



December 29, 2021

Jacey Cooper, Chief Deputy Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Director Cooper:

We are writing to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving California's request to renew its 1915(b) waiver, CMS control CA 17.R10, entitled California Advancing & Innovating Medi-Cal (CalAIM). This renewal will allow California to move Medi-Cal managed care delivery system programs, currently authorized under California's Medi-Cal 2020 section 1115 demonstration (Medi-Cal Managed Care (MCMC), Dental Managed Care, and Drug Medi-Cal-Organized Delivery System (DMC-ODS), into the section 1915(b) waiver that currently authorizes the Specialty Mental Health (SMH) program. This 1915(b) waiver is authorized under section(s) 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following sections of title XIX:

- Section 1902(a)(1) Statewideness;
- Section 1902(a)(10)(B) Comparability; and
- Section 1902(a)(23) Freedom of Choice

Our decision to approve the 1915(b) waiver is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all statutory and regulatory requirements for assuring beneficiaries' access to, and quality of services, will be a cost effective means of providing services to those beneficiaries in the California Medicaid population, and agreement from the state on compliance with the Special Terms and Conditions (STCs) associated with this letter.

CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, complex medical conditions among children, the increasing number of justice-involved populations who have significant clinical needs, and the increasing aging population. Through the 1915(b) CalAIM waiver renewal, CMS and California are partnering to further integrate the Medi-Cal managed care system in order to meet the physical, behavioral, developmental, long-term care, oral health, and health-related social needs of all Medicaid beneficiaries with an integrated, person-centered approach. This waiver will also assist the state in improving health outcomes and advancing health equity for beneficiaries by enabling California to provide an innovative array of new benefits to certain high-need, hard-to-reach "populations of focus."

CMS commends California for taking bold steps to advance health equity, address health disparities, and to strengthen access to care, including to home and community-based services (HCBS), through the implementation of a framework of alternative, “in lieu of services and settings” (ILOS). The CalAIM initiative aims to strengthen access to care and address health-related social needs by permitting managed care plans to cover alternative services or settings that are ILOS covered under the state plan to more effectively and efficiently address their beneficiaries’ physical, behavioral, and health-related social needs. California proposed fourteen ILOS as part of the CalAIM initiative to improve overall health outcomes and reduce or prevent utilization of other Medicaid services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, and reduce related program costs. As part of the CalAIM 1915(b) waiver, CMS considers the following twelve ILOS approved subject to the conditions specified below:

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Respite Services;
- Day Habilitation Programs;
- Nursing Facility Transition/Diversion to Assisted Living Facility;
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (Home Modifications);
- Asthma Remediation;
- Medically Tailored Meals; and
- Sobering Centers.

CMS has determined these twelve identified ILOS to be approved under 42 CFR § 438.3(e)(2) subject to all of the following conditions:

- (1) California’s submission of executed managed care plan contract actions are determined by CMS annually to be consistent with the documentation submitted by the state and reviewed by CMS as part of this waiver application and the STC requirements;
- (2) California’s submission of rate certifications incorporating the ILOS into capitation rates are determined by CMS annually to be consistent with the documentation submitted by the state and reviewed by CMS as part of this waiver application, any other documentation deemed necessary to determine that the capitation rates meet regulatory requirements, and the STC requirements; and
- (3) California’s compliance with the STC requirements and applicable federal statute, regulation and guidance, including but not limited to 42 CFR Part 438. CMS anticipates releasing further guidance on ILOS in 2022 and California must come into compliance with that guidance consistent with its effective date, including within the 5-year term of this 1915(b) CalAIM waiver renewal.

In accordance with 42 CFR § 438.3(e)(2), each ILOS must meet the following requirements:

- The state determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan;
- The enrollee is not required by the managed care plan to use the alternative service or setting;
- The approved ILOS is authorized and identified in the managed care plan contract, and will be offered to enrollees at the option of the plan; and
- The utilization and actual cost of each ILOS is taken into account in developing the component of the capitation rates that represents the covered state plan services or settings, unless a statute or regulation explicitly requires otherwise.

The twelve identified ILOS were determined to be approved by CMS, subject to the above conditions, based on the following ILOS framework:

- (1) Precedence established for the proposed ILOS, such as CMS has previously approved the ILOS and it complies with regulatory requirements for ILOS.
- (2) Precedence established for the proposed ILOS through cleared agency policy.
- (3) The proposed ILOS is a medically appropriate and cost effective substitute for a state plan covered service or setting.
- (4) The proposed ILOS is not used to cover any room and board costs due to the general prohibitions that apply to Medicaid payments for room and board under title XIX of the Social Security Act.
- (5) The proposed ILOS advances the objectives of the Medicaid program and is not used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid services, and that Medicaid beneficiaries always retain their right to receive the original Medicaid state plan covered service or setting on the same terms as would apply if an ILOS were not an option, in accordance with regulatory requirements.
- (6) The state has demonstrated, and CMS agrees, that the ILOS is cost effective. For CMS to make this determination, the state provided initial documentation and has committed to provide on-going evidence over the 5-year term of the CalAIM 1915(b) waiver renewal, including but not limited to research and additional documentation required by CMS. Additionally, the state has committed to ongoing evaluation, in which the state will demonstrate to CMS that the ILOS represents a cost effective substitute for a state plan service or setting covered under the managed care plan contract and is a reasonable and appropriate component of the overall Medicaid program costs.
- (7) The state has demonstrated a commitment to ongoing monitoring and oversight of ILOS, including a rigorous independent evaluation of each ILOS to determine the overall impact of it on furthering the purposes of the Medicaid program and that the ILOS is a medically appropriate and cost effective substitute for the services and settings covered under the state plan.
- (8) The state has clinically oriented definitions for the target population(s) for which each ILOS has been determined to be a medically appropriate and cost effective substitute, including assuring that each ILOS will be determined by a provider (at the plan or network level), and documented, to be appropriate for beneficiaries for whom there is an assessed risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.

Based on CMS’s analysis and the above ILOS framework, CMS will not consider approval of two proposed ILOS, short-term post-hospitalization housing and medical respite, due to the room and board components included in these services. Instead, these two services are approved as part of California’s CalAIM section 1115 demonstration. CMS does not consider such services to be appropriate under the ILOS framework due to the general prohibitions that apply to Medicaid payments for room and board under title XIX of the Social Security Act.

This CalAIM 1915(b) waiver memorializes the strong commitment between California and CMS to maximize CalAIM’s focus on expanding access while also improving monitoring and oversight that will result in increased accountability, improved data collection and analysis, and greater transparency into network adequacy and timely access. Through the STCs, California commits to take significant actions to improve network adequacy, strengthen access, and enhance monitoring and oversight of managed care plans to ensure medically necessary services are provided to Medicaid beneficiaries (including primary care services, specialty care, maternal health care, substance use disorder services, specialty mental health services, and oral health care). Specifically, the state will report sufficient information to create a comprehensive view of network adequacy and access, including network providers, medical loss ratios, where applicable, and other measures of access and utilization. This information will be measured and reported not only by the state’s directly contracted managed care plans, but also by any plans that have been delegated functions from the directly contracted plans via sub-capitation. For these purposes, for California, “delegated plans” includes any entity that accepts significant financial risk for beneficiaries, including if that entity is a provider receiving a capitated payment. California will use this plan information to monitor performance, address any system issues that arise, and improve access to care.

Additionally, through the STCs, CMS will require independent assessments for all managed care programs, including dental, substance use disorder, specialty mental health, and comprehensive managed care. As noted previously, CMS will require the state to submit information related to its monitoring and oversight functions, including on-going coordination with consumer advocates and stakeholder engagement on no less frequent than a quarterly schedule. Additionally, these actions will be reflected in new contract requirements for managed care plans, and will result in new state oversight functions. Importantly, the state will describe how it will use the information it collects to assess and improve plan performance. For those managed care plans that do not show improvement in providing beneficiary access to services, the state will identify the actions it has taken, or plans to take, to ensure accountability of its contracted managed care plans. As a whole, these STCs will create a broader and deeper picture of access within the state’s Medicaid managed care program, and will result in increased accountability, improved data collection and analysis, and greater transparency into network adequacy and timely access.

This 1915(b) waiver is effective for a five-year period beginning January 1, 2022 through December 31, 2026. The state may request renewal of this authority by providing evidence and documentation of satisfactory performance and oversight, including but not limited to cost effectiveness, accessibility, and quality of services. California’s request that this authority be renewed should be submitted to CMS no later than October 2, 2026.

California will be responsible for documenting the applicable cost effectiveness and quality requirements in subsequent renewal requests for this authority. On a quarterly basis, the state is required to submit to CMS the previous quarter's member months by approved Medicaid Eligibility Group (MEG) based on the associated 1915(b) Worksheet for State Reporting of Member Months template. When reporting Member Months, California will submit separate *1915(b) Worksheet for State Reporting of Member Months* for the behavioral health (SMH and DMC-ODS) and MCMC+Dental managed care plans. The report is due 30 days after the end of each quarter and should be submitted to the OneMac portal <http://onemac.cms.gov/>. The state should also conduct its own quarterly calculations using Tab D6 of the approved 1915(b) Waiver Cost Effectiveness Worksheets and request an amendment to this waiver should the state discover the waiver's actual costs are exceeding projections. Additionally, the state must submit a waiver amendment to reflect any major changes impacting the program, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, quality/access, monitoring plan.

We wish you success in the operation of the 1915(b) CalAIM waiver for Medicaid beneficiaries in California. If you have any questions regarding the 1915(b) waiver, please contact Bill Brooks at Bill.Brooks@cms.hhs.gov and John Giles at John.Giles1@cms.hhs.gov.

Sincerely,

Courtney L.
Miller -S

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Courtney Miller
Director
Medicaid and CHIP Operations Group

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Alissa Mooney DeBoy
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cc: Dan Tsai, CMS
Bill Brooks, CMS
John Giles, CMS
Lindy Harrington, CA

Enclosures: Special Terms and Conditions
1915(b) Worksheet for State Reporting of Member Months