider must agree to a rate for the provision of applicable Community Supports, consistent with DHCS guidance for these services, and in compliance with all related federal requirements.

d. Eligible settings for recuperative care and short-term post-hospitalization housing must have appropriate clinicians who can provide medical and/or behavioral health care. The facility cannot be primarily used for room and board without the necessary additional recuperative support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

8.4. **Provider Network Capacity.** Electing Medi-Cal managed care plans must ensure the two Community Supports authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the Community Supports, in accordance with the Medi-Cal managed care plan contracts and other DHCS guidance.

8.5. **Eligibility Criteria for Community Supports.** In accordance with the Medi-Cal managed care plan contracts and DHCS guidance, these Community Supports services are available to people experiencing homelessness or who are at risk of homelessness, and who have been determined by a provider (at the plan or network level) to have medical needs significant enough to result in emergency department visits, hospital admissions or other institutional care.

a. For this purpose, California is using the U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization, and (2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the HUD definition to thirty (30) days. Additional detail on eligibility for these services are outlined in Attachment U.

b. An electing Medi-Cal managed care plan will identify enrollees who may benefit from the Community Supports authorized under the demonstration, who meet these eligibility criteria, and for whom the Community Supports services will be medically appropriate as determined by a provider (at the plan or network level) and allow an individual to avoid institutionalization.

c. Medi-Cal managed care plans must accept requests and referrals for the Community Supports from enrollees and on behalf of enrollees from providers and organizations that serve them, including community-based organizations.

d. Community Supports shall supplement and not supplant services received by the Medi-Cal enrollee through other state, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

8.6. **Allowable HRSN Services and Definitions.** Recuperative care and short-term post-hospitalization housing settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits (as determined by a provider at the plan or network level), to receive treatment on a short-term basis. Eligible settings for recuperative care and short-term post hospitalization housing must have clinicians who can provide appropriate medical and/or behavioral health care. Short-term post-hospitalization housing settings must also offer transitional supports to help enrollees secure stable housing and avoid future readmissions. Recuperative care may be offered for up to ninety (90) days in duration, and short-term post-hospitalization housing may be offered once during the demonstration period for no more than six (6) months in duration. Electing Medi-Cal managed care plans will implement recuperative care and short-term post-hospitalization housing in accordance with the detailed service definitions, standards and requirements in Attachment U.

Requirements and limitations:

a. Recuperative care and short-term post-hospitalization services must be medically appropriate and cost-effective such that the aggregate cost of providing the service does not exceed the aggregate cost of institutional care in a nursing or inpatient facility.

b. Provision of these services will be optional both for the MCP to offer and the individual to receive the service.

c. Provision of either service does not make an enrollee ineligible for allowable services under the state plan, including institutional care.

8.7. **Excluded HRSN Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction costs (including building modification and building rehabilitation);

b. Capital investments;

c. Room and board, except as described in STC 8.6 and Attachment U;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

f. Services provided to individuals who are not lawfully present in the United States or are undocumented;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. School-based programs for children that supplant Medicaid state plan programs;

i. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

j. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this demonstration.

8.8. **General Guardrails and Reporting Requirements for Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.** While recuperative care and short-term post-hospitalization services are not ILOS authorized under the 1915(b) waiver authority, to reduce administrative burden, the state may coordinate reporting, monitoring, and evaluation efforts of the HRSN services, recuperative care and short-term post hospitalization services, in alignment with corresponding expectations stipulated in California's 1915(b)(1)/(4) CalAIM waiver, while also recognizing that there are additional expectations for monitoring and evaluation for recuperative care and short-term post hospitalization services as provided in these STCs that must also be met. To the extent appropriate, the state and CMS will work

collaboratively to assure there is no redundancy in reporting efforts under the section 1115 and 1915(b) authorities.

8.9. **Compliance with Federal Requirements.** The state shall ensure recuperative care and short-term post-hospitalization housing Community Supports are delivered in accordance with all applicable federal statute, regulation or guidance.

8.10. **HRSN Community Supports Protocol.** The state must submit, for CMS review and approval, the HRSN Community Supports Protocol covering the HRSN services authorized in this demonstration. Once approved, the Protocol will be affixed as Attachment X to these STCs. The state may stagger the submission of this Protocol, with the Maintenance of Effort (MOE; see STC 8.14) information submitted no later than 90 days after the inclusion of this STC in the demonstration approval. The remaining content of the Protocol must be submitted to CMS no later than nine months after this STC is effective.

a. A description of the process for identifying beneficiaries with HRSN, including outlining beneficiary qualification criteria for services.

b. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment and based on clinical and social risk factors, as applicable, may deem the service to be medically appropriate.

c. A description of the process for developing care plans based on assessment of need that is also culturally responsive and trauma informed.

d. A plan for establishing and/or improving information technology (IT) infrastructure, data sharing and partnerships with an array of health system and social services stakeholders, to the extent those entities are vital, to provide needed administrative and HRSN-related data on beneficiary characteristics, eligibility, screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

e. A plan for tracking and improving the share of Medicaid beneficiaries who are eligible for the Supplemental Nutrition Assistance Program (SNAP) who are enrolled in that program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries, including establishing a timeline for reporting.

f. Information as required per STC 8.14 (MOE).

g. Information as required per STC 8.15 (Partnerships with State and Local Entities).

8.11. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning and delivery of HRSN services. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state's conflict of interest policies.

8.12. **CMS Approval of Managed Care Contracts.**

a. As part of the state's submission of associated Medicaid managed care plan contracts to implement CalAIM, the state must provide documentation including, but not limited to:

    i. Beneficiary and plan protections, including but not limited to:

        i. Recuperative Care and Short-Term Post Hospitalization Housing Community Supports must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.

        ii. Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if Recuperative Care and Short-Term Post Hospitalization Housing Community Supports were not an option.

        iii. Medicaid beneficiaries always retain the right to file appeals and/or grievances if they request Recuperative Care and Short-Term Post Hospitalization Housing Community Supports offered by their Medicaid managed care plan, but were not authorized to receive the requested Recuperative Care and Short-Term Post Hospitalization Housing Community Supports services because of a determination that it was not medically appropriate or cost effective.

        iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving Recuperative Care and Short-Term Post Hospitalization Housing Community Supports or have received these services in the past.

        v. Managed care plans are prohibited from requiring a beneficiary to utilize Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

        vi. Managed care plans must timely submit any related data requested by the state or CMS, including, but not limited to:

            a. Data to evaluate the utilization and effectiveness of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

            b. Any data necessary to monitor health outcomes and quality metrics at the local and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities.

            c. Any data necessary to monitor appeals and grievances for beneficiaries.

                i. Documentation to ensure appropriate clinical support for the medical appropriateness of Recuperative Care and Short-Term Post Hospitalization Housing Community Supports, including but not limited to:

1. A documented process to authorize Recuperative Care and Short-Term Post Hospitalization Housing Community Supports for beneficiaries for whom there is an assessed risk of a need for other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This process must document that a provider using their professional judgment has determined it to be medically appropriate for the specific beneficiary as provision of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, states may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts.
2. Any data determined necessary by the state or CMS to monitor and oversee the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports.

ii. All data and related documentation necessary to monitor and evaluate cost effectiveness, including but not limited to:

1. The managed care plans must submit timely and accurate encounter data to the state on Recuperative Care and Short-Term Post Hospitalization Housing Community Supports provided to members. The state must seek CMS approval on what is considered and appropriate and reasonable timeframe for plan submission of encounter data. This encounter data must include data necessary for the state to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity efforts and efforts to mitigate health disparities undertaken by the state.
2. Any additional information requested by CMS, the state or oversight body to aid in on-going evaluation of the cost effectiveness of the Recuperative Care and Short-Term Post Hospitalization Housing Community Supports or any independent assessment or analysis conducted by the state, CMS, or an independent entity.

iii. Any additional information determined reasonable, appropriate and necessary by CMS.

8.13. **Rate Methodologies.** All new or modified payment rates, methodologies and/or associated data for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval following the normal managed care rate setting process, including via standard managed care rate certifications and, when applicable, through the state directed payments submission process and in accordance with 42 CFR 438.6(c).

8.14. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding, which the state will submit to CMS for CMS approval, for ongoing social services related to housing transition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of the approval of the demonstration amendment to integrate the community supports in the HRSN framework, as part of the HRSN Community Supports Protocol, the state will submit a plan to CMS for CMS approval that specifies how the state will determine baseline spending on these services. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.

8.15. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the person-centered plans as appropriate. The state will submit a plan to CMS as part of the HRSN Community Supports Protocol that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing upon conclusion of temporary Medicaid payment, as stated above. The plan must provide a timeline for the activities outlined. As part of the Quarterly and Annual Monitoring Reports described in STC 14.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Quarterly and Annual Monitoring Reports.

9. REENTRY DEMONSTRATION INITIATIVE

9.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medi-Cal beneficiaries and demonstration beneficiaries who would be eligible for CHIP except for their incarceration status, who are residing in state prisons, county jails, or youth correctional facilities, as specified by the implementation timeline in STC 9.8 and the implementation plan in STC 9.9. The objective of this component of the demonstration is to facilitate beneficiaries' access to certain healthcare services and case management, provided by Medicaid participating providers, CHIP participating providers, or by carceral providers who are not participating in Medicaid or CHIP, while beneficiaries are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to communities. This bridge to coverage begins prior to release and is expected to promote continuity of care and improve health outcomes for justice-involved individuals. Further, coverage beyond 30 days (for up to 90 days immediately before the expected date of release) is expected to provide a longer runway for enrollees to identify and begin to receive needed services, contribute to a reduction in post-release acute care utilization, and lead to a reduction in health crises, overdoses, and overdose-related deaths. The purpose of this reentry demonstration initiative is to provide short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious

conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, overdose-related death, and all-cause death in the near-term post-release.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans, and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings, and in the community to maximize successful reentry post-release;

e. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs;

f. Provide intervention for certain behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, with the goal of reducing decompensation, suicide-related death, overdose, and overdose-related death in the near-term post-release; and

g. Reduce post-release acute care utilization such as emergency department visits, inpatient hospitalizations, and all-cause deaths among recently incarcerated Medicaid beneficiaries and individuals otherwise eligible for CHIP if not for their incarceration status through robust pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) as well as increased receipt of preventive and routine physical and behavioral health care.

9.2. **Qualifying Criteria for Pre-Release Services.** In order to qualify to receive services under this component of the demonstration, a beneficiary must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, county jail, or youth correctional facility as defined in STC 9.4;

b. Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and

c. Meet one of the following site-specific requirements:

i. Is an individual residing in a state prison or county jail who meets at least one of the health-related criteria described below and further defined in Attachment W. Meeting such health-related criteria may be indicated by a beneficiary, found at an initial screening conducted by the correctional facility upon intake, determined during a beneficiary's incarceration, or found during assessment in the process of pre-release planning.

a. Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria as defined in Attachment W;

b. Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

c. Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria as defined in Attachment W;

d. Intellectual or developmental disability (I/DD), defined as a disability that begins before an individual has turned 18 years of age and that is expected to continue indefinitely and present a substantial disability as defined in Attachment W;

e. Traumatic brain injury or other condition that has caused significant cognitive, behavioral and/or functional impairment;

f. Positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS); or

g. Currently pregnant or within a 12-month postpartum period, as defined in Attachment W.

ii. Is an individual incarcerated in a youth correctional facility.

a. Has been identified as expected to be released in the next 90 days and identified for participation in the demonstration.

9.3. **Scope of Pre-Release Services**. The pre-release services authorized under the reentry demonstration initiative include the following services currently covered under the California Medicaid and CHIP State Plans, and further described in Attachment W. Contingent upon CMS's approval of the state's Reentry Demonstration Initiative Implementation Plan (see STC 9.9), the state may begin claiming FFP for services covered through the initiative at the time of inclusion of this STC, expected to begin April 1, 2024.

a. The pre-release services are:

i. Reentry case management services;

ii. Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

iii. Laboratory and radiology services;

iv. Medications and medication administration;

v. MAT, for all Food and Drug Administration-approved medications, including coverage for counseling; and

vi. Services provided by community health workers with lived experience.

b. In addition to the pre-release services specified in STC 9.3(a), qualifying beneficiaries will also receive covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) and durable medical equipment (DME) upon release, consistent with approved state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative comprises a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the California Medicaid or CHIP State Plans, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT benefit for qualifying Medicaid beneficiaries under age 21) are not available to qualifying beneficiaries through the reentry demonstration initiative.

9.4. **Participating Facilities**. The pre-release services will be provided at state prisons, county jails, and youth correctional facilities, or outside of the correctional facility with appropriate transportation and security oversight provided by the carceral facility, subject to DHCS approval of a facility's readiness, according to the phase-in schedule described in STC 9.8.

9.5. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under California state scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional-facility based providers.

c. All participating providers and provider staff, including carceral providers, shall have necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or carceral providers who have expertise working with justice-involved individuals.

9.6. **Suspension of Coverage**. Upon entry of a Medicaid beneficiary into a participating correctional facility, DHCS must not terminate and generally shall suspend their Medicaid coverage, as described in the Reentry Demonstration Initiative Implementation Plan.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medi-Cal and with submitting an application to the county departments of social services, unless the individual declines such assistance or wants to decline enrollment.

9.7. **Coverage of Individuals Otherwise Eligible for CHIP During Incarceration.** If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and they qualify to receive pre-release services per STC 9.2, pre-release services will be covered under this demonstration's expenditure authority.

9.8. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented on a phased-in approach, as described below. All participating state prisons, county jails, and youth correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying beneficiaries who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). DHCS will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medi-Cal and CHIP application and enrollment processes for individuals who are not enrolled in Medi-Cal or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine a beneficiary's qualification for pre-release services;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of the pre-release services, as listed in STC 9.3, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;

d. Coordination amongst partners with a role in furnishing health care and HRSN services to beneficiaries, including, but not limited to, social service departments, managed care plans, county behavioral health agencies, county departments of health, and community-based providers;

e. Appropriate reentry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and their managed care plan, and making referrals to care management and community supports providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan) and DME upon release, consistent with approved state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g. A data exchange process to support the care coordination and transition activities described in (d) and (e) of this subsection;

h. Reporting of requested data from DHCS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers that the correctional facilities will partner with for the provision of pre-release services.

9.9. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan to describe, at a minimum, the state's approach to implementing the reentry demonstration initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The state must submit the draft Implementation Plan to CMS for review no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to their draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment CC, and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the reentry demonstration initiative that are not already captured in the STCs (including any other attachments). CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services

provided through the reentry demonstration initiative at the time of inclusion of this STC, expected to begin April 1, 2024.

The Reentry Demonstration Initiative Implementation Plan must describe the implementation settings, the time period that pre-release services are available, and phase-in approach to implementation, as applicable. Other than providing such contextual information, the core requirement of the Implementation Plan is for the state to describe the specific processes, including timelines and programmatic content where applicable, for meeting the below milestones, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the Implementation Plan must document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that must be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the Implementation Plan must identify the main anticipated implementation challenges and the state's specific plans to address these challenges. The Implementation Plan is also required to document the state's strategies to drive positive changes in health care quality for all beneficiaries, thereby reducing disparities and improving health equity. The state will be required to provide the following information related to, but not limited to, the following milestones and actions.

a. **Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated**. The state must describe its plans to fully effectuate, no later than two years from approval of the expenditure authority, a state policy to identify Medicaid eligible individuals or individuals who would be eligible for CHIP, except for their incarceration status, and suspend a beneficiary's eligibility or benefits during incarceration. It must describe its processes to undertake robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. Other aspects to be included in the Implementation Plan related to this milestone include the state's plan to make available a Medicaid and/or managed care plan identification number or card to an individual, as applicable, upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state, e.g., relevant state Medicaid agency website, if the individual will be moving to a different state upon release.

b. **Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.** The state must describe its plan to implement a screening process to identify individuals who qualify for pre-release services, consistent with the qualifying criteria outlined in these STCs. The state must detail how the facilities will ensure that beneficiaries can access the demonstration benefit package, as clinically appropriate. The state must describe its approach and plans for implementing processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as

applicable, the state must establish state requirements for carceral health providers who are not participating in Medicaid or CHIP that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

c. **Milestone 3: Promoting continuity of care.** The state must describe its process to ensure that beneficiaries receive a person-centered plan for coordination post-release to address health needs, as well as HRSN and LTSS, as applicable. The state must detail its plans and timeline for implementing state policies to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. The state must describe its processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place. As applicable, the state must also describe the planning or projected activities to ensure that Medicaid managed care plan and county behavioral health plan contracts include requirements and processes for transfer of relevant health information from the carceral facility, community-based providers, and/or state Medicaid agency to the managed care plan to support continuity and coordination of care post-release.

d. **Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.** The state must describe how it will develop and implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe, per the guidelines in the forthcoming SMDL. The Implementation Plan must also capture how the state will monitor and adjust, as needed, ongoing post-release case management and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the state must describe how they will ensure that case managers are able to effectively serve demonstration beneficiaries transitioning into the community and recently released beneficiaries who are no longer demonstration beneficiaries.

e. **Milestone 5: Ensuring cross-system collaboration.** The state must describe how correctional facilities will facilitate access to incarcerated beneficiaries for community health care providers, including case managers, either in person or via telehealth. The state must also document its plans for establishing communication and engagement between corrections systems, community supervision entities, health care organizations, the state Medicaid agency, and supported employment and housing organizations. The state must also develop a system (for example, a data exchange, with requisite data-sharing agreements) and establish processes to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions. Further, the state must develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.

9.10. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the reentry demonstration initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment Report.

The Mid-Point Assessment Report must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the reentry demonstration initiative. The report must be completed by the end of the third year of demonstration implementation. In the event that the reentry demonstration initiative is implemented at a timeline within the demonstration approval period, such as not to provide adequate implementation period to contribute toward a meaningful mid-point assessment, the report may be completed during a future extension of the demonstration, assuming it would also extend the authority for the reentry demonstration initiative. In the event that CMS and the state do not extend the reentry demonstration initiative beyond the demonstration's approval period ending in December 31, 2026, the mid-point assessment must be completed and the report submitted to CMS no later than when the demonstration's Summative Evaluation Report is due to CMS, which is 18 months after the end of the demonstration approval period (STC 15.8). If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: pre- and post-release providers participating in the state's reentry demonstration initiative, eligible and participating beneficiaries, and other key partners in carceral and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol for ameliorating these risks subject to CMS approval.

Elements of the Mid-Point Assessment Report must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment Report.

9.11. **Reentry Initiative Reinvestment Plan**. To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries prior to the individual facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the CalAIM demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology and data sharing;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the justice-involved population and,

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within one hundred and twenty (120) days of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan as part of the implementation plan referred to in STC 9.8 for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment EE.

10. DESIGNATED STATE HEALTH PROGRAMS

10.1. **Designated State Health Programs (DSHP).** The state may claim FFP for designated state health programs subject to the limits described below. This DSHP authority will allow the state to support DSHP-funded initiatives, as described in STC 10.3. This DSHP authority will be available from DY19 - DY22.

a. The DSHP will have an established limit in the amount of $1,292,850,000 total computable expenditures, in aggregate, for DY19 - DY22.

b. The state may claim FFP for up to the annual amounts outlined in Table 3, plus any unspent amounts from prior years. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period, and the state may claim the remaining amount in a subsequent demonstration year. The total amount of DSHP FFP that the state may claim in DY 19 through 22 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives

Table 3. Annual Limits in Total Computable Expenditures for DSHP.

	DY19	DY20	DY21	DY22
Total Computable Expenditures	**$323,212,500**	**$323,212,500**	**$323,212,500**	**$323,212,500**

c. The state must contribute $114,075,000 in original, non-freed up DSHP funds, over the 5-year demonstration period towards its initiatives described in STC 5(b). These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable

statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. As a post-approval protocol, the state shall submit an Approved DSHP List identifying the specific state programs for which FFP in expenditures can be claimed within 90 days of the amendment approval date. The Approved DSHP List will be subject to CMS approval and will be limited to programs that are population- or public heath-focused, aligned with the objectives of the Medicaid program with no likelihood that the program will frustrate or impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations, and serve a community largely made up of low-income individuals. The state is not eligible to claim FFP for DSHP expenditures until the list is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. The Approved DSHP List will be appended to the STCs as Attachment Y and thereafter may be changed or updated only with CMS approval.

10.2. **Prohibited DSHP Expenditures.**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, etc.) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 5 percent of total provider expenditures or claims through DSHP identified as described in STC 10.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the total computable amounts of DSHP described in STC 10.1.

c. The following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

    i. Bricks and mortar;

    ii. Shelters, vaccines, and medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

10.3. **DSHP-Funded Initiatives.**

a. **Definition.** DSHP-funded initiatives are Medicaid or CHIP section 1115 demonstration activities supported by DSHPs.

b. **Requirements.** Expenditures for DSHP-funded initiatives are limited to costs not otherwise matchable under the state plan. CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including home- and community-based services and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care. DSHP-funded initiatives specifically associated with transitional non-service expenditures start-up costs for new initiatives is time limited to the current demonstration period and will not be renewed.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

i. All PATH initiatives and programs described in STC 5.14 and 5.15, excluding expenditures on Support for Sustaining Services Through the Transition to Managed Care, as described in STC 5.14.a.

10.4. **DSHP Claiming Protocol.** The state will develop and submit to CMS within 150 calendar days of the approval of this amendment, a DSHP Claiming Protocol subject to CMS approval with which the state will be required to comply in order to receive FFP in DSHP expenditures. State expenditures for the DSHP must be documented in accordance with the protocol. The state is not eligible to claim FFP for DSHP expenditures until the protocol is approved by CMS, and upon approval, the state may only claim FFP for DSHP retrospectively to the effective date of the demonstration amendment that added this STC. Once approved by CMS, the protocol becomes Attachment Z to these STCs, and thereafter may be changed or updated only with CMS approval. Changes and updates are to be applied prospectively. In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

i. Certification or attestation of expenditures.

ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 10.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

10.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the CMS-approved DSHP Claiming Protocol in Attachment Z.

10.6. **Sustainability Plan.** The DSHP Sustainability Plan will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. The state shall submit the DSHP Sustainability Plan to CMS no later than the end of December 31, 2024, after the approval of this authority. Upon CMS approval, the plan will become Attachment AA to these STCs. Any future modifications for the DSHP Sustainability Plan will require CMS approval.

11. Provider Rate Increase Requirement

11.1. The provider payment rate increase requirements, in California, described hereafter, are a condition for expenditure authorities as referenced in Expenditure Authority 12.

11.2. As a condition of approval and ongoing provision of FFP for DSHP and related expenditures over this demonstration period of performance, DY 19 through DY 22, the state will in accordance with these STCs increase and (at least) subsequently sustain, through DY 22, Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase for DY 20 and (at least) subsequently sustain through DY 22, network provider payment rates by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the services that comprise the state's definition of primary care, behavioral

health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio, as determined by STC 11.5 for a representative sample of these services for any of these three categories of services, is below 80 percent. The state will further increase the rate for these same services in service categories in the delivery systems with ratios below 80 percent. The total annual state cost for these rate increases for all categories of service combined shall be no less than $21.76 million. If the average Medicaid to Medicare provider rate ratio for a representative sample of these services under each of the state's Medicaid fee-for-service program and Medicaid managed care delivery system for any of these three categories of services is below 80 percent, the state shall only be required to increase provider payments for the delivery system for that category of service for which the ratio is below 80 percent.

11.3. State funds available as a result of receiving FFP in DSHP expenditures cannot be used to finance provider rate increases required under this section. Additionally, the state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this section (i.e., cost-shifting).

11.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health services.

11.5. By March 26, 2023, and if the state makes fee-for-service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios if applicable for each of the three categories of services as these ratios are calculated for the state and service category as noted in the following sources:

i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." *Health Affairs* 40(2): 343–348 (Exhibit 3); and

ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." *Substance Abuse Treatment, Prevention, and Policy* (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 11.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019; and

iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

11.6. To establish the state's ratio for each service category identified in STC 11.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 11.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 11.5(b) using Medicaid managed care provider payment rate and utilization data.

11.7. In determining the ratios required under STC 11.5 and 11.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans to make to providers, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and may not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a), and 438.6(d).

11.8. If the state is required to increase provider payment rates for managed care plans per STC 11.2 and 11.6, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of the percentage increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

11.9. For the entirety of DY 20 through DY 22, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 19, and such rate will be in effect on the first day of

DY 20. A required payment rate increase for a delivery system shall apply to all services in a service category as defined under STC 11.4.

11.10. If the state uses a managed care delivery system for any of the service categories defined in STC 11.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 20 through DY 22, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 19 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 11.4.

11.11. The state will provide the information to document the payment rate ratio required under STC 11.5 and 11.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

11.12. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

11.13. No later than March 26, 2023, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 11.5 and 11.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment BB:

California DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to DSHP related provider payment increase requirements for the demonstration period of performance DY 19 thru DY 22		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid*

		and Medicare to derive the ratio]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b); insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]*

In accordance with STCs 11.1 through 11.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments, with the exception of any state plan payments made using revenue derived by The California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56, 2016), and do not incorporate Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment increase will be applied to all the services in each of the three categories in each of the fee-for-service or managed care delivery systems with a ratio below 80 percent if these systems apply to the state's Medicaid program listed herein. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in DY 19 plus at least a two percentage point increase relative to the rate for the same or similar Medicare billing code through at least [*insert date*], in the total amount of state expenditure of at least $21.76 million across affected delivery systems.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system and under a

managed care delivery system, the state agrees to define primary care, behavioral health and obstetric care, including identify applicable service codes and providers types for each of primary care, behavioral health and obstetric care in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

The effective date of the rate increases is the first day of DY 20 and will be at least sustained, if not higher, through DY 22.

The additional payment increases required under STC 11.2 will also be made in the total amount of state expenditure of at least $21.76 million across the affected delivery systems.

California [*insert does or does not*] make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the DSHP STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid funding questions) as required by statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

The state will also provide similar documentation for the additional payment increases required under STC 11.2.

California [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*].

The state will also provide similar documentation for the additional payment increases required under STC 11.2.

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.8, I attest that necessary arrangements will be made to assure that 100 percent of the amount necessary, so that the Medicaid to Medicare ratio increases by two percentage points, will be paid by managed care plans to the providers of those service categories and none of this payment rate increase is retained by the managed care plans. The state will also assure that 100 percent of the additional payment increases under STC 11.2 will be paid to providers of the applicable services.
California agrees not to use DSHP funding to finance any provider payment rate increase required under Section 11. California further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under STC 11.
I, *[insert name of SMD or CFO (or equivalent position)*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] *[Provide printed name of signatory* _____] [*Provide date*_____]

12. Negative Balance

12.1. **Repayment of Payment Management System (PMS) Negative Account Balances:** As of November 6, 2021, California has negative account balances in some of its Medicaid PMS accounts. In order to bring the accounts into balance, the state shall do the following:

a. **Issue Resolution**. CMS and the state shall work collaboratively to resolve outstanding financial issues:

i. Delayed certified public expenditure reconciliations – The state should review all approved payment methodologies that require a final reconciliation and ensure that clear time frames are incorporated within the approved methodology. For any methodology not containing a clear timeline for completion of the final reconciliation, the state must submit a proposed revised methodology no later than December 31, 2022.

ii. Open deferrals – The state must immediately submit decreasing adjustments for any remaining placeholder claims after December 31, 2021. For all other open deferrals currently beyond the regulatory 120-day response period, the state must submit a timeline for resolving the deferral. This proposed timeline needs to be submitted no later than March 31, 2022. CMS will work collaboratively with the state to resolve each outstanding issue.

b. **Repayment Process.**

i. Negative Account Balances – For any negative account balances unresolved as of June 30, 2022, CMS will issue a demand letter to the state identifying the final negative account balance amount and the state's right to appeal. The state may request a repayment schedule in Attachment R that ensures repayment of any remaining amount of the negative account balances identified through Federal Fiscal Year 2020 through regular quarterly installments, plus interest, by the end of the waiver period (12/31/2020) or in three years or less from CMS' approval of the repayment schedule. Interest will begin on the date of the demand notice and end when the debt is paid in full. Additional repayment requirements are identified in section c through h below.

ii. Deferred Claims – For any deferred claims 1) not paid by CMS by June 30, 2022, 2) for which the state has drawn FFP from its PMS account, and 3) for which the state has not returned all drawn FFP to its PMS account by June 30, 2022, CMS shall proceed by disallowance in accordance with 42 CFR 430 Subpart C. The state may request a repayment schedule in accordance with 42 CFR 430 Subpart C. This repayment is not subject to the provisions of subsection (c) through (h) below.

c. **Repayment Period Interest**. Interest will accrue on the final unresolved negative account balance amount; at the Current Value of Funds Rate (CVFR) published by the U.S. Department of Treasury, beginning on the date of the demand letter issued by CMS pursuant to STC 12.1(b)(i) until the entire principle amount is repaid in full. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

d. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance until the debt is paid in full or otherwise resolved by CMS. CMS will adjust the repayment schedule to reflect any changes to the CVFR during the repayment schedule.

e. **Source of Repayment Funds.** The funding source of repayment cannot be derived from federal funds, including any Medicaid or CHIP funds available to the state in FY 2014 or later PMS accounts.

f. **Mechanism of Repayment.** The quarter payment amount due or payment in full may be sent via FedWire (preferred), Automated Clearing House (ACH), or check – specific instructions for FedWire or ACH may be obtained from your state's Division of Payment Management representative. The quarter payment amount due or in payment full via check should be made payable to: "The Department of Health and Human Services" and sent to the following address:

HHS Program Support Center
P.O. Box 979132
St. Louis, MO 63197

Please include your PMS account number and a brief description explaining the nature of the return. Please include a copy of this STC along with your payment.

g. **PMS Draws for Deferred FFP.** When CMS issues a deferral of claims for FFP to the state in accordance with the timelines set forth in 42 CFR 430.40, the state must immediately return the deferred FFP to the applicable PMS subaccount while the deferral is being resolved. After CMS reviews the deferred claims, CMS will determine the allowability of the claims. If CMS determines that a deferred claims are allowable under federal requirements, CMS will release the deferred funds to the appropriate PMS subaccount and will notify California that the funds are available for draw.

h. **Adjustments to Repayment Schedule.** The state may request a recalculation of the repayment schedule from CMS if the state decides to make accelerated repayment installments. CMS will work with the state to recalculate based on any existing positive amounts that may be available in the PMS subaccount(s) and/or any positive Medicaid grant awards issued that may reduce the outstanding negative PMS subaccount(s) balances. CMS will reissue the repayment schedule to reflect adjustments, if any.

i. **Cash Management Improvement Act (CMIA) Agreement.** The Repayment of Payment Management System (PMS) Negative Account Balances section of these STCs does not preclude action by other federal agencies, including the United States Department of Treasury resulting from a violation of the CMIA agreement between the State of California and the United States Department of Treasury.

13. Global Payment Program

13.1. California will operate a global payment program (GPP) to assist public health care systems (PHCS) that provide health care for the uninsured. The GPP is meant to focus on value, rather than volume, of care provided. The purpose is to support PHCS for their key role in providing services to California's remaining uninsured and to promote the delivery of more cost-effective and higher-value care to the uninsured. Promoting more cost-effective and higher value care means that the payment structure will reward the provision of care in more appropriate venues, rather than through the emergency department or through inpatient hospital settings. In addition to providing value-based care, the GPP will incorporate services that are otherwise available to the state's Medi-Cal beneficiaries under different Medicaid authorities with the aim of enhancing access and utilization among the uninsured, and thereby advancing health equity in the state. The state will continue to test and assess this approach to assist PHCS, and will strengthen the GPP performance and effectiveness for potentially broader application.

13.2. Under the GPP, participating PHCS will continue receiving GPP payments that will be calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings and reinforce structural changes to the care delivery system that will improve the options for treating both Medicaid and uninsured patients. The methodology for setting service values will incorporate measures of

value for the patient in conjunction with the recognition of costs to the health care system. Care being received in appropriate settings will be valued relatively higher than care given in inappropriate care settings for the type of illness.

13.3. Payments will not exceed the limits in Attachment K (GPP Funding and Mechanics Protocol), but may be less if the thresholds are not achieved. Services will be grouped into categories that reflect where care is being provided. Within each category services will be grouped into tiers of similar service intensity. This will assist in modifying relative values of services, so that their long-term value is incorporated and no longer an externality. Service tiers across categories that aim to provide the same end result would have relative values of generally equivalent care. The intent of this framework is to provide flexibility in provision of services while encouraging a broad shift to more cost-effective care that is person-centered.

13.4. The total amount of annual funding available for the GPP in PY1-12 is a combination of a portion of the state's DSH allotment that would otherwise be allocated to the PHCS and the amount associated with the historical Safety Net Care Uncompensated Care Pool (UC Pool) that existed before the GPP.

13.5. **Entities Eligible to Receive Global Payments.** Payments under the GPP are available for PHCS that are comprised of a designated public hospital (DPH) identified in Attachment C that agrees to participate in the GPP and that DPH's affiliated and contracted providers (collectively, for purposes of the GPP only, Public Health Care System or "PHCS"). For purposes of the GPP, multiple DPHs and their affiliated and contracted providers may comprise a single PHCS in accordance with criteria established and set forth in Attachment K (GPP Funding and Mechanics Protocol). DHCS shall identify to CMS all PHCS that will participate in the GPP.

13.6. **General Overview of Global Payments**

a. Global payments shall be available based on a GPP program year ("GPP PY"). The first GPP PY is for the period July 1, 2015 through June 30, 2016. GPP PY 6 aligned with the six-month period of July 1, 2020 through December 31, 2020. GPP PY7 aligned with the period of January 1, 2021 through December 31, 2021. GPP PYs 8 through 12 will continue to align with CY periods, beginning with GPP PY 8 aligning with the CY period of January 1, 2022 through December 31, 2022.

b. An annual GPP budget for each participating PHCS shall be established in accordance with the parameters set forth in Attachment K (GPP Funding and Mechanics Protocol). For the purposes of GPP PY 6, the annual GPP budget shall be established for a six-month period; for GPP PY7 and all future PYs, the global budget shall be established for a full calendar year. The aggregate GPP budget among participating PHCS shall not exceed the total computable amount of GPP funds available in a given GPP PY, as established by the limits set forth in STC 13.10(e).

c. PHCS shall be required to provide a threshold amount of care, measured in points, to earn their entire annual GPP budget amount. Points for services will be assigned in a manner that incorporates measures of value for the patient and that achieves other

programmatic goals, as set forth in Attachment L (GPP Valuation Methodology Protocol).

d. Each PHCS annual threshold point amount is determined through a baseline analysis, accounting for factors such as its historical and projected volume, cost and mix of services to the uninsured and estimated need, determined in accordance with Attachment L (GPP Valuation Methodology Protocol). These thresholds will ensure that PHCS only receive full GPP payments if the PHCS provides levels of services to the uninsured population necessary to meet its threshold that has been set based on the level of services that would otherwise have been provided to the uninsured. For purposes of the GPP, care will be considered uninsured for individuals for whom there is no source of third-party coverage for the specific service furnished by the PHCS. Furthermore, an individual will not be considered uninsured with regard to a non-traditional service (as identified in Attachment L, GPP Valuation Methodology Protocol) he or she receives from the PHCS if the individual has a source of third party coverage for the category of service for which the non-traditional service is being used as a substitute.

e. Interim GPP payments shall be made to PHCS on a quarterly basis, calculated as 25 percent of the PHCS's annual global budget, or, with respect to GPP PY 6, 50 percent of the PHCS's annual budget. Within nine months following the end of each GPP PY, the state shall reconcile interim payments to the amount earned for services as established by the reports submitted in accordance with f. below.

f. Attachment K (GPP Funding and Mechanics Protocol) sets forth a reporting schedule by which each PHCS will report its actual services provided under the GPP and the corresponding points valuation to be used by DHCS to determine the payments due. The report shall at least include the GPP-related services furnished by the PHCS during the applicable year, reported by category, tier, and type, and shall serve as the basis for reconciling interim GPP payments with final amounts due. As payments for services under the GPP are based on point value, no cost reconciliation protocol will apply. PHCS shall not be subject to the reporting requirements of 42 C.F.R. Section 447.299.

g. The full amount of a PHCS global budget shall be payable to the PHCS if it meets or exceeds its designated threshold for a given GPP PY. In the event a PHCS does not achieve or exceed its threshold for a given GPP PY, the PHCS's GPP payment shall equal its global budget as reduced by the proportion by which it fell short of its threshold.

h. The state, in accordance with procedures set forth in Attachment K (GPP Funding and Mechanics Protocol), shall redistribute unearned GPP funds that were available in a given GPP PY amongst other PHCS that have exceeded their respective threshold for that year.

i. The non-federal federal share of GPP payments will be provided by PHCS through intergovernmental transfers (IGT), subject to the requirements of STC 16.10 (Sources

of Non-Federal Share) below. Upon receipt of the IGTs, DHCS will draw the federal funding and pay both the non-federal and federal shares of the applicable GPP payments in accordance with the requirements and schedules described herein and in Attachment K (GPP Funding and Mechanics Protocol). In the event GPP payments are recouped upon reconciliation, DHCS will repay the corresponding federal share to CMS in accordance with federal regulations at 42 CFR 430.30, et seq.

j. GPP payments determined annually for each eligible PHCS, after accounting for finalization of the applicable DSH allotment and subparagraphs (g) and (h) as applicable, represent the final amounts available for that GPP PY.

13.7. **Valuation of Service**

a. Services under the GPP shall be valued in accordance with the methodology set forth in Attachment L (GPP Valuation Methodology Protocol). The valuation methodology allows for the continuation of services provided by Public Health Care Systems that were reimbursed under the DSH and SNCP structure that existed for PHCS prior to the GPP, while encouraging more cost-effective and innovative care where appropriate. Point values shall also be developed for those innovative or alternative services where there is currently little to no reimbursement. The valuation methodology reflects the following programmatic goals:

i. Facilitate a shift away from the previous cost-based payment that was restricted to mostly hospital settings and subject to prolonged periods of cost reconciliation;

ii. Broaden the settings in which Public Health Care Systems receive payment for services furnished to the uninsured, and encourages Public Health Care Systems to provide greater primary and preventive services, as well as to create access to alternative modalities such as telehealth, group visits and health coaching;

iii. Emphasize coordinated care and alternative modalities by recognizing the higher value of access to primary care, ambulatory care, and other core components of care management, as compared to the higher cost of avoidable emergency room visits and acute care hospital stays;

iv. Recognize the value of services that typically are not directly or separately reimbursed by Medicaid or other payors (“non-traditional” services), and that substitute or complement services for which payment is typically available upon provision of the service (“traditional” services).

v. Make GPP a potentially equity-enhancing program through valuation of additional services otherwise available for the state’s Medicaid beneficiaries such that the program can incentivize provision of such services to the uninsured population, potentially to begin addressing health inequities among populations these hospital systems serve.

b. All services eligible for points under the GPP are grouped into the four categories described below in STC 13.11:

c. Services within the categories are further stratified into tiers based on similar service intensity, activity and/or effort. Relative point values are assigned to tiers for purposes of reporting and generating payments.

d. The valuation methodology incorporates a phased approach in which traditional services, over the course of the demonstration approval period, reflect reduced point values. High intensity services will continue to be recognized for their value and importance, including recognition in the point system that emergency room visits and inpatient stays may be necessary and appropriate.

e. Relative point values will be initially set based on cost and then adjusted to a limited degree based on other measures of value, in order to assist in maintaining accountability for the amount of services provided compared to the funding PHCS receive. Higher relative value points may be assigned to services, including non-traditional services that help promote one or more of the objectives from the list below; however, the relative point value of services, except for those services for which cost information is not readily available, such as non- traditional services, may not vary from their initial cost-based amounts by more than 40 percent at any time during the GPP.

    i. Timeliness and convenience of service to patient;

    ii. Increased access to care;

    iii. Earlier intervention;

    iv. Appropriate resource use for a given outcome;

    v. Health and wellness services that result in improved patient; decisions and overall health status;

    vi. Potential to mitigate future costs;

    vii. Preventative services;

    viii. Likelihood of bringing a patient into an organized system of care; and

    ix. Additional criteria, to be designed by the state.

f. In GPP PYs in which point revaluation has occurred, point revaluation must be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if its utilization and the mix of services provided remained the same as in the baseline period used to determine the designated threshold. When DHCS develops for approval point values for additional services intended to increase health equity, this subparagraph shall not be interpreted to necessarily require revaluation of other existing services' values. However, the state must provide valuation for any additional services, as further described.

g. The exact methodology for assigning points to the services is reflected in Attachment L (GPP Valuation Methodology Protocol), as approved by CMS on March 21, 2016. This Protocol remains in effect until the state introduces additional services to the GPP. Any updates to Attachment L, including introduction of additional services, and any modifications to the valuation methodology, will be subject to CMS approval, and will require CMS approval before it can be implemented. If the state proposes to change point valuations or add new services, it must obtain CMS approval before they may be implemented in the program.

h. PHCS are not required to provide every service identified on Attachment LFF (GPP Valuation Methodology Protocol), but are allowed the flexibility to provide any combination of services, through their global payments budgets and service-related point thresholds, to address local needs.

13.8. **Global Payment Program Funding and Mechanics Protocol and Global Payment Program Service Valuation Methodology Protocol.** The GPP Funding and Mechanics Protocol (Attachment K) and the GPP Valuation Methodology Protocol (Attachment L) set forth in detail the parameters and procedures related to the operation of the GPP.

a. **Global Payment Program Valuation Methodology Protocol** includes the following:

i. The master list of services and activities for which points apply under the GPP and their associated point values, including the placement of services within the categories and tiers and how point values will change over the course of the demonstration.

ii. Methodology for calculating and modifying the PHCS thresholds.

b. **The Global Payment Program Funding and Mechanics Protocol specifies the following:**

i. How PHCS may be defined, including criteria for when multiple DPHs may comprise a single Public Health Care System.

ii. Methodology for establishing and modifying annual global budgets for each PHCS.

iii. Technical guidance on how eligible services to the uninsured are defined, accounted for and reported.

iv. Reporting schedule for PHCS to report services provided under the GPP.

v. IGT, interim payment and final payment reconciliation mechanics and schedules.

vi. Methods for redistributing unused portions of annual global budgets among PHCS that exceeded their point threshold.

Within 90 calendar days of CMS approval of the CalAIM demonstration, the state will submit an updated version of the GPP Funding and Mechanics Protocol (Attachment

K) and the GPP Valuation Methodology Protocol (Attachment L). Updates to both protocols must accommodate, among other things, inclusion of additional services available to Medi-Cal beneficiaries that the state will introduce in the GPP services with the aim of supporting health equity considerations in the state. For both the deliverables, the state must submit a revised Protocol within sixty (60) calendar days after receipt of CMS's comments, if any. Once the updated Protocols are finalized and approved, these will replace any previous CMS-approved versions, and the updated versions will be incorporated into the STCs as Attachments K and L, respectively.

13.9. **Global Payment Program Health Equity Monitoring Metrics Protocol:** No later than ninety (90) calendar days after the approval of the CalAIM demonstration extension, the state will submit to CMS a GPP Health Equity Monitoring Metrics Protocol outlining a set of metrics focused on access to, utilization of, and quality of health care and/or health outcomes that the state will systematically calculate and report for understanding existing health inequities among the state's uninsured population who receive GPP services, and thereafter, for tracking progress in bridging any such inequities. The metrics will, to the extent possible, leverage the national established quality measures, including but not limited to, Medicaid Adult, Child, and Maternity Core Sets, and will in general be reported annually once available. The state can also propose other nationally recognized measures or appropriate metrics that are aligned with its demonstration goals pertinent to the GPP, the uncompensated care pool, and its health equity considerations.

The state will work collaboratively with CMS through iterations of the Protocol to finalize an approvable set of health equity metrics and prioritize collection of data on race, ethnicity, language, disability status and other factors to the extent feasible, and using the data to identify disparities in access, health outcomes and quality and experiences of care. The Health Equity Monitoring Metrics Protocol will outline for each of the selected metrics the reporting timeline, which might be impacted by the state's data systems readiness, the baseline reporting period, and the reporting frequency. The state will report the progress and metrics data through its Quarterly and/or Annual Monitoring Reports, per the reporting schedule that will be established in the Protocol. To the extent the state will require ramp-up time to set up data systems to be able to begin reporting the various metrics data overall or for any of the key subpopulations of interest, the state should provide regular updates to CMS on progress with data systems readiness via the Monitoring Reports.

Once approved, the Health Equity Monitoring Metrics Protocol will be appended to these STCs as Attachment M.

13.10. **Funding and Annual Limits.**

a. Under the GPP, a portion of the state's DSH funding and funding from the UC Pool are combined to make payments to participating PHCS that incur costs for services to the remaining uninsured. During each GPP PY, FFP will be available for such GPP payment expenditures up to the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, adjusted as described in subparagraphs of this STC b and c below ("Adjusted DSH"), combined with the additional Demonstration UC funding amounts as set forth in subparagraph d below. For the purposes of GPP PY 6,

only the Adjusted DSH shall be reduced by 50 percent. In order to align federal fiscal year DSH allotment amounts with the conversion to calendar year GPP PYs, GPP PYs 7 through 12 will be funded 50 percent of the Adjusted DSH for the FFY beginning prior to the first GPP PY, and 50 percent of the Adjusted DSH for the FFY beginning during the GPP PY.

b. A portion of California's DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP. The amount set aside shall be identified in Attachment Q DSH Coordination Methodology.

c. In any year to which reductions to California's DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to GPP in a given GPP PY shall be reduced consistent with CMS guidelines.

d. The total computable amount available for the UC component shall equal $472 million in GPP PY1. For GPP PYs two through five, the UC component was determined by CMS based upon the information contained in the Independent Report on Uncompensated Care. As approved by CMS on July 14, 2016, the total computable amounts available for the UC component shall equal $472 million for each of GPP PYs two through five. For GPP PY 6 the total computable amount available for the UC component shall equal $236 million. For GPP PY 7 through 12, the total computable amount available for the UC component shall equal $472 million annually.

e. Taken together, the total computable annual limits for GPP payments will not exceed the limits set forth below:

GPP PY 1 (SFY 15-16) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 2 (SFY 16-17) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 3 (SFY 17-18) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 4 (SFY 18-19) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 5 (SFY 19-20) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 6 (July 1, 2020 – December 31, 2020) – Adjusted DSH at 50% + $236 million = approximately $1.45 billion
GPP PY 7 (CY 2021)- Adjusted DSH + $472 million= approximately $2.9 billion
GPP PY 8 (CY 2022) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 9 (CY 2023) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 10 (CY 2024) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 11 (CY 2025) – Adjusted DSH + $472 million = approximately $2.9 billion
GPP PY 12 (CY 2026) – Adjusted DSH + $472 million = approximately $2.9 billion

f. The non-federal share of payments under the GPP shall be funded by voluntary intergovernmental transfers made by PHCS, or governmental agencies affiliated with PHCS. The funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money excluded from use as state match, impermissible taxes, and non- bona fide provider-related donations. The State must have permissible sources for the non-federal share

of GPP expenditures, which may include permissible IGTs from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid or Medicare (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

g. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

13.11. **Categories.** Each service will be assigned into a category by the state that best reflects its characteristics of intensity and area delivered. These categories will assist in determining the point values of individual services. The categories listed below are intended to provide a broad overview of the categories and services. In addition to the categories below, the state will create a new category to include those services intended to address health equity; this new category will be in effect beginning in PY9. The full description of categories are included in Attachment M and shall be updated to reflect any additional services intended to address health equity.

a. **Category 1:** Traditional Outpatient – This category includes traditional outpatient services provided by a public hospital system facility:

i. Non-physician practitioner;

ii. Traditional, provider-based primary care or specialty care visit;

iii. Mental health visit;

iv. Dental;

v. Public health visit;

vi. Post-hospital discharge;

vii. Emergency room/Urgent Care; and

viii. Outpatient procedures/surgery, provider performed diagnostic procedures.

b. **Category 2:** Non-Traditional Outpatient – This category includes non-traditional outpatient encounters, where care is provided by non-traditional providers or in non-traditional settings

i. Community health worker encounters;

ii. Health coach encounters;

iii. Care navigation; and

iv. Health education & community wellness encounters.

c. **Category 3:** Technology-Based Outpatient – This category includes technology- based outpatient encounters that rely mainly on technology to provide care:

i. Call line encounters;

ii. Texting;

iii. Telephone and email consultations between provider and patient;

iv. Provider-to-provider eConsults for specialty care; and

v. Telemedicine;

d. **Category 4:** Inpatient and Facility Stays – This category includes traditional inpatient and facility stays by patients:

i. Recuperative/respite care days;

ii. Sober center days;

iii. Sub-acute care days; and

iv. Skilled nursing facility days;

13.12. **Service Threshold.** The threshold amounts for each PHCS will initially be constructed using the volume and cost of services occurring in participating providers, and will use the most recent complete state fiscal year data (Base SFY). Point values for each service will be consistent across all providers. The threshold amounts shall be determined in accordance with the methodology set forth in Attachment K (GPP Funding and Mechanics Protocol), which takes into account the following requirements and factors:

a. Historic point values for each service category on a per unit of service basis across all Public Health Care Systems, taking into account at a minimum, the varying methods for identifying units and categories of services, cost per unit, cost trends and service mix;

b. Base SFY utilization for each Public Health Care System; and

c. Adjustments to account for changes in uninsured service needs since Base SFY, including the coverage expansions resulting from ACA implementation; and,

d. Adjustments to account for public health emergencies or other state of emergency situations that impact the delivery of GPP services by a Public Health Care System.

e. This threshold will require approval by CMS before it can be finalized.

f. Thresholds for GPP PY2-PY12 will decline in proportion to reductions in annual limits.

13.13. **Coordination with DSH**

a. To maintain budget neutrality, the state will not make state plan-based DSH payments and uncompensated care payments to hospitals participating in the GPP.

b. Hospitals that meet DSH eligibility criteria and which are not participating within a PHCS may receive DSH payments under the applicable provisions of Attachment 4.19-A of the state plan, as modified pursuant to Attachment Q (DSH Coordination Methodology).

13.14. **Discontinuation of GPP**

DHCS may, in consultation with the participating PHCS, discontinue the GPP in any subsequent state fiscal year(s) for the remainder of the Demonstration and revert to financing uncompensated care costs for Medicaid and uninsured patients under the DSH program pursuant to the state plan. DHCS shall notify CMS no later than 30 calendar days prior to the start of the initial state fiscal year for which the GPP will be discontinued. DHCS will follow the appropriate processes as is necessary to facilitate DSH payments to affected PHCS under the State plan.

13.15. **DSH Payments and FFY**

The state is not authorized to make a DSH payment under the Medicaid state plan for any hospital for any federal fiscal year (FFY) in which that hospital is eligible for a GPP payment for a GPP PY or portion thereof that is within that FFY. A DSH payment is considered to be made for a FFY if the payment would count against the DSH allotment for that FFY. In the event that the GPP is not authorized for a full PY, the state is prohibited from making duplicate GPP and DSH payments to GPP-eligible hospitals and must submit, subject to CMS approval, a method for allocating GPP and DSH payments to avoid duplication during the affected period.

14. GENERAL REPORTING REQUIREMENTS

14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

14.2. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

14.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

14.4. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised

Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment DD. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 14.5), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS . The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

For the HRSN and reentry services, authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Health Equity Measure Slate from CMS. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and develop appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the HRSN Community Supports Protocol (STC 8.10(d)).

In addition, the state must describe in the Monitoring Protocol methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics.

These sources may include, but are not limited to (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (such as, services rendered, resolution of identified need, etc., as applicable), (4) social needs screening results from electronic health records, health plans, or other partner agencies, and (5) data related to carceral status Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

To the extent applicable, the state's selection and reporting of monitoring metrics for the HRSN services is expected to align with the monitoring required by the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services.

For the qualitative elements (e.g., operational updates as described in STC 14.5 below), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

14.5. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives, as applicable for all key demonstration initiatives and populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of reporting metrics data on quality of care and health outcomes that are known to be important for closing key equity gaps in Medicaid and CHIP (e.g. the National Quality Forum (NQF) "disparities sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate, as applicable to the demonstration initiatives and populations. If needed, the State may submit an amendment to its monitoring plan no more than 150 days after receiving the final Health Equity Measure Slate from CMS to incorporate these measures.

Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

For the approved HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, in addition to reporting on the metrics described above, the state may align with monitoring required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, as may be applicable. The state must track beneficiary participation in applicable services over time, as well as narratively report annually on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and contracted providers of applicable services (e.g., managed care plan and their contracted HRSN providers). Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid

beneficiaries enrolled in other public benefit programs (such as, Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) for which they are eligible.

The state's selection and reporting of quality of care and health outcomes metrics outlined above must also accommodate the newly approved reentry demonstration initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the reentry demonstration initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating carceral settings. In addition, the state is expected to monitor the number of beneficiaries served and types of services rendered under the demonstration Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and plans for addressing them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

In addition, the state must demonstrate through its Annual Monitoring Reports to CMS improvements in Medicaid fee-for-service base provider payment rates and payment rates for providers enrolled in managed care to the extent required by the DSHP-related STCs. As applicable, the state must also track the number and characteristics of contracted or participating organizations, specifically under the demonstration's HRSN and reentry initiatives, and corresponding payment-related metrics.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation

hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

14.6. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

14.7. **Close-Out Report.** Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state shall include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.7 and 15.8, respectively.

c. The state must present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out report.

e. The revised Close-Out report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 14.1.

14.8. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

14.9. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

15. EVALUATION OF THE DEMONSTRATION

15.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including, as applicable and in consultation and collaboration with the state, representation from the state's independent evaluators, and organizations associated with the demonstration operations—in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.

15.2. **Independent Evaluator**. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

15.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as

establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.7 and 15.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

15.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment T to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

15.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the Evaluation Design must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must analyze outcomes, such as enrollment and enrollment continuity, and measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health

Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

Specifically, hypotheses for the DMC-ODS component of the demonstration must include an assessment of the core goals of the program, to include (but are not limited to): initiation and engagement with treatment, reduction in unnecessary and inappropriate utilization of emergency department and inpatient hospitalization through expanded utilization of DMC-ODS services, and reductions in key outcomes such as deaths due to overdose. In addition, the state will also evaluate the effectiveness of the Contingency Management benefits provided to qualifying DMC-ODS beneficiaries. Further, the state will evaluate its program goals to improve alignment and integration and to enhance beneficiary experience under the expenditure authority provided in the demonstration for dually eligible beneficiaries.

Similarly, in alignment with the overarching goals of PATH and DSHP authority to support various infrastructure, transitional non-service expenditures, and capacity building efforts and the overall implementation and operationalization of CalAIM in the state, the evaluation of these demonstration components—for example—will analyze hypotheses focused on items such as how PATH (including the DSHP funding), in conjunction with related CalAIM initiatives, promotes: access to community-based providers of ECM, reentry services, and HRSN services, specifically, the two Community Supports authorized through this demonstration, and improved access and utilization of health care services at the community-level, with particular attention to historically under-resourced or marginalized populations. The evaluation will be informed by progress reports to be submitted to DHCS by Qualified Applicants on the need for and use of PATH funding and achievement of defined milestones.

The demonstration's GPP evaluation must study hypotheses and research questions that help understand, for example, whether the program leads to improvements in care delivery in more appropriate settings and improvements in health equity via improvements in access, quality and experience of care, and health outcomes among the state's uninsured population.

Hypotheses for the HRSN initiatives, i.e., short-term post-hospitalization services and recuperative care, must focus on assessing how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high acuity health care, and beneficiary physical and behavioral health outcomes. In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys). Given the populations of focus and the program designs of the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the

effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual and/or community level.

The state is required to examine whether and how state and local investments in housing and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include, in alignment with the evaluation required in the state's 1915(b)(1)/(4) Waiver for California Advancing & Innovating Medi-Cal (CalAIM) special terms and conditions for other similar services, a cost analysis to support developing comprehensive and accurate cost estimates of covering such services. The state is also required to include a robust assessment of potential improvements in the efficiency, quality, and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications, related to the provision of upstream HRSN services.

Evaluation of the reentry demonstration initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient provision of high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the reentry demonstration initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination, connections between carceral and community services, access to and quality of care in carceral and community settings, preventive and routine physical and behavioral health care utilization, non-emergent emergency department visits and inpatient hospitalizations.

The state must also provide a comprehensive analysis of services rendered by type of service over the duration of the 90-day coverage period immediately prior to the expected date of release—to the extent feasible, and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions, and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage or pre-release services.

The demonstration's evaluation efforts will be expected to include an examination of carceral provider qualifications and standards as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, similar to the state's HRSN initiative, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services.

The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated care costs. As noted above, the state

must also analyze the costs and cost effectiveness of the HRSN services and the budgetary effects of the reentry demonstration initiative. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the reentry demonstration initiative and the HRSN components, and beneficiary experience with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

15.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

15.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

15.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within thirty (30) calendar days.

15.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.

15.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

15.12. **Additional Publications and Presentations**. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

16. GENERAL FINANCIAL REQUIREMENTS

16.1. **Allowable Expenditures**. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

16.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) calendar days after the end of each quarter, the state shall submit form CMS-64 (Quarterly Medicaid Expenditure Report), showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid or Medicare funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on

the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare or Medicaid.

b. The state certifies that state and local monies are used as the source of non-federal share for the demonstration expenditures. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by federal law or these STCs. All sources of the non-federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations and are not derived from impermissible provider taxes or donations or federal funds (unless the other federal funding source by law allows use of federal funds for purposes of obtaining additional federal matching funds under Medicaid). For this purpose, federal funds do not include GPP payments, PATH payments, or patient care revenue received as payment for services rendered under programs such as Medicare and Medicaid. Further, these sources and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies, any sources determined to be impermissible by CMS shall be addressed within the time frames set by CMS. For non-federal share funding using intergovernmental transfers, the funding entity shall certify that the funds transferred qualify for federal financial participation pursuant to 42 CFR part 433 Subpart B, and are not derived from impermissible sources such as recycled Medicaid payments, federal money not permitted by law to be used as state share, impermissible taxes, and non-bona fide provider-related donations.

c. Under all circumstances, health care providers must retain 100 percent of their payments received under this demonstration. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of these demonstration payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

d. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and does not duplicate other sources of federal funds.

16.4. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with all applicable requirements for payments, including those in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

16.5. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

16.6. **State Monitoring of Non-Federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after the effective date of the demonstration amendment that added this STC. This deliverable is subject to the deferral as described in STC 14.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

16.7. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XII:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

16.8. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

16.9. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table below provides a master list of MEGs defined for this demonstration.

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
CBAS	Hypo	X		X	An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.
OOS FFCY	Hypo	X		X	Expenditures for extending eligibility for full Medicaid State Plan benefits to former foster care youth who are under age 26, were in foster care under the responsibility of another state or tribe in such state on the date of attaining 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date
DMC-ODS: IMD	Hypo	X		X	Expenditures for otherwise covered Medicaid services furnished to qualified beneficiaries who are primarily receiving treatment and withdrawal management services for substance use disorder as short-term residents in facilities that meet the definition of an IMD.

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
IHS Chiropractic Services	Hypo	X		X	Supplemental payments to support participating IHS and tribal facilities that incur costs associated with chiropractic services for which Medi-Cal coverage was eliminated hat are furnished by these providers to individuals enrolled in the Medi-Cal program.
HRSN Services	Capped Hypo		X	X	Recuperative care and Short-Term Post Hospitalization Housing
PATH Supports	Non-Hypo			X	Ensuring Access to Services During Transition and Delivery System Transformation and Innovation PATH program & Justice- Involved Planning and Implementation
IP UPL PH	Non-Hypo			X	Inpatient Upper Payment Limit for Public Hospitals
GPP	Non-Hypo			X	DSH & SNCP
Contingency Management	Non-Hypo			X	Expenditures for evidence-based, cost-effective treatment for substance use disorder that combines motivational incentives with behavioral health treatments.
Deemed SSI Asset Test	Hypo	X		X	Expenditures to extend eligibility for individuals in the following Deemed SSI populations 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

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Reentry Demonstration Initiative	Hypo	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state prisons, county jails, or youth correctional facilities.
Reentry Demonstration Initiative Transitional Non-Service Expenditures	Hypo		X	X	Expenditures to for planning and supporting the reentry demonstration initiative including for technology and IT services, hiring and training of staff, purchasing of necessary technology and electronic health records and billing systems, developing protocols and procedures, and other expenditures to provide support for pre-release services.
DSHP	Non-Hypo			X	Expenditures for costs of designated programs which are otherwise state-funded
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

16.10. **Reporting Expenditures and Member Months**. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00193/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the

two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** 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.

e. **Member Months**. As part of the Quarterly and Annual Monitoring Reports described in Section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible

member months. Appropriate exceptions, as applicable, must be documented in the state's Budget Neutrality Specifications Manual referenced in STC 16.6(e) The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual**. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
CBAS		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
OOS FFCY		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
DMC-ODS: IMD		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
IHS Chiropractic Services		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	Y	1/1/2022	12/31/2026
HRSN Services		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service/ Date of payment	MAP	Y	1/1/2022	12/31/2026
PATH Supports		See STC 16.6	Follow CMS-64.10 Base Category of Service Definition	Date of Service	ADM/ MAP	N	1/1/2022	12/31/2026
IP UPL PH		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	N	1/1/2022	12/31/2026
GPP		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	N	1/1/2022	12/31/2026
Contingency Management		See STC 16.6	Follow CMS-64.9 Base Category	Date of Service	MAP	N	7/1/2022	12/31/2026

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
			of Service Definition					
Deemed SSI Asset Test		See STC 16.6	Follow CMS-64.9 Base Category of Service Definition	Date of Service	MAP	Y	7/1/2022	12/31/2026
Justice Involved Initiative			Follow CMS-64.9 Base Category of Service Definition	Date of Services	MAP	Y	4/1/2024	12/31/2026
DSHP			Follow CMS-64.9 Base Category of Service Definition	Date of Payment	ADM	N	1/26/2023	12/31/2026
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Follow CMS-64.9 Base Category of Service Definition	Date of Payment	ADM	N	1/1/2022	12/31/2026

g. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 6: Demonstration Years		
Demonstration Year 18	January 1, 2022 to December 31, 2022	12 months
Demonstration Year 19	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 20	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 21	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 22	January 1, 2026 to December 31, 2026	12 months

h. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.

i. **Claiming Period**. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

j. **Future Adjustment to Budget Neutrality**. CMS reserves the right to adjust the budget neutrality expenditure limit:

    i. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

    ii. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality

agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law, whichever is earlier

iii. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

16.11. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 16.11c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.8. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

16.12. **Supplemental Payments to IHS and 638 Facilities.** The state shall make supplemental payments to participating Indian Health Service (IHS) and tribal 638 facilities that incur costs associated with providing chiropractic services. Supplemental payments shall be computed based on the cost for chiropractic services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing chiropractic services to non-IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment D. The annual limit for such supplemental payments shall be $1,550,000 total computable per year (DY 18-22).

16.13. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for CalAIM to ensure oversight and monitoring of demonstration claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after the renewal approval to account for changes and expansions to the waiver as described within these STCs for the CalAIM Demonstration.

17. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

17.1. **Budget Neutrality Effective Date.** All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2022. Notwithstanding this effective date, expenditures made for Uncompensated Care Pool payments under GPP during the temporary extension period of July 1, 2020 through December 31, 2021 are permitted.

17.2. **Limit on Title XIX Funding.** California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of three parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California and disproportionate share hospital (DSH) allotments. Spending under the budget neutrality limit is authorized for all spending related to approved expenditure authorities. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the demonstration extension (January1, 2022 through December 31, 2026). Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for General Financial Requirements Under Title XIX. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

17.3. **Risk.** California will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

17.4. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

17.5. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 7 : Main Budget Neutrality Test

MEG	PC or Agg.	WOW Only, WW Only, or BOTH	Trend Rate	DY 18	DY 19	DY 20	DY 21	DY 22
Contingency Management	Agg.	WW Only	N/A	$4,866,666	$29,200,000	$31,515,350	$31,515,350	$31,515,350
IP UPL PH	N/A	WOW Only	N/A	$863,054,000	$863,054,000	$863,054,000	$863,054,000	$863,054,000
DSHP	N/A	WW Only	N/A	The state must have savings to offset these expenditures.				
GPP-DSH	N/A	Both	N/A	The state shall calculate annually in accordance with Attachment Q.				
GPP- SNCP	N/A	WW Only	N/A	$472,000,000	$472,000,000	$472,000,000	$472,000,000	$472,000,000
PATH Supports	Agg.	WW Only	N/A	The state must have savings to offset these expenditures. DY18 expenditures will include all PATH Supports dollars including reentry services for this one year. See Table 8 for DY19-DY22 years.				

17.6. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing

them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

17.7. **Hypothetical Budget Neutrality Test 1:** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test. The following applies to hypothetical budget neutrality tests under this demonstration:

i. Actual expenditures for the CBAS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS services (whether provided through managed care or fee-for- service) to the SPD Medicaid-only population and to dual eligible.

ii. Actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the DMC- ODS benefit to the eligible population;

iii. Actual expenditures for the Deemed SSI asset limit increase and elimination will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be actual cost of increasing and eliminating the asset limit for the Deemed SSI populations;

Table 8: Hypothetical Budget Neutrality Test 1								
Eligibility Group (EG)	**PC or Agg.**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**
CBAS	PC	Both	0 %	$6.90	$6.90	$6.90	$6.90	$6.90
OOS FFCY	PC	Both	5.2%	$371.88	$391.22	$411.56	$432.96	$455.47
DMC-ODS IMD	PC	Both	5.2%	$2,795.87	$2,941.26	$3,094.21	$3,255.11	$3,424.38
IHS Chiropractic Services	PC	Both	4.7%	$539.98	$565.36	$591.93	$619.75	$648.88
Asset Test	PC	Both	4.50 %	$980.94	$1,025.08	$1,071.21	$1,119.41	$1,169.78
Reentry Demonstration Initiative	Agg.	Both		0	0	$36,209,915	$98,674,434	$183,187,586
PATH-Reentry Demonstration Initiative Transitional Non-Service Expenditures	Agg.	Both		0	$209,000,000	$201,000,000	$0	0

17.8. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in STC 8, CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority

under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

17.9. **Capped Hypothetical Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 9: Capped Hypothetical Budget Neutrality Test

MEG	Agg	WOW Only, WW Only, or Both	DY 18	DY 19	DY 20	DY 21	DY 22
HRSN Services	Agg	Both	$353,702,693	$371,919,141	$391,653,626	$412,906,148	$434,158,671

17.10. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

17.11. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 1, 2022 through December 31, 2026. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (07/01/2015 to 06/30/2020). If at the end of the demonstration approval

period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

17.12. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 17.11, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $99,215,335,167.

17.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 10: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 19 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 20 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent
DY 21 through DY22	Cumulative budget neutrality limit plus:	0.0 percent

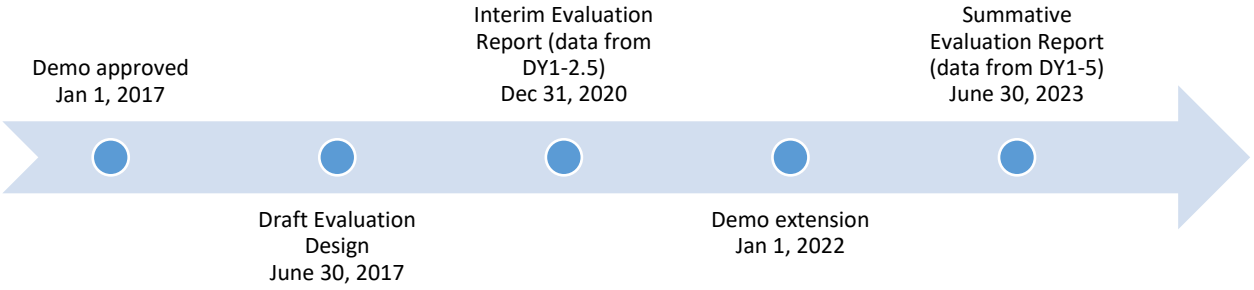
Attachment A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to

which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute

directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health

Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

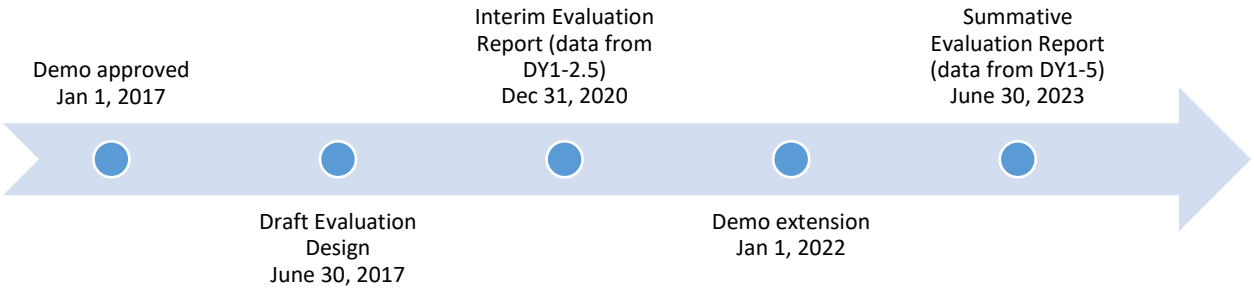
Attachment B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is

appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.

3) *Evaluation Period* – Describe the time periods for which data will be collected.

4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

D. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

a. If the state did not fully achieve its intended goals, why not?
b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C
Global Payment Program Participating Public Health Care Systems

Public Health Care Systems participating in the GPP consist of the following designated public hospitals (DPHs), including any successor or differently named hospital as applicable, and their affiliated and contracted providers. The DPHs are operated by a county, a city and county, University of California, or special hospital authority described in Section 101850 or 101852, *et seq.*, of the California Health & Safety Code.

1. Los Angeles County (LA Co.) health system
    a. LA Co. Harbor/UCLA Medical Center
    b. LA Co. Olive View Medical Center
    c. LA Co. Rancho Los Amigos National Rehabilitation Center
    d. LA Co. University of Southern California Medical Center
2. Alameda Health System
    a. Highland Hospital (including the Fairmont and John George Psychiatric facilities)
    b. Alameda Hospital
    c. San Leandro Hospital
3. Arrowhead Regional Medical Center
4. Contra Costa Regional Medical Center
5. Kern Medical Center
6. Natividad Medical Center
7. Riverside University Health System -- Medical Center
8. San Francisco General Hospital
9. San Joaquin General Hospital
10. San Mateo County General Hospital
11. Santa Clara Valley Medical Center
12. Ventura County Medical Center

Attachment D - Funding and Reimbursement Protocol for IHS

Funding and Reimbursement Protocol for Claiming IHS and 638 Facilities Uncompensated Care Payment Methodology The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from November 1, 2015 through December 31, 2020 as required by STC 16.12. Using the methodology escribed below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low-Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and December 31, 2014 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal. Costs for optional dental and psychology, that were eliminated through SPA 09-001, but have been added back in through State Plan Amendments are not available for reimbursement through these supplemental payments.

A. Provider Claiming Methodology for services provided November 1, 2015 through December 31, 2020

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
    b. Whether the service was provided to an IHS eligible individual; and
    c. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third-party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a

Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third-party payments received by each facility forthe qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility foruncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

Exhibit 1.B: Aggregate Encounter Report for January 1, 2022 through October 31, 2026

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____ _____

Title Date

_____

Signature (officer of the governmental entity)

Attachment E

SUD Health IT Plan

California Progress on SUD HIT Plan

Overview

The state's Department of Justice (DOJ) manages the Controlled Substance Utilization Review and Evaluation System (CURES), the state's prescription drug monitoring program (PDMP). CURES is governed by strict statutory and regulatory requirements that limit the entities—licensed prescribers, pharmacists, regulatory agency officials, and law enforcement officials--who can access the database. CURES stores Schedule II-V controlled substance prescription information that is reported as dispensed in California. Prescribers must consult CURES to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 6 months thereafter if the substance remains part of the treatment of the patient. In accordance with CMS' request, this document details the state of CURES for each functionality included in the SUD HIT.

Prescription Drug Monitoring Program Functionalities

- **Interstate sharing:** AB 1751 (Stats 2018, Ch 478, Low) authorized the DOJ, once final regulations addressing CURES access and use have been issued, to participate in interstate sharing. The DOJ is in the process of developing functionality within CURES to support interstate data sharing and plans to use both RxCheck and sPMPi to facilitate data sharing across states. Additionally, DOJ is actively working with potential data sharing partners. Data obtained from CURES may be provided to authorized users of another state PDMP if the entity operating the interstate data sharing hub, and the PDMP of that state, have entered into an agreement with the DOJ for interstate sharing of PDMP information. Implementation of this functionality is scheduled for Spring 2022.
- **Enhanced "ease of use" for prescribers and other state and federal stakeholders**. CURES launched the Information Exchange Webservice (IEWS) an interoperability platform in 2018 that allows for integration with providers' EHRs and with HIEs where users log into the data system. Currently, 50 health IT entities, including HIEs and large health systems, whose users are authorized to access CURES, use the platform. In addition, DOJ is engaged in a CURES optimization effort to update the "look and feel" of the web-portal and dashboard to promote ease of use. Additionally, interstate searches will be available through the IEWS. Implementation of the optimized CURES is scheduled for Spring 2022.
- **Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.** *See bullet immediately above*
- **Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.** CURES presents daily patient safety alerts within the CURES dashboard to prescribers when their patient's aggregate prescription level exceeds certain thresholds, including:
  - Patient is currently prescribed more than 90 morphine milligram equivalents per day

- Patient has obtained prescriptions from 6 or more prescribers or 6 or more pharmacies during last 6 months
- Patient is currently prescribed more than 40 morphine milligram equivalents of methadone daily
- Patient is currently prescribed opioids more than 90 consecutive days
- Patient is currently prescribed both benzodiazepines and opioids

The CURES database also provides health care practitioners and pharmacists with a messaging capability that allows a message to be sent to another health care practitioner regarding a mutual patient from within the secure CURES environment.

Current and Future PDMP Query Capabilities

- **Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query).** CURES uses an algorithm to de-duplicate patient entities and that considers various elements of a patient record. It is important to note that use of this algorithm is applied only when CURES generates daily patient safety alerts and for the production of CURES de-identified datasets.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes

- **Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.** The IEWS platform allows providers easy access to CURES through their EHR as detailed above. State statute requires prescribers to review a patient's history on CURES within 24 hours or one business day before prescribing a controlled substance. In accordance with state law, approved prescribers and pharmacists will be able delegate their authority to access CURES reports. This delegate functionality will become available within the web application in Spring 2022. Delegate access through IEWS is dependent on the National Council for Prescription Drug Programs (NCPDP) to adopt an update to the NCPDP SCRIPT Standard and is therefore on a longer timeframe.
- **Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.** In addition to the CURES functionality described above and related to patient alerts, CURES includes links to resources on safe prescribing of controlled substances. For example, the CURES public website includes links to the CDC prescribing guidelines, Medical Board of California guidelines, California's Department of Public Health (CDPH) opioid overdose surveillance dashboard, as well as the CDPH Guidance Letter.

Master Patient Index / Identity Management

- **Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.** See bullet above on master patient index/patient matching.

Overall Objective for Enhancing PDMP Functionality & Interoperability

- **Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.** Key functionalities intended to help minimize the risk of

inappropriate opioid overprescribing are described above. Additionally, in accordance with state statute and regulations, a public or private entity, including a Bona Fide Researcher, is eligible to obtain data from CURES, subject to the requirements of the data request process. Accordingly, there is no specific data transmittal that occurs between CURES and Medicaid. Related other state IT efforts, DHCS data and clinical staff regularly monitor inappropriate prescribing of opioids through its routine utilization monitoring, an effort that has increased in priority due to the current opioid crisis. Onsite reviews of suspect practitioners have resulted in Drug Code Limitation, a sanction restricting pharmacies from billing for prescriptions written by sanctioned practitioners, and suspension from the Medi-Cal program when there is evidence of potential fraud and/or patient harm. Fraud investigations are conducted and cases are referred to law enforcement for criminal investigation and prosecution when warranted.

Attachment F
Accounting Procedures

The following Accounting Procedures have been developed to ensure that no over claiming of expenditures occur and to provide for accurate reporting of mandated reports as required by CMS for the Demonstration. The Safety Net Financing Division's (SNFD) Hospital Contracts Unit (HCU), within the Inpatient Contract and Monitoring Section (ICMS), is responsible for preparing quarterly and annual reconciliation of program expenditures.

STATE-ONLY PROGRAMS - Reserved for State submission of accounting procedures for DY 6-10 DSHPs per paragraph 22.

I. CERTIFIED PUBLIC EXPENDITURES

CPEs are expenditures certified by counties, university teaching hospitals, or other governmental entities within a state, as having been spent on the provision of covered services to Medi-Cal beneficiaries and uninsured individuals. CPEs are eligible for reimbursement at the federal medical assistance percentage in effect on the date the service is provided.

Cost Submission

At least annually, designated public hospitals (DPHs) send to SNFD an estimate of their CPEs for the project (current) year, accompanied by an attestation of the costs. The CPEs are derived from the Medi-Cal 2552-96 cost report, a Workbook developed by SNFD, and other documentation to support the estimated CPEs. These CPEs are used to establish an interim per diem rate of reimbursement for the costs of providing inpatient care to Medi-Cal beneficiaries, and to determine DSH payments, and payments from the SNCP. In addition, the data is used as the basis of a tentative settlement made for inpatient services rendered to Medi-Cal beneficiaries.

1. Review Process

SNFD reviews all data submitted for accuracy and compliance with established procedures, and performs tests for reasonableness. If discrepancies or inconsistencies are identified, SNFD works directly with the DPH staff to resolve issues and correct data.

2. Interim Payment Process

Establish Inpatient Interim Rates
SNFD establishes the inpatient interim rate for each DPH based on the most current filed Medi-Cal 2552-96 and Workbook. SNFD instructs Provider Enrollment Division (PED) to update the Provider Master File (PMF) to reflect the new interim rates. The new interim rates are not retroactive and are applied to all claims for services rendered effective with the update.

Determine Interim Payment
SNFD reviews the most current filed Medi-Cal 2552-96 cost report and Workbook filed by each DPH for the purpose of determining a tentative settlement. The tentative settlement is made to settle on an interim basis all claims paid to date to reflect the difference between the interim rate paid and actual costs. The actual claims paid are based on the most current Medi-Cal claims payment data generated by California's fiscal intermediary. Based on the review and application of the current payment data, SNFD generates a notice of tentative settlement to each DPH that includes schedules supporting the calculation and a copy of the payment data. A copy of the notice is forwarded to A&I for preparation of an action notice authorizing California's fiscal intermediary to pay or recover the tentative settlement amount. California's fiscal intermediary will prepare a Statement of Account Status which will inform the hospital of the date of payment or instructions for repayment.

3. Final Reconciliation Process
The final audit report of the Medi-Cal 2552-96 cost report generated by A&I will be used as the basis for final determination and settlement of the CPEs. SNFD will instruct A&I to prepare an action notice informing California's fiscal intermediary of the final settlement. California's fiscal intermediary will issue a Statement of Account Status which will incorporate the previous tentative settlement and inform the DPH of any further payment or recovery.

II. INTERGOVERNMENTAL TRANSFERS (IGTs)

IGTs are transfers of public funds between governmental entities, such as from a county to the State. One source of the funding used for the transfer is local tax dollars. SNFD reviews the source of funding for each IGT that is proposed by a governmental entity to ensure that it meets state and federal requirements for permissible transfers.

Pre-Transfer

For IGTs used as the non-federal share of DSH payments, DHCS and the State Treasurer's Office (STO) are notified by the county or governmental entity, prior to the transfer of funds to ensure all arrangements are complete.

For IGTs used as the non-federal share of the supplemental payments under the provisions of section 14166.12 of the California Welfare and Institutions (W&I) Code, DHCS, the California Medical Assistance Commission (CMAC), and STO are notified by the county, or governmental entity, prior to the transfer of funds to assure that all arrangements are complete.

Transfer

1. IGTs used as the non-federal share of DSH payments.

The amounts of the IGTs are determined by the data submitted to DHCS by the DPHs. Staff of the DSH Payment Unit will coordinate the amount and timing of transfers from the DPHs

to STO.

2. IGTs used as the non-federal share of the supplemental payments.
   CMAC coordinates with HCU on the amount and timing of IGTs to the STO under the provisions of section 14166.12 of the W&I Code.

Post-Transfer

For all IGTs, the county, or governmental entity, notifies DHCS after the transfer is complete. The transfer is verified and documented, and DHCS deposits the transferred amount into the appropriate funds for payments.

III. SAFETY NET CARE POOL PAYMENTS

DPHs receive SNCP payments for hospital and clinic costs associated with health care services provided to uninsured individuals.

Payment Processes

The SNFD Program payment computation includes automated verification that the federal SNCP allotment, quarterly interim payments and the total SNCP funding level are not exceeded.
The payment process includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation occurs based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

IV. DISPROPORTIONATE SHARE HOSPITAL PROGRAM

DHCS disburses $1.0325 billion of the federal DSH allotment to eligible DPHs and non- designated public hospitals (NDPHs) annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines DPHs and NDPHs, specifies the funding level, and describes the distribution methodology.

The non-federal share of DSH payments to DPHs is comprised of CPEs and IGTs. DPHs use CPEs to claim DSH funding for up to 100 percent of their uncompensated care costs, and use IGTs to claim DSH funding for up to 175 percent of their uncompensated care costs, as permitted by the Omnibus Budget Reconciliation Act of 1993. By contract, the nonfederal share of DSH payments to NDPHs is the State General Fund.

Annually, the DSH Share Hospital Eligibility Unit submits a DSH Program audit report to CMS as required by the Social Security Act. The DSH Share Hospital Payment Unit (DSHPU) performs a final reconciliation of total DSH hospital-specific payments to ensure that funding provided during and after the project year does not exceed appropriate funding levels established by actual hospital uncompensated care costs, as required by the State Plan.

The DSH Program payment computations include automated verification that the federal DSH allotment, appropriate IGT funds invoiced for DSH payments, and the total DSH Program funding level are not exceeded.

The DSHPU protocol and procedures include quality audits to ensure that correct data is used appropriately and that correct amounts are disbursed to the appropriate hospitals.

A. DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source.

The check write memorandum includes a payment authorization notice (PAN) and a

memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. For payments using IGTs as the non-federal share of the payments, the PAN provides Accounting with authorization to use the federal DSH allotment and IGT funds from the Medicaid Inpatient Adjustment Fund. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for DPHs includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation is based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

EDS prepares the check write computer file for submission to SCO.

NON-DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal DSH allotment).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction.
The PAN provides Accounting with authorization to use the General Fund and federal DSH allotment. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH

Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for NDPHs includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information.

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover any overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

B. PRIVATE HOSPITALS

DHCS disburses approximately $465 million of DSH replacement funding to eligible private hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the State Plan, are eligible to receive DSH replacement funding. The State Plan defines private hospitals, specifies the funding level, and describes the funding distribution methodology. In addition to the DSH replacement funding, DSH-eligible private hospitals receive their pro rata share of payments from a defined pool within the annual DSH allotment.

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal Medicaid funding).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each paymenttransaction.
The PAN provides Accounting with authorization to use the State General Fund and federal Medicaid funds. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for private hospitals includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

V. PRIVATE HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi- Cal patients. Eligible private hospitals receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Private Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each packageincludes:

A memorandum addressed to the Financial Management BranchChief requesting authorization forpayment.

(i) An invoice for the signatures of the Chiefs of ICMS andHCU.
(ii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for programfiles.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request

and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VI. NON-DESIGNATED PUBLIC HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the SPCP to provide acute inpatient hospital care to Medi-Cal patients. Eligible NDPHs receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Non-designated Public Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.

(i) An invoice for the signatures of the Chiefs of ICMS and HCU.
(ii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VII. DISTRESSED HOSPITAL FUND PAYMENTS

CMAC negotiates contract amendments with participating SPCP hospitals that meet criteria for distressed hospitals. These hospitals must serve a substantial volume of Medi-Cal patients, be a critical component of the Medi-Cal program's health care delivery system, and be facing a significant financial hardship that may impair ability to continue their range of services for the Medi-Cal program.

The non-federal share of distressed hospital fund payments is funded by State Treasury funds that are 20% of the July 2005 balance of the prior supplemental funds (PFSs), accrued interest on the PFSs, and any additional amounts appropriated by the Legislature.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for payments from the Distressed Hospital Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request, and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VIII. CONSTRUCTION/RENOVATION REIMBURSEMENT PROGRAM (SB 1732)

In 1989, Senate Bill (SB) 1732 was enacted to establish the Construction/Renovation Reimbursement Program (also known as the SB 1732 program) (Welfare and Institutions Code 14085.5). Under this program, reimbursement is provided to eligible hospitals for the debt service costs incurred on revenue bonds used to finance eligible hospital construction project(s).

Invoice Submission

Invoices are submitted by participating hospitals to HCU no more than twice each year. The invoices consist of the following:

(i) A cover letter from the hospital's Chief Financial Officer, or other appropriate representative.
(ii) A reimbursement request that includes bond debt service payment (principal and/or interest).
(iii) Support documents verifying payment by the hospital to the debt holder.

Review Process

HCU verifies inclusion and accuracy of all required documents in the invoice package.

Payment Process

HCU calculates reimbursement amounts on a spreadsheet by:

(i) Determining the amount of debt service paid.
(ii) Deducting interest earned in the hospital's SB 1732 account.
(iii) Calculating the reimbursable amount based on the eligible portion of the construction project and the Medi-Cal Utilization Rate percentage.

HCU prepares a reimbursement payment package, which is reviewed and approved by the ICMS Chief, and submits it to California's fiscal intermediary.

HCU sends a notification letter to each eligible hospital and a copy of the notification letter is forwarded to CMAC.

California's fiscal intermediary forwards payment requests to SCO and sends copies of the payment requests to HCU.

SCO mails the payment to the hospital.

IX. SELECTIVE PROVIDER CONTRACTING PROGRAM

The SPCP was established in 1982 and operated under a two-year section 1915(b) waiver until August 31, 2005. On September 1, 2005, CMS approved the continuation of a restructured SPCP under California's new five-year section 1115 Medi-Cal Hospital/Uninsured Care Demonstration. The SPCP allows DHCS to selectively contract with acute care hospitals to provide inpatient hospital care to Medi-Cal beneficiaries. Under the SPCP, CMAC negotiates contract terms and conditions and per diem rates with participating hospitals on behalf of DHCS. This program has resulted in millions of dollars of savings each year which offset expenditures in this Demonstration to assist in achieving budget neutrality.

The non-federal share of SPCP payments is funded by amounts from the State General Fund.

Contract Process

CMAC forwards proposed contract(s)/amendment(s) to HCU for review. After review, final proposed contracts/amendments are presented at a CMAC meeting for approval by the Commissioners. The approved contracts/amendments are signed by authorized hospital representatives and submitted by CMAC to HCU for processing. The HCU analyst prepares contract/amendment packages for processing and obtains the signature of DHCS's delegated Contract Officer (SNFD Chief) to fully execute the contracts/amendments.

Notification Process

HCU notifies PED of new per diem rates and/or new Current Procedural Terminology codes, revenue codes, and Health Care Procedure Coding System codes, to update the Provider Master File with the hospital- specific information. This file is used by California's fiscal intermediary to process and pay claims submitted by all Medi-Cal providers, including those participating in the SPCP.

Distribution Process

HCU distributes fully executed contracts/amendments to the following:

(i) Contracted hospital
(ii) CMAC Executive Director
(iii) Medi-Cal Field Office
(iv) A&I

i. CMS-64 QUARTERLY EXPENSE REPORT

After the end of every quarter, Accounting summarizes all payments and claims made relating to the Demonstration during the quarter and sends the summary to SNFD to verify the payment period, amount and funding source. After the confirmation, Accounting prepares and submits the CMS-64 Quarterly Expense Report to CMS.

Attachment G

Demonstration and Program Years

CalAIM: Demonstration and Program Years

Demonstration Year (DY)	Dates
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

X.

Global Payment Program	
Program Year (PY)	**Dates**
PY 6	July 1, 2020 through December 31, 2020
PY 7	January 1, 2021 through December 31, 2021
PY 8	January 1, 2022 through December 31, 2022
PY 9	January 1, 2023 through December 31, 2023
PY 10	January 1, 2024 through December 31, 2024
PY 11	January 1, 2025 through December 31, 2025
PY 12	January 1, 2026 through December 31, 2026

Attachment H
Community-Based Adult Services (CBAS) Provider Standards of Participation

A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

4. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
5. Adhere to these waiver Standards of Participation (SOPs);
6. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
7. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
8. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
9. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. Future reference in these SOPs will specify CDA.

B. CBAS Center Services

1. CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of services and the duration of attendance of each participant at the center.
    a. Core services: each CBAS participant shall be scheduled to receive ALL of these services on each day of attendance at the center:

i. Professional nursing.
ii. Therapeutic activities.
iii. Social services and/or personal care services.
iv. One meal offered per day.

b. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
i. Restorative physical therapy.
ii. Restorative occupational therapy.
iii. Speech therapy.
iv. Behavioral health services.
v. Registered dietitian services.

c. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

2. Requirements specified in Section B.1 of these SOPs may be suspended in the event of qualifying emergencies pursuant to the CBAS STCs for Emergency Remote Services (ERS). All requirements for CBAS ERS specified in the CBAS STCs and further defined in state-issued policy letters must be met to be eligible for reimbursement.

C. Legal Authority and Requirements

1. CBAS providers shall:
   a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s), except when CBAS ERS supports and services are delivered in accordance with these STCs and SOPs and all requirements specified in state-issued policy letters.
   b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; in Medi-Cal Provider Bulletins and CBAS All Center Letters, and as set forth in these SOPs.
   c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
   d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.

2. If there is a change in adopted laws or regulations governing the licensing of ADHC centers and/or the certification of CBAS providers, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

D. Physical Plant and Health and Safety Requirements

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
    a. Comply with state and local building requirements and codes.
    b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
    c. Have a working, listed telephone number.
    d. Have a working FAX number.
    e. Have a working email address.
    f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
    g. Have a working heating and cooling system.
    h. Have adequate lighting.
    i. Have appropriate water supply and plumbing.
2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
    a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
    b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
    c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
    d. Appropriate office area(s).
3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.
4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.
5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.
6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.
2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months, as specified in the STCs, and must continue to be supported by the participant's IPC. Reauthorization for CBAS ERS is required at least every three months, in accordance with the STCs and all requirements specified in state-issued policy letters.
3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.
2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.
3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.
4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.
5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.
6. Be approved by the participant or participant's authorized representative and documented in the signed CDA ADHC/CBAS Participation Agreement attesting to having participated in the center's care planning process to develop the IPC. Signing the CDA ADHC/CBAS Participation Agreement shall occur after the participant's assessment or reassessment process has been completed and the IPC has been developed, and prior to the delivery of CBAS services identified on the IPC.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA), including days of service provided under CBAS ERS, from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.
    a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.
2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.
    a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN, providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.
3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.
4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants.
    a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
    b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).
5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.
6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times.
    a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
    b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.
2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.
3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.
4. Financial and accounting records that fully disclose the disposition of all funds.
5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.
6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
    a. Discharge plan at time of disenrollment from the CBAS center:
        i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
    b. Incident reports:
        i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.
7. Written policies and procedures for center operations and the provision of services to CBAS participants.
8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
    a. Use of the local 911 system.
    b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
    c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.
9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.
10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).

11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).
12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs. Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.
    a. A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.
    b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).
13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
    a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).
    b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.
    c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

Attachment I
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol (Updated September 16, 2020)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by Federal law to be used for such purpose. The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers, payments made to contracted managed care plans, and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver, authorized under California's Section 1915(b) waiver, and California's Medicaid State Plan to eligible Medi-Cal beneficiaries. Services provided to beneficiaries residing in an IMD will be reported in the necessary 1115 line items within the CMS-64 report, separate and apart from all other services rendered to beneficiaries residing outside of an IMD.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers for substance use disorder services rendered. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

Each DMC ODS county that contracts with a managed care plan pays the managed care plan a county specific interim per utilizer per month (PUPM) rate for all substance use disorder services rendered by county and non-county providers to each user each month. Each county-specific PUPM rate is reviewed and approved by DHCS, and is subject to reconciliation as described below.

The county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for

inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

The county-specific interim PUPM rates are based on the following criteria.

- Total enrollment for each county multiplied by assumed prevalence rates and penetration rates by age group equals estimated utilizers for each county.
- Estimated utilizers multiplied by the percentage of utilizers in Marin County, Riverside County, and San Mateo County who used each mode of service.
- Estimated utilizers by mode of services multiplied by the average rate per mode of service paid in Marin County, Riverside County, and San Mateo County or the Fiscal Year 2015-16 county cost trended forward, if available, determined the total cost for each mode of service.
- Summed the total cost across all modes of service to determine the total cost for the estimated utilizers.
- Divided the total estimated cost by the total estimated utilizers to determine the service component of the interim PUPM rate.

As the State reviews proposed county interim rates and county interim PUPM rates, the additional information that is considered in the review includes data that illustrates the contract providers' or contract managed care plan's projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate or contract managed care interim PUPM rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process and request additional justification and/or correction to the projections. DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(9) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report. A county with an approved PUPM rate will not be required to submit a cost report for non-county-operated providers. The reconciliation of those payments will be subject to a reconciliation based on payments and actual encounters. A county with an approved PUPM rate will be required to submit a county provider cost report for county-operated providers, and payments for services rendered by county-operated providers will be reconciled to county-operated provider cost.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types. There is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS. For the purposes of determining DMC ODS county certified public expenditures for county-operated and contract providers under the 1115 waiver, each county as contractor with the State receives and aggregates the legal entity cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) legal entities (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

This attachment will remain operative until the effective date for the State's implementation of behavioral health payment reform no sooner than July 1, 2023, which will include a shift from the CPE-based framework to a prospective reimbursement rate methodology in DMC-ODS; DHCS will provide CMS with at least 30 days written notice prior to the effective date for behavioral health payment reform and the sunset of CPE-based payments for DMC-ODS, but the State will not be required to seek a formal demonstration amendment.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.
2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. "DHCS" means the California Department of Health Care Services.
4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. "DMC" means Drug Medi-Cal.
6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare

Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).

7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).
9. "IOT" means intensive outpatient treatment.
10. "Legal Entity" means each county alcohol and drug department or agency, each corporation and its subsidiaries, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.
11. "NTP" or "OTP" means narcotic treatment program treatment.
12. "ODF" means outpatient drug free treatment.
13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.
14. "Interim Per Utilizer Per Month(PUPM) Rate" means the approved county specific monthly interim rate paid per beneficiary who utilized at least one substance use disorder service for the month in which the service(s) is rendered.
15. "PH" means partial hospitalization.
16. "SUD" means substance use disorder.
17. "Total Utilizer Months" means the number of months during which all beneficiaries utilized at least one substance use disorder service.

SUMMARY OF STATE-DEVELOPED COST REPORT

Modifications to the Current CMS Approved SUD Cost Report Forms

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services. and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost

settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs must submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)

This worksheet collects legal entity details, including entity name, address, other contact information, and all related legal entity information under the same county contract. This worksheet is also where the legal entity representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)

This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)

This worksheet requires the legal entity to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the legal entity related to their SUD services and it must demonstrate the allocation methodologies used by the legal entity (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 - ODF: Tab I - PH: Tab 12 - IOT: Tab 16 - Residential: Tab 20 - NTPI

This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 - ODF: Tab 9 - PH: Tab 13 - IOT: Tab 17 - Residential: Tab 21 - NTP

This worksheet allows the legal entity to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 - ODF; Tab 10 - PH: Tab 14 - IOT: Tab 18 Residential: Tab 22 - NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The legal entity will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 - ODF: Tab 1l - PH: Tab 15 - IOT: Tab 19 Residential: Tab 23 - NTP)

This worksheet requires the legal entity to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

PUPM Reconciliation Report Description

The PUPM Reconciliation Report reconciles costs eligible for reimbursement with the total PUPM payments the county made to the Managed Care Plan (i.e., Certified Public Expenditures). For non-NTP services provided by non-county-operated providers, cost eligible for reimbursement are equal to the lower of the amount the managed care plan paid the contract provider or the prevailing charge for the same or similar service. For non-NTP services provided by county-operated providers, costs eligible for reimbursement are equal to county-operated provider's allowable cost. Reimbursement for non-NTP inpatient hospital services, provided either by non-county-operated providers or county-operated providers, will not exceed the provider's customary charge for the service. For NTP services provided by non-county operated providers, the cost eligible for reimbursement is equal to the lower of the USDR, or the provider's usual and customary charge for the same or similar services. For NTP services provided by county-operated providers, the cost eligible for reimbursement is equal to the lower of county-operated provider's allowable cost, the USDR, or the provider's usual and customary charge for the same or similar service. The following describes each tab in the PUPM Reconciliation Report and how it is used to calculate costs eligible for reimbursement and to compare those costs eligible for reimbursement to the county's certified public expenditures.

DMC ODS County Information Worksheet

This worksheet captures detailed contact information for the DMC ODS County and its contracted managed care plan. Contact information includes the county code; county name; managed care plan; and name, phone number, and e-mail address of the person the county wants the state to contact with questions about the PUPM Reconciliation Report.

Total Beneficiaries Served Worksheet

The DMC ODS County or contracted managed care plan must enter the total unduplicated beneficiaries served by month and aid code group based upon a report generated by DHCS. This worksheet calculates Total Utilizer Months.

Approved Units of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the total approved units of service rendered by non-county-operated providers for the reporting fiscal year

by aid code group, modality, and population (i.e., perinatal or non-perinatal) based upon a report generated by DHCS.

Cost Per Unit of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the cost of services for each DMC ODS covered service modality provided to Medi-Cal beneficiaries enrolled in the DMC ODS County for which the reconciliation report is submitted. This worksheet calculates the cost per unit of service for each service modality. This worksheet is also prepopulated with the prevailing charge for each service modality. The USDR is the prevailing charge for NTP services.

Third Party Revenue Worksheet

The managed care plan must enter any revenue it received from third parties for the units of service reported in the Approved Units of Service Worksheet.

Eligible Cost Worksheet

This worksheet calculates the managed care plan's eligible costs for each DMC ODS service modality. Eligible costs for each service modality is equal to the total units of service multiplied by the cost per unit of service minus third party revenue.

Eligible Prevailing Charges Worksheet

This worksheet calculates the total prevailing charges less third party revenue for each DMC ODS service modality. Eligible prevailing charges is equal to the total units of service multiplied by the prevailing charge per unit of service minus third party revenue.

Cost Allocation Worksheet

This worksheet calculates the proportion of eligible costs that are to be reimbursed by the federal government, state government, and county government by service modality.

Prevailing Charges For Non-County-Operated Providers Allocation Worksheet

This worksheet calculates the proportion of eligible prevailing charges that would be reimbursed by the federal government, state government, and county government by service modality.

UPL/Budget Neutrality Demonstration Worksheet

This worksheet compares the total actual cost to total prevailing charges by aid code group, selects the lower of total actual cost or prevailing charges, and calculates federal reimbursement based upon the lower of total actual cost or prevailing charges.

County Contracted MCP Reconciliation Worksheet

This worksheet reconciles contracted managed care plan's actual costs eligible for reimbursement with the County interim PUPM payments to the managed care plan. The County or the contracted managed care plan must enter actual costs eligible for reimbursement by aid code group for county-operated providers as determined in the cost report form described on page 5. The worksheet adds the actual costs eligible for reimbursement for non-county-operated providers to calculate the total costs eligible for reimbursement. The county must enter the total interim payments made to the managed care plan. The amount of total costs eligible for reimbursement

less County interim payments to the contracted managed care plan equals the amount due to or from the contracted managed care plan.

DHCS County Reconciliation Worksheet

This worksheet reconciles the DMC ODS County's final total payments to the contracted managed care plan for DMC ODS services with total interim payments made to the DMC ODS County for those services. The DMC ODS County received an overpayment when interim payments exceed the DMC ODS County's final total payments. DHCS will recoup any overpayments to the DMC ODS County and return the overpayment to the federal government. The DMC ODS County received an underpayment when its final total payments to the managed care plan exceed interim payments. DHCS will made addition interim payments to the DMC ODS County when there is an under payment. DHCS will not pay a DMC ODS county more than the amount it paid the managed care plan for DMC ODS services rendered.

County Certification

The County Auditor Controller must certify the final total payments to the managed care plan as reported in the Total Payments Worksheet.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates or county interim PUPM rate for the covered services. Annual county interim rates for each covered service will be developed by the county and approved by the State. Annual county interim PUPM rates for the covered services will also be approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51. All interim payments for services rendered by contract providers and county operated providers will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements. All interim payments for services rendered through contracts with a managed care plan will be subject to an annual reconciliation.

Proposed county interim rates must be developed for each required and (if indicated) optional service modality. The proposed county interim rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and cost settlement.

Proposed county interim PUPM rates must be developed for all required and optional service modalities. The proposed county interim PUPM rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation.

The proposed county interim rates and county interim PUPM rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be calculated for each service including both county directly

delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers and managed care plans are considered to be actual expenditures according to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.

For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

For a county that contracts with a managed care plan, the USDR rates for NTP services will serve as the upper payment limit for reconciliation purposes. The managed care plan will pay the provider the lower of the USDR or the provider's usual and customary charge for NTP services.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP. Interim payments for FFP for county contracts with county-specific rates by covered service will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Interim payments of FFP for services rendered through county contracts with managed care plans will be available through claim adjudication at the county Interim PUPM rate for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share

expenditure), and claims integrity requirements. Claims will be reimbursed at the interim PUPM rate developed by the county participating in the demonstration and approved by the State. All interim PUPM rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS – COUNTY SPECIFIC RATES

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS noninstitutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such

as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

INTERIM RECONCILIATION OF INTERIM PUPM PAYMENTS

DHCS will complete the interim reconciliation and settlement of DMC ODS counties' interim PUPM payments to managed care plans with which they contract no later than twelve months after the close of the State fiscal year. Each DMC ODS county that contracts with a managed care plan must submit a PUPM Reconciliation Report to DHCS by November 1st following the close of the fiscal year. DHCS staff will review the PUPM Reconciliation Report to validate the total beneficiaries served, total approved units of service, and rate per service modality. If the Interim Reconciliation Worksheet shows that the DMC ODS County made additional payments to the managed care plan, DHCS will make an additional payment of FFP to the DMC ODS County. If the Interim Reconciliation Worksheet shows that the DMC ODS County recouped a portion of the Interim PUPM payments already paid to the managed care plan, DHCS will recoup those funds from the DMC ODS County and return them to the federal government. Participating counties and their contracted managed care plan must maintain fiscal and statistical records for the period covered by PUPM Reconciliation report that are accurate and sufficiently detailed to substantiate the PUPM reconciliation data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.

All records of funds expended and services rendered are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final reconciliation and settlement of the cost report or PUPM reconciliation within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report or reconciliation are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State

determines that the county received an underpayment, the State makes an additional payment to the county.

COVID-19 PUBLIC HEALTH EMERGENCY

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for non-NTP services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- Each DMC ODS county may pay contracted providers at up to 100 percent above the approved county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed in this Attachment.
- For purposes of interim Medicaid payments, claims will be reimbursed at the lower of the county's billed amount or the approved annual interim rates for each covered service increased by 100 percent.
- For purposes of interim and final reconciliation, DHCS will settle interim payments for outpatient services to actual allowable cost. The limitation of customary charges is suspended.
- For inpatient hospital-based residential and withdrawal management services (including ASAM levels 3.7 and 4), DHCS will continue to settle interim payments to the lower of actual allowable cost or usual and customary charges.

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.

Attachment J
SUD Monitoring Protocol
(Reserved)

Attachment K
Global Payment Program Funding and Mechanics

A. Public Health Care Systems (PHCS)

GPP Payments are available for PHCS, which are comprised of a designated public hospital and its affiliated and contracted providers. Each PHCS participating in the GPP is listed in Attachment CC. Where multiple designated public hospitals are operated by the same legal entity, the PHCS includes multiple designated public hospitals, as set forth in Attachment C. The GPP provides support for the delivery of more cost-effective and higher value care for indigent, uninsured individuals. PHCS will provide an assurance that, to the extent the GPP exceeds the amount that is attributable to the state's Adjusted DSH (determined pursuant to STC 13.10), a percentage of GPP points earned by each PHCS will be associated with care and activities that are furnished through charity care and discount payment policies for financially qualified, uninsured individuals that adhere to California state law ability-to-pay requirements. The required percentage is equal to the amount of the GPP that is in excess of the Adjusted DSH divided by the total GPP for the year. For the first year of the GPP, each PHCS is required in the aggregate to satisfy the above assurance for at least 21.4% of GPP points earned.
Each PHCS shall identify to DHCS the affiliated and contracted providers that will constitute the PHCS, and shall notify DHCS of changes.

B. Determination of GPP Annual Limits

For each GPP PY, DHCS shall work with CMS to determine the annual limit for the GPP consistent with STC 13.10. The annual limit shall be calculated as the sum of the Adjusted DSH allotment and the Uncompensated Care Component for PY 1-7. F. The Adjusted DSH allotment shall be determined consistent with the provisions of Attachment Q (DSH Coordination Methodology).

C. Establishment of Participating PHCS global budgets

DHCS will determine for each PHCS a global budget for each GPP PY, which is the total amount of funding each PHCS will earn if it meets or exceeds its applicable threshold. Threshold amounts for each PHCS for GPP PY1 are set forth in Attachment L, section B. Threshold amounts for subsequent GPP PYs will be calculated through adjustments in proportion to changes in the size of the aggregate GPP annual limits, except where otherwise allowed during a public health emergency or other state of emergency, as set forth in Attachment L, section B.

To determine a PHCS' global budget for a GPP year, DHCS shall calculate the PHCS' allocation percentage, which is the PHCS's point threshold for a GPP PY divided by the sum of all PHCS point thresholds for the same GPP PY. The PHCS's global budget shall equal the allocation percentage multiplied by the total computable annual limit for the GPP, as set forth in 170 of the Special Terms and Conditions ("Funding and Annual Limits").
DHCS shall determine an initial total computable annual limit for a GPP PY based on the initial CA DSH allotment published by CMS for the applicable GPP PY and any uncompensated care funding allocated under the Medi-Cal 2020 Waiver. DHCS shall determine initial threshold amounts and annual budgets for each PHCS based on this information and publish the

information on its GPP webpage within 10 days of the determination. DHCS shall determine the final total computable annual limit for a GPP PY once the final CA DSH allotment is published by CMS and shall publish the final amounts, and associated PHCS threshold amounts and annual budgets within 10 days of such determination.

D. Reporting Requirements

By August 15th following each GPP PY, or with respect to GPP PY6 and 7, by February 15th following the GPP PY, each PHCS shall submit an interim year-end summary report summarizing the aggregate number of uninsured units of service provided during the GPP PY, broken out by the service categories, tiers, and types as defined in Attachment L (Valuation Protocol). The summary report will also compute the number of points earned based on the corresponding point valuations for the services provided, and the payments due to the PHCS (net of any payments previously received for the GPP PY). Data contained in the interim year-end summary report will be based on the best data available through the close of the GPP PY. Revisions to the interim data will be reflected in the final reconciliation report.

By March 31st following the close of each GPP PY, or with respect to GPP PY 6 and 7, by September 30th following the GPP PY each PHCS shall submit a final year-end reconciliation summary report in the same format as the interim year-end summary report referenced above that includes the PHCS final submission with regard to the services, points, and funds earned for the GPP PY. The final reconciliation summary report shall reflect any necessary revisions to the interim data and shall serve as the basis for the final reconciliation of GPP payments for the GPP PY.

Starting with GPP PY 2, each PHCS shall submit encounter-level data on their uninsured services in order to provide auditable verification that the reported uninsured services were provided. For this purpose, encounter-level data may include line-level encounters or documentation of claims or other reliable methods for determining the number of contracted units of service to the uninsured by contracted providers. Such reporting shall be provided at the time of the final reconciliation summary reports. All reports shall be submitted in a manner and format as set forth by DHCS. In addition, for all GPP PYs, PHCS shall maintain documentation of services and shall make such information available to DHCS or CMS upon request.

DHCS shall review all summary reports and data submitted for accuracy and compliance with established procedures, and perform tests for reasonableness. If discrepancies or inconsistencies are identified, DHCS shall work directly with PHCS staff to promptly resolve issues and correct data and reporting. PHCS shall provide a formal response to DHCS inquiries within five (5) business days of receipt of an inquiry or question; additional time to respond may be requested by the PHCS and approved by DHCS.

The interim year-end summary report and the final year-end reconciliation summary report shall be due at the times specified in Table 1 below. If the identified date falls on a weekend or holiday, the report shall be due at the close of the following business day.

Table 1: Reporting timeline

Report name	**Reporting period**	**Report due date to DHCS**	**Reporting Period**	**Report Due Date to DCHS**	**Reporting Period**	**Report Due Date to DHCS**
Interim year-end summary report	July 1 – June 30	August 15 (following program year)	GPP PY 6A July 1 – December 31	February 15 (following program year)	GPP PY 7 January 1- December 31	February 15 (following program year)
Final year-end reconcil	July 1 – June 30	March 31 (following program year)	GPP PY 6A July 1 – December 31	September 30 (following program year)	GPP PY 7 January 1 – December 31	September 30 (following program year)

E. Payment schedule.

Interim Payments

PHCS shall receive interim quarterly GPP payments based on 25% of their annual global budget for the first three quarters of the GPP PY. DHCS will notify PHCS of the IGT due dates and payment dates according to Table 2. For GPP PY 6, PHCS shall receive only two quarterly payments, each based on 50% of their annual budget. DHCS will notify PHCS of the IGT due dates and payment dates according to Table 2A. Payments will be made within 15 days after the quarter end as long as IGTs are submitted by the IGT due date as identified in Table 2. For a PHCS that is comprised of more than one DPH, payments will be made to the health system under which the DPHs operate.

For the fourth quarter of each GPP PY, an interim payment shall be made to each PHCS that is sufficient to bring the PHCS' interim payments for the GPP PY to the amount earned by the PHCS based on its interim year-end summary report. The total Interim payments earned by a PHCS shall be determined by multiplying the PHCS's annual global budget by the ratio of the value of the points earned during the GPP PY to the PHCS's threshold, as reported in the interim year-end summary report; however, no PHCS may earn more than its annual global budget prorated by the number of months in the reporting period. The fourth quarter interim payment shall be calculated based on the amount earned by the PHCS for the GPP PY, net of any GPP payments previously received by the PHCS for the GPP PY. If the PHCS' interim year-end summary report reflects an annual payment that is less than 75% of its total annual budget, no additional interim payment shall be made for the fourth quarter. DHCS shall calculate the amount of the required IGTs for the fourth quarter and make GPP IGT notifications to all PHCS no later than 30 calendar days after submission of the interim year-end summary report, as shown in Table 2. PHCS shall submit IGTs within 7 days of receiving notification. Interim payments will be made to all PHCS no later than one month following their respective IGT notification date, if IGTs are received within the required 7 days.

Final Reconciliation and Redistribution Process

There will be a final reconciliation annually following the submission of each PHCS' final reconciliation summary report and (beginning with GPP PY 2) the required supporting encounter data. DHCS shall determine the amount earned by each PHCS based on the total number of points earned by each PHCS for the GPP PY, as reported in the final year-end reconciliation summary reports. For PHCS that exceeded their threshold for the GPP PY, the amount earned is subject to adjustment in accordance with the following redistribution process set forth below.

DHCS will identify any GPP global budget amounts that PHCS were individually unable to claim and redistribute such unclaimed amounts to the PHCS that exceeded their point thresholds for the applicable GPP PY. To determine redistribution amounts, DHCS shall first calculate a dollar amount of funding per GPP point by dividing the total GPP annual limit for the GPP PY by the aggregate threshold points for all PHCS. DHCS will then multiply this dollar amount by the amount by which each PHCS has exceeded its threshold to determine the PHCS's maximum redistribution amount. Each PHCS that has exceeded its threshold will receive its maximum redistribution amount if there are sufficient unused funds for the year from other PHCS. If there are insufficient unused funds to pay all PHCS that exceeded their thresholds their maximum redistribution amount, then each PHCS will receive an adjusted redistribution amount, prorating the amount of unused funds available by the number of points each PHCS is above its applicable threshold. The redistributed amounts following this determination shall be added to the GPP amounts earned by the applicable PHCS for the purposes of the final reconciliation.

Based on the final reconciliation amounts determined as set forth above, DHCS shall adjust, as necessary, the interim payments previously made to the PHCS for the GPP PY. Within 90 calendar days of receiving the final reconciliation summary reports from the PHCS DHCS shall calculate the amount of the required IGTs for the reconciliation and make GPP IGT notifications to all PHCS, as shown in Table 2.

PHCS shall submit IGTs within 14 days of receiving notification. Final payments will be made to all PHCS no later than 45 days following their respective IGT notification date, if PHCS have submitted the IGTs within the 14-day requirement. If the necessary IGTs are submitted past the 14-day requirement, final payments, as well as any other associated payments, will be made no later than 45 days following submission of the necessary IGT amounts. If, at the end of the reconciliation process, it is determined that the interim GPP funds for a GPP PY exceeded the amounts due upon final reconciliation, DHCS shall recoup the amounts from the appropriate PHCS. In the event of any recoupments, DHCS shall return the

associated IGT funds to the transferring entity within 14 calendar days.

Payment Summary Report to CMS

For each GPP PY, DHCS will submit a Payment Summary Report to CMS (following the schedule in Table 2) that summarizes all GPP transactions to date which pertain to that GPP PY and includes a list of entities that have provided IGTs

during the report period and the amount of the IGTs provided.
Transactions include interim payments, final payments, and recoupments. Each transaction record will include the name of the PHCS to which the transaction pertains, whether the transaction is an interim, reconciliation, or redistribution payment, the interim year-end Summary Report or Final Reconciliation Summary Report that supports the transaction, and the Quarterly Expenditure Report on which the transaction was or will be reported. The Payment Summary Report following the Final Reconciliation Summary Report will show how the sum of all transactions for each PHCS matches the PHCS final reconciliation amount.

Table 2: Interim and Final Payment timeline, GPP PY 1-5

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	25% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	25% of Annual	December 15	December 22	January 15	February 15
Interim Quarter 3	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 4	Final Interim based on interim year-end summary report	September 15 following the GPP PY end	September 22 following the GPP PY end	October 15 following GPP PY end	November 15 following GPP PY end
Final Reconciliation	Final reconciled amount	June 30 following the GPP PY	July 14 after notification date	August 15 after notification	September 15 after notification date

Table 2A: Interim and Final Payment timeline, GPP PY 6

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	50% of Annual	September 15	September 22	October 15	November 15
Interim Quarter 2	50% of Annual	December 15	December 22	January 15	February 15

Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Table 2B: Interim and Final Payment timeline, GPP PY 7-12

Payment	**Payment Amount**	**Payment Amount & IGT Notification Date**	**IGT Due Date**	**Payment Date**	**Payment Summary Report to CMS**
Interim Quarter 1	25% of Annual	March 15	March 22	April 15	May 15
Interim Quarter 2	25% of Annual	June 15	June 22	July 15	August 15
Interim Quarter 3	25% of Annual	September 15	September 22	October 15	November
Interim Quarter 4	Final Interim based on interim year-end summary report	March 15 following the GPP PY end	March 22 following the GPP PY end	April 15 following GPP PY end	May 15 following GPP PY end
Final Reconciliation	Final reconciled amount	December 31 following the GPP PY end	January 14 after notification date	February 15 after notification date	March 15 after notification date

Attachment K
Global Payment Program Valuation

A. Valuation of Services

Each eligible uninsured service a PHCS provides will earn the PHCS a number of points based on this protocol. Each service has an identical point value for every PHCS, but the assigned point values per service shall vary by GPP Program Year (GPP PY) as described in detail below.

1. Categories and tiers of service

Services associated with points in the GPP are shown in Table 1 below, grouped into both categories (1-4) and tiers within categories (A-D). These groupings can contain both traditional and non-traditional services. The groupings were intended to better display the full range of services that may be provided to the uninsured under the GPP, to help develop initial point values for non-traditional services (for which cost data is not available), and to clarify which service types it made sense to revalue up or down for GPP purposes over time.
Categories 1 through 4 are groupings of health care services that are organized according to their similar characteristics. For example, Category 1 contains outpatient services in traditional settings, mostly "traditional" services provided by licensed practitioners. Category 2 is made up of a range of outpatient services provided by non-provider care team members, both inside and outside of the clinic, including health education, health coaching, group and mobile visits, etc. Category 3 services are technologically- mediated services such as real-time video consultations or e-Consults between providers. Category 4 services are those involving facility stays, including inpatient and residential services.
Grouping of services into tiers was based on factors including training/certification of the individual providing the service, time or other resources spent providing the service, and modality of service (in- person, electronic, etc.). Generally speaking, within each category, tier D is the most intensive and/or costly, and often requires individuals with the most advanced training or certifications, resulting in higher initial point values on average, whereas tier A is on the other end of the spectrum in intensity and resource use. However, there can still be significant point value variation within tiers, based on cost, resource utilization, or other relevant factors.
The services whose values would decline over time under the GPP (as described in section 4 below) are most service types in categories 1C (emergent outpatient) and 4B (inpatient medical/surgical and mental health), which are higher-cost and judged as the most likely to be reducible through efforts at coordination, earlier intervention, and increased access to appropriate care.

Table 1: GPP Service Types by Category and Tier, with Point Values

Category and description	Tier	Tier description	Service type	Traditional / non-traditional	Initial point value
1: Outpatient in traditional settings	A	Care by Other Licensed or Certified Practitioners	RN-only visit	NT	50
			PharmD visit	NT	75
			Complex care manager	NT	75
	B	Primary, specialty, and other non-emergent care (physicians or other licensed independent practitioners)	Primary/specialty **(benchmark)**	T	100
			Contracted primary/specialty (contracted provider)	T	19
			Mental health outpatient	T	38
			Substance use outpatient	T	11
			Substance use: methadone	T	2
			Dental	T	62
	C	Emergent care	OP ER	T	160
			Contracted ER (contracted provider)	T	70
			Mental health ER / crisis stabilization	T	250
	D	High-intensity outpatient services	OP surgery	T	776
2: Complementary patient support and care services	A	Preventive health, education and patient support services	Wellness	NT	15
			Patient support group	NT	15
			Community health worker	NT	15
			Health coach	NT	15
			Panel management	NT	15
			Health education	NT	25
			Nutrition education	NT	25
			Case management	NT	25
			Oral hygiene	NT	30
	B	Chronic and integrative care services	Group medical visit	NT	50
			Integrative therapy	NT	50
			Palliative care	NT	50
			Pain management	NT	50
	C	Community-based face-to-face encounters	Home nursing visit	NT	75
			Paramedic treat and release	NT	75
			Mobile clinic visit	NT	90
			Physician home visit	NT	125
3: Technology-based outpatient	A	Non-provider care team telehealth	Texting	NT	1
			Video-observed therapy	NT	10
			Nurse advice line	NT	10
			RN e-Visit	NT	10
	B	eVisits	Email consultation with PCP	NT	30
	C		Telehealth (patient - provider) - Store & Forward	NT	50

		Store and forward telehealth	Telehealth (provider - provider) – eConsult / eReferral	NT	50
			Telehealth – Other Store & Forward	NT	65
	D	Real-time telehealth	Telephone consultation with PCP	NT	75
			Telehealth (patient - provider) - real time	NT	90
			Telehealth (provider - provider) - real time	NT	90
4: Inpatient	A	Residential, SNF, and other recuperative services, low intensity	Mental health / substance use residential	T	23
			Sobering center	NT	50
			Recuperative / respite care	NT	85
			SNF	T	141
	B	Acute inpatient, moderate intensity	Medical/surgical	T	634
			Mental health	T	341
	C	Acute inpatient, high intensity	ICU/CCU	T	964
	D	Acute inpatient, critical community services	Trauma	T	863
			Transplant/burn	T	1,131

2. Valuation of traditional services

Services for which payment typically is made available upon provision of the service, referred to herein as "traditional" services, will receive initial point valuations based on their cost per unit of service in the historical year SFY2013-14. These traditional services are grouped into categories that reflect generally where care is being provided and intensity. Gross costs incurred for services provided to the uninsured by PHCS in SFY 2013-14, as determined under the applicable claiming methodologies, are summed across all PHCS by service type, using the most complete and reliable data when available, to obtain an average cost per unit for each traditional service. All traditional services are assigned point values based on their relative cost compared to an outpatient primary and specialty visit, which serves as the benchmark traditional service. These initial points are shown in table 1; the relative costs per unit of service are shown in Appendix 1.

3. Valuation, non-traditional services

Non-traditional services typically are not directly or separately reimbursed by Medicaid or other payors, and are often provided as substitutes for or complementary to traditional services. These services are assigned initial point values based on their estimated relative cost compared to the benchmark traditional service, and their value in enhancing the efficiency and effectiveness of traditional services.

The non-traditional services in the table 1 provide value to the delivery of health care to the uninsured population by enhancing the efficiency and effectiveness of traditional services, by improving uninsured individuals' access to the right care, at the right time, in the right place. For example, instead of needing to go to the emergency department, an uninsured individual could have telephone access to his or her care team, which would both help address and treat the presenting condition, as well as help connect the patient back to the entire breadth of primary care services. Likewise, a PHCS deploying eReferral/eConsult services would be able to better prioritize which uninsured individuals need early access to face-to-face specialty care expertise, or which can benefit from receipt of specialty care expertise via electronic collaboration between their PCP and a specialist. This collaboration enhances the PCPs' capacity to provide high-quality, patient-centered care, and allows the individual receiving that care to avoid specialty care wait times and the challenges of travelling to an additional appointment to a specialist who may be located far from where they live. This increased ability to provide timely access to specialty expertise will result in earlier treatment of complex conditions and help uninsured individuals avoid the need to seek emergent or acute care for untreated or partially treated sub-acute and chronic conditions. More detail on non-traditional services, including codes where available and descriptions, is in Appendix 2.

Individuals will be considered uninsured with respect to a non-traditional service if he or she has no source of third party coverage for a comparable traditional service. For example, an individual with coverage for outpatient visits would not be considered uninsured with regard to technology-based outpatient services, even if his or her insurance does not cover those services. DHCS shall, in consultation with the DPH systems, issue guidance letters addressing whether individuals shall be considered uninsured in specific factual circumstances, to ensure that the requirements are consistently applied.

4. Point revaluation over time

Point values for services will be modified over the course of the GPP, from being linked primarily to cost to being linked to both cost and value. The provision of general medical/surgical acute inpatient services and emergent services will receive fewer points over time. The changing point structure will be designed to incentivize PHCS to provide care in the most appropriate and cost-effective setting feasible.

Point revaluation will be calibrated so that the overall impact would not lead to any PHCS receiving additional total points in any given GPP PY if utilization and the mix of services provided remained constant. Specifically, for any PHCS, if its utilization and mix of services does not change from the baseline year of SFY 2014-15, it will not earn any more points in GPP PY 1 than it earned under the baseline year, and in subsequent GPP PYs shall earn fewer points.

As points for certain services are revalued over the course of the GPP, PHCS will be incentivized to provide more of certain valued services and less of certain more costly and avoidable services. This revaluation will be phased in over time to enable PHCS to adapt to the change in incentives. In GPP PY 1, points will be identical to the initial cost-based point values. In GPP PY 2, 20% of the full change will be made to point values. In GPP PY 3, an additional 30% of the revaluation will be phased in, with the final 50% change occurring in GPP PY 4, except that in GPP PY 6A, an

additional point value change will be made at the same average annual pace of changes from PY1 to PY5. This phase-in is illustrated in Table 2.
Point values will not vary from their initial cost-based amounts by more than 40% at any time during the GPP.

Table 2: Revaluations to categories of service, by year, compared to initial point value

Category of service	Initial point value	Point value (% change), GPP PY 1	Point value (% change),	Point value (% change),	Point value (% change),	Point value (% change),	Point value (% change),	Point value (% change),
OP ER	160	160 (0%)	158 (-1%)	156 (-2.5%)	152 (-5%)	152 (-5%)	151 (-5.5%)	151 (-5.5%)
Mental health ER / crisis	250	250 (0%)	248 (-1%)	244 (-2.5%)	238 (-5%)	238 (-5%)	236 (-5.5%)	236 (-5.5%)
IP med/surg	634	634 (0%)	630 (-0.6%)	624 (-1.5%)	615 (-3%)	615 (-3%)	613 (-3.3%)	613 (-3.3%)
IP mental	341	341 (0%)	339 (-0.6%)	336 (-1.5%)	331 (-3%)	331 (-3%)	329 (-3.3%)	329 (-3.3%)

Values for categories not listed are unchanged. Contracted IP and ER values are changed identically with other IP/ER.

B. PHCS-Specific Point Thresholds

DHCS established GPP PY 1-point thresholds for each PHCS by collecting utilization data for all traditional uninsured services (by each traditional table 1 category) provided in SFY 2014-15, and then multiplying those service counts by corresponding initial point values. The thresholds for PY1 are shown in Table 3.
For GPP PY 2 and onward, each threshold shall be adjusted proportionally to the total GPP funds available for that PY under STC 13.10, compared to the total GPP funds available in GPP PY 1, e.g. if total GPP funding in PY 2 is 5% less than PY 1 each PHCS threshold will be reduced by 5%.

During a period of public health emergency or other state of emergency only, thresholds may be further adjusted without modifying the applicable total GPP payments available for achieving such thresholds by a determined percentage based upon estimated impact to utilization rates. All threshold adjustment methodologies shall be approved by CMS. In response to the COVID-19 public health emergency GPP PY 5 PHCS thresholds will be reduced by 10%. PHCS threshold adjustment for GPP PY 6A will be proposed once the extent of the impact to the delivery of GPP services due to the public health emergency is determined.

Table 3: GPP PY 1 PHCS Thresholds, Based on FY2014-15 Uninsured Services

Public Health Care System	**System Threshold, GPP PY1**
Los Angeles County Health System	101,573,445
Alameda Health System	19,151,753
Arrowhead Regional Medical Center	7,525,819
Contra Costa Regional Medical Center	5,674,651
Kern Medical Center	3,633,669
Natividad Medical Center	2,959,964
Riverside University Health System – Medical Center	8,066,127

San Francisco General Hospital	12,902,913
San Joaquin General Hospital	3,021,562
San Mateo County General Hospital	8,733,292
Santa Clara Valley Medical Center	19,465,293
Ventura County Medical Center	9,213,731

Appendix 1
Table 4: Categories of Service and Point Values, Traditional

Category	Tier	Service Name	Cost/unit	Initial point
1: Outpatient	B	OP Primary / Specialty (**benchmark, 100)**	587	**100**
	B	Dental	365	**62**
	B	MH Outpatient	225	**38**
	B	SU Outpatient	62	**11**
	B	SU Methadone	11	**2**
	B	Contracted Prim/Spec	110	**19**
	C	OP ER	942	**160**
	C	Contracted ER	411	**70**
	C	MH ER/Crisis Stabilization	1,470	**250**
	D	OP Surgery	4,554	**776**
4: Inpatient	A	SNF	829	**141**
	A	MH/SU Residential	138	**23**
	B	Med/surg	3,721	**634**
	B	MH Inpatient	2,000	**341**
	C	ICU/CCU	5,663	**964**
	D	Trauma	5,069	**863**
	D	Transplant/Burn	6,644	**1,13**

Table 5: Categories of Service and Point Values, Non-Traditional

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
Service Category 1: Outpatient				
A	RN Visit[84][85] (includes Wound Assessment visits)	**99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.		50
A	PharmD Visit[86]	**99605, 99606, 99607** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment, and intervention if provided;		75
A	Complex Care Manager[87]	**99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored.		75
Service Category 2: Complementary Patient Support and Care Services				
A	Wellness[88,89]	G0438 Annual wellness visit; includes a personalized prevention plan of service (PPPS),		15

[84] CMS Source: https://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215, Accessed 11/14/2015 [85] Understanding When to Use 99211, Family Practice Management, http://www.aafp.org/fpm/2004/0600/p32.html, Accessed 11/10/2015

[86] Pharmacist Services Technical Advisory Coalition, http://www.pstac.org/services/mtms-codes.html, accessed 11/15/2015

[87] CMS Medicare Learning Network, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf, Accessed 11/15/2015

[88] https://www.careimprovementplus.com/pdf/PROVIDER_COMMUNICATION_WELLNESS_AND_PHYSICAL_EXAMINA TION_CODES.pdf

[89] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		initial visit G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit **S5190** Wellness assessment, performed by non-physician **Z00.00, Z00.01x`**		
A	Patient Support Group	**Non-physician Health Care Professional CPT Code** **98961** Education And Training For Patient Self-Management By A Qualified, Nonphysician Health Care Professional Using A Standardized Curriculum, Face-To-Face With The Patient (Could Include Caregiver/ Family) 2-4 Patients **98962** Education And Training as above; 5-8 Patients		15
A	Community Health Worker (CHW)		Encounters in which a Community Health Worker assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs[90]	15
A	Health Education		Services provided for the purpose of promoting health and preventing illness or injury. These include risk factor reduction interventions, preventive medicine counseling and behavior change	25
A	Nutrition	**97802** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient **97803** Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient		25

[90] Bureau of Labor and Statistics, Standard Occupational Classification: 21-1094 Community Health Workers. http://www.bls.gov/soc/2010/soc211094.htm, Accessed 11/24/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	Education[91,92]			
A	Case management		Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[93] **Case manager is assigned** to the patient and engages in direct care **OR** coordination of care **OR** manages patient's access to care **OR** initiates and/or supervises other health care services needed by the patient[94]	25
A	Health coach		Health and behavior intervention performed by non-provider member of the health care team to build the knowledge, skills, and confidence required to manage their chronic conditions and improve their health. Includes motivational interviewing, self-management goal setting, patient education and activation and chronic disease support[95]	15
A	Panel management		Document in patient's medical record when staff proactively reach out to a patient and speak with them regarding preventive services, chronic illness management, their care plan, problem list, health goals, and/or treatment	15

[91] National Coverage Determination (NCD) for Medical Nutrition Therapy (180.1), https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=252&ncdver=1&NCAId=53&NcaName=Medical+Nutrition+Therapy+Benefit+for+Diabetes+%2526+ESRD&IsPopup=y&bc=AAAAAAAAIAAA&, Accessed 11/24/2015
[92] CMS, DHHS: Medical Nutrition Therapy (MNT) Services for Beneficiaries With Diabetes or Renal Disease - POLICY CHANGE, November 1, 2002. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A02115.pdf, Accessed 11/10/2015
[93] Case Management Society of America, http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx, Accessed 11/15/2015 [94] Oregon APM Patient Touches, direct communication with Oregon Health Authority
[95] Per 11/30/2015 communication with Dr. Nwando J. Olayiwola, Associate Professor, Department of Family and Community Medicine, and Director of the Center for Excellence in Primary Care (CEPC), University of California San Francisco. CEPC is a recognized national leader in Health Coach training.

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			options[96]	
A	Oral Hygiene Encounters		Adult and Pediatric oral health services including dental varnishing, oral health education and other prevention services provided by dental hygienists	30
B	Group medical visits	**99411-99412** Preventive medicine counseling and/or risk factor reduction provided to individuals in a group setting **99078** Physician educational services rendered to patients in a group setting (eg, obesity or diabetic instructions)		50
B	Integrative medical therapies	**97810-97811:** Acupuncture, one or more needles, without electrical stimulation, personal one-on-one contact with the patient		50
B	Palliative Care	**0690-0699 Pre-hospice/Palliative Care Services**: Services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education, and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists. Unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.	Encounters with non-provider care team members that focus on preventing and relieving suffering, and improving the quality of life of patients and their families facing serious illness. Palliative care is provided by an interdisciplinary team which works with primary and specialty care providers to identify and treat pain and other distressing symptoms, provide psychosocial and spiritual support, and assist in complex decision-making and advance care planning.	50
B	Pain management		Encounter provided by a non-provider caregiver or care team focused on enhancing self-management of chronic pain, implementing behavioral strategies for managing pain, discussing medication effectiveness and side effects, assessing treatment effectiveness, and adjusting treatment plan and goals. Chronic pain visits may also include assessment for signs of substance use or mental health disorder as well as motivational interviewing or other treatment strategies for these disorders	50
C	Physician Home	**99341 - 99347** Home visit, new patient; **99347 - 99350** Home visit, established patient		125

[96] Oregon APM Patient Touches

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	Visits[97]			
C	Home nursing visits	**G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)	Visits by RNs to patients at home for acute or chronic disease management. May include history taking, physical exam, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level, or medications.	75
C	Mobile Clinic Visits	**CPT Physician Code** **99050** Service(s) provided in office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service **99051** Service(s) provided in the office during regularly scheduled evening, weekend or holiday hours, in addition to basic service **99056** Services typically provided in the office, provided out of the office at request of patient, in addition to basic service Use POS code 15 with the above codes to signify a services provided in a mobile setting[98]		90
C	Paramedic treat and release		Paramedic assessment, treatment if appropriate, and discharge of a patient without ambulance transport[99]	75
Service Category 3: Technology-Based Outpatient[100]				
A	Texting		Texting services provided by the care team to an established patient, parent, or guardian to support care management. Cannot focus on administrative tasks such as scheduling appointments. Must not originate from a related assessment and management service provided	1

[97] CMS Billing and Coding Guidelines - L31613 PHYS-081 - Home and Domiciliary Visits: https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31613_1/L31613_PHYS081_CBG_050111.pdf, Accessed 11/10/2015

[98] https://www.supercoder.com/my-ask-an-expert/topic/mobile-clinic

[99] Millin, M. et al. EMS provider determinations of necessity for transport and reimbursement for ems response, medical care, and transport: Combined resource document for the national association of EMS physicians position statements, http://www.naemsp.org/Documents/Position%20Papers/POSITION%20Determinationoftransport-Resource%20Doc-PEC_2011.pdf, Accessed 11/24/2015

[100] General resource for this section is the American Telemedicine Association Letter to CMS on Telehealth Services, December 31, 2013. http://www.americantelemed.org/docs/default-source/policy/medicare-code-request-for-2015.pdf?sfvrsn=4, Accessed 10/28/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
			within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment	
A	Video Observed Therapy		Observation of patients taking their tuberculosis medication in their homes. Observation is done using a live video telephone on both the patient and provider ends[101]	10
A	Nurse advice line[102,103]	**98966, 98967, 98968** Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment		10
A	RN e-Visit[104]	**98969** Online evaluation and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network		10
B	Email consultation with PCP[105]	**99444** Online evaluation and management service provided by a physician or other qualified health care professional who may		30

[101] California Department of Public Health Tuberculosis Control Branch - Guidance for Developing a Video Observed Therapy (VOT) - Policy and Procedures. https://www.cdph.ca.gov/programs/tb/Documents/TBCB-SPM-Cert- Guidance-VOT-Policy-And-Procedures.doc, Accessed 11/24/15
[102] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015
[103] American Academy of Pediatrics, Charging for Nurse Telephone Triage. https://www.aap.org/en-us/professional-resources/practice-support/Telephone-Care/pages/Charging-for-Nurse-Telephone-Triage.aspx, Accessed 10/20/2015
[104] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015
[105] *Ibid*

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
		report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network		
C	Telehealth (patient - provider) - Store & Forward[106,107]	Digital Retinal Screening **92250** (global) Fundus photography with interpretation and report		50
C	Telehealth – Store & Forward	+GQ modifier for distant site: **99241-99243** Office consultation, new or established patient **99251-99253** Initial inpatient consultation **99211-99214** Office or other outpatient visit **99231-99233** Subsequent hospital care OR **99446-99449**: Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations	Store and Forward services that include images, such as Teleophthalmology and Teledermatology	65
C	Telehealth (provider - provider) – eConsult/ eReferral[108]	**99446-99449**, the new "Non-Face-To-Face Services: Interprofessional Telephone/Internet Consultations OR **99241-5** with GT modifier for distant site		50
D	Telephone consultation with PCP[109]	**CPT Physician Code** **99441** through 99443. Telephone E&M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	ALTERNATIVE DESCRIPTION: PCP speaks via telephone with patient about medical/dental/MH/substance use condition or medications AND discusses or creates care plan OR discusses treatment options	75
D	Telehealth (patient -	**99201-99215** with modifier **GT**		90

[106] July 2015, Medi-Cal Ophthalmology Update. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ophthal_m01o03.doc, Accessed 10/15/2015

[107] communication with Jorge Cuadros, OD, PhD, Director of Clinical Informatics Research, UC Berkeley School of Optometry, CEO of EyePacs

[108] RTR- ECONSULT CPT CODES, UC Davis. https://static1.squarespace.com/static/52d9c6c5e4b021f2d93416db/t/534c2d9fe4b0d8fffdf288f5/1397501343957/CPT+Codes.pdf, plus communication 10/27/2015 with Timi Leslie, BluePath Health and Rachel Wick, Blue Shield of CA Foundation in reference to BSCF eConsult grant program.

[109] CMS, DHHS: Summary of Policies in the 2008 Medicare Physician Fee Schedule and the Telehealth Originating Site Facility Fee Payment Amount, February 1, 2008. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1423CP.pdf, Accessed 10/20/2015

Tier	Service	Relevant codes and description if available (CPT, ICD)	Definition [source] Where no nationally recognized code exists	Relative Points
	provider) - real time[110,111]	"Office or other outpatient visits" Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems"		
D	Telehealth (provider - provider) - real time[112]		Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems	90
Service Category 4: Inpatient				
A	Sobering Center[113]		Nurse assessment and monitoring, to determine and ensure safety for individuals found intoxicated in public[114]	50
A	Recuperative/Respite Care[115]		Provision of acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. Services may include recuperative care, completion of therapy (e.g, antibiotics, wound care), temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults[116]	85

[110]CMS Medicare Learning Network: Telehealth Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf, Accessed 10/28/2015

[111] Medi-Cal Provider Manual: Telehealth, December 2013. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc, Accessed 10/28/2015 [112] *Ibid*

[113] San Francisco Department of Public Health, Housing and Urban Health, Medical Respite and Sobering Center. https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp, Accessed 11/25/2015

[114] 12/23/2015 communication with Dr. Hali Hammer, Medical Director for Ambulatory Services, San Francisco Health Network.

[115] National Health Care *for the* Homeless Council, definition of Recuperative Care https://www.nhchc.org/ accessed 11/24/2015

[116] Ibid 12/23/2015 communication with Dr. Hammer.

Attachment L

Global Payment Program Valuation Methodology Protocol

(Reserved)

Attachment M
Global Payment Program Health Equity Monitoring Metrics Protocol
(Reserved)

Attachment N
Providing Access and Transforming Health (PATH) Funding and Mechanics Protocol
(Reserved)

Attachment O
Providing Access and Transforming Health (PATH) Operational and Monitoring Protocol
(Reserved)

Attachment P
Historical Information-Budget Neutrality Test
(Reserved)

Attachment Q
DSH Coordination Methodology

During any year in which the State of California conducts the Global Payment Program ("GPP"), the state shall make the modifications listed in this Attachment Q to its methodologies for making disproportionate share hospital payments under the DSH State Plan provisions (Attachment 4.19-A, commencing with page 18).

1. The state shall not make disproportionate share hospital payments during a state fiscal year to any designated public hospital that participates in the Global Payment Program during that year.

2. Prior to the start of the applicable GPP PY, or as soon thereafter as possible, the full amount of the federal DSH allotment under SSA § 1923(f) for the FFY that commences in the applicable GPP PY shall be determined. For this purpose, the allotment identified for California for the applicable FFY in the Preliminary Disproportionate Share Hospital Allotments that is published by CMS shall be initially used.

3. Hospitals that meet DSH eligibility criteria and are "non cost-based DSH facilities," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non cost-based DSH facilities, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

4. Hospitals that meet DSH eligibility criteria and are "non-government operated hospitals," as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-government operated hospitals, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.

5. The federal DSH allotment set-aside amounts determined above for non cost-based DSH facilities in paragraph 3, and for non-government operated hospitals in paragraph 4, will be subtracted from the full federal DSH allotment amount identified in paragraph 2.

6. Hospitals that meet DSH eligibility criteria, and are "cost-based DSH facilities" as defined under the DSH State Plan provisions, and which are licensed to the University of California, will receive DSH payments pursuant to the applicable State Plan methodology, subject to an annual aggregate cap on the associated federal DSH allotment for those payments. The annual aggregate cap is equal to an applicable percentage multiplied by the amount of the federal DSH allotment that is left after the set-asides for non cost-based DSH facilities and non-government operated hospitals, as calculated in paragraph 5, which shall be the DSH allotment amount set aside for the University of California DSH facilities. The applicable percentages for each GPP PY are as follows:

GPP PY 1: 26.296%
GPP PY 2: 24.053%
GPP PY 3: 23.150%
GPP PY 4: 21.896%
GPP PY 5: 21.896%
GPP PY 6A 21.896%

7. The full federal DSH allotment amount, less the aggregate DSH allotment set-aside amounts determined for non-cost-based DSH facilities in paragraph 3, for non-government operated hospitals in paragraph 4, and for cost-based DSH facilities licensed to the University of California in paragraph 6, shall constitute the initial "Adjusted DSH" component of the funding for the GPP described in STC 13.10. For GPP PY 6A, the "Adjusted DSH" component shall reflect an additional reduction of 50%. The initial "Adjusted DSH" component is determined no later than May 15 prior to the start of each GPP program year.

8. The final Adjusted DSH component of the GPP shall be determined pursuant to the steps in paragraphs 1 – 7 above, which shall take into account the following:

    a. The allotment identified for California for the applicable FFY in the Final Disproportionate Share Hospital Allotments that is published by CMS;

    b. The actual amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the results of the applicable DSH audits for the hospitals, including any adjustments that increase or decrease DSH payments to the hospitals.

9. Adjustments shall be made to the GPP total computable annual limit and GPP annual budgets to take into account the final Adjusted DSH component for the applicable GPP PY determined in paragraph 8, and, notwithstanding the final payment timeline set forth in Attachment K, all final reconciliation payments for the applicable GPP PY made pursuant to Attachment K shall be subject to these adjustments.

10. Within 30 days of its determination of the initial "Adjusted DSH" component discussed in step 7, the state will submit a report to CMS stating the amount of the initial "Adjusted DSH" component for the applicable GPP PY (with explanation for how "Adjusted DSH" component was calculated) and projected DSH payment amounts for all hospitals that will receive DSH payments.

11. Within 30 days of its determination of the final "Adjusted DSH" component discussed in step 7, the state will submit a report to CMS stating the amount of the final "Adjusted DSH" component for the applicable GPP PY, the actual and final amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the final GPP total paid to each GPP hospital.

12. The state will report all DSH payments to "non cost-based DSH facilities," "non-

government operated hospitals," "cost-based DSH facilities" licensed to the University of California, and designated public hospitals not participating in the Global Payment Program, on Forms CMS-64.9 WAIVER, with waiver number 11-W-00193/9, under Waiver Name "DSH," and with project number extension indicating the demonstration year corresponding to the federal fiscal year of the DSH allotment for which the payments were made.

Attachment R

Negative Balance
Payment Schedule
(Reserved)

Attachment S
CBAS Program Integrity

Following a determination that a credible allegation of fraud exists with respect to a CBAS provider, and that there is no good cause not to suspend payments, the State will initiate an email notification within one business day to all contracted Managed Care Plans (MCPs) that have provider networks in which the CBAS provider participates. Commencing with payments made by an MCP on or after April 1, 2016, MCPs will be required to report to the State all payments made to a CBAS provider for whom a credible allegation of fraud exists for dates of services rendered after the date the MCP was notified. The procedures below outline details regarding the reporting and recoupment process:

- The State's notification email to the MCPs will contain specific instructions for reporting requirements. MCPs will utilize the "Total MCP Payments to CBAS under Credible Allegation of Fraud" form to track total payments made to the applicable CBAS provider on a quarterly basis, commencing with the first quarter that the MCP was notified of the credible allegation of fraud. Reports for all subsequent quarters will indicate the total payments made for the given quarter, as well as the cumulative total payments made to the CBAS provider from the date following initial notification of the credible allegation of fraud.

- MCPs will submit quarterly reports to the State within seven business days from the end date of each quarter. The State will, in turn, submit quarterly reports to CMS reflecting all MCP payments made to applicable CBAS providers within fifteen business days from the end date of each quarter.

- Reporting requirements will remain in effect until the State notifies the MCP that the law enforcement agency investigating the credible allegation of fraud has either charged the CBAS provider with fraud or has informed the State that there is insufficient evidence to bring charges. Upon receipt of such information from the investigating agency, the State will notify the MCPs of the determination via email within three business days.

- The notification of the MCP by the State that there no longer exists a credible allegation of fraud against a CBAS provider will immediately extinguish the MCP's responsibility for quarterly reporting to the State and the State's responsibility for quarterly reports regarding payments to that CBAS provider to CMS.

- If, after investigation, the law enforcement agency brings charges against a CBAS provider for fraud, and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs, the following actions will be required to ensure recovery of all payments made to the CBAS provider:

Recoupment to the State	Recoupment to CMS
1. The MCP will submit to the State within 15 business days of notification of a final report reflecting payments for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs. 2. Within 90 days of receiving the final report, the State will recoup the CBAS provider fraud amount from the MCP capitated payment. The statement issued to the MCP will reflect the CBAS provider fraud amount.	1. The State will submit to CMS within 15 business days of receipt of a final report reflecting MCP payments made to the applicable CBAS provider for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement indicating fault by the provider occurs. 2. The State will reimburse CMS in accordance with its established repayment system by: A. Setting up an Accounts Receivable to reimburse the State General Fund through the MCP's recoupment for the Total Computable (federal and state share), and B. When applicable, completing Federal repayment paper work to reimburse CMS from the State General Fund.

Attachment T
CalAIM Evaluation Design
(Reserved)

Service	Service Definition	Eligibility	Duration	Settings
Short-term Post-hospitalization Housing	Services for eligible individuals who do not have a residence to continue their physical/psychiatric/substance use disorder recovery and need for appropriate medical care upon exiting an institution. Based on the individual's needs and a person's level of care, the services provided may include appropriate physical, mental health, and SUD care, including psychiatric supports as determined by a qualified medical professional, as well as additional supports including: • Support for gaining/regaining ability to perform ADLs • Case management, including connections to Enhanced Care Management The Community Support of housing transition navigation services must be offered to all beneficiaries during the period of Short-Term Post-	An individual must be exiting an institution. An institution is described as including: recuperative care, inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential SUD or mental health treatment facility, correctional facility, or nursing facility. An individual must have one of the following: • Receiving enhanced care management, or • Have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a	No more than 6 months during the course of the demonstration period.	Only facility types with appropriate clinical supports, consistent with the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness/Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
	Hospitalization housing to prepare them for transition from this setting. These housing transition navigation services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization.	result of a substance use disorder. • Individuals who meet the U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization and (2) the timeframe for an		

Service	Service Definition	Eligibility	Duration	Settings
		individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessnes s under the current HUD definition to thirty (30) days and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionali zation or requiring residential services as a result of a substance use disorder. For the		

Service	Service Definition	Eligibility	Duration	Settings
		purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or • An individual must have on-going physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of post-		

Service	Service Definition	Eligibility	Duration	Settings
		hospitalization housing.		
Recuperative Care (Medical Respite)	Short-term residential care and ongoing need of medical care, including monitoring of the individual's physical or behavioral health condition, such as: • monitoring of vital signs • assessments • wound care • medication monitoring • limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs 2 • Coordination of transportation to post-discharge appointments • Connection to any other on-going services an individual may require including mental health and substance use disorder services • Support in accessing benefits and housing • Gaining stability with	Individuals requiring on-going recovery in order to heal from an injury or illness and who meet the following criteria: • The U.S. Department of Housing and Urban Development's (HUD) current definition of homeless and individuals who are at-risk of homelessness as codified at 24 CFR 91.5, with two modifications: (1) if exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization and	No more than 90 days in duration.	Only facility types, with appropriate clinical supports added, consistent with requirements in the STCs, are eligible. These can include, but is not limited to: • Health Centers and Other Clinics • Wellness/Respite Centers • Social Service Centers • Skilled Nursing Facilities • Assisted Living Facilities • Residential Group Homes or Small Apartment Buildings • Community Centers

Service	Service Definition	Eligibility	Duration	Settings
	case management relationships and programs	(2) the timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless and 21 days for individuals considered at-risk of homelessness under the current HUD definition to thirty (30) days.		

Attachment V
Contingency Management Procedures and Protocols

In accordance with the State's "California Advancing and Innovating Medi-Cal (CalAIM)" Section 1115(a) Demonstration Waiver (Project Number 11-W-00193/9) and Special Terms and Conditions (STCs), this protocol provides additional detail regarding the distribution of motivational incentives to Medi-Cal beneficiaries receiving contingency management as required by STCs 55 and 57. The Department of Health Care Services' (DHCS) contingency management program is based on established clinical research demonstrating effective contingency management treatment and California's unique needs. The contingency management treatment program consists of a structured 24-week outpatient contingency management program, during which motivational incentives will be available, followed by six or more months of additional recovery support services, during which motivational incentives will not be available. DHCS' contingency management program may be provided to eligible Medi-Cal beneficiaries and is intended to complement other substance use disorder (SUD) treatment services already offered by Drug Medi-Cal Organized Delivery System (DMC-ODS) providers. Motivational incentives earned through DHCS' contingency management program shall be excluded from participating beneficiaries' modified adjusted gross income (MAGI)-based eligibility determinations, non-MAGI-based eligibility determinations, and share of cost determinations when determining those beneficiaries' eligibility for Medi-Cal.

I. Treatment Framework

A. Beneficiary Eligibility and Participation. Beneficiaries who meet the contingency management eligibility criteria detailed in STC 54 and who consent to treatment may participate in the contingency management program. A participating beneficiary will be considered to have dropped out of the contingency management program if they are absent from contingency management services for more than 30 days. If the beneficiary later returns to the contingency management provider, they will be invited to re-start the contingency management program if they continue to meet eligibility criteria. Participation in contingency management will have no impact on beneficiary eligibility for, or obligation or right to use, other DMC-ODS services.

B. Incentives. Beneficiaries will receive motivational incentives, as defined in STC 55, for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. At the discretion of the State and consistent with STC 55, the definition of target behavior may be revised in accordance with the evidence-base for contingency management as a treatment intervention for SUD to include non-use of substances other than stimulants, and/or other target behaviors such as treatment/medication adherence. During the initial phase of the pilot, DHCS shall set a maximum dollar amount of total incentives in a calendar year that participating beneficiaries will be able to receive for successful completion of the treatment protocol. As described in Attachment V, Section IV below, and consistent with the guardrails described in STC 55, providers have no discretion to determine the size or distribution of motivational incentives.

Attachment V, Sections I.C-F below describe an example of how DHCS will implement the incentive delivery schedule and corresponding dollar amounts. The final delivery schedule

and corresponding dollar amounts are subject to change by DHCS.

C. Treatment Schedule Overview. The contingency management program will consist of two phases: 1) contingency management treatment; followed by 2) contingency management aftercare.

Contingency management treatment will consist of a 24-week outpatient program, during which motivational incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of contingency management treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the maintenance period.

After completing 24-weeks of contingency management treatment, the participating beneficiary will receive contingency management aftercare consisting of six months, or more, of aftercare and treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of contingency management aftercare, participating beneficiaries may receive informal engagement and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

D. Weeks 1-12: Escalation/Reset/Recovery Period. During the initial 12 weeks of the contingency management treatment, participating beneficiaries will be asked to visit the treatment setting in person for a minimum of two treatment visits per week. Visits will be separated by at least 72 hours (e.g., Monday and Thursday/Friday, or Tuesday and Friday) to help ensure that drug metabolites from the same drug use episode will not be detected in more than one UDT. Participating beneficiaries will be able to earn motivational incentives during each visit the UDT indicates they have a negative sample for stimulants (or other target behaviors, such as a negative sample for other substances, or treatment adherence/medication, as determined by the State and consistent with Section VII of the STCs).

The initial motivational incentive value for the first sample negative for stimulants in a series is $10. For each week the participating beneficiary demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the motivational incentive is increased by $1.50. The maximum aggregate motivational incentive a participating beneficiary can receive during this initial 12-week period is $438.

A “reset” will occur when the participating beneficiary submits a positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their motivational incentive amount will return to the initial value of $10.

A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating beneficiary will recover their previously earned motivational incentive level without having to restart the process.

E. Weeks 13-24: Maintenance Period. During weeks 13–24, participating beneficiaries will be asked to visit the treatment setting for testing a minimum of once a week. During weeks 13–18, participating beneficiaries will be eligible to receive $15 per stimulant-negative

UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative test, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate motivational incentive a participating beneficiary will be able to receive during weeks 13–24 is $161.

F. Hypothetical Example: Incentive Delivery Schedule for Perfect Performance. Table 1 illustrates an incentive delivery schedule for a participating beneficiary in a scenario where the beneficiary has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant-Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

Note: The incentive delivery schedule and corresponding dollar amounts in the section above are an illustrative example of how DHCS will implement the contingency management program. This incentive delivery schedule and corresponding dollar amounts are subject to change by DHCS.

II. Contingency Management Provider and Staffing Criteria

A. Contingency Management Providers. DMC-ODS providers meeting the criteria detailed in STC 57 and other applicable STCs (e.g., per STC 53, residential providers cannot deliver contingency management; per STC 56, contingency management providers must comply with data reporting requirements) will be eligible to deliver the contingency management benefit

B. Contingency Management Coordinator. At least one trained contingency management coordinator will administer the participating DMC-ODS provider's contingency management program. The contingency management coordinator must meet the practitioner requirements listed in STC 57(c).

C. Role of the Contingency Management Coordinator. The contingency management coordinator will be the main point of contact for all contingency management program participating beneficiaries and will be responsible for collecting UDT samples, inputting test results, and supporting the delivery of motivational incentives as described in Attachment V, Section IV below.

III. Urine Drug Testing

During each visit, the contingency management coordinator will collect a urine sample from the participating beneficiary. The sample will be tested for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opioid, to rapidly indicate whether recent stimulant use occurred (or other substance use defined by the State and consistent with STC 55). Samples will be collected in a point-of-care test cup with specimen validity measures.

IV. Incentive Delivery

A. Overview. The contingency management coordinator will immediately inform the participating beneficiary of the results of the UDT, and enter the results into a secure incentive management program that includes strict safeguards against fraud and abuse. The incentive management program will compute the appropriate motivational incentive earned according to the protocol detailed above in Attachment V, Section I. The incentive amount can be immediately delivered electronically to participating beneficiaries via e-gift cards sent to participating beneficiaries' emails, sent to the provider to print the gift card, or delivered using other strategies developed by the incentive management program. The immediate delivery of the motivational incentive to the beneficiary following the determination of the motivational incentive amount earned by the incentive management program is a critical component of the contingency management benefit and consistent with the evidence-base.

B. Incentive Calculations. A secure incentive management program will automatically calculate the appropriate motivational incentive amount based on the UDT results with adjustments for the escalating value, reset and recovery features as described above in Attachment V, Section I. The program will be designed to prevent tampering with, modifying or overriding the protocol amounts. Upon each visit, the results of the UDT will

be entered into the incentive management program. The incentive management program will operate using an algorithm based on the motivational incentive delivery schedule described above. Using this algorithm, when a result is entered, the program will report the amount of any motivational incentive the participating beneficiary should receive per the protocol. A positive test for stimulants will result in the participating beneficiary receiving no motivational incentive. A negative test for stimulants (or other substances as defined at State discretion and consistent with STC 56) will result in an incentive amount as indicated by the software, considering escalations and resets.

C. Oversight. As a safeguard against fraud, waste and abuse, the contingency management coordinator, or other staff trained in the delivery of contingency management under the supervision of a Licensed Practitioner of the Healing Arts (LPHA) consistent with STC 57 when the contingency management coordinator is not available, will be permitted to enter the results of the participating beneficiary's UDT into the incentive management program during the visit. On a recurring basis, the DMC-ODS provider must conduct and document that a regular audit of the incentive delivery functions has been completed, including the software calculations recommended and incentive distributed. This provider audit must be conducted by an individual who has responsibility for overseeing the use of organizational funds (e.g., program or fiscal manager). The providers will be required to routinely submit the results of the audit to their DMC-ODS contracted county. The DMC-ODS county will be required to share the results of the audits with DHCS.

D. Incentive Delivery Method and Parameters. After the motivational incentive amount is determined, the incentive management program will disburse the motivational incentive and will track all motivational incentives awarded to all participating beneficiaries, including the date the incentive was distributed and the amount of the motivational incentive.

E. Incentive Types. To redeem earned motivational incentives consistent with the protocol described in this Attachment V, participating beneficiaries will be able to choose gift or debit cards from a range of retail outlet options to use or redeem the incentive balance, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol or lottery tickets.

Attachment W
Reentry Demonstration Initiative Qualifying Conditions and Pre-Release Services

Table 1. Adult Health Care Need Criteria Definitions for the Reentry Demonstration Initiative

Qualifying Condition	Definition
Mental Illness	A person with a "Mental Illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The beneficiary has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The beneficiary's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder (SUD)	A person with a "Substance Use Disorder" is a person who either: i. Meets SUD criteria, according to the criteria of the current editions of the Diagnostic and/or Statistical Manual of Mental Disorders and/or the International Statistical Classification of Diseases and Related Health Problems; OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, or other state-approved screening tool.
Chronic Condition or Significant Non-Chronic Clinical Condition	A person with a "Chronic Condition" or a "Significant Non-Chronic Clinical Condition" shall have ongoing and frequent medical needs that require treatment and can include one of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: • Active cancer; • Active COVID-19 or Long COVID-19; • Active hepatitis A, B, C, D, or E;

Qualifying Condition	Definition
	• Advanced liver disease; • Advanced renal (kidney) disease; • Dementia, including but not limited to Alzheimer's disease; • Autoimmune disease, including but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis; • Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy; • Chronic neurological disorder; • Severe chronic pain; • Congestive heart failure; • Connective tissue disease; • Coronary artery disease; • Currently prescribed opiates or benzodiazepines; • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g. anticoagulation) therapy after reentry; • Cystic fibrosis and other metabolic development disorders; • Epilepsy or seizures; • Foot, hand, arm, or leg amputee; • Hip/pelvic fracture; • HIV/AIDS; • Hyperlipidemia; • Hypertension; • Incontinence; • Severe migraine or chronic headache; • Moderate to severe atrial fibrillation/arrhythmia; • Moderate to severe mobility or neurosensory impairment (including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy); • Obesity; • Peripheral vascular disease; • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related); • Previous stroke or transient ischemic attack (TIA); • Receiving gender affirming care; • Active respiratory conditions, such as severe bronchitis, COPD, asthma or emphysema; • Severe viral, bacterial, or fungal infections;

Qualifying Condition	Definition
	• Sickle cell disease or other hematological disorders; • Significant hearing or visual impairment; • Spina Bifida or other congenital anomalies of the nervous system; • Tuberculosis; or • Type 1 or 2 diabetes.
Intellectual or Developmental Disability	A person with an "Intellectual or Developmental Disability" is a person who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury	A person with a "Traumatic Brain Injury" means a person with a traumatic brain injury or other condition, where the condition has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with "HIV/AIDS" means a person who has tested positive for either human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is "Pregnant or Postpartum" is a person who is either currently pregnant or within the 12-month period following the end of the pregnancy.

Table 2. Service Definitions for the Reentry Demonstration Initiative.

Covered Service	Definition
Case Management	Case management will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate reentry planning into the community in order to: (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services shall include: • Conducting a health risk assessment, as appropriate; • Assessing the needs of the individual in order to inform development, with the client, of a discharge/reentry person-centered care plan, with input from the clinician providing consultation services and correctional facility's reentry planning team; o While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with specialty county behavioral health coordinators and managed care providers are arranged; • Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared with managed care plans, and, as relevant, to physical and

Covered Service	Definition
	behavioral health/SMI/SUD providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days from release.
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to support the creation of a comprehensive, robust and successful reentry plan, including: conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); providing recommendations or orders for needed medications and durable medical equipment (DME) that will be needed upon release; and consulting with the pre-release care manager to help inform the pre-release care plan. Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the client after release, including behavioral health warm linkages. Services may include, but are not limited to: • Addressing service gaps that may exist in correctional care facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, in order to ensure control of qualifying conditions prior to release (e.g. to suggest medication changes or to prescribe appropriate DME for post-release); • Supporting reentry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to clinical assessment, patient education, therapy, counseling, SUD Care Coordination

Covered Service	Definition
	(depending on county of residence), Peer Support services (depending on county of residence), and Specialty Mental Health Services Targeted Case Management covered in the Medi-Cal State Plan.
Laboratory and Radiology Services	Laboratory and radiology services will be provided consistent with the State Plan.
Medications and Medication Administration	Medications and medication administration will be provided consistent with the State Plan.
Medication-Assisted Treatment	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT. Services may be provided by correctional facilities that are not DMC-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.
Community Health Worker Services	Community Health Worker Services will be provided consistent with the Community Health Worker State Plan.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan). • DME consistent with Medi-Cal State Plan requirements.

Attachment X
Health-Related Social Needs (HRSN) Community Supports Protocol (Reserved)

Attachment Y

Approved DSHP List (Reserved)

Attachment Z

DSHP Claiming Protocol (Reserved)

Attachment AA

DSHP Sustainability Plan (Reserved)

Attachment BB

California DSHP-Related Provider Payment Increase Assessment Attestation Table (Reserved)

Attachment CC

Reentry Demonstration Initiative Implementation Plan (Reserved)

Attachment DD
Monitoring Protocol (Reserved)

Attachment EE
Reentry Demonstration Initiative Reinvestment Plan (Reserved)