

**Section 1915(b) Waiver
Proposal for California Advancing and Innovating
Medi-Cal (CalAIM)**



Submitted to the Centers for Medicare & Medicaid Services on
June 30, 2021, for
Waiver Period of January 1, 2022, to December 31, 2026

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ATTACHMENTS

Attachment I: Dental MC Boilerplate Contract

Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage

COMMONLY USED ACRONYMS

A&I	Audits & Investigations
AAAH	Accreditation Association for Ambulatory Health Care
AAS	Alternative Access Standard
ABGAR	Annual Beneficiary Grievance and Appeals Reports
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
AH	Acute Hospital
AI/AN	American Indian and Alaska Native
ANC	Annual Network Certification
APL	All Plan Letter
ARRA	American Recovery and Reinvestment Act of 2009
ASAM	American Society of Addiction Medicine
BDE	Beneficiary Dental Exception
BH-SAC	Behavioral Health Stakeholder Advisory Committee
BOS	Board of Supervisors
BY	Base Year
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalAIM	California Advancing & Innovating in Medi-Cal
CalEQRO	California External Quality Review Organization
CBAS	Community Based Adult Services
CBHDA	County Behavioral Health Directors Association of California
CBHPC	California Behavioral Health Planning Council
CAC	Compliance Advisory Committee
CAP	Cost Allocation Plan or Corrective Action Plan
CCAC	Cultural Competence Advisory Committee
CCC	Children with Chronic Conditions

COMMONLY USED ACRONYMS

(continued)

CCI	Coordinated Care Initiative
CCP	Cultural Competence Plan
CCPR	Cultural Competence Plan Requirements
CCR	California Code of Regulations
CCS	California Children's Services
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	California Health and Wellness
CMC	Cal MediConnect
CMHPC	California Mental Health Planning Council
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COC	Continuity of Care
COHS	County-Organized Health System
CQS	Comprehensive Quality Strategy
CRM	Customer Relationship Management
CSHCN	Children with Special Health Care Needs
CSR	Customer Services Representative
CY	Calendar Year
Dental MC	Dental Managed Care
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DOP	Date of Payment
DOS	Date of Service

COMMONLY USED ACRONYMS

(continued)

DRG	Diagnostic Related Group
DSH	Disproportionate Share Hospital
D-SNP	Dual Eligible Special Needs Plan
DTI	Dental Transformation Initiative
ECM	Enhanced Care Management
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FAQ	Frequently Asked Questions
FCC	Family Centered Care
FFP	Federal Financial Participation
FFPSA	Family First Prevention Services Act
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FURS	Family Urgent Response System
FY	Fiscal Year
FFY	Federal Fiscal Year
GMC	Geographic Managed Care
GME	Graduate Medical Education
HCB	High-Cost Beneficiary
HCBS	Home and Community Based Services
HCO	Health Care Options
HEDIS	Healthcare Effectiveness Data and Information Set
HHAMB	Home Health Agency Market Basket

COMMONLY USED ACRONYMS

(continued)

HIPAA	Health Insurance Portability and Accountability Act of 1996
ICF/MR	Intermediate Care Facilities for the Mentally Retarded
IHSS	In Home Supportive Services
IHP	Indian Health Program
IHP-ODS	Indian Health Program Organized Delivery System
IMD	Institutions for Mental Disease
IMR	Independent Medical Review
IP	Inpatient
LEP	Limited English Proficient
LOC	Level of Care
LOS	Length of Stay
LTSS	Long-Term Services and Supports
MAA	Medi-Cal (or Medicaid) Administrative Activities
MCAS	Managed Care Accountability Set
MCMC	Medi-Cal Managed Care
MCO	Managed Care Organization
MCP	Managed Care Plan
MEG	Medicaid Eligibility Group
MHP	Mental Health Plan (referred to as “County MHP”)
MIPAA	Medicare Improvements for Patients and Providers Act
MIS/DSS	Management Information System/Decision Support System
MLR	Medical Loss Ratio
MLTSS	Managed Long-Term Services and Supports
MMIS	Medicaid Management Information System
MPL	Minimum Performance Level
MHSIP	Mental Health Statistics Improvement Program
MSSP	Multipurpose Senior Services Program

COMMONLY USED ACRONYMS
(continued)

NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NF	Nursing Facilities
NOA	Notice of Action
NOABD	Notices of Adverse Benefit Determinations
NOM	National Outcome Measures
OACT	Office of the Actuary
OBRA	Omnibus Budget Reconciliation Act
OMB	U.S. Office of Management and Budget
PACE	Program of All-Inclusive Care for the Elderly
PAD	Physician Administered Drug
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Physician
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Plan
PMPM	Per Member Per Month
POS	Performance Outcomes System
PPS	Prospective Payment System
PRIHD	California DHCS Primary, Rural, and Indian Health Division
PSP	Population-Specific Health Plan
QA-UR	Quality Assurance and Utilization Review
QI	Quality Improvement
QIP	Quality Improvement Project
RFP	Request for Proposal

COMMONLY USED ACRONYMS

(continued)

RHC	Rural Health Center
SAC	Stakeholder Advisory Committee
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance (for children)
SFH	State Fair Hearing
SFY	State Fiscal Year
SHP	Specialty Health Plan
SMD	State Medicaid Director
SMI	Serious Mental Illness (for adults)
SMHS	Specialty Mental Health Services
SPA	State Plan Amendment
SPD	Seniors with Persons with Disabilities
STC	Special Terms and Conditions
SUD	Substance Use Disorder
SURS	Surveillance and Utilization Review System
TAR	Treatment Authorization Request
TBS	Therapeutic Behavioral Services
TDD	Telecommunication Device for the Deaf
TPL	Third Party Liability
TTY	TeleTYpe
UCC	Uncompensated Care
UCLA	University of California Los Angeles
UMP	Utilization Review Management Program
UPL	Upper Payment Limit
URC	Utilization Review Accreditation Commission
WPC	Whole Person Care
WIC	California Welfare and Institutions Code

COMMONLY USED ACRONYMS
(continued)

YSS	Youth Services Survey
YSS-F	Youth Services Survey for Families

Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State of California** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **California Advancing & Innovating Medi-Cal (CalAIM)**. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

☐ initial request for new waiver. All sections are filled.

☐ amendment request for existing waiver, which modifies Section/Part ☐

☐ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver). Document is replaced in full, with changes highlighted

☒ renewal request

☐ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

☒ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is ☒ replaced in full

☐ carried over from previous waiver period. The State:

☐ assures there are no changes in the Program Description from the previous waiver period.

☐ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ☒ replaced in full

☐ carried over from previous waiver period. The State:

☐ assures there are no changes in the Monitoring Plan from the previous waiver period.

☐ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/amendment is requested for a period of **5** years; effective **January 1, 2022** and ending **December 31, 2026**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is **Saralyn Ang-Olson** and can be reached by telephone at **(916) 345-8380**, or fax at **Not Applicable**, or e-mail at **Saralyn.Ang-Olson@dhcs.ca.gov**. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

DHCS Response

The State regularly seeks advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs (IHPs), or Urban Indian Organizations as required by the American Recovery and Reinvestment Act of 2009 (ARRA). On April 7, 2021, California's Department of Health Care Services (DHCS) provided a memorandum to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see [Tribal public notice](#)). The State requested that comments be provided within 30 days of the date of the memo, or May 7, 2021.

On April 7, 2021, the State shared the [Tribal public notice](#) and information for the Tribal and designees of IHPs advisory meeting to be held on April 30, 2021, via email to the IHPs' listservs. The public notice and information were also posted on the [DHCS IHP homepage](#) and in the [Notices of Proposed Changes to Medi-Cal Program webpage](#).

On April 30, 2021, from 2:00 to 3:30 pm Pacific Time, State Medicaid Director Jacey Cooper, along with the DHCS Primary, Rural, and Indian Health Division (PRIHD), hosted the Tribal advisory meeting with approximately 43 attendees. The meeting was held electronically via Zoom to promote social distancing and mitigate the spread of COVID-19. The State made online video streaming and telephonic conference capabilities available to ensure statewide accessibility, as well as closed captioning. During the webinar, Director Cooper provided an overview of the CalAIM waivers, highlighted the potential impact on Tribes of the changes to the Medi-Cal program proposed in the CalAIM waivers, and engaged in a discussion with participants to consider questions and comments.

During the meeting, participants raised concerns about the conclusion of the Tribal Uncompensated Care (UCC) program under the CalAIM Section 1115 demonstration application and impacts to Tribal health programs that do not elect to become Tribal Federally Qualified Health Centers (FQHCs). Additionally, commenters were concerned that Tribal FQHC policies were not yet published. Participants also noted support for the proposed Indian Health Program Organized Delivery System (IHP-ODS), including access to traditional healers and natural helpers in the Drug Medi-Cal-Organized Delivery System (DMC-ODS) program as a way to provide culturally appropriate substance use disorder (SUD) services and supports. The State thanked the Tribes for the operational questions and support and responded that additional details on the Tribal FQHCs' implementation would be available later in May 2021. DHCS published additional [Tribal FQHC guidance](#) on May 14, 2021, including details for providers on [billing services rendered by Tribal FQHCs](#)

and [billing codes](#), and reviewed the new policy with IHP providers and Tribal organizations on June 11, 2021. As described above, in response to comments, DHCS is seeking authority under the CalAIM Section 1115 demonstration to reinstate the Tribal UCC payments for chiropractic services, which are not accessible for Tribal health programs that do not elect to enroll as a Tribal FQHC.

The PowerPoint presentation used during the Tribal public hearing was posted on the [DHCS IHP's Meetings, Webinars, and Presentations webpage](#) and is accessible [here](#).

In addition to the April 30 webinar, DHCS also discussed the CalAIM Section 1115 demonstration application during the regularly scheduled Tribal Quarterly Meetings (March 5, 2021, & May 28, 2021). During the May 28 webinar, DHCS received three comments regarding payment rates for Peer Support Specialists, natural helpers, and traditional healers, as well as a request to continue the Tribal UCC program and a request for responses to public comments submitted during the CalAIM Waiver public comment period on the waiver proposals. DHCS thanked the Tribes for their questions and noted all public comments will be posted on the [DHCS CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#), with responses addressed in the CalAIM Section 1115 demonstration application.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

DHCS Response

Medi-Cal—California's Medicaid and Children's Health Insurance Program (CHIP)—provides comprehensive health care coverage at no or low cost for 13.4 million low-income individuals, or one in three Californians. More than 11 million individuals access their coverage through Medi-Cal's managed care delivery system programs, which consist of:

- *Medi-Cal Managed Care (MCMC)*
- *Dental Managed Care (Dental MC)*
- *The Specialty Mental Health Services (SMHS) Program; and*
- *The Drug Medi-Cal Organized Delivery System (DMC-ODS).*

Section 1915(b) waivers relevant to specialty mental health services have been in effect in California since 1995. The Medi-Cal Specialty Mental Health Services (SMHS) Consolidation Section 1915(b) waiver expires December 31, 2021.

California is requesting a tenth renewal of the 1915(b) waiver along with amendments to consolidate Medi-Cal managed care delivery system programs currently authorized under California's Medi-Cal 2020 Section 1115 demonstration— MCMC, Dental MC, and DMC-ODS—with SMHS under the Section 1915(b) waiver. Alignment of all managed care authorities will enable the State to simplify California's Medi-Cal managed care delivery system and advance the goal of improving health outcomes and reducing health disparities for Medi-Cal beneficiaries. For example, leveraging one primary federal managed care

authority will support standardizing federal requirements to the extent possible and reducing administrative complexity. This simplification in turn supports efforts to innovate and drive improvements in quality and health equity. It also provides an aligned platform for seeking approval for and implementing other improvements over time. This five-year Section 1915(b) waiver renewal and amendment will rename California's SMHS Consolidation waiver as the CalAIM Section 1915(b) waiver.

The context and history of these programs, major milestones, and requests under the 1915(b) waiver renewal are described briefly below.

Medi-Cal Managed Care (MCMC)

MCMC is the foundational delivery system that provides coverage for physical health and nonspecialty mental health services for approximately 82 percent of the Medi-Cal population through Medi-Cal managed care plans (MCPs). MCMC operates in all 58 counties in the State through six MCMC models that vary by county or region:

- County-Organized Health System (COHS): Beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority.
- Two-Plan: Beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan.
- Geographic Managed Care (GMC): Beneficiaries choose from multiple commercial plans.
- Regional: Beneficiaries choose between two or more commercial plans operating in 18 contiguous counties as one service area.
- Imperial: Beneficiaries in Imperial County choose between two commercial plans.
- San Benito: Beneficiaries in San Benito County choose between a single commercial plan and Medi-Cal fee-for-service (FFS).

MCMC boilerplate contracts are available [here](#).

History and Key Milestones. MCMC has been authorized in California under successive iterations of Section 1115 demonstrations. Under the original Section 1115 demonstration and its subsequent amendments, the MCMC program expanded to additional counties, began covering seniors and persons with disabilities, and grew to include additional benefits.

Currently, most Medi-Cal children, pregnant women, parents/caretaker relatives, and most other beneficiaries are required to enroll in MCMC to access their services (mandatory enrollment). American Indians and Alaska Natives, dual eligibles in certain counties, foster children and youth in non-COHS counties, all beneficiaries in San Benito County, and several other populations have the option but are not required to enroll in MCMC (voluntary enrollment). Certain populations—such as beneficiaries with other health care coverage in non-COHS counties and beneficiaries in rural zip codes in non-COHS counties—are excluded from MCMC enrollment, meaning they do not have the opportunity to enroll in an MCP and instead access their Medi-Cal services through FFS (excluded).

While most Medi-Cal State Plan services are covered under MCMC, depending on the MCMC model, the responsibility to provide certain benefits may fall under the responsibility of another delivery system.¹ Services not covered under MCMC include SMHS, SUD services, dental, and most long-term services and supports, except that long-term care is covered under MCMC in the seven Coordinated Care Initiative (CCI) counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara) and in COHS counties. The lack of an aligned managed care delivery system complicates the delivery of care and impedes care coordination.

Requests. *Through this Section 1915(b) waiver renewal and amendment, California is seeking to shift the following MCMC program-related authorities previously approved in the Section 1115 demonstration (set to expire December 31, 2021) to Section 1915(b).² Specifically, the 1915(b) waiver would:*

- Continue the authority for mandatory enrollment into MCMC; and*
- Require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits in 2022, and it would include institutional long-term care as a managed care benefit in CCI counties, prior to the proposed statewide requirement for dually eligible beneficiaries and long-term care in 2023 (see further below).*

In addition to transitioning previously approved Section 1115 authority, California is seeking in this Section 1915(b) to:

- Require additional populations to enroll in MCMC (including nearly all dual eligibles in 2023), and*
- Further standardize benefits offered across California's managed care delivery system.*

These changes promote more coordinated and integrated care statewide and provide beneficiaries who have been in FFS or who have not been required to enroll in an MCP with a network of primary care providers and specialists.

- Require additional populations to enroll in MCMC (including nearly all dual eligibles in 2023). Starting in 2022, the aid code groups required to enroll in MCMC in all counties are: Trafficking and Crime Victims Assistance Program (except share of cost); Individuals participating in accelerated enrollment; Child Health and Disability*

¹ Pursuant to Executive Order N-01-19, the State is in the process of carving out pharmacy benefits from MCPs as a component of the Medi-Cal Rx initiative.

² The Medi-Cal 2020 demonstration includes language outlining that Medi-Cal beneficiaries in selected COHS counties are permitted to enroll in a Program of All-Inclusive Care for the Elderly (PACE) independent of the COHS MCP. CMS has confirmed that express waiver authority is not necessary to continue this allowance under the CalAIM Section 1915(b) waiver for COHS counties where a PACE plan is available.

Prevention infant deeming); and Pregnancy-related Medi-Cal³ (Pregnant Women only, 138–213 percent of the federal poverty level (FPL) citizen/lawfully present). Some American Indians and Alaska Natives may be eligible for Medi-Cal coverage in these additional aid code groups that will be subject to mandatory MCMC enrollment. As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of MCMC. Starting in 2022 in non-COHS counties, beneficiaries with other health coverage and beneficiaries in rural zip codes will no longer be excluded and will be subject to mandatory MCMC enrollment.

California is transitioning the CCI—the Medi-Cal managed care program in seven counties that is designed to provide integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community—to a statewide aligned enrollment structure. The CCI is comprised of: (1) Cal MediConnect (CMC), a Section 1115A demonstration project under the federal Financial Alignment Initiative that combines acute, primary, institutional, and home- and community-based services into a single benefit package for Medicaid eligible individuals who are fully or partially eligible for Medicare; and (2) mandatory Medi-Cal managed care enrollment for dual eligibles for most Medi-Cal benefits and Medi-Cal managed care carve-in for long-term care and some managed long-term services and supports (MLTSS). As noted in the above discussion on shifting MCMC program-related authorities previously approved in the Section 1115 demonstration, DHCS will continue to require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits in 2022, and include institutional long-term care as a managed care benefit in CCI counties. In 2023, DHCS will require dual eligibles to enroll in MCMC statewide. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, including a dual eligible special needs plan (D-SNP), DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2023, and will expand this approach statewide in future years.⁴

- *Further standardize benefits offered through MCMC. California is seeking to further standardize benefits offered by the MCPs statewide, which will mitigate MCMC enrollee confusion and streamline DHCS administrative rate-setting processes. DHCS intends to carve out to FFS: pharmacy benefits that are billed by a pharmacy on a pharmacy claim including covered outpatient drugs and physician administered drugs (PADs), as described in the Medi-Cal Rx All Plan Letter (APL 20-020)⁵; the*

³ Under pending State legislation, pregnant women accessing services FFS prior to January 1, 2022, will remain in FFS through their postpartum period and not be mandatorily enrolled in MCMC.

⁴ To comply with the Families First Coronavirus Response Act Section 6008(b) conditions to access enhanced match, Share of Cost (non-long term care) beneficiaries will not be disenrolled from CMC until after the expiration of the public health emergency.

⁵ In January 2021, Centene Corporation announced that it plans to acquire Magellan Health; Magellan Health is the State's contracted vendor to transition the pharmacy benefit from MCMC to

Multipurpose Senior Services Program (MSSP, currently carved-in to MCMC in CCI counties) effective 2022; and SMHS from the MCMC benefit package for certain Medi-Cal members enrolled in Solano and Sacramento counties no sooner than July 2022 (in alignment with the transition from a cost-based to a rate-based reimbursement in SMHS). DHCS intends to carve into the MCMC benefit package statewide major organ transplants by 2022 and institutional long-term care services (e.g., skilled nursing facilities, pediatric/adult subacute care, disabled/habilitative/nursing services) by 2023. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits through MCMC.

Consistent with State legislation, DHCS has authority for the implementation of a dental integration pilot in San Mateo County as a component of the Medi-Cal 2020 Section 1115 demonstration, or successor thereto. Under the pilot program, Medi-Cal beneficiaries enrolled in MCMC in San Mateo County will be required to access their dental services through the Health Plan of San Mateo. Accordingly, California is seeking the authority for the new pilot—by carving dental services into the benefit package offered by Health Plan San Mateo—in the consolidated Section 1915(b) waiver. The anticipated implementation date for the pilot under the new Section 1915(b) authority is January 2022.

Dental Managed Care (Dental MC)

Dental services are currently provided through Dental MC plans in two California counties—Sacramento and Los Angeles. In the remaining counties, dental services are available through FFS. The Dental MC boilerplate contract is included for reference in “Attachment I: Dental MC Boilerplate Contract.”

History/Key Milestones. *Under the authority of the Section 1115 demonstration, the Dental MC – GMC Sacramento program was implemented in 1995 to explore the effectiveness of managed care as a delivery system for providing eligible Medi-Cal members with dental services. GMC services are provided by dental plans contracted and licensed by the state pursuant to the Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act). Through a Section 1915(a) waiver no longer in use by CMS, the Dental MC – PHP Los Angeles program has operated since 1995.*

Request. *Like MCMC, Dental MC in Sacramento County is currently authorized under California's Medi-Cal 2020 Section 1115 demonstration through December 31, 2021. California is seeking to shift authority for Dental MC in Sacramento to Section 1915(b). DHCS affirmed with CMS that Dental MC in Los Angeles County may remain under Section 1915(a) and does not require additional authority under the Section 1915(b) waiver. DHCS*

FFS pursuant to [Executive Order N-01-19](#). Given the unexpected acquisition and additional time required to ensure acceptable conflict avoidance protocols are in place to address adjudication of pharmacy prior authorization requests and pharmacy claims of all Medi-Cal beneficiaries, the Medi-Cal Rx transition has been delayed. A revised timeline for the pharmacy benefit transition has not yet been determined as of this writing, and the [Governor's May Revision budget](#) assumes a transition will take place January 1, 2022. The State is continuing with its plans to transition Medi-Cal Rx and will update the public as plans are solidified.

continues to evaluate the effectiveness of Dental MC and may seek modifications to the delivery system program in the future based on that evaluation and/or State legislative or budget changes.

Specialty Mental Health Services (SMHS)

SMHS are currently provided by 56 county mental health plans (County MHPs) covering all 58 counties throughout the State, including two joint-county arrangements in Sutter/Yuba and Placer/Sierra. The County MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties who meet criteria for services, consistent with beneficiaries' mental health treatment needs and goals. The SMHS boilerplate contract is available [here](#).

History/Key Milestones. *In 1995, under the authority of a Section 1915(b) waiver (the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver), California made county mental health departments responsible both for mental health services provided under the Short-Doyle Medi-Cal program (in which community mental health services were delivered by counties through directly operated and contracted providers) and for those provided under the FFS Medi-Cal program, such as psychiatric inpatient hospital services. In 1997, under the authority of a renewed, modified, and renamed Section 1915(b) waiver (the Medi-Cal SMHS Consolidation waiver) California consolidated responsibility for inpatient hospital and outpatient, professional, case management, and other SMHS under the responsibility of a single MHP in each county.*

The SMHS program evolved through numerous renewals to the State's current Section 1915(b) waiver for SMHS and other policy changes. Major milestones in this evolution include the transfer of responsibility for the SMHS waiver program from California's Department of Mental Health to DHCS; various State Plan Amendments (SPAs) to update sections describing SMHS and reimbursement; and other contract, quality improvement, and monitoring programs updates and improvements. In addition, State program responsibilities and revenues were realigned to local governments (primarily counties) in 1991 and 2011. In total, the 2011 realignment provided \$6.3 billion to local governments (primarily counties) to fund various criminal justice, mental health, and social services programs in 2011–12, and ongoing funds for these programs annually thereafter.

Request. *The SMHS program is currently authorized under California's SMHS Section 1915(b) waiver through December 31, 2021. Through the renewal of the Section 1915(b) waiver, California is seeking to renew that authority and consolidate other Medi-Cal managed care authorities with SMHS.*

DHCS is also seeking to add new SMHS services at county option. Consistent with State legislation, DHCS will be establishing peer support specialist services. Peer support specialist services are culturally competent services, provided by certified peer support specialists, that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and

geographic regions. DHCS will use the Medi-Cal State Plan to include peer support specialist services and, as part of this Section 1915(b) waiver, request authority to make peer support specialist services available at the option of each county under SMHS consistent with State legislation. (Peer support specialist services will also be available in DMC-ODS, discussed further in the next section.)

DHCS is also clarifying the authority for specialty mental health services to be delivered: (1) by Family Urgent Response System (FURS) county mobile response and stabilization teams to current and former foster children and youth and their caregivers, and (2) as part of the Family First Prevention Services Act (FFPSA) service requirements for children, youth, and families in the child welfare system. These programs may have a staggered rollout or be limited to counties that opt to provide them. CMS confirmed that waivers for comparability and statewideness applicable to SMHS will extend to the implementation of these services and will provide the necessary federal authority to implement FURS and FFPSA to targeted populations and on a phased or county-by-county basis.

Additional Details. *In tandem with the consolidated Section 1915(b) waiver, California will also make programmatic changes to the SMHS delivery system that will be implemented through State legislation and regulation; County MHP contract; and policy and operational guidance. These changes are aimed at improving access to appropriate care and standardizing access to the SMHS delivery system statewide. A core improvement is clarifying the current division of responsibilities between Medi-Cal MCPs and County MHPs and updating the criteria for access to SMHS both for adults and for beneficiaries under age 21.*

As defined in State law, Medi Cal MCPs are responsible for providing covered nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders, as well as beneficiaries with potential mental health disorders not yet diagnosed. Consistent with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate under Social Security Act (the Act) § 1905(r), Medi-Cal MCPs are responsible for providing all medically necessary nonspecialty mental health services for beneficiaries under the age of 21.

County MHPs are responsible for covering specialty mental health services for Medi-Cal beneficiaries who meet specified criteria for services, which differ for adult beneficiaries and for beneficiaries under age 21. SMHS are defined and detailed in the County MHP contract. Consistent with the EPSDT mandate, County MHPs are responsible for providing all medically necessary SMHS for beneficiaries under the age of 21.

DHCS is also making programmatic changes to: improve access to care prior to formal diagnosis; streamline intake, assessment, referral, and documentation processes; move from a cost-based to a rate-based reimbursement approach. Finally, during this next Section 1915(b) waiver period, DHCS will be working towards administrative integration of specialty mental health and SUD services into one behavioral health managed care program. The goals of administrative integration are to improve outcomes for beneficiaries

through coordinated treatment across the continuum of care and to reduce administrative and fiscal burdens for counties, providers, and the State.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

California counties have the option to participate in the DMC-ODS program under the Medi-Cal 2020 Section 1115 demonstration to provide Medi-Cal beneficiaries who reside in their county with a range of evidence-based SUD treatment services in addition to those that were available under the Medi-Cal State Plan at the time. As of June 2021, 37 of California's 58 counties have implemented DMC-ODS, covering 96 percent of the total Medi-Cal population across the State. DHCS is actively engaging with prospective new counties to participate in DMC-ODS, with the goal of eventually expanding DMC-ODS services to Medi-Cal beneficiaries statewide.

The DMC-ODS boilerplate contract is available [here](#).

History/Key Milestones. *Medi-Cal has long provided coverage of certain SUD treatment benefits through its DMC-ODS program, which is authorized through the Medi-Cal State Plan and administered by counties. In 2015, the State created the DMC-ODS program and secured a Section 1115 demonstration amendment to standardize service delivery across participating counties, and provide a broader continuum of high-quality, evidenced-based SUD treatment services. In connection with the DMC-ODS program, the State was first in the nation to receive expenditure authority for services that were previously not eligible for reimbursement due to the IMD (institutions for mental diseases) exclusion.*

Request. *The DMC-ODS program was originally authorized under California's Medi-Cal 2020 Section 1115 demonstration, and extended through December 31, 2021. Under CalAIM, DHCS is continuing and strengthening the SUD treatment system, building on the existing DMC-ODS program. To minimize unnecessary reliance on a Section 1115 demonstration and to pursue a consistent approach to its delivery system authorities, California is seeking to:*

- *Shift the managed care authority for DMC-ODS to the consolidated Section 1915(b) waiver;*
- *Use the Medi-Cal State Plan to authorize most benefits; and*
- *Secure waivers of statewideness and comparability in the Section 1915(b) waiver to continue to offer these services at county option.*

Consistent with State legislation, DHCS will be establishing peer support specialist services (described above in SMHS). DHCS will use the Medi-Cal State Plan to include peer support specialist services and, as part of this Section 1915(b) waiver, requests authority to make peer support specialist services available at the option of each county under DMC-ODS. (DHCS is submitting a similar Section 1115 demonstration request for Drug Medi-Cal (DMC).)

California is also seeking to use Section 1915(b)(3) authority for Contingency Management services, pending State budget authority.

Finally, expenditure authority to reimburse Medi-Cal services not otherwise reimbursable due to the IMD exclusion for short-term residential services will remain in the Section 1115 demonstration.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
 - a. ☐ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
 - b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
 - c. ☒ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority. (*Applies to DMC-ODS*)
 - d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- ☒ MCO (*Applies to MCMC*)
- ☒ PIHP (*Applies to SMHS, DMC-ODS*)
- ☒ PAHP (*Applies to Dental MC*)
- ☐ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- ☐ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):
 - a. ☒ **Section 1902(a)(1)** - Statewide--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This

waiver program is not available throughout the State. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

- b. **X Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program. *(Applies to MCMC, SMHS, DMC-ODS)*
- c. **X Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- d. **X Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here). *(Applies to Dental MC, SMHS, DMC-ODS)*
- e. **X Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

DHCS Response

In addition to the above waivers of the Act § 1902, DHCS requests waivers of the following federal regulations for the operation of CalAIM:

Table 1: Waivers of Regulatory Provisions for the Operation of CalAIM

Statutory/Regulatory Section	Applies to:
42 CFR § 438.10(g)-(h)	SMHS, DMC-ODS
42 CFR § 438.10(i)	DMC-ODS
42 CFR § 438.52(a)(1)	SMHS, DMC-ODS
42 CFR § 438.56	SMHS, DMC-ODS
42 CFR § 438.350	DMC-ODS

CMS previously approved waivers of these regulatory provisions in California's SMHS Section 1915(b) waiver for SMHS or Medi-Cal 2020 Section 1115 demonstration for DMC-ODS.

42 CFR § 438.10(g)-(h): *DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content, and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to*

beneficiaries when they first access SMHS through the County MHP and on request, and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g) and (h) would apply to the distribution requirements only, not to any other provisions of the subsections except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS through a County MHP, or SUD services through DMC-ODS.

42 CFR § 438.10(i): DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content, and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS.

42 CFR § 438.52(a)(1), .56: DHCS requests a waiver of 42 CFR § 438.52(a)(1), which provides that a State that requires Medicaid beneficiaries to enroll in an MCO, a PIHP, or a PAHP must provide beneficiaries with a choice of at least two MCOs, PIHPs, or PAHPs. DHCS also requests a waiver of 42 CFR § 438.56, which provides the circumstances in which a state must allow a beneficiary to disenroll from an MCO, a PIHP, or a PAHP. The waiver of these two regulatory provisions is necessary to permit DHCS to restrict:

- Beneficiaries to receive SMHS from their County MHP, without any option for disenrollment; and
- Beneficiaries in counties that have implemented DMC-ODS to receive SUD services to their county's DMC-ODS PIHP, without any option for disenrollment.

CMS previously approved waivers of these regulatory provisions in California's SMHS Section 1915(b) waiver for SMHS and Medi-Cal 2020 Section 1115 demonstration for DMC-ODS.

42 CFR § 438.350: DHCS requests a waiver of 42 CFR § 438.350, which requires the performance of an external quality review for the first year of a county's implementation of DMC-ODS. Counties will be required to comply with all external quality review requirements

after year one of their implementation of the DMC-ODS program. CMS previously approved a waiver of this regulatory provision in California's Medi-Cal 2020 1115 demonstration.

Inapplicable Regulatory Provisions

Finally, based on prior DHCS discussions with CMS and through SMHS and DMC-ODS boilerplate contract review and approvals, CMS made the determination a number of provisions of 42 CFR Part 438 are not applicable to SMHS and DMC-ODS either because they are nonrisk PIHPs or these requirements are not consistent with the design and structure of the delivery system. For clarity, DHCS is including these inapplicable provisions here.

Provisions that do not apply to SMHS and DMC-ODS, except as noted:

- 42 CFR § 438.3(b) Standard Contract Requirements – Entities eligible for comprehensive risk contracts
- 42 CFR § 438.3(c) Standard Contract Requirements – Payment
- 42 CFR § 438.3(g) Standard Contract Requirements – Provider preventable conditions (SMHS only)
- 42 CFR § 438.3(o) Standard Contract Requirements – Long term supports and services (LTSS) contract requirements
- 42 CFR § 438.3(p) Standard Contract Requirements – Special rules for HIOs
- 42 CFR § 438.3(s) Standard Contract Requirements – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
- 42 CFR § 438.4 Actuarial Soundness
- 42 CFR § 438.5 Rate Development Standards
- 42 CFR § 438.6 Special Contract Provisions Related to Payment
- 42 CFR § 438.7 Rate Certification Submission
- 42 CFR § 438.8 Medical Loss Ratio (MLR) Standards
- 42 CFR § 438.9 Provisions that Apply to Non-emergency Medical Transportation
- 42 CFR § 438.10(i) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Formulary (SMHS only)
- 42 CFR § 438.50 State Plan Requirements
- 42 CFR § 431.51(b)(2) and § 441.202 (No family planning services, including abortion procedures, are provided through the DMC-ODS or SMHS delivery system)
- 42 CFR § 438.54(c) Voluntary Managed Care Enrollment
- 42 CFR § 438.70 Stakeholder engagement when LTSS is delivered through a managed care program
- 42 CFR § 438.71(b)(1)(i) and (iii), (c) and (d) – Client Support System
- 42 CFR § 438.74 State Oversight of the Minimum MLR Requirement
- 42 CFR § 438.104 Marketing Activities
- 42 CFR § 438.110 Member Advisory Committee
- 42 CFR § 438.114 Emergency and Post-Stabilization Services
- 42 CFR § 438.116 Solvency Standards
- 42 CFR § 438.208(c)(1) Identification of Individuals with Special Health Care Needs
- 42 CFR § 438.700-730 Sanctions
- 42 CFR § 438.802 Basic Requirements
- 42 CFR § 438.810 Expenditures for Enrollment Broker Services

- *42 CFR § 438.816 Expenditures for the Beneficiary Support System for Enrollees Using LTSS*
- *42 CFR § 455.100-104 Disclosure Requirements*
- *Specific provisions related to Religious or Moral Objections to Delivering Services*
- *Specific provisions related to Drug Formularies and Covered Outpatient Drugs, including but not limited to 42 CFR § 438.3(s)*
- *Specific provisions related to LTSS, including but not limited to 42 CFR § 438.3(o) and 438.70*

California's negotiations with the federal government and any changes required by State legislation and/or the State budget could lead to refinements in the authorities sought, or the federal approval for such authorities, as DHCS works with CMS to move the CalAIM initiative forward.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

- a. ☒ **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

(Applies to MCMC)

- b. ☒ **PIHP**: Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.
Note: this includes MCOs paid on a non-risk basis.

☐ The PIHP is paid on a risk basis.

☒ The PIHP is paid on a non-risk basis. *(Applies to SMHS, DMC-ODS)*

- c. ☒ **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

☒ The PAHP is paid on a risk basis. *(Applies to Dental MC)*

☐ The PAHP is paid on a non-risk basis.

- d. ☐ **PCCM**: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

- e. ☐ **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to

meet certain reimbursement, quality, and utilization standards.

Reimbursement is:

_____ the same as stipulated in the state plan

_____ is different than stipulated in the state plan (please describe)

f. _____ **Other:** (Please provide a brief narrative description of the model.)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc.):

☒ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience) (*Applies to MCMC for the commercial plans operating in the GMC-PHP, Regional, Imperial, San Benito, and Two-Plan counties; Dental MC*)

_____ **Open** cooperative procurement process (in which any qualifying contractor may participate)

_____ **Sole source procurement**

☒ **Other** (*Applies to MCMC for the county operated plans in the COHS counties and the local initiative plan in the Two-Plan counties, SMHS, DMC-ODS*) (please describe)

DHCS Response

MCMC: *In COHS counties, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. The county Board of Supervisors (BOS) may establish, by ordinance, a commission to negotiate a COHS contract with DHCS. The commission serves as an independent oversight entity for the delivery of Medi-Cal managed care services in that county. COHS contracts may be on a non-bid basis and exempt from Chapter 2 of Part 2 of the Public Contract Code. See California Welfare and Institutions Code (CA WIC) Article 2.8, Chapter 7, Part 3, Division 9. In Two-Plan counties, beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan. Counties establish a Local Initiative by county ordinance. See CA WIC, Prepaid Plans, Chapter 8, Part 3, Division 9 and California Code of Regulations, Title 22, Section 53800 et. Seq.*

SMHS: *CA WIC § 14712 directs DHCS to implement managed mental health care for Medi-Cal beneficiaries through contract with MHPs. MHPs may include individual counties, counties acting jointly, or nongovernmental entity determined by DHCS to meet MHP standards. A contract may be exclusive and may be awarded on a geographic basis.*

DMC-ODS: Any county that elects to opt into DMC-ODS services shall submit an implementation plan to DHCS for approval by DHCS and CMS. Upon approval of the implementation plan, the DHCS enters into an intergovernmental agreement with the County to provide or arrange for the provision of DMC-ODS services.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

— The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.
(Applies to SMHS, DMC-ODS)

DHCS Response

DHCS requests a waiver of the Act §1902(a)(4) for SMHS and DMC-ODS. CMS previously approved waivers of this provision in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 1115 demonstration.

SMHS: Pursuant to 42 CFR § 438.68, 438.206, and 438.207, and CA WIC § 14197, DHCS contractually requires County MHPs to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities. County MHPs are contractually required to meet and require their providers to meet State-established standards for provider ratios, time and distance, and timely access to care and services, taking into account the urgency of need for services. To accomplish this, County MHPs must establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance with timely access requirements; and take corrective action in response to identified noncompliance.

Further, County MHPs are required to provide beneficiaries access to out-of-network providers if an in-network provider is not available within the time and distance standards per 42 CFR § 438.206(b)(4); California Information Notice 21-

008. Also, pursuant to CA WIC § 14197.04, if DHCS grants the County MHP's request for an alternative access standard for psychiatrists, upon request from the beneficiary, the County MHP must assist the beneficiary in obtaining an appointment with a psychiatrist within the time and distance standards. If the County MHP is unable to arrange such appointment, the beneficiary's MCP must arrange transportation for the enrollee.

The lack of choice between multiple County MHPs in each county is not detrimental to beneficiaries' access to services because California's network adequacy requirements, provided by CA WIC § 14197 and set forth in greater detail in Information Notice 21-023 and the County MHP contract, ensure that all beneficiaries have adequate access to all medically necessary covered services as required by 42 CFR § 438.68, 438.206, and 438.207 and a choice of providers within the County MHP network.

If a County MHP is unable to comply with the time or distance standards set forth in the contract, the County MHP must submit an alternative access standard request to DHCS for review and approval.

Per 42 CFR § 438.207(b), County MHPs are required to submit network certification documentation to DHCS annually. The documentation must demonstrate that the County MHP's provider network meets the network adequacy standards for availability and accessibility of services and offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county) and maintains a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the services area (i.e., county). DHCS certifies the network of each County MHP and submits assurances of adequacy to the CMS. DHCS reviews State and county-level data and information, including network data submissions by the County MHPs, to conduct an analysis of the adequacy of each County MHP's network.

DHCS reviews County MHPs' network adequacy standards documentation for County MHPs' compliance in the following areas:

- I. Time and distance standards – geographic access mapping;*
- II. Network composition and capacity;*
- III. Timely access;*
- IV. Continuity of care;*
- V. Mandatory provider types;*
- VI. Language assistance capabilities; and*
- VII. System infrastructure.*

Pursuant to 42 CFR § 438.358(b)(iv), and CA WIC § 14197.05, the External Quality Review Organization (EQRO) annually assesses each County MHP's

compliance with the network adequacy standards. If DHCS determines that a County MHP does not meet the network adequacy standards, or a DHCS-approved alternate access standard, the County MHP will be required to submit a corrective action plan to DHCS demonstrating steps the County MHP will take to come into compliance with the standards. DHCS will monitor the County MHP's corrective actions and require updated information from the County MHP on a monthly basis until the County MHP meets the applicable standards.

If the County MHP is not making satisfactory progress toward compliance with applicable standards, DHCS may impose sanctions pursuant to CA WIC § 14197.7, including monetary sanctions, and the temporary withholding of payments.

Per 42 CFR § 438.207(c)(3), all County MHPs, whether under an approved alternative access standard or not, must submit documentation to DHCS, within ten business days, anytime there is a significant change in the County MHP's operations that would affect the adequacy of the County MHP's capacity or services, including a change in services, benefits, geographic service area, composition of or payments to its provider network, or enrollment of a new member population.

In addition to the network adequacy requirements, County MHPs are required to provide beneficiaries access to out-of-network providers if an in-network provider is not available within the time and distance standards. (42 CFR 438.206(b)(4); California Information Notice 21-008)

DMC-ODS: *Under DMC-ODS, county-operated PIHPs providing coverage under the DMC-ODS program are contractually required to maintain a network of providers that is sufficient to provide beneficiaries with adequate access to all covered services. In establishing and monitoring the network, the PIHP must document the anticipated number of Medi-Cal-eligible beneficiaries, the expected utilization of services, the expected number and types of providers needed to meet anticipated utilization, and the geographic location of providers and their accessibility to beneficiaries, as well as other relevant factors identified in the Intergovernmental Agreement between the county and DHCS. In addition, the PIHP must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. PIHPs must establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance with timely access requirements; and take corrective action in response to identified noncompliance.*

In addition, PIHPs must, when requested by DHCS, demonstrate that they offer an appropriate range of SUD treatment services and a network of providers that

is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

When a beneficiary makes a request for covered services, the PIHP must require services to be initiated with reasonable promptness and have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. If the PIHP is unable to provide necessary service, DHCS requires the PIHP to adequately and timely cover these services out-of-network for the beneficiary. Moreover, PIHPs must monitor accessibility of services as part of their ongoing quality assessment and performance improvement program.

DHCS also contracts with the EQRO to ensure compliance with contractual obligations and that network adequacy standards are met (including but not limited to array of services, timely access, time and distance) for the DMC-ODS plans.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- ☒ Two or more MCOs (*Applies to MCMC for Two Plan, GMC, Regional, and Imperial counties*)
- ☐ Two or more primary care providers within one PCCM system.
- ☐ A PCCM or one or more MCOs
- ☐ Two or more PIHPs.
- ☒ Two or more PAHPs. (*Applies to Dental MC*)
- ☒ Other: (please describe) (*Applies to MCMC for COHS counties and San Benito, SMHS, DMC-ODS*)

DHCS Response

MCMC: *Six models of MCMC operate in the State, varying by county and region. In general, enrollees in non-COHS counties have a choice of MCPs. Dual eligible enrollees in certain non-COHS counties are enrolled in the MCP aligned with their choice of Medicare Advantage plan whenever possible to allow for greater integration and coordination of care. (These beneficiaries retain the ability to opt out of the aligned MCP if they choose.) These MCP choices are further described by MCMC model below.*

- **COHS:** *Under the COHS model, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. A COHS plan must enroll all Medicaid beneficiaries residing in the county in which it operates, except when an alternative delivery system is authorized and available in the county. These single, local plans are considered Health Insuring Organizations (HIO), which are managed care delivery systems unique to California and operate under the authority of § 9517(c) of Consolidated Omnibus Budget*

Reconciliation Act (COBRA) 1985, which was subsequently amended by § 4734 of Omnibus Budget Reconciliation Act (OBRA) 1990 and Medicare Improvements for Patients and Providers Act (MIPAA) 2008. HIOs are exempt from the managed care requirements of § 1932 of the Act (implemented through 42 CFR § 438) because they are not subject to the requirements under § 1903(m)(2)(A) that apply to MCOs and contracts with MCOs. 42 CFR § 438.2 identifies these as county-operated entities and California State law that passed simultaneously with OBRA 1990 identifies these as COHS. Consistent with treatment under the Bridge to Reform and Medi-Cal 2020 1115 demonstrations, the Health Plan of San Mateo is considered a COHS, but is not considered an HIO by federal standards because it became operational after January 1, 1986.

- *Two-Plan: Beneficiaries choose between a single publicly run entity known as a local initiative plan and a single commercial plan.*
- *GMC: Beneficiaries choose from multiple commercial health plans.*
- *Regional: Beneficiaries choose between two or more commercial health plans.*
- *Imperial: Beneficiaries in Imperial County choose between two commercial health plans.*
- *San Benito: Beneficiaries in San Benito County choose between a single commercial plan and FFS, and enrollment in managed care is voluntary.*

Beneficiaries ages 21 and over with an AIDS diagnosis who reside in Los Angeles County also have the option to enroll in Positive Healthcare (PHC) California, a special-needs Medi-Cal managed care plan operated by the AIDS Healthcare Foundation.

Dental MC: *In Sacramento County, Medi-Cal child and adult enrollees receive their dental services through Dental MC. Enrollees choose from three plans.*

SMHS: *Enrollees who meet criteria for SMHS services must receive services through their County MHP. See response in previous selection about the mechanisms DHCS has in place to assure a network of appropriate providers that is sufficient to provide adequate access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities.*

DMC-ODS: *Enrollees who reside in a participating county and meet criteria for DMC-ODS services must receive services through the county's DMC-ODS PIHP. See response in previous selection about the mechanisms DHCS has in place to assure a network of appropriate providers that is sufficient to provide adequate*

access to all covered services for all beneficiaries, including those with limited English proficiency or physical and mental disabilities.

Regardless of managed care delivery system, DHCS requires the MCO/HIO/PIHP/PAHP to ensure the availability and accessibility of adequate numbers of providers, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions as outlined in federal and State statutes, regulations, and plan contracts. Beneficiaries are provided with a choice of providers within the plans and an opportunity to change providers whenever feasible. California's network adequacy requirements, provided by CA WIC § 14197 and set forth in greater detail in All Plan Letter 20-003 and the plan contract, ensure that all beneficiaries have adequate access to all medically necessary covered services as required by 42 CFR § 438.68, 438.206, and 438.207.

Together, the foregoing network adequacy requirements and enforcement and compliance mechanisms for MCMC, Dental MC, DMC-ODS, and SMHS result in adequate access to services and quality of care, notwithstanding that beneficiaries are not provided with a choice of plans in COHS counties under MCMC, SMHS, and DMC-ODS.

3. Rural Exception.

- _____ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

- _____ Beneficiaries will be limited to a single provider in their service area (please define service area).
- _____ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

X **Statewide** -- all counties, zip codes, or regions of the State (*Applies to MCMC, SMHS*)

X **Less than Statewide** (*Applies to Dental MC; peer support specialist services, FURS and FFPSA in SMHS; DMC-ODS*)

DHCS Response

DHCS is establishing peer support specialist services to expand the use of certified peer support specialists, which will be available at the option of each county under SMHS and DMC-ODS, consistent with State legislation.

DHCS offers SMHS delivered through two special programs for foster children and caregivers:

- County mobile response and stabilization teams provide SMHS services through FURS to current and former foster children and youth and their caregivers.*
- FFPSA service requirements for children, youth, and families in the child welfare system.*

FURS has been implemented in all counties, as of July 2021. FFPSA prevention services may be limited to counties that opt to provide the services, or counties may have a staggered rollout. Waivers for comparability and statewideness applicable to SMHS extend to the implementation of these services and provide the necessary federal authority to implement FURS and FFPSA to targeted populations and on a phased or county-by-county basis. FFPSA services to children, youth, and families in the child welfare system are limited to counties that opt to provide them.

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

DHCS Response

MCMC:

DHCS will be re-procuring MCPs in certain counties in late 2021/early 2022, which could shift the entities noted below, effective January 1, 2024. DHCS will amend with updated information when it becomes available.

Table 2: MCMC Entities

County	Managed Care Model	Type of Program	Name of Entity
<i>Alameda</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>Alameda Alliance for Health; Anthem Blue Cross Partnership Plan (ABC)</i>
<i>Alpine</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; California Health and Wellness (CHW)</i>
<i>Amador</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Butte</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Calaveras</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Colusa</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Contra Costa</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>ABC; Contra Costa Health Plan</i>
<i>Del Norte</i>	<i>COHS</i>	<i>HIO</i>	<i>Partnership Health Plan of California (PHP)</i>
<i>El Dorado</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Fresno</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>ABC; CalViva Health</i>
<i>Glenn</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Humboldt</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Imperial</i>	<i>Imperial</i>	<i>MCO</i>	<i>CHW; Molina Healthcare of California Partner Plan, Inc. (Molina)</i>
<i>Inyo</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Kern</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>Health Net Community Solutions, Inc. (Health Net); Kern Family Health Care</i>
<i>Kings</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>ABC; CalViva Health</i>
<i>Lake</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Lassen</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Los Angeles</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>Health Net; L.A. Care Health Plan</i> <i>Beneficiaries ages 21 and over with an AIDS diagnosis residing in Los Angeles County also have</i>

County	Managed Care Model	Type of Program	Name of Entity
			<i>the option to enroll in Positive Healthcare (PHC) California, a special-needs Medi-Cal managed care plan operated by the AIDS Healthcare Foundation.</i>
<i>Madera</i>	<i>Two-Plan</i>	<i>MCO</i>	<i>ABC; CalViva Health</i>
<i>Marin</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Mariposa</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Mendocino</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Merced</i>	<i>COHS</i>	<i>HIO</i>	<i>Central California Alliance for Health</i>
<i>Modoc</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Mono</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Monterey</i>	<i>COHS</i>	<i>HIO</i>	<i>Central California Alliance for Health</i>
<i>Napa</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Nevada</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Orange</i>	<i>COHS</i>	<i>HIO</i>	<i>CalOptima</i>
<i>Placer</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Plumas</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Riverside</i>	<i>Two Plan</i>	<i>MCO</i>	<i>Inland Empire Health Plan (IEHP); Molina</i>
<i>Sacramento</i>	<i>GMC</i>	<i>MCO</i>	<i>Aetna Better Health of California (Aetna); ABC; Health Net; Kaiser Permanente; Molina</i>
<i>San Benito</i>	<i>GMC</i>	<i>MCO</i>	<i>ABC</i>
<i>San Bernardino</i>	<i>Two Plan</i>	<i>MCO</i>	<i>IEHP; Molina</i>
<i>San Diego</i>	<i>GMC</i>	<i>MCO</i>	<i>Aetna; Blue Shield of California Promise Health Plan; Community Health Group Partnership Plan; Health Net; Kaiser Permanente; Molina; UnitedHealthcare Community Plan</i>
<i>San Francisco</i>	<i>Two Plan</i>	<i>MCO</i>	<i>ABC; San Francisco Health Plan</i>
<i>San Joaquin</i>	<i>Two Plan</i>	<i>MCO</i>	<i>Health Net; Health Plan of San Joaquin</i>
<i>San Luis</i>	<i>COHS</i>	<i>HIO</i>	<i>CenCal Health</i>

County	Managed Care Model	Type of Program	Name of Entity
<i>Obispo</i>			
<i>San Mateo</i>	<i>COHS</i>	<i>HIO/MCO⁶</i>	<i>Health Plan of San Mateo</i>
<i>Santa Barbara</i>	<i>COHS</i>	<i>HIO</i>	<i>CenCal Health</i>
<i>Santa Clara</i>	<i>Two Plan</i>	<i>MCO</i>	<i>ABC; Santa Clara Family Health Plan</i>
<i>Santa Cruz</i>	<i>COHS</i>	<i>HIO</i>	<i>Central California Alliance for Health</i>
<i>Shasta</i>	<i>COHS</i>	<i>HIO</i>	<i>Partnership Health Plan of California (PHP)</i>
<i>Sierra</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Siskiyou</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Solano</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Sonoma</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Stanislaus</i>	<i>COHS</i>	<i>HIO</i>	<i>Health Plan of San Joaquin</i>
<i>Sutter</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Yuba</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Tehama</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Trinity</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>
<i>Tulare</i>	<i>Two Plan</i>	<i>MCO</i>	<i>ABC; Health Net</i>
<i>Tuolumne</i>	<i>Regional</i>	<i>MCO</i>	<i>ABC; CHW</i>
<i>Ventura</i>	<i>COHS</i>	<i>HIO</i>	<i>Gold Coast Health Plan</i>
<i>Yolo</i>	<i>COHS</i>	<i>HIO</i>	<i>PHP</i>

Dental MC:

Table 3: Dental MC Entities

County	Type of Program	Name of Entity
<i>Sacramento</i>	<i>PAHP</i>	<i>Access Dental Plan; Health Net of California, Inc.; Liberty Dental Plan of California, Inc.</i>

⁶ As previously provided for under the Bridge to Reform and Medi-Cal 2020 1115 demonstrations, Health Plan of San Mateo is considered a COHS, even if it is not considered an HIO by federal standards because it became operational after January 1, 1986.

SMHS:*Table 4: SMHS Entities*

County	Type of Program	Name of Entity
<i>Alameda</i>	<i>PIHP</i>	<i>Alameda Behavioral Health Care Services</i>
<i>Alpine</i>	<i>PIHP</i>	<i>Alpine County Behavioral Health Services</i>
<i>Amador</i>	<i>PIHP</i>	<i>Amador County Behavioral Health</i>
<i>Butte</i>	<i>PIHP</i>	<i>Butte County Department of Behavioral Health</i>
<i>Calaveras</i>	<i>PIHP</i>	<i>Calaveras County Behavioral Health Services</i>
<i>Colusa</i>	<i>PIHP</i>	<i>Colusa County Department of Behavioral Health</i>
<i>Contra Costa</i>	<i>PIHP</i>	<i>Contra Costa County Mental Health Services</i>
<i>Del Norte</i>	<i>PIHP</i>	<i>Del Norte County Mental Health Branch</i>
<i>El Dorado</i>	<i>PIHP</i>	<i>El Dorado Health and Human Services Agency</i>
<i>Fresno</i>	<i>PIHP</i>	<i>County of Fresno Department of Behavioral Health</i>
<i>Glenn</i>	<i>PIHP</i>	<i>Glenn County Department of Mental Health</i>
<i>Humboldt</i>	<i>PIHP</i>	<i>Humboldt County Health and Human Services</i>
<i>Imperial</i>	<i>PIHP</i>	<i>Imperial County Behavioral Health Services</i>
<i>Inyo</i>	<i>PIHP</i>	<i>Inyo County Mental Health</i>
<i>Kern</i>	<i>PIHP</i>	<i>Kern County Mental Health Department</i>
<i>Kings</i>	<i>PIHP</i>	<i>Kings County Behavioral Health</i>
<i>Lake</i>	<i>PIHP</i>	<i>Lake County Behavioral Health Department</i>
<i>Lassen</i>	<i>PIHP</i>	<i>Lassen County Health and Social Services</i>
<i>Los Angeles</i>	<i>PIHP</i>	<i>Los Angeles County Department of Mental Health</i>
<i>Madera</i>	<i>PIHP</i>	<i>Madera County Behavioral Health Services</i>
<i>Marin</i>	<i>PIHP</i>	<i>Marin County Health and Human Services</i>
<i>Mariposa</i>	<i>PIHP</i>	<i>Mariposa County Mental Health</i>
<i>Mendocino</i>	<i>PIHP</i>	<i>Mendocino County Mental Health</i>
<i>Merced</i>	<i>PIHP</i>	<i>Merced County Mental Health</i>
<i>Modoc</i>	<i>PIHP</i>	<i>Modoc County Health Services</i>
<i>Mono</i>	<i>PIHP</i>	<i>Mono County Behavioral Health</i>
<i>Monterey</i>	<i>PIHP</i>	<i>County of Monterey</i>
<i>Napa</i>	<i>PIHP</i>	<i>Napa County Health & Human Services</i>
<i>Nevada</i>	<i>PIHP</i>	<i>Nevada County Behavioral Health</i>
<i>Orange</i>	<i>PIHP</i>	<i>Orange County Healthcare Agency Behavioral Health Services</i>
<i>Placer</i>	<i>PIHP</i>	<i>Placer County Adult Systems of Care</i>
<i>Plumas</i>	<i>PIHP</i>	<i>Plumas County Mental Health</i>
<i>Riverside</i>	<i>PIHP</i>	<i>Riverside Department of Mental Health</i>
<i>Sacramento</i>	<i>PIHP</i>	<i>Health & Human Services</i>
<i>San Benito</i>	<i>PIHP</i>	<i>San Benito County Behavioral Health</i>
<i>San Bernardino</i>	<i>PIHP</i>	<i>San Bernardino County Behavioral Health</i>

County	Type of Program	Name of Entity
<i>San Diego</i>	<i>PIHP</i>	<i>San Diego County Behavioral Health</i>
<i>San Francisco</i>	<i>PIHP</i>	<i>San Francisco Community Behavioral Health Services</i>
<i>San Joaquin</i>	<i>PIHP</i>	<i>San Joaquin County Behavioral Health Services</i>
<i>San Luis Obispo</i>	<i>PIHP</i>	<i>San Luis Obispo County Behavioral Health</i>
<i>San Mateo</i>	<i>PIHP</i>	<i>San Mateo County Behavioral Health & Recovery Services</i>
<i>Santa Barbara</i>	<i>PIHP</i>	<i>Santa Barbara County Alcohol, Drug & Mental Health Services</i>
<i>Santa Clara</i>	<i>PIHP</i>	<i>Santa Clara County Valley Health and Hospital Systems Mental Health Department</i>
<i>Santa Cruz</i>	<i>PIHP</i>	<i>Santa Cruz County Mental Health and Substance Abuse Services</i>
<i>Shasta</i>	<i>PIHP</i>	<i>Shasta Mental Health, Alcohol and Drug</i>
<i>Sierra</i>	<i>PIHP</i>	<i>Placer County Adult Systems of Care</i>
<i>Siskiyou</i>	<i>PIHP</i>	<i>Siskiyou County Health and Human Services Agency</i>
<i>Solano</i>	<i>PIHP</i>	<i>Solano County Health and Social Services</i>
<i>Sonoma</i>	<i>PIHP</i>	<i>Sonoma County Department of Health Services</i>
<i>Stanislaus</i>	<i>PIHP</i>	<i>Stanislaus County Behavioral Health and Recovery Services</i>
<i>Sutter/Yuba</i>	<i>PIHP</i>	<i>Sutter/Yuba Mental Health Services</i>
<i>Tulare</i>	<i>PIHP</i>	<i>Tulare County Health and Human Services Agency</i>
<i>Tuolumne</i>	<i>PIHP</i>	<i>Tuolumne County Health and Human Services</i>
<i>Ventura</i>	<i>PIHP</i>	<i>Ventura County Behavioral Health Department</i>
<i>Yolo</i>	<i>PIHP</i>	<i>Yolo County Department of Alcohol, Drug, and Mental Health Services</i>

DMC-ODS:

Table 5: DMC-ODS Entities

County	Type of Program	Name of Entity
<i>Alameda</i>	<i>PIHP</i>	<i>County of Alameda</i>
<i>Contra Costa</i>	<i>PIHP</i>	<i>County of Contra Costa</i>
<i>El Dorado</i>	<i>PIHP</i>	<i>County of El Dorado</i>
<i>Fresno</i>	<i>PIHP</i>	<i>County of Fresno</i>
<i>Imperial</i>	<i>PIHP</i>	<i>County of Imperial</i>
<i>Kern</i>	<i>PIHP</i>	<i>County of Kern</i>
<i>Los Angeles</i>	<i>PIHP</i>	<i>County of Los Angeles</i>
<i>Marin</i>	<i>PIHP</i>	<i>County of Marin</i>
<i>Merced</i>	<i>PIHP</i>	<i>County of Merced</i>

County	Type of Program	Name of Entity
<i>Monterey</i>	<i>PIHP</i>	<i>County of Monterey</i>
<i>Napa</i>	<i>PIHP</i>	<i>County of Napa</i>
<i>Nevada</i>	<i>PIHP</i>	<i>County of Nevada</i>
<i>Orange</i>	<i>PIHP</i>	<i>County of Orange</i>
<i>Placer</i>	<i>PIHP</i>	<i>County of Placer</i>
<i>Riverside</i>	<i>PIHP</i>	<i>County of Riverside</i>
<i>San Bernardino</i>	<i>PIHP</i>	<i>County of San Bernardino</i>
<i>San Diego</i>	<i>PIHP</i>	<i>County of San Diego</i>
<i>San Francisco</i>	<i>PIHP</i>	<i>County of San Francisco</i>
<i>San Joaquin</i>	<i>PIHP</i>	<i>County of San Joaquin</i>
<i>San Luis Obispo</i>	<i>PIHP</i>	<i>County of San Luis Obispo</i>
<i>San Mateo</i>	<i>PIHP</i>	<i>County of San Mateo</i>
<i>Santa Barbara</i>	<i>PIHP</i>	<i>County of Santa Barbara</i>
<i>Santa Clara</i>	<i>PIHP</i>	<i>County of Santa Clara</i>
<i>Santa Cruz</i>	<i>PIHP</i>	<i>County of Santa Cruz</i>
<i>Stanislaus</i>	<i>PIHP</i>	<i>County of Stanislaus</i>
<i>Ventura</i>	<i>PIHP</i>	<i>County of Ventura/Ventura County Behavioral Health Department</i>
<i>Yolo</i>	<i>PIHP</i>	<i>County of Yolo/Yolo County Department of Alcohol, Drug, and Mental Health Services</i>

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

DHCS Response

A breakdown of MCMC enrollment by aid code group and MCMC model is included for reference as "Attachment II: Managed Care Enrollment Proposed Aid Code Group Coverage."

- 1. Included Populations.** The following populations are included in the Waiver Program:

X Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

X Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

☐ Voluntary enrollment

☒ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

☒ Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)
☐ Voluntary enrollment

☒ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

☒ Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)
☐ Voluntary enrollment

☒ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

☒ Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)
☐ Voluntary enrollment

☒ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

☒ Mandatory enrollment (*Applies to MCMC, SMHS, DMC-ODS*)
☐ Voluntary enrollment

☒ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

☒ Mandatory enrollment (*Applies to MCMC in COHS counties, Dental MC, SMHS, DMC-ODS*)

DHCS Response

Although foster care children are mandatorily enrolled, if they request to disenroll, there is an expedited disenrollment

process for this population under the conditions specified in Title 22, CCR, § 53889(j).

X Voluntary enrollment (*Applies to MCMC in non-COHS counties*)

X **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

X Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)
___ Voluntary enrollment

X **Section 1902 (a)(10)(A)(i)(VIII)** Adult beneficiaries are nonpregnant adults ages 19 through 64 who are not otherwise mandatorily eligible for Medicaid and with income at or below 133 percent of the FPL.

X Mandatory enrollment (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)
___ Voluntary enrollment

DHCS Response

American Indians/Alaska Natives. In 2022, American Indians and Alaska Natives will be subject to mandatory enrollment; however American Indians and Alaska Natives residing in non-COHS counties will have the ability to opt out of MCMC for FFS.

Dual eligible: In 2022, DHCS will continue to require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits, and include institutional long-term care as a managed care benefit in CCI counties. In 2023, DHCS will require dual eligible, except for individuals otherwise excluded from MCMC, such as those with a Share of Cost not in institutional Long-Term Care and other MCMC excluded populations, to enroll in MCMC statewide. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, including a D-SNP, DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2023, and will expand this approach statewide in future years.

- 2. Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the

program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Other Insurance**--Medicaid beneficiaries who have other health insurance.

☒ **Reside in Nursing Facility or ICF/MR**--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR). *(Applies to Dental MC)*

DHCS Response

Dental MC members in Sacramento County who are enrolled in Medi-Cal Section 1915(c) waiver programs, such as Nursing Facility/Acute Hospital (NF/AH), may request a temporary medical exemption from mandatory plan enrollment. If granted, members can see their regular dentist until the complex medical condition is resolved. The temporary waiver can continue up to 12 months (or 90 days after a member gives birth).

☐ **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program.

☐ **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☒ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). *(Applies to Dental MC)*

DHCS Response

Dental MC members in Sacramento County who are enrolled in Medi-Cal waiver programs, such as Home and Community Based Services (HCBS), may request a temporary medical exemption from mandatory plan enrollment. If granted, members can see their regular dentist until the complex medical condition is resolved. The temporary waiver can continue up to 12 months (or 90 days after a member gives birth).

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

___ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

X **Other** (Please define):

DHCS Response

MCMC:

Limited aid code groups will be excluded from the waiver and receive Medi-Cal FFS. The excluded groups are:

- **OBRA Restricted scope in Napa, Solano, and Yolo counties.** See description [here](#).
- **Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost).** Individuals who are in medically needy Share of Cost (also referred to as an SOC) and are responsible to pay toward their medical-related services, supplies, or equipment before Medi-Cal will begin to pay.
- **Presumptive eligibility.** See description [here](#).
- **State medical parole, county compassionate release, and incarcerated individuals.** See description [here](#). As part of the pending Section 1115 demonstration renewal, California is requesting authority to provide targeted Medi-Cal services to eligible justice-involved populations 30 days pre-release; services will include Enhanced Care Management (ECM) and limited community-based clinical consultation services provided via telehealth or e-consultation, and a 30-day supply of medication for use post-release into the community.
- **Non-citizen pregnancy-related aid codes enrolled in Medi-Cal.** Pregnant individuals who have unsatisfactory immigration status.

- ***Certain pregnancy-related Medi-Cal.*** Pregnant women with incomes 138-213 percent FPL who are citizens or lawfully present will be mandatorily enrolled in MCMC starting in 2022. Pending State legislation would create a special exception for those pregnant women accessing services FFS prior to January 1, 2022 – they will be excluded from MCMC and remain in FFS through their postpartum period.

Program of All-Inclusive Care for the Elderly (PACE). In addition, Medi-Cal beneficiaries enrolled in a PACE will be excluded from the waiver.⁷

____ **Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

____ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

DHCS Response

DHCS will provide a breakdown of services covered by Medi-Cal's managed care delivery system programs and through FFS to CMS for review.

1. Assurances.

X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

(Applies to MCMC, Dental MC, SMHS, DMC-ODS except as noted below)

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).

⁷ The Medi-Cal 2020 Section 1115 demonstration includes language that outlines Medi-Cal beneficiaries in selected COHS counties are permitted to enroll in PACE independent of the COHS MCP. CMS has confirmed that express waiver authority is not necessary to continue this allowance under the Section 1915(b) waiver for COHS counties where a PACE plan is available.

DHCS Response

DHCS offers specialty mental health services delivered through two special programs for foster children and caregivers:

- *County mobile response and stabilization teams provide SMHS services through the FURS to current and former foster children and youth and their caregivers.*
- *FFPSA service requirements for children, youth, and families in the child welfare system.*

Waivers for comparability and statewideness applicable to SMHS extend to the implementation of these services and provide the necessary federal authority to implement FURS and FFPSA to targeted populations and on a phased or county-by-county basis.

- Access to emergency services will be assured per Section 1932(b)(2) of the Act and 42 CFR 438.114.

DHCS Response

Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

SMHS: *Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

DMC-ODS: *Emergency services are not provided in connection with DMC-ODS.*

- Access to family planning services will be assured per Section 1905(a)(4) of the Act and 42 CFR 431.51(b)

DHCS Response

Note that family planning services are not provided in connection with the Dental MC, SMHS, or DMC-ODS programs

— The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

SMHS: *Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

DMC-ODS: *Emergency services are not provided in connection with DMC-ODS.*

- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

- X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver. *(Applies to MCMC, SMHS, DMC-ODS)*

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of Section 1902 of the Act for the purposes listed in Sections 1915(b)(1)-(4) of the Act. However, within Section 1915(b) there are prohibitions

on waiving the following subsections of Section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) – freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that Section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with Sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

X The PIHP, PAHP, or FFS Selective Contracting program does not cover emergency services. (*Applies to SMHS, DMC-ODS*)

DHCS Response

Note that 42 CFR § 438.114 and 1932(b)(2) are inapplicable to SMHS and DMC-ODS.

SMHS: *Emergency and post-stabilization services as defined under these provisions are not provided under SMHS. Emergency and post-stabilization services for all Medi-Cal beneficiaries are covered through the capitation payment made to MCPs. SMHS includes psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services. There are provisions for emergency admission to a psychiatric inpatient hospital; however, this is not equivalent to emergency services described in 42 CFR § 438.114.*

DMC-ODS: *Emergency services are not provided in connection with DMC-ODS.*

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- ☒ The MCO/PIHP/PAHP will be required to reimburse out- of-network family planning services (*Applies to MCMC*)
- ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
- ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.
- ☐ Other (please explain):
- ☒ Family planning services are not included under the waiver. (*Applies to Dental MC, SMHS, DMC-ODS*)

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- ☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- ☒ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC: (*Applies to MCMC*)

DHCS Response

Per CA WIC § 14087.325, MCPs must attempt to contract with each FQHC in their service area, where available. MCPs must annually demonstrate they are contracted with FQHCs. If an MCP is unable to contract with an FQHC, it must submit documentation to the State detailing the reasons the MCP was unable to contract with the FQHC. In accordance with CMS State Health Official letter #16-006, MCOs are required to contract with at least one FQHC in their service area, if

available. MCPs are required to annually demonstrate to the State efforts to improve access to FQHCs.

- _____ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. EPSDT Requirements.

- X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

6. 1915(b)(3) Services.

- X This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

DHCS Response

Pending State budget authority, DHCS is seeking to cover Contingency Management under DMC-ODS on a pilot basis. Contingency Management is an evidence-based behavioral health treatment that uses motivational incentives alongside cognitive behavioral therapy and other therapeutic interventions as part of a comprehensive outpatient treatment program for psycho-stimulant use disorders. Contingency management is the only treatment that has demonstrated robust outcomes for individuals with psycho-stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.

- **Service Description:** *Individuals in treatment earn small motivational incentives for meeting treatment goals (e.g., negative urine drug screen). These incentives are in the form of low-denomination gift cards that individuals can exchange for goods and services from a variety of retail stores.*
- **Populations Eligible:** *DMC-ODS beneficiaries who have a completed American Society of Addiction Medicine (ASAM) Criteria assessment, are diagnosed with stimulant use disorder*

(current or prior to incarceration or a stay in an institutional setting), and engaged in a comprehensive treatment program that includes other services delivered in person or via telehealth.

- **Geographic Availability:** *Contingency management will be available in DMC-ODS counties that elect to cover the services. DHCS intends to gradually phase-in coverage of Contingency Management in DMC-ODS counties beginning in January 2022, using a request for application process and providing technical assistance to counties throughout the implementation process.*
- **Provider Type and Reimbursement Method:** *Incentives will be managed and disbursed through a state-approved computer or mobile app that includes strict safeguards against fraud and abuse. Incentives will be subject to an aggregate limit of \$599 per twelve months, which aligns with the minimum effective incentive demonstrated by studies to create lasting change.*

DHCS will conduct a robust evaluation on the provision of Contingency Management.

7. Self-referrals.

X *The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e., access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract: (Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

MCMC: *The MCP contract prohibits plans from requiring prior authorization for emergency services, family planning services, preventive services, some mental health services, basic prenatal care, sexually transmitted disease services, or HIV testing.*

Dental MC: *The GMC-Sacramento contract prohibits Dental MC plans from requiring prior authorization for emergency services.*

SMHS: *Referrals to the County MHP for SMHS may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to any health care providers, schools, county welfare departments, other County MHPs, conservators, guardians, family members, and law enforcement agencies. County MHPs may not deny an initial screening process or assessment to determine whether a beneficiary meets the medical necessity criteria for receiving services from the County MHP; however, the County MHP may require beneficiaries to request these*

initial assessments through a formal system at the County MHP. County MHP informing materials provide beneficiaries with the information needed to obtain services from the County MHP.

DMC-ODS: *Under the DMC-ODS program, prior authorization is not required for any non-residential DMC-ODS services.*

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable. *(Applies to MCMC, Dental MC SMHS, DMC-ODS)*

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

Please note that 42 CFR § 438.206(b)(2) (Women's Health Services) does not apply to DMC-ODS or SMHS since these services are not provided through DMC-ODS waiver or SMHS waiver.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
- a. ____ Availability Standards. The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. ____ PCPs (please describe):
2. ____ Specialists (please describe):
3. ____ Ancillary providers (please describe):
4. ____ Dental (please describe):
5. ____ Hospitals (please describe):
6. ____ Mental Health (please describe):
7. ____ Pharmacies (please describe):
8. ____ Substance Abuse Treatment Providers (please describe):
9. ____ Other providers (please describe):

- b. ____ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ____ PCPs (please describe):
2. ____ Specialists (please describe):
3. ____ Ancillary providers (please describe):
4. ____ Dental (please describe):
5. ____ Mental Health (please describe):
6. ____ Substance Abuse Treatment Providers (please describe):
7. ____ Urgent care (please describe):

8. ____ Other providers (please describe):

c. ____ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ____ PCPs (please describe):

2. ____ Specialists (please describe):

3. ____ Ancillary providers (please describe):

4. ____ Dental (please describe):

5. ____ Mental Health (please describe):

6. ____ Substance Abuse Treatment Providers (please describe):

7. ____ Other providers (please describe):

d. ____ Other Access Standards (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

- X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- _____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a._____ The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b._____ The State ensures that there are adequate number of PCCM PCPs with open panels. Please describe the State's standard.
- c._____ The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.
- d._____ The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to Be in PCCM			
1.			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

e. ____ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f. ____ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	PCCM-to-Enrollee Ratio

<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. ____ **Other capacity standards** (please describe):

- 3. Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

Please note that 42 CFR § 438.208(b)(3) does not apply to SMHS and 42 CFR § 438.208(c) does not apply to SMHS and DMC-ODS.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

- a. X The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that **the PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination. *(Applies to SMHS, DMC-ODS)*

DHCS Response

SMHS: *There is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the State criteria for accessing SMHS.*

DMC-ODS: *There is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the State criteria for accessing DMC-ODS services.*

- b. **X Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe. *(Applies to MCMC, Dental MC)*

DHCS Response

MCMC and Dental MC: *The State provides MCPs and Dental MC plans with enrollment files that include the aid codes associated with each newly enrolled beneficiary. For beneficiaries enrolling in managed care from FFS, the MCPs and Dental MC plans also receive the beneficiary's FFS utilization data. The aid code and FFS utilization data, if provided, are used by plans to identify individuals as seniors, persons with disabilities, or persons with other special health care needs.*

- c. **X Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe. *(Applies to MCMC, Dental MC)*

DHCS Response

MCMC: *Each MCP is contractually required to provide case management services to all members at a level appropriate to their need including basic case management, complex case management and, with the implementation of CalAIM, Enhanced Care Management (ECM).*

Basic case management must be provided by the primary care provider, in collaboration with the MCP, which includes an initial health assessment in which a provider of primary care services can comprehensively assess the member's current acute, chronic, and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies. Each MCP must apply a State-approved health risk stratification mechanism or algorithm to identify newly enrolled seniors and persons with disabilities with higher risk and more complex health care needs within 44 days of enrollment.

Upon the enrollment of a beneficiary who is a senior or person with disabilities (SPD), each MCP must provide, or ensure the provision of, person-centered planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.

In addition, each MCP must develop methods to identify enrollees who may benefit from complex case management services, using the risk stratification and health risk assessment results as well as utilization and clinical data and any other available information across medical, LTSS, and behavioral health domains, as well as self and provider referrals.

Each MCP is also required to implement and maintain a program for Children with Special Health Care Needs (CSHCN). CSHCN are defined by the State as those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional condition and who require health or related services of a type or amount beyond that required by children generally. Each MCP's CSHCN program is required to include standardized procedures for identifying CSHCN at enrollment and on a periodic basis after enrollment. Members identified as CSHCN must receive comprehensive assessment of health and related needs. The MCP must implement methods for monitoring and improving the quality and appropriateness of care for CSHCN.

A key feature of CalAIM is the introduction of the statewide availability of ECM in MCMC. MCPs will be responsible for administering ECM. ECM will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services and comprehensive care management. ECM is part of a broader population health system design within CalAIM, under which MCPs will risk stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. ECM will be implemented on a phased basis beginning in January 2022, ahead of broader population health requirements, which will start in 2023. DHCS has identified seven mandatory ECM "populations of focus." MCPs must proactively identify their high-need, high-cost members who meet the populations of focus criteria and offer them ECM. More information about ECM is available [here](#).

Dental MC: Dental MC plans are contractually obligated to provide basic case management services to each member and to monitor the coordination of care provided to members. The dental plans are

also required to implement and maintain a program for CSHCN, which includes standardized procedures such as dental care provider training for the identification of CSHCN at and after enrollment. Members identified as CSHCN receive comprehensive oral assessment and a written dental treatment plan. The dental plans are required to implement methods for monitoring and improving the quality and appropriateness of care for CSHCN.

- d. ☒ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
(Applies to MCMC, Dental MC)
1. ☒ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 2. ☒ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 3. ☒ In accord with any applicable State quality assurance and utilization review standards.
- e. ☒ Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs. *(Applies to MCMC, Dental MC)*
3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.
- a. ☐ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.
 - b. ☐ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.
 - c. ☐ Each enrollee is receives health education/promotion information. Please explain.

- d. ____ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.
 - e. ____ There is appropriate and confidential exchange of information among providers.
 - f. ____ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.
 - g. ____ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
 - h. ____ Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
 - i. ____ Referrals: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.
4. **Details for 1915(b)(4) only programs**: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR ~~438.202, 438.204~~, 438.210, 438.214, ~~438.218~~, 438.224, ~~438.226~~, 438.228, 438.230, 438.236, ~~438.240~~, and 438.242 in so far as these regulations are applicable. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

_____ The State seeks a ~~waiver of a~~ waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

DHCS Response

The text stricken out above are regulatory sections that are outdated and no longer exist in the regulatory code, or appear to be typographical errors in the pre-print template.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR ~~438.202, 438.204~~, 438.210, 438.214, ~~438.218~~, 438.224, ~~438.226~~, 438.228, 438.230, 438.236, ~~438.240~~, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

DHCS Response

The regulatory sections stricken out above are outdated and no longer exist in the regulatory code.

X 1932(c)(1)(A)(iii)-(iv) of the Act ~~and 42 CFR 438.202~~ requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State

assures CMS that this quality strategy was initially submitted to the CMS Regional Office on **July 2, 2018** (Applies to MCMC, SMHS, DMC-ODS)

DHCS Response

In 2018, DHCS wrote the Medi-Cal Managed Care Quality Strategy Report in response to this requirement. To update this report, DHCS combined updates from the Medi-Cal Managed Care Quality Strategy Report with updates and revisions to the DHCS Strategy for Quality Improvement in Health Care Report, and created the DHCS Services Comprehensive Quality Strategy (CQS) report. The CQS outlines the Department's process for developing and maintaining a broader quality strategy to assess the quality of care that all of our beneficiaries receive, regardless of delivery system, and defines measurable goals and tracks improvement while adhering to the regulatory managed care requirements of 42 CFR § 438.340. The CQS covers all Medi-Cal managed care delivery systems, including the Medi-Cal MCPs, County MHPs, DMC-ODS plans, and the Dental MC plans, as well as non-managed care departmental programs. The report also highlights delivery system reform; the coordination of efforts to improve performance on behavioral health CMS Core Set Measures; and proposed CalAIM changes. The DHCS CQS has been revised based on comments received from the public, but finalization of the CQS has been delayed to allow inclusion of additional details related to COVID-19 and the resulting CalAIM implementation delay. DHCS plans to finalize and submit the final CQS to CMS in 2021. The 2018 DHCS CQS Reports and 2019 proposed CQS Report are available [here](#).

- X** The State assures CMS that it complies with Section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

Table 6: External Quality Review (EQR) Activities

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
MCMC	Health Services Advisory Group, Inc.	✓	<ul style="list-style-type: none"> Assessment of the MCMC quality strategy Compliance reviews of MCPs, including 	<ul style="list-style-type: none"> Validation of encounter data submitted by MCPs (conducted at

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
			<p><i>follow-up on audits and corrective action plans</i></p> <ul style="list-style-type: none"> • <i>Assessment of Performance Improvement Projects</i> • <i>Calculation and validation of performance measures for MCPs, analysis of trends across years (when available), and follow-up on corrective action plans</i> • <i>Follow-up on the EQRO's prior year's recommendations, both to DHCS and to MCPs</i> <p><i>The EQRO is also contracted to validate network adequacy as specified under 42 CFR §438.358(b)(1)(iv); however, CMS has not yet provided the protocols for this activity, so the EQRO cannot yet provide an assessment.</i></p> <p><i>The State also mandates the following EQR activities:</i></p> <ul style="list-style-type: none"> • <i>Alternative Access Standards (Network Adequacy) CA WIC § 14197.05(a)(b) and (d)</i> • <i>Skilled Nursing Facility/Intermediate Care Facility (Network Adequacy) CA WIC § 14197.05(c) and (d)</i> 	<p><i>least every three years)</i></p> <ul style="list-style-type: none"> • <i>Administration and validation of Consumer Surveys: CAHPS Medicaid Adult & Child Survey and CHIP Women & Child Statewide Survey</i> • <i>Administration of focused studies: Studies active as of April 2021 are Health Disparities; Statewide Network Analysis; Network Hot Spots; Population Needs Assessment</i> • <i>Technical assistance to MCPs on quality improvement topics through calls, webinars, and email support and annual quality conference</i> <p><i>The EQRO is also contracted to provide assistance with quality rating of MCPs consistent with 42 CFR § 438.334; however,</i></p>

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
				<i>CMS has not yet provided protocols for this activity, so the EQRO cannot yet provide an assessment.</i>
Dental Managed Care	<i>Health Services Advisory Group, Inc.</i>	✓	<ul style="list-style-type: none"> • <i>Validation of performance improvement projects</i> • <i>Calculation and validation of Dental MC plan performance measures</i> • <i>Compliance reviews of Dental MC plans</i> • <i>Validation of Dental MC plan network adequacy</i> 	
SMHS	<i>Behavioral Health Concepts (contract through June 2024). Will be re-bid during Section 1915(b) waiver period.</i>	✓	<ul style="list-style-type: none"> • <i>Validation of Performance Improvement Projects</i> • <i>Validation of County MHP performance measures</i> • <i>Compliance reviews of County MHPs</i> • <i>Validation of MHP network adequacy</i> 	<ul style="list-style-type: none"> • <i>Validation of encounter data reported by County MHP</i> • <i>Validation of consumer satisfaction surveys</i> • <i>Technical assistance to County MHPs through participation in Statewide Quality Improvement Coordinator meetings</i> • <i>Conduct additional Performance Improvement Projects or focused studies</i>

Program	Name of Organization	Activities To Be Conducted 2022 - 2026		
		EQR Study	Mandatory Activities	Optional Activities
DMC-ODS	<i>Behavioral Health Concepts (has contract through June 2021 and currently undergoing extension). Will be re-bid during Section 1915(b) waiver period.</i>	✓	<ul style="list-style-type: none"> • Validation of Performance Improvement Projects • Validation of DMC-ODS plan performance measures • Compliance reviews of DMC-ODS plans • Validation of DMC-ODS plan network adequacy 	<ul style="list-style-type: none"> • Validation of encounter data reported by DMC-ODS plan • Validation of Treatment Perception Surveys • Conduct additional Performance Improvement Projects or focused studies • Technical assistance to DMC-ODS plans

2. Assurances For PAHP program.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable. *(Dental MC)*

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Dental MC)*

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

- a. ____ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.
- b. ____ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.
1. ____ Provide education and informal mailings to beneficiaries and PCCMs;
 2. ____ Initiate telephone and/or mail inquiries and follow-up;
 3. ____ Request PCCM's response to identified problems;
 4. ____ Refer to program staff for further investigation;
 5. ____ Send warning letters to PCCMs;
 6. ____ Refer to State's medical staff for investigation;
 7. ____ Institute corrective action plans and follow-up;
 8. ____ Change an enrollee's PCCM;
 9. ____ Institute a restriction on the types of enrollees;
 10. ____ Further limit the number of assignments;
 11. ____ Ban new assignments;
 12. ____ Transfer some or all assignments to different PCCMs;
 13. ____ Suspend or terminate PCCM agreement;
 14. ____ Suspend or terminate as Medicaid providers; and
 15. ____ Other (explain):
- c. ____ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a

PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ☐ Initial credentialing
 - B. ☐ Performance measures, including those obtained through the following (check all that apply):
 - ☐ The utilization management system.
 - ☐ The complaint and appeals system.
 - ☐ Enrollee surveys.
 - ☐ Other (Please describe).
4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. ☐ Other (please describe).

d. ____ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs**: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

- X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable. *(Applies to MCMC, Dental MC)*

DHCS Response

The requirements at the Act § 1932(d)(2) and 42 CFR § 438.104 related to marketing are not applicable to SMHS and DMC-ODS since there is no choice of plan.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC)*

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1. ____ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .
2. X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted. (*Applies to MCMC, Dental MC*)

DHCS Response

MCPs and Dental MC plans are permitted to engage in media advertising, and make printed, illustrated, or videotaped materials available to members or prospective members by posting materials in public places, by participating in organized community or neighborhood health fairs, at through health care options presentations sponsored by the State. See 22 CCR § 53880. All marketing materials, including printed materials, must be approved by the State in writing prior to distribution. CA WIC § 14408. In addition, each MCP and Dental MC plan must submit a marketing plan for review and approval on an annual basis. Id.

MCPs and Dental MC plans are prohibited from conducting door-to-door, cold call, and telephone marketing activities for the purposes of enrolling current or potential Medi-Cal beneficiaries.

3. ____ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this. (*Applies to MCMC, Dental MC*)
2. ____ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages

listed below (If the State does not translate or require the translation of marketing materials, please explain):

(Applies to MCMC, Dental MC)

The State has chosen these languages because (check any that apply):

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. ___ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.
- iii. X Other (please explain):

DHCS Response

MCPs and Dental MC plans must provide fully translated member information, including but not limited to marketing information, in all prevalent non-English languages in the service area, consisting of the primary language of 3,000 beneficiaries or five percent of the beneficiary population in the service area (whichever is lower), as well as any language identified as a primary language of a population that meets the concentration standards of 1,000 individuals in a single ZIP code or 1,500 individuals in two contiguous ZIP codes.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

X The State seeks a ~~waiver of~~ a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (*Applies to SMHS, DMC-ODS*)

DHCS Response

42 CFR § 438.10(g)-(h): *DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SMHS through the County MHP and on request and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g)-(h) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS through a County MHP, or SUD services through DMC-ODS.*

42 CFR § 438.10(i): *DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and provider lists that meet the content requirements of § 438.10 to*

beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS

The text stricken out above appears to be a typographical error in the pre-print template.

- X** The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

- _____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages

- X** Potential enrollee and enrollee materials will be translated into the prevalent non-English languages listed below (If the State does not require written materials to be translated, please explain):
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

The State defines prevalent non-English language as:
(check any that apply):

1. _____ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. _____ The languages spoken by approximately _____ percent or more of the potential enrollee/ enrollee population.
3. **X** (Applies to MCMC, Dental MC, SMHS, DMC-ODS)
Other (please explain):

DHCS Response

MCMC, Dental MC, and DMC-ODS: The prevalent non-English languages consist of any languages identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population residing in the service area (whichever is lower), as well as any language identified as a primary language of a population that meets the concentration standards of 1,000 individuals in a single ZIP code or 1,500 individuals in two contiguous ZIP codes.

SMHS: The prevalent non-English languages consist of any languages identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population in the service area (whichever is lower). They are referred to in the SMHS program as “threshold languages.”

- X Please describe how **oral translation services** are available to all potential enrollees and enrollees, regardless of language spoken.

DHCS Response

MCMC: MCPs are required by contract to provide 24-hour oral interpreter services at all key points of contact, either through in-person interpreters, telephone language services, or video remote interpreting services. The services must be available in all languages spoken by Medi-Cal members and potential enrollees. Key points of contact include in the medical care setting – telephone, advice, and urgent care transactions, and outpatient encounters with health care providers including pharmacists; and in the non-medical care setting – member services, orientations, and appointment scheduling.

Dental MC: Dental MC plans are required by contract to provide linguistic services to ensure equal dental services for limited English proficient members. Plan network providers and members are able to access interpretation services 24-hour a day, 7-days a week, without charge to the member. Interpretation services include but not limited to TTY/TDD and telecommunication relay services.

SMHS and DMC-ODS: County MHPs and DMC-ODS plans are required, as specified in regulations, contracts and/or cultural competence plans, to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language, available upon

request and free of charge for any language and to notify beneficiaries that the service is available and how to access it.

- X** The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

DHCS Response

MCMC and Dental MC: *DHCS has a robust program in place to help enrollees and potential enrollees understand the managed care program. The program, known as Health Care Options, provides enrollees and potential enrollees with information on how MCMC and Dental MC works, who must enroll, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, and how to choose a plan. All of this information is provided on a State website, healthcareoptions.dhcs.ca.gov. Also included on the website is quality reporting and provider directories for each participating plan. Additionally, all beneficiaries receive an annual mailing that provides information about the plan options in their county and an enrollment form through which they can select or change plans. The Health Care Options program also hosts in-person information sessions throughout the State in non-COHS counties, where prospective enrollees are presented with information about the MCMC and Dental MC (if applicable) program and help choosing a plan. DHCS also has a Health Care Options call center that is open Monday to Friday, 8 am to 6 pm, except holidays. Toll-free numbers are provided for 18 different languages as well as a TTY line. The Health Care Options program is administered by Maximus, which is under contract with DHCS to serve as Medi-Cal's enrollment broker and perform other outreach and education activities.*

SMHS: *County MHPs provide a beneficiary handbook regarding the SMHS program that includes the county's toll-free 24/7 access line, and a booklet that provides basic information about SMHS and how to access them.*

DMC-ODS: *DMC-ODS plans provides a beneficiary handbook regarding DMC-ODS that includes the toll-free 24/7 access line, and a booklet that provides basic information about DMC-ODS services and how to access them.*

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

_____ State

X contractor (please specify) **Maximus** (Applies to MCMC, Dental MC)

X There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP) (Applies to SMHS, DMC-ODS)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) X the State

(ii) X State contractor (please specify): Information required to be provided under 42 CFR § 438.10 (f)(2)) (Applies to MCMC and Dental MC)

(iii) X the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider (Applies to SMHS, DMC-ODS)

DHCS Response

42 CFR § 438.10(g)-(h): DHCS requests a waiver of 42 CFR § 438.10(g)-(h), which establishes specific requirements for the types, content and distribution of information describing the SMHS and DMC-ODS programs. This allows County MHPs to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SMHS through the County MHP and on request and DMC-ODS to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsections (g)-(h) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's SMHS Section 1915(b) waiver and Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS through a County MHP, or SUD services through DMC-ODS.

42 CFR § 438.10(i): *DHCS requests a waiver of 42 CFR § 438.10(i), which establishes specific requirements for the types, content and distribution of information describing DMC-ODS. This allows the DMC-ODS plan to provide informing materials and provider lists that meet the content requirements of § 438.10 to beneficiaries when they first access SUD services through the DMC-ODS and on request. The waiver of subsection (i) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution. CMS previously approved a waiver of this regulatory provision as 42 CFR § 438.10(f)(3) (prior to amendments made through CMS' 2016 Medicaid managed care rule) in California's Medi-Cal 2020 Section 1115 demonstration. To the extent necessary, the continuation of waivers previously granted are requested of all sections of the federal regulations that mention the obligation to inform all enrollees, to instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SUD services through DMC-ODS*

C. Enrollment and Disenrollment

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

X The State seeks a ~~waiver of a~~ waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C) *(Applies to SMHS, DMC-ODS)*

DHCS Response

Waivers of 42 CFR § 438.56 have been granted previously by CMS. DHCS requests that these waivers again be granted, as they have not detrimentally impacted access to or quality of care.

The text stricken out above appears to be a typographical error in the pre-print template.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

— This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.** Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. X **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

DHCS Response

MCMC and Dental MC: As stated above, DHCS has a robust program in place to help enrollees and potential enrollees understand the managed care program. The program, known as Health Care Options, provides enrollees and potential enrollees with information on how MCMC and Dental MC works, who must enroll, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, and how to choose a plan. All of this information is provided on a State website, healthcareoptions.dhcs.ca.gov. Also included on the website is quality reporting and provider directories for each participating plan. Additionally, all beneficiaries receive an annual mailing that provides information about the options in their county and an enrollment form through which they can select or change plans. DHCS hosts information sessions throughout the State in connection with the Health Care Options program at which State representatives explain the MCMC and Dental MC programs and help beneficiaries choose a plan. DHCS also has a Health Care Options call center that is open Monday to Friday, 8 am to 6 pm, except holidays. Toll-free numbers are provided for 18 different languages.

SMHS and DMC-ODS: DHCS provides information about the SMHS and DMC-ODS programs to potential enrollees, providers, and other interested

parties through the Medi-Cal website and Medi-Cal handbook, which is provided to beneficiaries upon enrollment.

b. Administration of Enrollment Process.

- ☒ State staff conducts the enrollment process. *(Applies to SMHS, DMC-ODS)*
- ☒ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. *(Applies to MCMC, Dental MC)*
- ☒ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: **Maximus**

Please list the functions that the contractor will perform:

- ☒ choice counseling
- ☒ enrollment
- ☐ other (please describe):

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

- ☐ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):
- ☒ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

DHCS Response

MCMC: *Under CalAIM, DHCS is proposing to further standardize MCMC enrollment and require certain additional aid code groups to enroll in MCMC in all counties starting in 2022, and require all dual eligibles to enroll in MCMC in 2023. This will allow MCPs to provide more coordinated and integrated care statewide and provide beneficiaries who have been in FFS or who have not been required to enroll in*

an MCP with a network of primary care providers and specialists.

Effective January 1, 2022. *Mandatory enrollment of:*

- *Trafficking and Crime Victims Assistance Program (except share of cost);*
- *Individuals participating in accelerated enrollment;*
- *Child Health and Disability Prevention infant deeming;*
- *Pregnancy-related Medi-Cal⁸ (Pregnant Individuals only, 138-213 percent FPL citizen/lawfully present);*
- *American Indians and Alaska Natives in non-COHS counties⁹;*
- *Beneficiaries with other health care coverage in non-COHS counties; and*
- *Beneficiaries living in rural zip codes in non-COHS counties.*

Mandatory enrollment of these additional aid code groups will be implemented all at once.

Effective January 1, 2023. *Mandatory enrollment of all dual and non-dual individuals eligible for long-term care services and all partial and full dual aid code groups, except share of cost or restricted scope. Mandatory enrollment of these additional aid code groups will be implemented all at once.*

- X** If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan. *(Applies to MCMC in non-COHS counties, Dental MC)*
- i. **X** Potential enrollees will have **30 days**~~month(s)~~ to choose a plan.
- ii. **X** Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

⁸ Under pending state legislation, pregnant women accessing services FFS prior to January 1, 2022, will remain in FFS through their postpartum period and not be mandatorily enrolled in MCMC.

⁹ As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of MCMC for FFS.

DHCS Response

In non-COHS counties for MCMC and for Dental MC in Sacramento, DHCS uses an auto-assignment algorithm to reward plans with automatic enrollment of Medi-Cal beneficiaries based on encounter data quality and performance measures related to quality and support of safety-net providers. In assigning enrollees through the default process, DHCS does not consider the individual needs or medical and/or dental history of any particular beneficiary. However, a beneficiary who was previously enrolled in a plan or has a family member who is enrolled in a plan will be defaulted into the prior plan or family member's current plan, rather than assigned to a plan through the auto-assignment process. The State refers to this as a continuity of care default.

- X The State **automatically enrolls** beneficiaries
— on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- X on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)(Applies to SMHS, DMC-ODS)
- X on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs:
(Applies to MCMC in COHS counties)

DHCS Response

MCMC: *Under the COHS model, beneficiaries are served by a single plan that is created and administered by a county's board of supervisors, or other local health authority. These single, local plans are considered HIOs, which are managed care delivery systems unique to California and operate under the authority of § 9517(c) of COBRA 1985, which was subsequently amended by § 4734 of OBRA 1990 and MIPAA 2008. HIOs are exempt from the managed care requirements of § 1932 of the Act (implemented through 42 CFR § 438) because they are not subject to the requirements under § 1903(m)(2)(A) that apply to MCOs and*

contracts with MCOs. 42 CFR § 438.2 identifies these as county-operated entities and California state law that passed simultaneously with OBRA 1990 identifies these as COHS. The entities covered by the Section 1915(b) waivers operate under the HIO authority to deliver benefits to State plan populations; the Health Plan of San Mateo is considered a COHS, but is not considered an HIO by federal standards because it became operational after January 1, 1986. A COHS plan must enroll all Medicaid beneficiaries residing in the county in which it operates except when an alternative delivery system is authorized and available in the county.

In certain counties (Humboldt and Orange at the time of this submission), beneficiaries may be subsequently disenrolled from COHS to be enrolled in PACE, if eligible.

In 2022, dual eligible beneficiaries in CCI and COHS counties are subject to mandatory enrollment in MCMC for Medi-Cal benefits, and in non-COHS and non-CCI counties are subject to voluntary enrollment in MCMC for Medi-Cal benefits. Starting January 1, 2023, all dual eligibles except for individuals otherwise excluded from MCMC such as those with a Share of Cost not in institutional long term care and other MCMC excluded populations, will be subject to mandatory enrollment in MCMC. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. These beneficiaries retain ability to opt out of the aligned Medi-Cal MCP if they choose. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2023, and will expand this approach statewide in future years.

_____ The State provides guaranteed eligibility of _____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

X The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:
(Applies to MCMC, Dental MC)

DHCS Response

MCMC – COHS, GMC, Two-Plan, Regional, and Imperial Models:

22 CCR § 53887 governs medical and dental exemption requests. A beneficiary who is receiving a course of treatment for a complex medical (dental) condition that cannot be interrupted from a FFS provider may request a temporary exemption from mandatory enrollment in an MCP. A DHCS approved exemption allows the beneficiary to continue the course of treatment for the complex medical (or dental) condition with the FFS provider. DHCS is authorized to approve or deny a request for medical or dental exemption and an approval is valid for a period of up to 12 months for purposes of continuity of care.

22 CCR § 53887 prohibits DHCS from approving a request for exemption from MCP enrollment for a beneficiary who: (i) has been a member of a plan in the beneficiary's county on a combined basis for more than 90 calendar days; (ii) has a current FFS Medi-Cal provider who is also contracted with an MCP in the beneficiary's county; or (iii) began or was scheduled to begin treatment for the complex medical condition after the date of plan enrollment.

To receive a temporary medical or dental exemption, a beneficiary must submit a form titled, "Request for Temporary Medical (or Dental) Exemption from Plan Enrollment" to DHCS for a determination of whether the clinical information supports approving the exemption. The form is available on DHCS' website and upon request from the MCMC Health Care Options Program.

If the exemption is approved, the beneficiary may continue to receive care from their FFS provider for up to 12 months unless the complex medical (or dental) condition has stabilized to a point where the beneficiary can safely transition to an MCP, or in the case of pregnancy, 90 days after a beneficiary gives birth. See 22 CCR § 53887

After a beneficiary's temporary medical or dental exemption expires, they may apply for a new exemption. If a beneficiary's application for exemption is denied, the beneficiary may be seen by their FFS provider for an additional 12 months, if the provider and the MCP can agree to the continuity of care policies of the beneficiary's MCP. See California Health & Safety Code § 1373.96.

Dental MC:

Pursuant to CA WIC § 14089.09(b)(2), DHCS implemented the Beneficiary Dental Exception (BDE) process for Medi-Cal members in Sacramento County who are unable to secure access to services through their dental plan, in accordance with applicable contractual timeframes and the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with § 1340) of Division 2 of the California Health and Safety Code). The BDE process allows DHCS staff to work with the plans on behalf of the members to facilitate the scheduling of appropriate appointments based on the identified needs of the member. If an appointment is available within the required timeframe, DHCS will work with the plan and the member to coordinate care.

If an appointment is not available within the required timeframe, the member may request to opt-out of Dental MC and move into Dental FFS delivery system where they may select their own dental provider on an ongoing basis. The member may remain in FFS until he or she chooses to opt back into Dental MC.

- X (Applies to MCMC, Dental MC) The State automatically re-enrolls a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

DHCS Response

Waivers of 42 CFR § 438.56 have been granted previously in connection with SMHS and DMC-ODS. DHCS requests that these waivers again be granted, as they have not detrimentally impact access to or quality of care

- X The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
(Applies to MCMC in non-COHS counties, Dental MC)

- i. X Enrollee submits request to State.

DHCS Response

Disenrollments and plan changes are submitted to the State's enrollment broker, Maximus. Maximus processes these requests on behalf of the State.

- ii. ___ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

X The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area. *(Applies to MCMC in COHS counties, SMHS, DMC-ODS)*

DHCS Response

MCMC: *In COHS counties, mandatory enrollees are restricted to a single plan. Under all other models, mandatory enrollees have a choice of plans, and in San Benito County, a choice between a single plan and FFS.*

SMHS and DMC-ODS: *Beneficiaries receive SMHS and DMC-ODS from their county's plans, without any option for disenrollment.*

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ___ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

DHCS Response

X The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request. *(MCMC in non-COHS counties, Dental MC)*

X The State permits MCOs/PIHPs/PAHPs and PCCMs to request disenrollment of enrollees. Please check items below that apply: *(Applies to MCMC, Dental MC)*

- i. **X** MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

DHCS Response

MCMC: Any reason determined by the state to constitute good cause as set forth in 22 CCR § 53891(a)(7).

- ii. **X** (*Applies to MCMC, Dental MC*) The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. **X** (*Applies to MCMC, Dental MC*) If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. **X** (*Applies to MCMC, Dental MC*) The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee Rights

1. Assurances.

- X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- _____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- _____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- X State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:
 - a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
 - b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
 - c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable. (*Applies to MCMC, SMHS, DMC-ODS*)

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

- X** The State requires enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing. *(Applies to MCMC, SMHS, DMC-ODS)*

DHCS Response

As per 42 CFR § 438.402, an enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination. And, if the MCO, PIHP, or PAHP fails to adhere the notice and timing requirements under 42 CFR § 438.408, the enrollee is deemed to have exhausted the MCO, PIHP, or PAHP appeals process and may initiate a State fair hearing.

- ___ The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

- X** The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **60** days (between 20 and 90). *(Applies to MCMC, SMHS, DMC-ODS)*

- ___ The State's timeframe within which an enrollee must file a **grievance** is ___ days.

DHCS Response

This question appears out-dated. Per 42 CFR § 438.402(c)(2)(i), a Medicaid plan enrollee may file a grievance at any time. DHCS has adopted this standard consistent with federal requirements.

c. Special Needs

- X** The State has special processes in place for persons with special needs. Please describe.

DHCS Response

MCPs must ensure California Children Services (CCS) members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. CCS-eligible members enrolled in managed care are provided the same grievance, appeal, and SFH rights as other MCP members. MCPs must have time

processes for accepting and acting upon member grievances and appeals. Enrollees appealing a CCS eligibility determination must appeal to the county CCS program.

In accordance with CA WIC § 14094.13, MCPs may extend the CCS continuity of care (COC) period, at their discretion, beyond the initial 12 month period. MCPs must provide CCS eligible members with a written notification 60 days prior to the end of the 12 month COC period informing members of their right to request a COC extension and the CCS appeal process for COC limitations. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes set by the State. If MCPs deny requests for extended COC, they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion.

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services. (*Dental MC*)

 X The State has a grievance procedure for its ___ PCCM and/or X PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
 ___ the State
 ___ the State's contractor. Please identify: _____
 ___ the PCCM
 X the PAHP.

 X Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

DHCS Response

The PAHP maintains an appeals and grievance system to ensure the recipient, review, and resolution of grievances and appeals. Appeal and grievance are defined as follows:

- *Appeals: An appeal is a review by the PAHP of an adverse benefit determination.*
- *Grievances: A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by the PAHP to make an authorization decision.*

X Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

DHCS Response

The committee that reviews and resolves requests for review is an PAHP Administrator function. The PAHP has a grievance and appeals committee that meets on a quarterly basis to discuss, track, and trend grievances and appeals. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified. All grievances and appeals related to dental quality of care issues are immediately submitted to the PAHP's dental director for action.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

DHCS Response

- *Appeals must be filed within 60 calendar days from the date on the Notice of Action (NOA) letter to file an appeal. If the enrollee is currently receiving treatment and wishes to continue getting treatment, the enrollee must ask for an appeal within 10 days from the date of the postmarked NOA or before the date the PAHP says services will stop.*
- *Grievances can be filed at any time.*

X Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

DHCS Response

- *Appeals: The PAHP has 30 days to provide a response. The response is communicated through a "Notice of Appeal Resolution" (NAR) letter. This letter will tell the enrollee what the PAHP has decided. If the enrollee does not get a letter within 30 days, the enrollee can ask for an Independent Medical Review (IMR) within 180 days from the date of the NAR letter, an outside reviewer that is not related to the PAHP will review the case, or request a state hearing and an administrative law judge will review the case. For the request for state hearing, the enrollee must request (by phone or writing) it no later than 120 days from the date of the NAR letter.*
- *Grievances resolution should not exceed 30 calendar days from the date of the receipt of the grievance.*

X Establishes and maintains an expedited review process for the following reasons:_____. Specify the time frame set by the State for this process_____

DHCS Response

- *Appeals: An enrollee can request expedited appeals if the enrollee is in pain or thinks waiting 30 days will harm their health or dental function. The PAHP will make a decision within 72 hours of receiving enrollee's appeal. 42 CFR § 438.408 (b) and (c) allows for a 14 calendar day extension for standard and expedited appeals.*
- *Grievances: 42 CFR § 438.408(b) and (c) allow for a 14 calendar day extension for standard and expedited appeals. This does not apply to grievances.*

X Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

DHCS Response

The PAHP provides the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony. The PAHP informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified and in the case of expedited resolution.

- X** Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

DHCS Response

- *NOA: Formal letter informing an enrollee of an adverse benefit determination.*
- *NAR: Formal letter of the results of the resolution and date it was completed.*
- *Grievances: In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the PAHP shall notify the member in writing of the status of the grievance and the estimated date of resolution in accordance with existing state regulations.*

____ Other (please explain):

F. Program Integrity

1. Assurances.

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

2. Assurances For MCO or PIHP programs

- X** The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- X** State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- _____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X** The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.*(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require

the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Part I: Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

DHCS Response

DHCS' 10-year vision for Medi-Cal is to implement a whole-system, person-centered, population health approach to equitable health and social care. This is an integrated "wellness" system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health. Services and support will deliver high-quality care that is accessible and useable to achieve more equal health outcomes across the entire continuum of care, for all.

DHCS envisions transitioning to this future state via immediate recovery efforts arising out of the COVID-19 pandemic and longer-term strategy leveraging the CalAIM initiative. The COVID-19 pandemic had clear impact on health care delivery and outcomes, in addition to exacerbating underlying health care disparities. In direct response to this, DHCS' immediate quality efforts will include focused efforts to address gaps in care and eliminate longstanding health care disparities in: 1) children's preventive services, 2) integrated behavioral health and 3) maternal outcomes, particularly in the postpartum period. In parallel, the quality strategy will focus on the implementation of Population Health Management, which serves as a cornerstone of the CalAIM proposal. This cohesive plan of action for addressing member needs across the continuum of care based on data-driven risk stratification, predictive analytics, identifying gaps in care, and standardized assessment processes will allow DHCS to drive quality and equitable outcomes for all beneficiaries via a foundation of preventive care, patient-centered chronic disease management, and whole-person care for high-risk populations that address and mitigate social determinants of health.

All of these efforts will be built upon foundational principles of data-driven improvements that address the whole person, eliminating health care disparities through community-centered collaboratives, and transparency and accountability, as reflected in the monitoring activities below.

The following reflects across the four delivery system programs that DHCS is seeking to authorize under this Section 1915(b) waiver:

- Medi-Cal Managed Care (MCMC), which are MCOs and HIOs;*
- Dental Managed Care (Dental MC), which are PAHPs;*
- The Specialty Mental Health Services (SMHS) Program, which are PIHPs; and*
- The Drug Medi-Cal Organized Delivery System (DMC-ODS), which are PIHPs.*

Table 7: Overview of Monitoring Activities

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
a) Accreditation for Non-duplication				MCMC, Dental MC							MCMC, Dental MC	MCMC, Dental MC
b) Accreditation for Participation				MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC	MCMC, Dental MC
c) Consumer Self-Report data					MCMC		MCMC, SMHS, DMC-ODS					MCMC, Dental MC, SMHS, DMC-ODS
d) Data Analysis (non-claims)			MCMC, Dental MC			MCMC, Dental MC, SMHS, DMC-ODS	See j. Network Adequacy Assurance by Plan	MCMC, Dental MC	MCMC, Dental MC			
e) Enrollee Hotlines	MCMC, Dental MC		MCMC, Dental MC									

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
f) Focused Studies							MCMC	MCMC				MCMC,
g) Geographic Mapping								MCMC, Dental MC, SMHS, DMC-ODS				
h) Independent Assessment												
i) Measure Any Disparities by Racial or Ethnic Groups												MCMC
j) Network Adequacy Assurance by Plan	SMHS, DMC-ODS					SMHS, DMC-ODS	MCMC, Dental MC, SMHS, DMC-ODS	MCMC, Dental MC, SMHS, DMC-ODS	MCMC, Dental MC, SMHS, DMC-ODS			

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
k) Ombudsman			<i>MCMC, Dental MC, SMHS, DMC-ODS</i>		<i>MCMC, Dental MC, SMHS, DMC-ODS</i>							
l) On-Site Review	<i>SMHS, DMC-ODS</i>		<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>	<i>Dental MC, SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>	<i>Dental MC, SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>
m) Performance Improvement Projects					<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>
n) Performance Measures						<i>SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>		<i>SMHS, DMC-ODS</i>		<i>SMHS, DMC-ODS</i>	<i>MCMC, Dental MC, SMHS, DMC-ODS</i>

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
o) Periodic Comparison of # of Providers								MCMC				
p) Profile Utilization by Provider Caseload												
q) Provider Self-Report Data												
r) Test 24/7 PCP Availability					SMHS, DMC-ODS	SMHS, DMC-ODS	MCMC					
s) Utilization Review												MCMC, SMHS, DMC-ODS
t. 1.) Other: Annual Marketing Plan		MCMC, Dental MC										

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
t. 2.) Other: Ongoing Monitoring Activities of SMHS and DMC-ODS	SMHS, DMC-ODS			SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS	SMHS, DMC-ODS

Part II: Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

A. Accreditation for Non-Duplication

- a. X Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

X NCQA
____ JCAHO
____ AAAHC
____ Other (please describe)

DHCS Response

Applicable programs: MCMC and Dental MC

Personnel responsible: Delegated to plan (MCPs)

Detailed description of activity: DHCS does not currently require NCQA accreditation of its MCPs; however, many MCPs have chosen to pursue accreditation voluntarily, or because they also provide Qualified Health Plan coverage through Covered California (the State's health insurance marketplace) in which plans are required to be accredited by National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC). As of December 2020, 17 of the 24 MCPs in the State are NCQA accredited. Dental MC plans are not required to be accredited by NCQA or a private independent

accrediting entity; however, DHCS will require all MCPs achieve NCQA accreditation by 2026.

DHCS deems any MCP that is NCQA-accredited for credentialing in the State's annual Audits & Investigations (A&I) medical audits; in other words, NCQA-accredited MCPs are exempt from the credentialing section of the medical audit.

Frequency of use: *The A&I medical audit occurs annually. MCPs that are accredited are reviewed by NCQA every three years.*

How it yields information about the area(s) being monitored: *NCQA accreditation covers six categories: quality improvement, population health management, network management, utilization management, credentialing, and member experience. Accreditation by NCQA ensures that the MCP has met the similar DHCS requirements for credentialing. MCPs are deemed to have met the DHCS credentialing requirements, because the NCQA standard is considered consistent with and as stringent as the DHCS standard for credentialing. By deeming, DHCS relieves both the MCP and A&I State auditing staff of this particular section of the audit review.*

B. Accreditation for Participation

b. X Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- X NCQA
- JCAHO
- AAAHC
- Other (please describe)

DHCS Response

Applicable programs: *MCMC and Dental MC*

Personnel responsible: *Delegated to plan (MCPs)*

Detailed description of activity: *As noted above, DHCS will require all MCPs achieve NCQA accreditation by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal MCPs meet particular State and federal Medicaid requirements, as it does with credentialing today. DHCS will review and consider additional elements of NCQA health plan accreditation standards for deeming and vet these elements with stakeholders before finalizing decisions.*

Frequency of use: *MCPs with NCQA accreditation are reviewed by NCQA every three years.*

How it yields information about the area(s) being monitored:
 NCQA health plan accreditation yields information in six categories: quality improvement, population health management, network management, utilization management, credentialing, and member experience. Accreditation by NCQA will assist in streamlining DHCS monitoring and oversight of MCPs in these areas. As noted above, DHCS already utilizes NCQA accreditation to deem MCPs in one area, credentialing.

C. Consumer Self-Report Data

c. X Consumer Self-Report data

- X CAHPS (CAHPS 5.0 Adult Medicaid and CAHPS 5.0 Child Medicaid Health Plan Surveys with the HEDIS supplemental item set)
- ___ State-developed survey
- ___ Disenrollment survey
- ___ Consumer/beneficiary focus groups

DHCS Response

Applicable programs: MCMC

Personnel responsible: EQRO

Detailed description of activity: The administration of CAHPS surveys is optional under federal laws for Medicaid external quality review (EQR) activities at 42 CFR § 438.358(c)(2). This Medicaid EQR activity assesses managed care beneficiaries' satisfaction with their health care services in the areas that contribute to quality of care. The goal is to provide performance feedback that is actionable and will aid in improving overall beneficiary satisfaction and to illuminate any issues with quality of care for the State and MCPs to address. DHCS chooses to require that CAHPS surveys are periodically administered to both adult beneficiaries and parents or caretakers of child beneficiaries and contracts with an EQRO to administer and report results from:

- Title XIX Medicaid Managed Care Adult and Child Population (Medicaid): This is a statewide aggregated report, presenting statewide data and stratified by MCP. It includes the global and composite measures below in Table 8.
- Title XXI Children's Health Insurance Program population (CHIP): This is a statewide aggregated report, presenting statewide data, but not MCP-specific stratifications. It differs from the Title XIX Medicaid CAHPS report above in that

while it includes the global and composite measures, it also includes the Children with Chronic Conditions (CCC) composite measures and items. See Table 8 for more.

Frequency of use:

- The Title XIX Medicaid CAHPS survey and report have traditionally been conducted every three years, but beginning in 2020, the frequency increased to every two years.
- The Title XXI CHIP CAHPS survey and report are conducted annually.

How it yields information about the area(s) being monitored:

The standardized data and results are used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time. Together, these assessments take into consideration beneficiary feedback and therefore contribute to monitoring efforts that lead to improved quality and provision of health care under Medi-Cal. According to CMS, “the quality of services is measured clinically, administratively, and through the use of patient experience of care surveys.”¹⁰ An overview of CAHPS results appears in the annual EQR Technical Report that is published in accordance with 42 CFR § 438.364.

Table 8: Global and Composite Measures for Title XIX Medicaid and Title XXI CHIP CAHPS Reports. The surveys include questions that address each listed topic within a rating/measure category. The CCC composite measures apply only to children with chronic conditions.

Global Ratings	Composite Measures	CCC Composite Measures and Items
<i>Rating of Health Plan</i>	<i>Getting Needed Care</i>	<i>Access to Specialized Services</i>
<i>Rating of All Health Care</i>	<i>Getting Care Quickly</i>	<i>Family Centered Care (FCC): Personal Doctor Who Knows Child</i>
<i>Rating of Personal Doctor</i>	<i>How Well Doctors Communicate</i>	<i>Coordination of Care for Children with Chronic Conditions</i>
<i>Rating of</i>	<i>Customer</i>	<i>Access to Prescription Medicines</i>

¹⁰ CAHPS Survey Webpage, Centers for Medicare and Medicaid Services, at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS>, accessed April 23, 2021.

Global Ratings	Composite Measures	CCC Composite Measures and Items
<i>Specialist Seen Most Often</i>	<i>Service</i>	
	<i>Shared Decision Making</i>	<i>FCC: Getting Needed Information</i>

Applicable programs: Dental MC, SMHS, and DMC-ODS

Personnel responsible: Dental MC plans, County MHPs, and DMC-ODS plans

Detailed description of activity: DHCS utilizes consumer perception surveys to obtain feedback from beneficiaries regarding the care and services received from Dental MC plans operating in Sacramento and Los Angeles counties, County MHPs, and DMC-ODS plans. Surveys are provided by the Dental MC plans, County MHPs, and DMC-ODS plans to beneficiaries and parent/caregivers of children and youth who receive services from county-operated contracted providers (as applicable).

For dental beneficiaries, the surveys are administered by SPH Analytics who report the results of the Child Dental Satisfaction Survey as part of its process for evaluating the quality of dental services provided to children enrolled in Dental MCPs plans. The survey is designed to evaluate overall consumer satisfaction with Dental MCPs and the network of contracted providers.

For SMHS and DMC-ODS beneficiaries, the survey results also inform the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures (NOMs) reporting.

Frequency of use: Consumer perception surveys are conducted annually using a convenience sampling method.

How it yields information about the area(s) being monitored: The surveys collect descriptive information from each beneficiary and include questions about beneficiary satisfaction with services and quality of care (Dental MC, SMHS, DMC-ODS); timely access to care and providers available to beneficiaries (Dental MC, SMHS, DMC-ODS); whether the services improved the beneficiaries' functions across several domains (SMHS) and ability to abstain from drugs and alcohol (DMC-ODS); beneficiary engagement in

treatment planning (DMC-ODS); and plans' cultural sensitivity (DMC-ODS) – all areas of DHCS monitoring.

D. Data Analysis (non-claims)

- d. X Data Analysis (non-claims)
- | | |
|-------------|---|
| <u> </u> | Denials of referral requests |
| <u>X</u> | Disenrollment requests by enrollee (MCMC, Dental MC) |
| <u> </u> | <u>X</u> From plan (MCMC) |
| <u> </u> | From PCP within plan |
| <u>X</u> | Grievances and appeals (MCMC, Dental MC, SMHS, DMC-ODS) |
| <u>X</u> | PCP termination rates and reasons (MCMC) |
| <u> </u> | Other (please describe) |

DHCS Response

Strategy 1: Disenrollment requests by enrollee from MCP

Applicable programs: MCMC and Dental MC

Personnel responsible: State staff and Health Care Options (HCO) contractor

Detailed description of activity: HCO processes enrollments and disenrollments from MCPs that are requested by the beneficiary. Beneficiaries can request an enrollment and/or disenrollment by phone or by mail by mailing in the Choice Forms. For disenrollments, beneficiaries can disenroll from their MCP for various reasons. Some reasons include:

- *Enrolled incorrectly into an MCP*
- *Problem using the HCO*
- *Other health or dental coverage*
- *Moved out of county*
- *Plan did not cover beneficiary needs*
- *Could not choose doctor beneficiary wanted*

The Ombudsman also processes disenrollments when requested by the beneficiary.

To track enrollee disenrollment requests, Customer Service Representatives (CSRs) at the HCO call center use the Customer Relationship Management (CRM) database, and the Ombudsman uses the Salesforce database and the Cisco VoIP system. These databases are used to record the number of calls, types of calls, language of the caller, caller's county, and subject of calls. So that the State can monitor beneficiaries' disenrollment requests, HCO and the Ombudsman produce reports on all disenrollment activity

(see below for frequency of reports and information yielded). HCO CSRs and the Ombudsman also work to maintain current governmental policies and procedures and any changes that may directly affect beneficiaries.

Frequency of use: *Monthly and quarterly – HCO produces and submits its Disenrollment Report monthly to DHCS for review; the Ombudsman produces its Disenrollment Report quarterly and shares it with the Advisory Group and posts it to the DHCS website, in accordance with State Senate Bill 97.*

How it yields information about the area(s) being monitored: *The HCO and Ombudsman-produced reports cover all disenrollment activity, such as the quantity of disenrollments and reasons for disenrollment. DHCS reviews the information provided to identify fluctuations and/or trends in MCMC and Dental MC disenrollments and takes action as needed.*

Strategy 2: Grievance and appeal data

Applicable programs: *MCMC, Dental MC, SMHS, DMC-ODS*

Personnel responsible: *State staff, Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans*

Detailed description of activity: *DHCS requires Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans to collect grievance and appeals data and submit this information to DHCS using a standardized reporting format. These reports summarize the numbers of grievances, appeals, expedited appeals, and information on whether the grievances, appeals, and expedited appeals are related to areas such as access, denial of services, change of provider, quality of care, confidentiality, or other issues. Information is also provided regarding dispositions (e.g., resolved, still pending).*

DHCS reviews the information provided and identifies specific deficiencies that would need to be addressed through local quality improvement processes, which may include data analysis, assessment, and comparison against established quality improvement goals, and design and implementation of interventions to improve performance. DHCS also works with MCPs, Dental MC plans, County MHPs, and DMC-ODS plans on corrective actions resulting from the annual on-site reviews, as well as through focused reviews based on significant findings identified outside of regularly scheduled audits.

For SMHS and DMC-ODS, DHCS plans to integrate reporting by County MHPs and DMC-ODS plans during this waiver period, supporting an integrated oversight approach among county-operated behavioral health programs.

Frequency of use:

- MCMC, Dental MC: Quarterly
- SMHS, DMC-ODS: Annually

How it yields information about the area(s) being monitored:

Grievance and appeal data provides information on the categories, process, and disposition of concerns affecting beneficiaries, particularly in the areas of access to and quality of care. DHCS is able to use this information to identify deficiencies and trends. DHCS also reviews grievance and appeals data alongside data on out-of-network requests and State fair hearings to better understand if coordination of care and continuity of care requirements are being met by MCPs – grievance data can be used to highlight member concerns relating to coordination of care and/or continuity of care, while out-of-network requests can show the effectiveness of care coordination and State fair hearings can indicate improper denials of continuity of care or an MCP's coordination of a member's care.

Strategy 3: Primary care provider (PCP) termination rates and reasons

Applicable programs: MCMC

Personnel responsible: State staff and MCPs

Detailed description of activity: MCPs are required to submit quarterly Provider Network Reports and Subcontractors Reports. Among other things, the reports include all PCP terminations that occurred during the reporting period. The PCP termination data identifies whether MCPs can maintain an adequate provider network and indicate if there are significant network changes.

MCPs must notify DHCS immediately upon discovery, within 10 days of learning of a PCP's exclusion from participation in the Medical program, or at least 60 days prior to a voluntary termination of a PCP that impacts 2,000 or more beneficiaries, or results in the MCP to no longer be compliant network adequacy. MCPs must submit a narrative including how the MCP intends to provide services to impacted beneficiaries, the reason for PCP termination,

and the identity of the receiving provider, if applicable. Additionally, MCPs may submit required documentation to help DHCS determine if the MCP's provider network is adequate to provide covered services to its members.

Frequency of use: MCPs submit quarterly Provider Network Reports and Subcontractor Reports. MCPs must also notify DHCS when there is a PCP termination immediately upon discovery, within 10 days of learning of a PCP's exclusion from participating in the Medi-Cal program, or at least 60 days prior to the termination effective date.

How it yields information about the area(s) being monitored: PCP termination data identifies whether MCPs can continue to maintain compliance with network adequacy requirements. Re-certification of providers may be required when PCP terminations result in significant changes to the MCP's provider network or their members' access to care.

E. Enrollee Hotlines Operated by State

e. X Enrollee Hotlines operated by State

DHCS Response

Applicable programs: MCMC and Dental MC

Personnel responsible: HCO contractor

Detailed description of activity: Through its enrollee hotline, HCO provides information to Medi-Cal beneficiaries about MCPs. Beneficiaries can call the HCO line toll free at 1-800-430-4263 (English) Monday – Friday from 8 am – 6 pm Pacific Time for information on how Medi-Cal managed care works, who must enroll, beneficiary disenrollment requests, how to get a medical or non-medical exemption from enrollment, what medical and dental benefits are covered, how to choose an MCP, and the beneficiary's enrollment status. There are additional toll-free numbers for the 18 other spoken threshold languages and TTY at 1-800-430-7077. HCO CSRs can also help beneficiaries complete enrollment/disenrollment over the phone.

Frequency of use: On a monthly basis, HCO produces an Enrollment Summary Report, a Beneficiary Information Report, and a Telephone Call Center Report for DHCS review.

How it yields information about the area(s) being monitored: As noted above, CSRs at the HCO call center use the CRM database for various

tracking purposes. The database records the number of calls, types of calls, language of the caller, caller's county, and subject of calls, among other things. DHCS and the HCO contractor review the information to identify any trends or concerns that may lead to enhancements to the HCO enrollee hotline.

F. Focused Studies

- f. **X** Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

DHCS Response

Applicable programs: MCMC

Personnel responsible: EQRO

Detailed description of activity: DHCS contracts with an EQRO to conduct focused studies in accordance with 42 CFR § 438.358(c)(5) to gain a better understanding of and identify opportunities for improving clinical and non-clinical services provided to beneficiaries. Focused study topics and lengths of studies vary. During the past several years, the EQRO has conducted focused studies on a range of topics, including a long-acting reversible contraceptive utilization; opioids and tobacco cessation; timely access to care; and health disparities in the Asian sub-population demographic.

For each focused study, in accordance with CMS protocols, the EQRO defines the scope of work and expected objectives for the focused study topic; conducts an in-depth literature review to identify the best practices for the populations under study; and develops a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data collection process, and analytic plan. Each focused study may require the adaptation of standard health care quality measures for applicability to special populations; as a result, DHCS requires that the EQRO's analytic plan details the technical specification for these measures to ensure methodological soundness and reliable calculability for the populations under study.

Frequency of use: Annually.

How it yields information about the area(s) being monitored: At the end of each focused study, the EQRO produces a stand-alone report in the format and with the content approved by DHCS to yield information on

the area being monitored. In addition to presenting the findings associated with the study question(s), the focused study report discusses the implications of results in light of the policy environment within the State and presents actionable recommendations to improve the delivery of health care to beneficiaries. DHCS uses focused study findings to inform its approach for improving actions related to quality monitoring or performance improvement activities in partnership with the MCPs. For example, methodology development began in 2016 for the first annual Timely Access study, which appeared in the 2017-18 EQR Technical Report. This recurring study yields information on how well MCPs are providing urgent and non-urgent appointment times within the established time allowances across provider specialties. In addition to publicly publishing the results in the annual EQR Technical Report, DHCS also shares the results with the MCPs and, where applicable, mandates improvements if an MCP's performance is inadequate. Another example of the EQRO's focused studies is the Asian Sub-Population Disparity study, which found that quality of care differed among linguistic sub-populations within the larger racial/ethnic category labeled "Asian." In addition to the focused study results appearing in stand-alone reports, summaries of the results and conclusions also appear in the annual EQR Technical Report, as required by 42 CFR § 438.364.

G. Geographic Mapping of Provider Network

g. X Geographic mapping of provider network

DHCS Response

Applicable programs: MCMC and Dental MC

Personnel responsible: State staff, Medi-Cal MCPs, Dental MCPs

Detailed description of activity: DHCS' Annual Network Certification (ANC) process includes verification of MCPs and Dental MC plans' geographic allocation of network providers and compliance with time and distance standards. MCPs and Dental MC plans submit accessibility analyses and geographic access maps to demonstrate compliance. The analyses must demonstrate coverage of the MCPs and Dental MC plans entire service area(s) for current and anticipated beneficiaries for all ZIP codes by provider type.

If an MCP or Dental MC plan is unable to comply with the time or distance standards, the MCP or Dental MC plan must submit an alternative access standard (AAS) request to DHCS for review and approval. The MCP or Dental MC plan must prove it has exhausted all other reasonable options for contracting with providers in order to meet time and distance standards before DHCS will consider approving the AAS request. MCPs or Dental

MC plans that fail to meet the ANC requirements or any other network adequacy requirements imposed by State or federal law or the plan contract may be placed under a corrective action plan and be subject to monetary sanctions.

Frequency of use: Annual for the ANC process. As needed for AAS requests and plan ANC non-compliance.

How it yields information about the area(s) being monitored:

Accessibility analysis and geographic access maps are used to ensure MCPs and Dental MC plans are compliant with time or distance standards, with results stratified by adult and pediatric populations and provider types including PCPs, specialty providers, hospitals, and pharmacies.

Applicable programs: SMHS and DMC-ODS

Personnel responsible: State staff, County MHPs, and DMC-ODS plans

Detailed description of activity: *County MHPs and DMC-ODS plans must submit rendering provider locations to DHCS on an annual basis. DHCS uses geographic mapping technology to plot provider locations and transpose the locations of Medi-Cal eligible individuals per county, service type, and age group (as obtained from DHCS Medi-Cal Eligible Data System) to analyze compliance with time and distance standards. The analyses must demonstrate coverage of County MHPs and DMC-ODS entire service area(s) for current and anticipated beneficiaries for all ZIP codes by provider type. Once the analyses are complete, DHCS notifies each county of identified deficiencies,*

If a County MHP or DMC-ODS plan is unable to comply with the time or distance standards, the County MHP or DMC-ODS plan must submit an AAS request to DHCS for review and approval. The County MHP or DMC-ODS plan must prove it has exhausted all other reasonable options for contracting with providers in order to meet time and distance standards before DHCS will consider approving the AAS request. County MHPs or DMC-ODS plans that fail to meet network adequacy time and distance standards, or any other requirements imposed by State or federal law or the County MHP or DMC-ODS contract, may be placed under a corrective action plan and be subject to administrative or financial sanctions.

Frequency of use: Annual.

How it yields information about the area(s) being monitored:

Accessibility analysis and geographic access maps are used to ensure County MHPs and DMC-ODS plans are compliant with State time and distance standards, with results stratified by adult and pediatric

populations and provider types.

H. Independent Assessment

- h. Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

I. Measurement of Any Disparities by Racial or Ethnic Groups

- i. X Measurement of any disparities by racial or ethnic groups

DHCS Response

Applicable programs: MCMC

Personnel responsible: State staff and EQRO

Detailed description of activity:

- ***Health Disparities Reports:*** DHCS contracts with an EQRO to conduct an annual analysis of health disparities and generate a report of their findings. The report relies on the quality measures reported by all full scope MCPs. Quality measures are stratified by demographics such as race/ethnicity and primary language to identify health disparities by certain populations.
- ***Preventive Services Report:*** DHCS, with assistance from its EQRO, develops an annual Preventive Services Report that focuses on statewide MCP-level results of pediatric health outcomes and health care utilization measures. The report stratifies by demographics such as race/ethnicity, primary language, age, gender, Medi-Cal managed care delivery type model, population density, and county. Health disparity analysis is available for each reported measure, with a particular focus on CMS Child Core Set Measures, and compared with nationwide and statewide data (when available).
- ***Medi-Cal Managed Care Performance Dashboard:*** DHCS collects and stratifies data for race/ethnicity, primary language, and geographic region through the quarterly Medi-Cal Managed Care Performance Dashboard, housed in the CHHS Open Data Portal. The Dashboard is a comprehensive collection of data on Medi-Cal enrollment, utilization, appeals, grievances, network adequacy, and quality of care. Moving forward, DHCS plans to leverage this data and the State's ability to stratify by race/ethnicity, primary language, and other critical demographics to better identify, prevent, mitigate, and understand health disparities in Medi-Cal.

Frequency of use: Annually.

How it yields information about the area(s) being monitored:

- Health Disparities Report: The annual health disparity analysis report helps assess health disparities and provides information to the State and MCPs to address health disparities and improve health equity. The report is posted online and provides information about the differences between populations at the State level. The EQRO also produces an analysis at the MCP level that is provided to each MCP. Data provided to the MCPs must be used by the MCP in their Population Needs Assessments, and may inform other MCP quality improvement activities, including but not limited to Performance Improvement Projects. The report is also utilized by DHCS to establish strategic goals, identify opportunities to drive improvements in health equity through Medi-Cal policy, and help inform further data analysis, which may take the form of a Focus Study (see f. above).
- Preventive Services Report: Disparities findings from the Preventive Services Report analysis focus on children enrolled in Medi-Cal and are shared with MCPs to help deploy targeted interventions to improve outcomes in regions or in certain demographic groups where disparities have been identified.
- Medi-Cal Managed Care Performance Dashboard: The quarterly analysis will be used to identify, prevent, mitigate, and understand health disparities based on critical demographics enrolled in Medi-Cal managed care. This is part of DHCS' larger goal to address health disparities and discrimination in Medi-Cal.

J. Network Adequacy Assurance Submitted by Plan

j. X Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

DHCS Response

Applicable programs: MCMC, Dental MC, SMHS, and DMC-ODS

Personnel responsible: State staff, Medi-Cal MCPs, Dental MCPs, County MHPs, and DMC-ODS plans

Detailed description of activity: In accordance with 42 CFR § 438.207, DHCS certifies Medi-Cal MCPs', Dental MC plans', County MHPs', and DMC-ODS plans' provider networks to ensure compliance with State and

federal standards as part of DHCS' ANC. DHCS reviews all Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan network adequacy submissions to ensure they demonstrate compliance in the following areas:

- *Time and distance standards—geographic access mapping;*
- *Network composition and capacity;*
- *Provider-to-beneficiary ratios (MCMC, SMHS, and Dental MC only);*
- *Timely access to appointments;*
- *Continuity of care;*
- *Minimum contracts with mandatory provider types; and*
- *Language assistance capabilities.*

*All Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans are required to submit enrollment and provider network data to DHCS that demonstrate that their provider networks meet the **network adequacy standards for availability and accessibility of services**. Provider networks must also offer an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (e.g., the county). Each Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan must maintain a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in their service area. DHCS reviews data and information from multiple sources – including network data, claims data, enrollment data, eligibility data, external quality reviews, and provider files submitted by the plans – to analyze the adequacy of each provider network.*

In addition, Medi-Cal MCPs, Dental MC plans, County MHPs and DMC-ODS plans are required to immediately notify DHCS any time there has been a significant change in their operations that would affect the adequacy and capacity of services, including (but not limited to) the composition of the provider network.

*Each Medi-Cal MCP, Dental MC plan, and County MHP must also submit data that documents the **timeliness of services** provided to beneficiaries. Each Medi-Cal delivery system has a specific approach to assess compliance with timely access standards and leverage the data to enable more detailed monitoring and oversight of timely access:*

- **MCMC:** *DHCS contracts with the EQRO to conduct a Timely Access Survey, the results of which are shared with DHCS for DHCS review. DHCS also shares the results of the Timely Access Survey with the MCPs on a quarterly basis and mandates improvements if an MCP's performance is determined as inadequate, per State timely access standards. DHCS also publishes a Timely Access Report annually that presents the results by MCP and shows how MCPs' performances compare with*

one another across the State.

- **Dental MC:** Dental MC plans report to DHCS compliance data and conduct phone calls on a random sample of primary and specialty dental providers within the plans' reported networks; DHCS reviews the data collected, which is then used to establish a baseline for each plan with the number of days and an average range of time it takes enrollees to access services in their county.
 - Initial Appointment – 4 weeks
 - Routine Appointment (non-emergency) – 4 weeks
 - Preventive Dental Care Appointment – 4 weeks
 - Specialist Appointment (adult) – 30 business days
 - Specialist Appointment (children) – 30 calendar days
 - Emergency Appointment – 24 hours

In addition, the Dental MC plans survey all primary care dentists on the average amount of time it takes for members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments. The Dental MC plans also use surveys to collect data on the number of “no show” appointments, the number of rescheduled appointments, the availability of interpreter services and an answering service, and the ratio of members to primary care dentists. DHCS collects and monitors the timely access data on a quarterly basis leading up to the ANC submission to CMS, as required by 42 CFR § 438.20.

- **SMHS:** The timely access data collected is used to establish a baseline for County MHPs that includes, but is not limited to, the number of days and an average range of time it takes to receive an assessment and/or treatment appointment in their county. DHCS analyzes the date of a beneficiary's first request for an assessment and the first appointment date offered. For non-urgent, non-psychiatrist appointments, counties must provide an appointment within 10 business days as per CA WIC § 14197(d)(1), for 70 percent of beneficiaries.

For DMC-ODS, DHCS reviews each DMC-ODS plan's policy and procedures regarding timely service to ensure compliance with timely access standards. Aligning with County MHPs (beginning FY 2022 – 2023 and continuing onward), each DMC-ODS plan will be required to submit data that documents the timeliness of services provided to Medi-Cal beneficiaries. The data will include information such as all service requests received by the DMC-ODS plan (and its network providers) during the applicable reporting period. The timely access data collected from each DMC-ODS plan will be used to establish a baseline for each DMC-ODS plan that includes the number of days and an average range of

time it takes to receive an assessment and/or treatment appointment in their county.

To analyze the adequacy of each provider network, DHCS reviews State, Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan-level data and information including network data, claims data, enrollment data, eligibility data, external quality review findings, and provider files submitted by the delivery systems' plans.

As previously noted, Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans that fail to meet ANC requirements will be placed under an ANC corrective action plan. As part of the corrective action plan process, Medi-Cal MCPs, Dental MC plans, and County MHPs must submit a plan of action detailing the steps they will take to remedy deficiency findings. Compliance requirements depend on the conditions of the corrective action plan and the specific delivery system – for example, Medi-Cal MCPs generally have six months to correct all deficiencies and meet compliance prior to DHCS closing the corrective action plan. DHCS also has authority to impose monetary sanctions for failure to comply with network adequacy requirements.

Frequency of use: *Each Medi-Cal MCP, Dental MC plan, County MHP, and DMC-ODS plan submits documentation assuring adequate capacity and services on an annual basis, in accordance with § 438.207(c).*

How it yields information about the area(s) being monitored: *The information described above allows DHCS to assure plans meet federal and State requirements of maintaining an adequate network to serve beneficiaries. This includes, but is not limited to, ensuring the required provider-to-beneficiary ratios, access to providers within applicable time and distance standards, and access to appointments within timely access standards. The assurance further allows DHCS to confirm that plans that are not compliant with ANC requirements are still able to coordinate and arrange for services for beneficiaries while remedying deficiencies through the corrective action plan process.*

DHCS submits its Assurance of Compliance to CMS on an annual basis as required by 42 CFR § 438.207(d) and posts the report, once approved by CMS, on [DHCS' Network Adequacy webpage](#).

K. Ombudsman

k. X Ombudsman

DHCS Response

Applicable programs: *MCMC, Dental MC, SMHS, and DMC-ODS*

Personnel responsible: *State staff*

Detailed description of the activity: *The purpose of the Ombudsman is to help solve problems from an independent and neutral standpoint to ensure that beneficiaries receive all medically necessary covered services for which Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans are contractually responsible.*

The Ombudsman:

- *Serves as an objective resource to resolve issues between Medi-Cal managed care beneficiaries and Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans.*
- *Helps beneficiaries with urgent enrollment and disenrollment problems.*
- *Offers information and referrals.*
- *Identifies ways to improve the effectiveness of the Medi-Cal managed care program.*
- *Educates beneficiaries on how to effectively navigate through the Medi-Cal managed care system.*
- *Connects beneficiaries with the right person/department to help them resolve a problem.*
- *Connects beneficiaries with local resources in their county who can help.*
- *Connects beneficiaries with patients' rights services.*

Beneficiaries are able to contact the office 24 hours a day, 7 days a week by email. Ombudsman staff are available Monday – Friday from 8 am to 5 pm Pacific Time, excluding holidays.

Frequency of use: *The Ombudsman produces the Senate Bill 97 Report quarterly, which includes all beneficiary calls received by the Ombudsman. These reports include the number of contacts received by phone and email, the average time for the Ombudsman to answer, the number and rate of calls abandoned, the results of the contacts including the destination of the referred calls, the number of calls referred to another entity, and demographic information.*

How it yields information about the area(s) being monitored: *The Ombudsman utilizes the Salesforce and Cisco VoIP system database for tracking purposes. This database is used to record and produce reports on the numbers of calls, type of calls, language of the caller, caller's county, and subject area of calls. Ombudsman staff capture enrollment/disenrollment transactions via Salesforce to document the reason for each transaction. DHCS reviews the information provided to*

identify fluctuations and/or trends in Medi-Cal Managed Care enrollment/disenrollment.

L. On-Site Review

I. X On-site review

DHCS Response

Plan Oversight Reviews (also known as annual medical audits and triennial reviews)

To determine compliance with DHCS contract requirements as well as applicable State and federal laws and regulations, DHCS conducts regular oversight reviews of Medi-Cal MCPs, Dental MC plans, County MHPs, and DMC-ODS plans. Historically, these oversight reviews have occurred on-site. However, with advances in technology and the COVID-19 pandemic, DHCS has been able to conduct these oversight reviews virtually in an effective manner. Ongoing, DHCS will leverage a combination of on-site and virtual modalities to conduct oversight reviews.

Applicable programs: MCMC, Dental MC, SMHS, DMC-ODS

Personnel responsible: State staff

Detailed description of activity: DHCS conducts annual oversight reviews, known as “**annual medical audits**” of MCMC MCPs and Dental MC plans in accordance with CA WIC § 14456. Medical audits evaluate MCPs’ compliance with DHCS contract requirements and applicable State and federal laws, regulations and guidelines. The audit scope encompasses six categories including:

- Utilization management;
- Case management and coordination of care;
- Access and availability;
- Member rights;
- Quality improvement; and
- Administrative and organizational capacity.

The annual medical audit generates a report that summarizes the findings of the compliance review. MCPs may be placed on a corrective action plan for each deficiency that is found to be out of compliance. The MCP must respond to the corrective action plan by proposing a corrective action and/or documentation of the implementation of the corrective action. State staff review CAPs and provide technical assistance to the MCP, as needed, until the deficiencies are resolved. As noted, through 2020 and 2021, DHCS has successfully conducted annual medical audits virtually and may continue to do so, where applicable and appropriate, in the

coming years.

DHCS also conducts **triennial oversight reviews** onsite or virtually of each County MHP and DMC-ODS plan to determine compliance with federal and State regulations as well as the terms of the MHP and DMC-ODS plan contract. At the conclusion of the triennial review, DHCS identifies strength-based practices of the County MHP and DMC-ODS plan and provides feedback on areas of noncompliance. DHCS provides the County MHP and DMC-ODS plan with a written report of findings, which includes a description of each finding, a description of any corrective actions needed, and timeframes required for the SHMS MHP and DMC-ODS plan to come into compliance. Using a collaborative and educational approach, DHCS provides guidance and technical assistance if it determines that the MHP or DMC-ODS plan is out of compliance.

Frequency of use: Annual for MCMC and Dental MC; at least every three years for SMHS and DMC-ODS.

How it yields information about the area(s) being monitored: Oversight reviews provide DHCS with valuable information needed to evaluate plan performance on access and availability, utilization management, case management and coordination of care, quality improvement, member rights, and administrative and organizational capacity. These audits help DHCS determine plan compliance with requirements, and the corrective action plan process allows DHCS to monitor the progress with corrective actions, to ensure that compliance in the future.

Site Reviews

Applicable programs: MCMC

Personnel responsible: Delegated to Medi-Cal MCPs

Detailed description of activity: State law requires MCPs to ensure adequate facilities and service site locations are available to meet contractual requirements for the delivery of primary care within their service areas. All primary care provider sites must have the capacity to support the safe and effective provision of primary care services. To ensure compliance, MCPs are required to perform initial and subsequent site reviews, consisting of a Facility Site Review and a Medical Record Review, using the DHCS tools and standards.

DHCS oversees and monitors the MCP implementation of the site review policy. Monitoring may include, but is not limited to: DHCS-conducted site reviews; oversight of the MCP methods for monitoring provider sites

between periodic site reviews; and verification of appropriate use of the reviewers within their legal scope of practice, the standards outlined in this policy, and local collaborative processes. Monitoring methods may also include observing site reviewer training and certification processes, assessing data collection methods, and evaluating aggregate reports.

Frequency of use: At least every three years

How it yields information about the area(s) being monitored: *This activity helps DHCS and the MCPs ensure network providers are meeting regulatory and contractual requirements – including requirements regarding safe and complete provision of care and the provision of preventive services to beneficiaries – which informs DHCS and the MCPs on the quality of care being delivered to beneficiaries. When providers are not performing adequately, they are placed under a corrective action plan and are required to make necessary changes to their practice to ensure the deficiencies are corrected. This helps ensure that MCMC beneficiaries are offered the same, high-level quality of care – for example, in line with preventive services recommendations based on national standards, such as the American Academy of Pediatrics, United States Preventive Services Task Force, and American College of Obstetricians and Gynecologists.*

M. Performance Improvement Projects

- m. **X** Performance Improvement projects [**Required** for MCO/PIHP]
X Clinical (MCMC, SMHS, DMC-ODS)
X Non-clinical (Dental MC, SMHS, DMC-ODS)

DHCS Response

Applicable programs: MCMC

Personnel responsible: State staff, MCPs, and EQRO

Detailed description of activity: *Per 42 CFR § 438.330(b)(1) and (d)(1-4), all MCPs, as a part of their ongoing comprehensive quality assessment and performance improvement program, are required to conduct Performance Improvement Projects. Per DHCS' contracts with its MCPs, each MCP is required to conduct or participate in two annual PIPs. The PIPs are detailed quality improvement (QI) projects that utilize a rapid cycle Plan-Do-Study-Act (PDSA) methodology to test and adapt interventions to foster QI change. DHCS' EQRO monitors each MCP's PIPs, which are submitted in modules. An MCP is required to pass each module before progressing to the next module. Once the PIP is concluded, the EQRO validates the results of the PIP by assessing the validity and reliability of the MCPs' PIP results based on CMS' validation*

protocols. The annual technical report can be found on the DHCS [Medi-Cal Managed Care Quality Improvement Reports webpage](#).

Frequency of use: Ongoing—each MCP is required to conduct two PIPs at all times; each PIP lasts approximately 18 months.

How it yields information about the area(s) being monitored: The rigorous process of conducting the PIPs, similar to other QI activities, can yield information on quality of care and access to care by testing and adapting interventions to address quality and access issues, so that they reach optimal impact. When an MCP finds a successful intervention through this process, they expand the intervention to other areas of their operation, as feasible, leading to greater quality and access to care. The QI process required by the PIPs can also uncover disparities in the access, provision, and/or receipt of health care. The PIPs, like other QI activities, help drive improvement through targeted provider and beneficiary specific interventions.

Applicable programs: Dental MC

Personnel responsible: Delegated to Dental MCPs and EQRO

Detailed description of activity: Through the Dental MC contract, MCPs are required to participate in two annual Quality Improvement Projects (QIPs), a “Statewide Collaborative QIP” and an “Individual QIP” (PIP). For the “Statewide Collaborative QIP,” DHCS designates the topic of review, choosing a key area for all Dental Medi-Cal MCPs to focus on. In January 2018, DHCS issued APL 18-002, establishing the goal of the Statewide Collaborative QIP. Consistent with the objective of Domain 1 of the Dental Transformation Initiative (DTI), the Statewide Collaborative QIP aims to increase the annual percentage of preventive services utilization of children ages 1-20 by 10 percent over a five-year period.

For the “Individual QIP” (PIP), the MCPs have the discretion to focus on any area identified by the MCP as in need of improvement. The EQRO is tasked with producing the annual technical report in compliance with Title 42, 42 CFR § 438.464 and 457.1250. The annual technical report can be found on the DHCS website [here](#).

Frequency of use: Annually, Dental MCPs submit two reports: (1) intervention progress report to the EQRO for the “Statewide Collaborative QIP” and (2) QIP submission to DHCS.

How it yields information about the area(s) being monitored: DHCS requires the Dental MCPs to conduct their PIP using the EQRO’s rapid-cycle PIP process, which can yield information on quality of care and

access to care. The QI process required by the PIP can also uncover disparities in the access, provision, or receipt of health care. The PIP activities can help drive improvement through targeted provider and beneficiary specific interventions.

Applicable programs: SMHS and DMC-ODS

Personnel responsible: State staff, County MHPs, DMC-ODS plans, and EQRO

Detailed description of activity: Pursuant to federal and State regulations, County MHPs and DMC-ODS plans are required to conduct two annual PIPs – one clinical and one non-clinical – focused on improving specific administrative and clinical performance in order to improve access to and quality of SMHS and DMC-ODS services.

The EQRO conducts external quality reviews of County MHPs and DMC-ODS plans and evaluates and collects information regarding the PIPs. The EQRO summarizes its findings in individual County MHP and DMC-ODS plan reports, quarterly PIP reports, and annual aggregate summary reports. The reports can be found on CalEQRO's website [here](#).

Frequency of use: Ongoing; each MHP and DMC-ODS plan is required to conduct two PIPs at all times. Each PIP lasts approximately 12 months.

How it yields information about the area(s) being monitored: PIPs provide information to County MHPs and DMC-ODS plans that assist them to continue to make program enhancements and improve the coordination, quality, effectiveness, and/or service efficiency. The ultimate goal of a PIP is to drive continuous quality improvement activities.

N. Performance Measures

- n. X Performance measures [Required for MCO/PIHP]
- | | |
|---------------|---|
| <u> </u> | Process |
| <u> X </u> | Health status/outcomes (MCMC, SMHS, DMC-ODS) |
| <u> X </u> | Access/availability of care (MCMC, SMHS, DMC-ODS) |
| <u> X </u> | Use of services/utilization (MCMC, SMHS, DMC-ODS) |
| <u> </u> | Health plan stability/financial/cost of care |
| <u> </u> | Health plan/provider characteristics |
| <u> X </u> | Beneficiary characteristics (SMHS, DMC-ODS) |

DHCS Response

Applicable programs: MCMC

Personnel responsible: State staff, Medi-Cal MCPs, and EQRO

Detailed description of activity: In accordance with 42 CFR § 438.330, all Medi-Cal MCPs, as a part of their ongoing comprehensive quality assessment and performance improvement program, are required to participate in the collection and submission of performance measurement data. Full scope MCPs must report annually on a series of quality metrics known as the Managed Care Accountability Set (MCAS). Measures on the MCAS are all derived from the CMS Adult and Child Core Sets and include preventive care measures, access to care measures, measures of chronic disease management, and behavioral health measures for adults, pregnant women, and infants and children.

DHCS establishes thresholds or benchmarks for certain MCAS measures that MCPs are required to meet (the Minimum Performance Level or MPL). If MCPs do not meet the MPL of a required measure, the MCPs may be subject to required quality improvement work, financial sanctions, and/or corrective action plans with increased monitoring.

As required by 42 CFR § 438.358, 438.364, and 457.1250, DHCS contracts with an EQRO to conduct an independent assessment of the Medi-Cal program and to prepare an annual technical report. As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and CHIP populations, including a description of the manner in which the data from all activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of and access to the care furnished by the MCP. The EQRO's independent assessment covers the calculation and validation of performance measures for Medi-Cal MCPs.

Frequency of use: Annual.

How it yields information about the area(s) being monitored: The performance measures are reported annually to DHCS via the EQRO, which audits and validates MCPs' performance measurement rates. The performance measure rates provide a record of how each MCP performs compared to the national benchmarks as well as to one another, and helps DHCS and the MCPs identify priorities for intervention and action. Performance on health outcome or process measures provides a picture of the overall quality of care provided by the MCP. If MCPs fail to meet DHCS' performance standards (the MPL), DHCS may require quality improvement activities, financial sanctions, and/or corrective action plans. Overall, the results provide DHCS with valuable information on the quality, access, and timeliness of care provided to beneficiaries at both the MCP and county levels. The EQRO's annual technical report can be found on the DHCS website [here](#).

Applicable programs: Dental MC

Personnel responsible: State staff, Dental MCPs, and EQR

Detailed description of activity: DHCS maintains ongoing oversight of Dental MC plans' utilization through the monitoring of the following 13 performance measures:

- Annual Dental Visit
- Use of Preventive Services
- Use of Sealants
- Count of Sealants
- Count of Fluoride Varnishes
- Use of Diagnostic Services
- Treatment/Prevention of Caries
- Exams/Oral Health Evaluations
- Use of Dental Treatment Services
- Preventive Services to Fillings
- Overall Utilization of Dental Services (one year, two years, three years)
- Continuity of Care
- Usual Source of Care

DHCS uses Healthcare Effectiveness Data and Information Set (HEDIS)-like criteria to calculate performance measure utilization for Dental MC plans. DHCS uses Current Dental Terminology codes, which includes dental-specific procedure codes, to accurately capture Dental MC utilization.

DHCS retrieves encounter data from the MIS/DSS data warehouse to calculate Dental MC utilization for each of the 13 performance measures above. DHCS also validates the encounter data from the plans on a quarterly basis by cross-referencing it with the plans' self-reported performance measure reports.

Pursuant to CA WIC § 14459.6, the utilization performance measures are available for public review on a quarterly basis on DHCS' website [here](#).

Frequency of use: Annual.

How it yields information about the area(s) being monitored: The performance measures are reported annually to DHCS via its EQRO, which audits and validates the plans' performance measurement rates. The results provide DHCS information about the quality, access, and timeliness of care provided to beneficiaries at the Dental MC plan and county-level. This helps DHCS and Dental MC plans identify priorities for intervention and action.

Applicable programs: SMHS

Personnel responsible: State staff, County MHPs, and EQRO

Detailed description of activity: As described in DHCS' Medi-Cal Managed Care Quality Strategy, available [here](#), DHCS conducts statewide continuous quality improvement efforts to improve the quality and performance of the SMHS program; these efforts include monitoring and oversight of County MHPs' performance and quality improvement activities.

The Performance Outcomes System (POS) and the SMHS Section 1915(b) waiver Special Terms and Conditions (STCs) (2015 – 2021) both require DHCS to develop SMHS performance reports and dashboards. In developing these reports and dashboards, DHCS has greatly strengthened its quality measures and reporting methodologies, which serve as a strong foundation upon which DHCS will continue to improve its SMHS quality assessment and performance improvement program.

The quality improvement goals and priorities for SMHS include:

- Providing high-quality and accessible SMHS; and
- Improving coordination of care within DHCS' service delivery systems as well as other service systems the SMHS beneficiaries commonly access.

The seven domains of DHCS' quality measurement and reporting program for SMHS include:

- Access;
- Engagement;
- Service Appropriateness to Need;
- Service Effectiveness;
- Linkages;
- Cost Effectiveness; and
- Satisfaction.

DHCS publishes statewide population reports based on county sizes (small rural, small, medium, large, very large) and county-level reports (formerly known as the POS) to the SMHS Performance Dashboard.

In addition, pursuant to the SMHS Section 1915(b) waiver STCs, DHCS has developed and published an SMHS Performance Dashboard for each MHP, which must be published on both the State's and County MHPs' websites in a manner that is easily accessible by the public. The SMHS Performance Dashboards must include MHP performance in the following areas: quality, access, timeliness, and translation/interpretation

capabilities. Archived Statewide Aggregate SMHS Performance Dashboards and the County-Level SMHS Performance Dashboards are accessible on the DHCS website [here](#). The SMHS Performance Dashboards for 2019 and beyond are accessible on the CHHS Open Data Portal [here](#).

Benchmarks and performance targets for SMHS are evolving areas and DHCS will continue its efforts to determine appropriate benchmarks and performance targets for County MHPs.

Frequency of use: Annual.

How it yields information about the area(s) being monitored: The reports described above include data on the demographics for four populations (Adult, Children/Youth, Children/Youth with an Open Child Welfare Case, Children/Youth in Foster Care) by age, gender, and race/ethnicity. Penetration information is provided for each population served and not served. The importance of including demographic information is to help better understand each population receiving SMHS program services. Utilization of services reports are shown in terms of dollars, as well as by service in time increments. This information helps identify which services are being utilized most over time and those that are not. The snapshot data show mental health service utilization by group, providing a view of each population in the system as of a certain point in time. Data on step-down services (i.e., time to next contact after an inpatient discharge) are also made available to help the State better identify issues with timeliness.

Applicable programs: DMC-ODS

Personnel responsible: State staff and DMC-ODS plans

Detailed description of activity: Using Section 1115 demonstration authority, DHCS implemented DMC-ODS plans through counties that opted in to develop and implement DMC-ODS services between 2015 and 2021. As of May 2021, there are 37 counties providing DMC-ODS services in various stages of implementation from the early adopters that have been providing services for three years to the more recent counties that began implementation in July 2020.

As described in DHCS' Medi-Cal Managed Care Quality Strategy, posted [here](#), DHCS will be developing performance measures for DMC-ODS services based on the findings from the EQRO review process, UCLA evaluation findings, and the DHCS DMC-ODS reviews and oversight activities as described elsewhere in this document.

The quality improvement goals and priorities for DMC-ODS are to provide high-quality and accessible DMC-ODS services and improve coordination of care within DHCS' service delivery systems as well as other service systems the DMC-ODS beneficiaries commonly access.

Frequency of use: Annual.

How it yields information about the area(s) being monitored: *The collection and review of performance measures will help determine the effectiveness of the DMC-ODS program while assisting the State and stakeholders with identification of gaps in services, disparities, and quality issues. The DHCS quality measures for the DMC-ODS are intended to measure whether organized SUD care increases the success of DMC-ODS beneficiaries while decreasing other system health care costs.*

O. Periodic Comparison of Number and Types of Medicaid Providers Before and After Waiver

- o. X Periodic comparison of number and types of Medicaid providers before and after waiver

DHCS Response

Applicable programs: MCMC

Personnel responsible: State staff and Medi-Cal MCPs

Detailed description of activity: *DHCS captures the number and types of MCMC providers through various reporting mechanisms, among them:*

- *The ANC process, which reviews the number of Medi-Cal providers (primary care physicians and specialists) in each MCP's network to identify provider-to-member ratios, and the number and types of providers available in each MCP's service area(s) to determine compliance with time and distance standards;*
- *Network Provider Templates submitted by MCPs to DHCS on a quarterly basis outlining new contracts, as well as contract terminations that occurred during the reporting period;*
- *Monthly data submitted by MCPs through the 274 File on the number and types of Medi-Cal providers, including but not limited to primary care, specialty care, facilities, vision care, mental health, and ancillary providers; and*
- *Monthly data checks by DHCS to analyze MCP compliance with provider reporting requirements.*

Frequency of use: Monthly, Quarterly, and Annually.

How it yields information about the area(s) being monitored: During the ANC, DHCS evaluates the MCPs' networks to ensure that MCPs have the sufficient number of providers to meet provider-to-member ratios and are able to meet time and distance standards. As described in greater detail elsewhere in this document, MCPs that are non-compliant with either of these components (provider-to-member ratios and time and distance standards) are placed under a CAP until the MCP has rectified the deficiency(ies). Further, DHCS performs quality checks on MCPs' monthly 274 File submissions to ensure that provider information is entered correctly, and provides technical assistance when errors are identified.

P. Profile Utilization by Provider Caseload

p. ____ Profile utilization by provider caseload (looking for outliers)

Q. Provider Self-Report Data

q. ____ Provider self-report data
____ Survey of providers
____ Focus groups

R. Test 24 Hours/7 Days a Week PCP Availability

r. **X** Test 24 hours/7 days a week PCP availability

DHCS Response

Applicable programs: MCMC

Personnel responsible: Medi-Cal MCPs

Detailed description of activity: DHCS requires MCPs to monitor 24/7 plan physician availability through the Medi-Cal managed care contracts. MCPs must have a plan or contracting physician available to coordinate the transfer of care of a beneficiary whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel. MCPs must submit to DHCS policies and procedures related to these requirements and are subject to a medical audit, in the event it is required.

Frequency of use: MCPs submit policies and procedures upon becoming a Medi-Cal MCP and when edits have been made.

How it yields information about the area(s) being monitored: This activity provides information about adherence to contract requirements

and MCP policy and procedures related to access to care. MCPs must have approved timely access policies and procedures and must monitor network providers' compliance with access requirements. DHCS auditors may review policy and procedures and call transcripts or recordings to ensure lines are operational. Auditors may also review complaints for call lines if beneficiaries are not receiving timely access to appointments or care. Auditors may also call physician line to ensure availability.

Applicable programs: SMHS and DMC-ODS

Personnel responsible: DHCS, County MHPs, and DMC-ODS plans

Detailed description of activity: County MHPs conduct test calls to test the 24/7 access line and submit test call results to DHCS quarterly. DHCS reviews and analyzes the results and provides technical assistance during monthly individual county calls, as needed. DHCS also conducts test calls to test the 24/7 access line before each triennial review. DHCS intends to extend this requirement to DMC-ODS plans.

Frequency of use: Ongoing—monthly, quarterly, annually, and triennially.

How it yields information about the area(s) being monitored: If the County MHP or DMC-ODS plan is found to be partially or totally out of compliance based on the test call, the County MHP or DMC-ODS plan will be required to submit a corrective action plan, and DHCS will monitor the progress of corrective action plan implementation and resolution.

S. Utilization Review

- s. X Utilization review (e.g. ER, non-authorized specialist requests)

DHCS Response

Applicable programs: MCMC

Personnel responsible: EQRO

Detailed description of activity: On an annual basis, DHCS, with assistance from the EQRO, undertakes extensive analysis of children's utilization of preventive care services in MCMC. Utilization rates for pediatric preventive care are analyzed in the DHCS- and EQRO-developed Preventive Services Report, which focuses on statewide MCMC MCP-level results of pediatric health outcomes and health care utilization measures. This effort is in addition to tracking health care utilization through the established set of measures for MCMC MCPs through MCAS. Utilization data is analyzed by measure, age, and various demographic factors, with the goal of identifying patterns of health

disparities and underutilization of preventive care services.

Frequency of use: *Annually.*

How it yields information about the area(s) being monitored: *The findings from the Preventive Services Report help inform MCP actions for the upcoming year as it relates to performance improvement actions, provider engagement, and other steps that either the MCP or DHCS can leverage to help drive improvement in utilization of preventive care services among pediatric populations.*

Applicable programs: *SMHS and DMC-ODS*

Personnel responsible: *EQRO*

Detailed description of activity: *DHCS contracts with an EQRO to perform extensive analysis of children's and adults' utilization of behavioral health services provided under the SMHS and the DMC-ODS programs. Utilization rates for behavioral health care are analyzed in separate County MHP and DMC-ODS county reports as well as in an Annual Statewide Technical Report. Utilization data is analyzed by performance measure, age, and various demographic factors with the goal of identifying patterns of behavioral health disparities and underutilization of behavioral health care services.*

Frequency of use: *Annually.*

How it yields information about the area(s) being monitored: *The findings from the individual County MHP/DMC-ODS county reports and the Annual Statewide Technical Report help inform County MHP and DMC-ODS county actions for the upcoming year as it relates to performance improvement actions, provider engagement, and other steps that the County MHPs, DMC-ODS counties, or DHCS can leverage to help drive improvement in utilization of behavioral health care services.*

T. Other

t. X Other: (please describe)

DHCS Response

1. Annual Marketing Plan

Applicable programs: *MCMC and Dental MC*

Personnel responsible: *State staff*

Detailed description of activity: DHCS conducts an annual review of the detailed marketing plans submitted by each MCMC MCP and Dental MC plan. DHCS also conducts recurring reviews of submissions for events and materials to ensure items meet contract requirements and adhere to the State-approved marketing plan. Items subject to State review include:

- Member evidence of coverage;
- Provider directory (including personalized provider directory, if applicable to county);
- Marketing events;
- MCP-developed programs (i.e., well-baby, well-woman, asthma control); and
- DHCS-developed programs and services (i.e., Pediatric Palliative Care, Health Homes).

Frequency of use: Ongoing – annually for State review of the MCP marketing plans; daily (as needed) for State review of marketing event and material submission.

How it yields information about the area(s) being monitored: The State's review of MCPs' marketing-related materials helps ensure adherence to approved marketing plans, overall accuracy, and compliance with State and federal requirements (e.g., requirements enumerated in 42 CFR § 438.10) and contract requirements.

2. Ongoing Monitoring Activities

Applicable programs: MCMC, SMHS, DMC-ODS

Personnel responsible: DHCS, MC MCPs, County MHPs, and DMC-ODS plans, EQRO

Detailed description of activity: DHCS conducts ongoing monitoring of County MHPs and DMC-ODS plans' compliance through:

- **Tiered Review Approach.** DHCS utilizes a tiered compliance rating system to monitor County MHPs and DMC-ODS plans' rates of compliance with contract requirements. County MHPs and counties may move from tier to tier depending on their overall compliance percentage for each review. DHCS may identify the need to improve upon or modify the tiered process to be more effective and efficient.
- **Focused Reviews, Focused Training, and Technical Assistance.** DHCS conducts focused and/or more frequent reviews regarding compliance deficiencies and potential compliance concerns. Based on the focused reviews, DHCS may

provide focused training and technical assistance activities, such as site-specific trainings. Also, the EQRO provides technical assistance to the MCPs for EQRO activities. This includes calls, webinars, email support, and hosting a Quality Conference.

- **Monitoring Calls/Webinars.** *DHCS conducts a monthly call/webinar with all of the County Behavioral Health Departments and the California Behavioral Directors Association (CBHDA). DHCS conducts individual monthly monitoring calls/webinars with each MCMC MCP, County MHP, and DMC-ODS plan. If in the course of monthly monitoring activities, it is determined that a MCMC MCP, County MHP, or DMC-ODS plan requires additional oversight (e.g., increased grievances related to contractual requirements), then DHCS may initiate focused review. DHCS conducts weekly webinars with MCPs and quarterly meetings with MCP Chief Executive Officer's to provide necessary updates that impact the MCPs.*
- **Quarterly Monitoring.** *DHCS conducts quarterly monitoring of MCPs by validating each MCP's data submission on network access components (i.e., provider to member ratios, Timely Access Survey results, and out-of-network requests) and member grievances to assess MCPs' compliance with access and member rights. Any instances of noncompliance or insufficient progress on previously identified deficiencies require MCPs to provide responses to DHCS. DHCS provides technical assistance to MCPs to correct deficiencies.*

Frequency of use:

- *Tiered Review System: Determined Annually*
- *Focused Review and Focused Training/Technical Assistance: As needed*
- *Monitoring Call/Webinar: Monthly for County MHPs and DMC-ODS plans, Weekly and Quarterly for MCPs*
- *Quarterly Monitoring: Quarterly*

How it yields information about the area(s) being monitored: *The tiered review approach yields systemic ways to track County MHPs and DMC-ODS plans' compliance rate changes and allows DHCS to proactively identify potential compliance concerns. The focused review and focused training/technical assistance is an additional monitoring mechanism to address potential compliance issues with additional support for County MHPs and DMC-ODS plans to come into compliance. Monthly all county behavioral health and CBHDA calls provide technical assistance to all county behavior health programs regarding changes, trends, and focused areas affecting the counties' compliance with regulatory and contractual requirements of the SMHS Section 1915(b) waiver. Monthly individual monitoring calls/webinar with each county yield information*

about the county's progress in corrective action plan implementation and the implementation of any changes and new regulatory and contractual requirements, and provide an opportunity for enhanced monitoring and technical assistance.

EQRO Technical Assistance yields information about best practices on a range of quality improvement topics. Examples include iterative feedback to MCPs to help them conduct the Plan Do Study Act cycle for PIPs, as well as the EQRO creating a collaborative forum for MCPs to share methods such as those that successfully encouraged participation in women's health screening in immigrant communities and outreach efforts that improved the rate of well child visits in some counties. Weekly meetings are conducted with all MCPs, and quarterly meetings are conducted with all MCP Chief Executive Officers to provide updates, implementations of any changes and new regulatory and contractual requirements. Reoccurring monitoring calls are conducted with MCPs to provide updates and any changes that impact the plan(s) and to ensure MCPs are compliant with all contract reporting and submission requirements. The quarterly monitoring activities analyze MCPs' provider to member ratios, timely access, mandatory provider types, and grievances to ensure MCPs are compliant with contractual requirements outside of the ANC. Any instances of noncompliance are followed up by DHCS, and MCPs are required to remedy any deficiencies.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

☐ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

☒ This is a renewal request.

☐ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

☒ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

Confirm it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.

Summarize the results or findings of each activity. CMS may request detailed results as appropriate.

Identify problems found, if any.

Describe plan/provider-level corrective action, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.

Describe system-level program changes, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

___ Yes

___ No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)

The following monitoring results are applicable to SMHS.

A. Accreditation for Non-Duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the State-specific standards)

N/A

B. Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

N/A

C. Consumer Self-Report Data

DHCS Response

Strategy 1: Consumer Perception Survey

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

Consumer perception surveys were conducted using a convenience sampling method. During a one week survey period, twice a year, surveys were provided by counties to consumers and parent/guardians of child consumers who received services from county-operated and contracted providers. The surveys were originally developed and used in compliance with SAMHSA requirements for the Mental Health Block Grant, so surveys were provided to all consumers who received community mental health services (both non-Medi-Cal mental health services as well as Medi-Cal SMHS).

The surveys collected descriptive information from each consumer and included questions about consumer satisfaction with services and whether the services improved their ability to function across several domains. Four types of forms were used: Adult (for ages 18-59), Older Adult (for ages 60+), Youth Services Survey (YSS); for ages 13-17 and transition-age youth who still receive services in the child system, and YSS for Families (YSS-F); for parents/caregivers of youth under age 18)). The forms were available in eight languages: English, Arabic, Chinese, Hmong, Russian, Spanish, Tagalog, and Vietnamese.

The data was analyzed in accordance with the SAMHSA Scoring Protocols for consumer perception surveys. California's Adult and Older Adult Survey items were scored together to yield federal Mental Health Statistics Improvement Program (MHSIP) results; and California's Youth and Caregiver Surveys were scored together to yield federal YSS/YSS-F results.

Below are the results of the convenience sampling process.

Percentage of Positive Responses Adults and Older Adults Receiving Services in FY 2015-16:

- *Access 85.2 percent (total responses: 40,709)*
- *Quality and Appropriateness 88.8 percent (total responses: 39,895)*
- *Outcomes 69.7 percent (total responses: 37,696)*
- *Participation in Treatment Planning 79.5 percent (total responses: 38,598)*
- *General Satisfaction with Services 90.2 percent (total responses: 41,128)*
- *Functioning 69.6 percent (total responses: 38,242)*
- *Social Connectedness 67.8 percent (total responses: 38,083)*

Percentage of Positive Responses Youth Receiving Services in FY 2015-16:

- *Access 79.5 percent (total responses: 17,370)*
- *General Satisfaction with Services 84.8 percent (total responses: 17,734)*
- *Outcomes 69.0 percent (total responses: 17,431)*
- *Family Member Participation in Treatment Planning 80.1 percent (total responses: 17,543)*
- *Cultural Sensitivity of Staff 91.0 percent (total responses: 16,802)*
- *Functioning 73.1 percent (total responses: 17,265)*
- *Social Connectedness 82.9 percent (total responses: 17,343)*

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

DHCS Response

Strategy 2: Onsite Triennial System Review of MHP Beneficiary Satisfaction Policies/Process

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

During the triennial onsite reviews, State staff reviewed the strategies used by County MHPs related to beneficiary satisfaction. All County MHPs are required to have a mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. The County MHPs are asked to provide examples of how they have used satisfaction survey results or outcomes to identify opportunities for improvement and what steps the MHP has taken to make such improvements or address any concerns raised. Examples of changes that might be made are changes to policies, procedures, processes, forms, in addition to treatment services and programs. The County MHPs are required to have baseline statistics with goals for each year.

Average compliance ratings related to the County MHPs having a mechanism in place to regularly gather and measure beneficiary satisfaction are reflected in the table below:

Table 9: Area of Compliance: Beneficiary Satisfaction

<i>Fiscal Year</i>	<i>Number of County MHPs Reviewed</i>	<i>Average Percent Compliance</i>
<i>FY 2014-2015</i>	<i>20</i>	<i>95%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>100%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>100%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>100%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>94%</i>
<i>AVERAGE LAST THREE-YEAR CYCLE</i>		<i>98%</i>

Problems identified:

Overall there was a high level of compliance in this area. There were a small number of County MHPs identified that did not present adequate documented evidence that the MHP regularly gathered and measured beneficiary satisfaction.

Corrective action (plan/provider level):

County MHPs were required to submit corrective action plans to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

D. Data Analysis (non-claims)

DHCS Response

Strategy 1: Grievance and Appeals: Review and Analysis of MHP Annual Reports

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

County Mental Health Plans submitted to DHCS Annual Beneficiary Grievance and Appeals Reports (ABGAR) which included data on grievances, appeals, expedited appeals and Notices of Adverse Benefit Determinations (NOABD). The grievance and appeals data was analyzed to identify potential trends and/or issues that should be addressed with individual County MHPs or that indicate statewide trends that may require technical assistance or policy clarification. For example, an MHP's data could show a significant increase or decrease in grievances, appeals and NOABDs issued in comparison to the previous three fiscal years.

DHCS staff reviewed all information and reports provided by County MHPs to address any inconsistencies or data incongruities (e.g., sum of individual categories did not add up to totals). Once the accuracy of the information was confirmed, DHCS analyzed the information and identified trends such as County MHPs that reported either unusually high or low numbers of grievances and/or appeals and worked with County MHPs to obtain additional information and/or provide technical assistance.

Pursuant to the 2015—2020 Section 1915(b) SMHS waiver STCs, DHCS submitted annual grievance and appeal reports to CMS.

Corrective Action (plan/provider level):

County MHPs analyzed their data and trends and worked with local quality improvement committees to develop strategies to improve quality of services. DHCS worked with County MHPs that had unusually low numbers of grievances or appeals to ensure that County MHPs were well informed on the correct grievance and appeals to report and the established reporting mechanism to collect data. For

example, one MHP had a significant decrease in grievances and appeals in FY 2017-18 in comparison to FY 2016-17. The MHP was in the process of building an electronic tracking system to centralize the collection of the MHP's grievance, appeals, and NOABD data synchronized which led to significant decrease of data reported. An additional factor in the reduction in grievances was due in large part to a better understanding by MHP staff on how to classify grievances received by the MHP. In previous ABGAR reports, the MHP would include grievances and complaints receive from non-Medi-Cal beneficiaries, including those related to Social Security and services not provided by the MHP. The Patient Rights Manager who has oversight of grievances, worked to ensure the MHP staff correctly categorizes grievances received.

Program change (system-wide level):

DHCS revised the ABGAR reporting form to clarify areas that led to counties submitting inconsistent information since counties appeared to have inconsistent understandings about what information to report and how to report it. DHCS updated and refined definitions and instructions to the ABGAR template in FY 2017-18 and every year after with feedback from County MHPs which resulted in more accurate data reporting.

DHCS Response

Strategy 2: Onsite Triennial System Review: MHP Grievance and Appeals Policies and Procedures

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

All County MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. During the triennial onsite reviews, State staff reviewed documentation of these strategies and evidence that the annual evaluation occurred. Staff also asked the County MHP to provide examples of grievances or appeals from receipt through resolution.

Average compliance ratings related to the County MHPs evaluation of Beneficiaries Grievances/Appeals as follows:

Table 10: Area of Compliance: Grievances/Appeals

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
FY 2014-2015	20	100%
FY 2015-2016	17	100%
FY 2016-2017	19	100%

<i>FY 2017-2018</i>	<i>20</i>	<i>100%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>88%</i>
<i>AVERAGE LAST THREE-YEAR CYCLE</i>		<i>96%</i>

Problems identified:

Overall there is a high level of compliance in this area and there were no significant problems or trends identified during the waiver period. The decrease in compliance in FY 2018-2019 is attributed to only a small number of County MHPs. Corrective action plans were required to be submitted for out-of-compliance items.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

DHCS Response

Strategy 3: Fair Hearing Data

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

The following state hearing data is collected by the California Department of Social Services, State Hearing Division. The total number of filings may not represent the total activity in a given period because a request for a state hearing can be filed in one month and be heard, postponed, withdrawn or adjudicated in the following month(s).

In Calendar Year (CY) 2015-2016, 14 State Hearings concerning Mental Health were reported.

In CY 2016-2017, 47 State Hearings concerning Mental Health were reported.

In CY 2017-2018, 55 State Hearings concerning Mental Health were reported.

In CY 2018-2019, 52 State Hearings concerning Mental Health were reported.

In CY 2019-2020, 40 State Hearings concerning Mental Health were reported.

The summary results from the State Hearing database are as follows:

	CY 2015-2016	CY 2016-2017	CY 2017-2018	CY 2018-2019	CY 2019-2020
<i>Total number of Completed State Hearings Filed</i>	14	47	55	52	40
<i>Case Granted: Decision for Beneficiary</i>	2	15	11	0	1
<i>Case Denied: Decision for MHP</i>	10	1	5	13	4
<i>Case Dismissed: Nonappearance/No Jurisdiction</i>	1	18	19	16	12
<i>Case Withdrawals: Beneficiary voluntarily withdrew case</i>	1	13	20	23	23

The results indicate that while the number of State Hearing cases remained consistent the majority of the cases were filed due to denial of services; however, most of the filed cases were ultimately withdrawn or dismissed. DHCS continues to monitor State Hearings looking for trends which could indicate additional follow up is needed with the County MHPs.

Problems identified:

None

Corrective action (plan/provider level):

NA

Program change (system-wide level):

NA

E. Enrollee Hotlines Operated by State

N/A

F. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

N/A

G. Geographic Mapping of Provider Network

N/A

H. Independent Assessment

N/A

I. Measurement of Any Disparities by Racial or Ethnic Groups

DHCS Response

Strategy 1: Review/Analysis of Data

Confirmation it was conducted as described:

 X Yes

 No. Please explain:

Summary of results:

Data from a variety of sources is reviewed and analyzed for indicators of potential disparities in beneficiary access to SMHS in the context of race/ethnicity analyzed by gender, age, diagnosis, and other factors when such information is available.

DHCS developed several Mental Health Services Dashboard Demographic datasets that are currently available on the CHHS Open Data Portal [here](#). The datasets were generated from mental health claims, encounters, and eligibility data from FY 2014-15 through 2017-18. They are categorized in two groups: [children/youth under 21](#) and [adults 21 and over](#) and can be used to compare and analyze mental health services utilization by race, age, sex, and spoken language.

An Excel-based report tool is also available on both landing pages (links above), which allows users to easily create reports from the Mental Health Services Dashboard Demographics datasets.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

**Strategy 2: Onsite Triennial System Review: County MHPs
Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate
Services**

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

County MHPs are required to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of racial, ethnic, cultural, and linguistic characteristics. Furthermore, all County MHPs are required to have mechanisms or activities in place whereby the County MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the County MHP. Such mechanism(s) include but are not limited to:

- A list of non-English language speaking providers in the beneficiary's service areas;
- Culture-specific providers and services in the range of programs available;
- Beneficiary handbook and provider directory in the MHP's identified threshold languages;
- Outreach to underserved target populations informing them of the availability of cultural/linguistic services and programs;
- A statewide toll-free telephone number, available 24 hours a day, seven days a week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about access, services, and the use of beneficiary problem resolution/fair hearings; and
- Interpreter services.

During the Section 1915(b) SMHS waiver period from 2015-2021, DHCS implemented revised Cultural Competence Plan Requirements (CCPRs). For more detail on the MHP Cultural Competence Plans, see Strategy 2 under

“External Quality Reviews” in this section. In addition to reviewing the CCPR submissions as part of that process, DHCS staff monitored County MHPs’ compliance with the CCPRs during the triennial onsite reviews. During the onsite reviews, DHCS staff reviewed information provided by County MHPs to determine MHP compliance with cultural competency requirements.

Average compliance ratings related to the County MHPs informing Limited English Proficient (LEP) individuals, in languages that the LEP individuals understand, that they have a right to free language assistance services are as follows:

Table 11: Area of Compliance: Language Assistance

<i>Fiscal Year</i>	<i>Number of County MHPs Reviewed</i>	<i>Average Percent Compliance</i>
<i>FY 2014-2015</i>	<i>20</i>	<i>90%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>100%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>100%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>100%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>100%</i>
<i>AVERAGE LAST THREE-YEAR CYCLE</i>		<i>100%</i>

Average compliance ratings related to County MHPs’ development of plans and implementation of training programs to improve the cultural competence skills of staff and contract providers, including administrative and management staff; and a process that ensures the interpreters are trained and monitored for language competence are as follows:

Table 12: Area of Compliance: Cultural Competence Training

<i>Fiscal Year</i>	<i>Number of County MHPs Reviewed</i>	<i>Average Percent Compliance</i>
<i>FY 2014-2015</i>	<i>20</i>	<i>95%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>82%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>88%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>80%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>87%</i>

AVERAGE LAST THREE-YEAR CYCLE	85%
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Average compliance ratings related to the County MHPs having a statewide toll-free telephone number available 24 hours a day, seven days a week, with language capability in all languages spoken by beneficiaries of the county that provide information to beneficiaries about access, services, and the use of beneficiary problem resolution/fair hearings are as follows:

Table 13: Area of Compliance: Test Calls

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
<i>FY 2014-2015</i>	<i>20</i>	<i>72%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>75%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>82%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>80%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>76%</i>
AVERAGE LAST THREE-YEAR CYCLE		79%

Average compliance ratings related to the County MHPs' test call logs are as follows:

Table 14: Area of Compliance: Test Call Logs

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
<i>FY 2014-2015</i>	<i>20</i>	<i>50%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>74%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>82%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>81%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>70%</i>
AVERAGE LAST THREE-YEAR CYCLE		78%

Problems identified:

While there has been significant improvement since FY 2014-2015, County MHPs continue to experience challenges to meet all the requirements of the statewide toll-free 24/7 access line. However, while there are still some instances

of County MHPs being out of compliance with specific components of these requirements, in most cases County MHPs are either in compliance or in partial compliance. This is an area of continued focus for training and technical assistance.

Corrective action (plan/provider level):

MHPs were required to submit corrective action plans to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS staff followed up with the County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

J. Network Adequacy Assurance Submitted by Plan (required for MCO/PIHP/PAHP)

DHCS Response

Strategy 1: MHP Contract

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

During the 2015-2021 1915(b) SMHS waiver, the Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) established network adequacy standards in Medicaid and CHIP managed care for certain providers and provides flexibility to states to set state-specific standards.

As a result, DHCS established network adequacy standards pursuant to 42 CFR § 438.68 and 438.206, and 438.207 as specified in Chapter 738, Statutes of 2017, Assembly Bill 205 and CA WIC § 14197.

Each County MHP must maintain and monitor a provider network adequate to serve, within scope of practice under state law, the population of adults and children/youth Medi-Cal beneficiaries eligible for SMHS. County MHPs must meet or exceed network capacity requirements and proportionally adjust the number of network providers to support any anticipated changes in enrollment and the expected utilization of SMHS.

Federal regulations require each MHP to submit to DHCS data and documentation on which the State bases its certification that the MHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR § 438.68 and 438.206, and 438.207.

DHCS certifies the network of each MHP and submits assurances of adequacy to CMS. DHCS reviews State- and MHP-level data and information, including network data submissions by the County MHPs, to conduct an analysis of the adequacy of each MHP's network. DHCS conducts a comprehensive review of each MHP's provider network in accordance with the annual network certification requirements set forth in 42 CFR §438.207.

California currently has network adequacy standards in place that meet these requirements. The State also maintains network adequacy standards/requirements that exceed those that are required in the Final Rule. Assembly Bill 205 (Chapter 738, Statutes of 2017) codified and amended California's network adequacy standards in CA WIC § 14197.

In addition, the contract between each MHP and DHCS requires County MHPs to report to DHCS when a significant change occurs in the MHP's operation that could impact network adequacy.

The 2018 Network Adequacy Certification was DHCS' inaugural effort to certify the County MHPs' provider networks. DHCS used this network certification review to establish a baseline of each MHP's provider network, as well as to determine targets for improving access to SMHS for Medi-Cal beneficiaries. As such, for the 2018 certification period, DHCS determined that, overall, two County MHPs passed and 54 County MHPs conditionally passed the network certification requirements. For the 2019 Network Adequacy Certification, 27 County MHPs passed and 29 conditionally passed the network certification requirements. For the 2020 Network Adequacy Certification, 13 County MHPs passed and 43 conditionally passed the network certification requirements, which was largely due to the implementation of the Time and Distance Standard requirement, whereas in previous years counties were only required to meet Time or Distance standards. Additionally, for the 2020 certification, timely access standards, language capacity, and continuity of care reports were added as oversight measures.

Problems identified:

Provider-to-Beneficiary ratio, Time and Distance, Timely Access, and Language Line deficiencies.

For the 2018 year, all CAPS were for Time and Distance.

For the 2019 certification year:

- *28 County MHPs were on a corrective action plan for Provider-to-Beneficiary ratio deficiencies. County MHPs can be deficient in more than one category. The details are as follows:*
 - *Six did not meet the Adult Psychiatry Ratio.*
 - *15 did not meet the Children/Youth Psychiatry Ratio.*
 - *11 did not meet the Adult Outpatient SMHS.*
 - *22 did not meet the Children/Youth Outpatient SMHS.*

- One MHP was on a CAP for Time and Distance but submitted an Alternative Access Standard Request that was approved.

Of the initial 29 counties on a corrective action plan in 2019, 15 counties were able to resolve these deficiencies.

By the 2020 Certification Year:

- 15 County MHPs were on a corrective action plan for Provider-to-Beneficiary ratio deficiencies. County MHPs can be deficient in more than one category. The details are as follows:
 - No counties were deficient in Adult Outpatient SMHS providers.
 - Three counties had a corrective action plan in Children/Youth Outpatient SMHS.
 - 14 had a corrective action plan in Psychiatry services with the majority being in Children/youth Psychiatry
- 12 County MHPs were on a corrective action plan for Time and Distance. County MHPs can be deficient in meeting Time and Distance standards for more than one service category
- Two County MHPs were on a corrective action plan for deficient intensive Care Coordination and Intensive Home Based Services providers.
- 18 County MHPs were on a corrective action plan for Language Capacity
- 17 County MHPs were on a corrective action plan for Timely Access
- Nine County MHPs were on a corrective action plan for Continuity of Care Report submission.

To date, out of the initial 43 County MHPs that were on a 2020 Certification Period CAP, only four County MHPs remain on a corrective action plan for Provider-to-Beneficiary ratios. Those counties are Riverside, Plumas, Yolo, and San Joaquin. Marin County and San Mateo County MHPs remain on a corrective action plan for a Timely Access deficiency.

For county-specific corrective action plan information, the reports are located on the [DHCS, Network Adequacy page](#).

Corrective action (plan/provider level):

All counties received findings reports and were placed on corrective action plans that must be fully resolved by January of the year following the advisement of deficiency. The majority of counties were able to resolve deficiencies by the January 2020 corrective action plan resolution timeline. At this time, only four County MHPs remain on a corrective action plan for provider ratios and two for Time and Distance. Counties that do not resolve deficiencies may be subject to financial or administrative sanctions.

Program change (system-wide level):

N/A

Strategy 2: Onsite Triennial System Review: MHP Policies/Procedures Regarding Numbers and Types of Providers

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

Each MHP is required to have a QI Work Plan, which includes a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area and also includes goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care. The QI plan must also monitor the County MHP's delivery capacity. Specifically, the QI must include goals for the number, types, and geographic distribution of mental health services within the County MHP's provider network.

During the triennial onsite reviews, State staff reviewed information from each MHP regarding the array of services it provides, including the number, type, and geographic distribution of services across the County MHP's provider network. State staff also reviewed each County MHP's QI Work Plan and Work Plan Evaluation to verify that it includes goals for the number, type, and geographic distribution of mental health services within the County MHP's provider network.

Average compliance ratings regarding the County MHPs' goals related to the numbers, types, and geographic distribution of providers are as follows:

Table 15: Area of Compliance: Goals Related to Numbers, Types, and Geographic Distribution of Providers

Fiscal Year	Number of County MHPs Reviewed	Average Percent Compliance
<i>FY 2014-2015</i>	<i>20</i>	<i>72%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>100%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>100%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>98%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>88%</i>
AVERAGE LAST THREE-YEAR CYCLE		96%

Problems identified:

In some cases, there was evidence the County MHPs were reviewing data related to number, type, and geographic distribution of mental health services with the QI Committee. While a small number of County MHPs presented some relevant data for review, they did not establish goals for the number, type, and geographic distribution of mental health services in their respective counties. In addition, those County MHPs did not show clear evidence that the QI Committee reviewed data related to the number, type, and geographic distribution of services in the county.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve non-compliance with these requirements. DHCS implemented a corrective action plan validation process in 2017 to review quality of corrective action plans, and subsequently DHCS improved the process by implementing corrective action plan approval, resolution, and tracking mechanisms in 2019 to provide close monitoring of corrective action plan implementation. DHCS staff continues to follow up with the County MHPs monthly to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

K. Ombudsman**DHCS Response****Strategy 1: Incorporate Ombudsman Unit****Confirmation it was conducted as described:**

 X Yes

 No. Please explain:

Summary of results:

During the 2015-2021 Section 1915(b) SMHS waiver period, the Ombudsman Unit within the former Mental Health Division was incorporated into DHCS' Office of the Ombudsman.

The Office of the Ombudsman serves as a resource to help resolve issues between beneficiaries and their MCPs, DMC-ODS plans, and County MHPs. The Office of the Ombudsman helps beneficiaries resolve concerns; offers information and referrals; identifies ways to improve the effectiveness of the County MHPs; educates beneficiaries on how to effectively navigate the Medi-Cal managed care systems; helps beneficiaries find information in order to access appropriate mental health

services; connects beneficiaries with the appropriate individuals, departments, and resources to help them resolve their problems; and connects beneficiaries with patients' rights services.

While the Office of the Ombudsman tracks information about the number of mental health-related calls in managed care, it is not feasible to distinguish between nonspecialty mental health and SMHS calls.

Below is an estimate of the number of mental health calls received by the Office of the Ombudsman. These estimates do not reflect the entirety of mental health-related calls that are received, because staff need to choose one call reason from the available options. This means if a caller has multiple issues they are inquiring about, the call will only be logged under one type of issue (e.g., for a call regarding dental services and mental health, the call may be logged as dental and not a mental health-related call).

Table 16: Estimate of Mental Health Calls Received by Office of Ombudsman

Mental Health Calls	Calls Presented	Calls Abandoned	Percent Abandoned	Calls Handled	Percent Calls Handled
2016	1808	269	15%	1539	85%
2017	1655	347	21%	1308	79%
2018	2127	275	13%	1852	87%
2019	2320	358	15%	1968	85%
Q1 2020	736	108	15%	628	85%

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

L. On-site Review

DHCS Response

Strategy 1: Triennial System Reviews of the MHP

Confirmation it was conducted as described:

X

Yes

No. Please explain:

Summary of results:

The triennial on-site system reviews of the County MHPs are conducted to determine County MHPs' compliance with State and federal regulations, provisions of the approved Section 1915(b) waiver, and DHCS/County MHP contractual requirements.

During waiver period nine, DHCS implemented a tier system to better track, enhance, and oversee County MHP compliance. Originally there were three tiers, but after further evaluation, DHCS determined that more tiers were needed and, as such, a seven-tier system was implemented. DHCS also completed two County MHP focused reviews with significant or continuing compliance concerns. These reviews focused on a County MHP's specific compliance issues and included more in-depth training and technical assistance.

The average tier placements and compliance findings obtained from FY 2014-2015 through FY 2018-2019 Annual Reviews for Consolidated SMHS and Other Funded Services are summarized in the two tables below.

Table 17: System Review Tier Standings

Tier	In Compliance Range	System Reviews FY 2015-2016 Number/Percent of County MHPs	System Reviews FY 2018-2019 Number/Percent County MHPs
<i>Tier 1</i>	<i>95-100%</i>	<i>23 County MHPs (41%)</i>	<i>29 County MHPs (52%)</i>
<i>Tier 2</i>	<i>90-94%</i>	<i>11 County MHPs (20%)</i>	<i>10 County MHPs (18%)</i>
<i>Tier 3</i>	<i>80-89%</i>	<i>16 County MHPs (29%)</i>	<i>14 County MHPs (25%)</i>
<i>Tier 4</i>	<i>70-79%</i>	<i>4 County MHPs (7%)</i>	<i>2 County MHPs (3%)</i>
<i>Tier 5</i>	<i>60-69%</i>	<i>2 County MHPs (3%)</i>	<i>1 MHP (3%)</i>
<i>Tier 6</i>	<i>50-59%</i>	<i>0 County MHPs (0%)</i>	<i>0 County MHPs (0%)</i>
<i>Tier 7</i>	<i>0-49%</i>	<i>0 County MHPs (0%)</i>	<i>0 County MHPs (0%)</i>

Table 18: Triennial System Reviews

Fiscal Year	Number of County MHPs Reviewed	Total Number of Items in the Annual Protocol	Average Percent In Compliance	Average Percent Out or Partial Compliance
2014-2015	20	151	88%	11%
2015-2016	17	187	95%	12%
2016-2017	19	200	94%	5%
2017-2018	20	245	91%	6%
2018-2019	17	365	93%	8%
Average last three-year cycle	18.6	270	94%	6%

Problems identified:

While the County MHPs have an overall high level of compliance (above 90 percent), some County MHPs experienced challenges with the 24/7 toll-free telephone access and with the written log of initial requests for SMHS.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made a concerted effort to work with the County MHPs to improve their compliance with contractual and regulatory requirements through various mechanisms, including providing ongoing training and technical assistance.

During onsite reviews, DHCS staff provide feedback and technical assistance to County MHPs related to out-of-compliance issues, as well as other critical issues for which performance can be improved.

Following the onsite review, County MHPs are notified in writing of all out-of-compliance items. County MHPs are required to submit a corrective action plan for all out-of-compliance items, which is due within 60 days after receipt of the final report. If the County MHP wishes to appeal any of the out-of-compliance items, the County MHP may do so by submitting an appeal in writing within 15 working days after receipt of the final report.

Once the corrective action plan is received, DHCS staff conducts corrective action plan Validation to determine whether the corrective action plan is complete and is likely to address any out-of-compliance findings. DHCS staff also follows up with the MHP to verify that the corrective action plan has been implemented and is effective and offers continued technical assistance.

In addition, DHCS staff conduct monthly calls with each county to monitor the progress of corrective action plan development, implementation, and resolution, and provide technical assistance. DHCS also conducts a monthly all-county call to provide information and technical assistance.

Program change (system-wide level):

In FY 2014-2015, the review protocol was revised to include an indication of partial compliance, as appropriate, for select items on the protocol in order to give a more accurate picture of the County MHP's level of compliance for each of these items. For example, DHCS conducts test calls of the County MHP's 24/7 access line to determine compliance. In many cases, the County MHP is found to be in compliance with some of the test calls, while others are found to be out of compliance. The designation of partial compliance allows for a more accurate understanding of the County MHP's level of compliance and helps in the identification of the exact nature of the problem.

Strategy 2: Triennial Outpatient Chart Reviews - Non-Hospital Services (Outpatient) Adult and Children/Youth

Confirmation it was conducted as described:

 X Yes

_____ No. Please explain:

Summary of results:

A chart review team, consisting of licensed mental health clinicians, reviews the County MHP's non-hospital services provided to Medi-Cal beneficiaries (half adult charts/half children/youth charts) on a triennial basis. The principal focus of these reviews is to ensure County MHPs and their providers comply with federal and State requirements and the MHP's contractual requirements. The State provides oversight to ensure that the County MHP's claims for SMHS meet medical necessity criteria for reimbursement.

During the waiver period, DHCS implemented a tier system in tracking MHP compliance. Originally there were three tiers but after further evaluation, DHCS determined that more tiers were needed and as such a seven-tier system was implemented.

The average tier placements and compliance findings obtained from FY 2014-2015 through FY 2018-2019 are summarized in the two tables below. As the tables indicate, County MHP compliance rates improved significantly over the waiver period.

Table 19: Chart Review Tier Standings

Tier	In Compliance Range	Chart Reviews FY 2015-2016	Chart Reviews FY 2018-2019
<i>Tier 1</i>	95-100%	3 County MHPs (5%)	17 County MHPs (30%)
<i>Tier 2</i>	90-94%	4 County MHPs (7%)	16 County MHPs (29%)
<i>Tier 3</i>	80-89%	9 County MHPs (16%)	15 County MHPs (27%)
<i>Tier 4</i>	70-79%	8 County MHPs (14%)	6 County MHPs (11%)
<i>Tier 5</i>	60-69%	5 County MHPs (9%)	2 County MHPs (3%)
<i>Tier 6</i>	50-59%	7 County MHPs (13%)	0 County MHPs (0%)
<i>Tier 7</i>	0-49%	20 County MHPs (36%)	0 County MHPs (0%)

Table 20: Triennial Outpatient Chart Reviews

Fiscal Year	Number of County MHPs Reviewed	Number of Claims Reviewed	Number of Claims Disallowed	Percent of Total Claims Disallowed
2014-2015	20	7623	3803	50%
2015-2016	17	7615	1383	18%
2016-2017	19	6524	637	10%
2017-2018	20	6059	872	14.4%
2018-2019	17	6605	656	10%
<i>Average last three year cycle</i>	18	6396	722	11%

Problems identified:

The top five reasons for recoupment in FY 2018-2019 were: 1) the progress note did not match the claim, in terms of the SMHS claimed; 2) the progress note did not match the claim, in terms of time; 3) services were claimed when the planned intervention was not included on the client plan; 4) the service claimed did not meet definition of an SMHS; and 5) progress notes did not clearly include (a) the number of providers and their specific involvement, and/or (b) applicable travel and documentation time.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made concerted efforts in working with the County MHPs to make improvements in their chart documentation through ongoing training and technical assistance, which led to improvements as demonstrated in the tables above.

A written corrective action plan for all out-of-compliance items is required from the MHP within 60 days of the receipt of the final report. The corrective action plan must specify the corrective actions taken to address the items out of compliance. DHCS staff review the corrective action plans, provide follow-up and technical assistance, and ensure the corrective action plans are implemented.

A disallowance is taken for each claim line for which there is insufficient documentation. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings.

Program change (system-wide level):

N/A

Strategy 3: SD/MC Hospital Inpatient Reviews

Confirmation it was conducted as described:

 X Yes

_____ No. Please explain:

Summary of results:

A summary of the overall and average findings of the inpatient chart reviews are reflected in the table below, which shows significant improvement during the waiver period. Deficiencies are mainly related to documentation of medical necessity for continued stay and documentation for administrative days, specifically documentation of required contacts for placement and the status of those contacts. There has been significant improvement in the hospitals meeting medical necessity and documentation requirements over the past four years.

Table 21: Triennial Short Doyle Medi-Cal Inpatient Psychiatric Hospitals Chart Reviews

Fiscal Year	Number of Hospitals Reviewed	Percent of Acute Days Disallowed	Percent of Administrative Days Disallowed	Percent of Total Days Disallowed
2014-2015	6	50%	58%	54%
2015-2016	6	57%	63%	55%
2016-2017	6	31%	17%	30%
2017-2018	6	18%	5%	23%
2018-2019	5	33%	14%	30%
Average last three year cycle	6	30%	12%	28%

Problems identified:

The principal reasons for disallowance were that documentation did not meet medical necessity criteria for continued stay services and documentation did not meet criteria for administrative day services. This information enables the State to recoup federal financial participation (FFP) funds for those hospital days that do not meet appropriate regulatory requirements.

Corrective action (plan/provider level):

During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS made concerted efforts to work with County MHPs and the hospitals to make improvements in their chart documentation through ongoing training and technical assistance, which led to improvements as demonstrated in the tables above.

County MHPs are notified of all deficiencies identified during the inpatient review. A disallowance was taken for each claim line for which there was insufficient documentation to support either continued stay services or administrative day services. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings. County MHPs are required to submit a corrective action plan, which is reviewed by DHCS staff, and if determined to be deficient, DHCS staff works with the County MHP to revise them.

Program change (system-wide level):

N/A

Strategy 4: Provider Certification On-Site Reviews

Confirmation it was conducted as described:

 X Yes

 No. Please explain:

Summary of results:

DHCS conducted onsite reviews of county-owned-and-operated providers, and certified or recertified 1,025 providers as eligible to claim for the provision of SMHS. The number of onsite certification reviews of county-owned-and-operated providers continued to increase during this waiver period. In part, this may have been due to the increased need for services resulting from the Affordable Care Act Medicaid Expansion in California and County MHPs being awarded Senate Bill 82 grants for new programs.

County MHPs monitor and track the recertification for their contracted organizational providers. During the 2015-2021 Section 1915(b) SMHS waiver period, DHCS has processed 5,548 certifications and recertifications from the County MHPs for their contracted providers.

Results are reported for FY 2014-2015 through FY 2018-2019 in the table below.

Table 22: Certification and Recertifications of County MHPs

<i>Fiscal Year</i>	<i>County Owned & Operated</i>	<i>MHP Contracted Providers</i>	<i>Total by Fiscal Year</i>
<i>FY 14/15</i>	<i>227</i>	<i>859</i>	<i>1086</i>
<i>FY 15/16</i>	<i>165</i>	<i>1321</i>	<i>1486</i>
<i>FY 16/17</i>	<i>244</i>	<i>1145</i>	<i>1389</i>
<i>FY 17/18</i>	<i>234</i>	<i>1037</i>	<i>1271</i>
<i>FY 18/19</i>	<i>155</i>	<i>1186</i>	<i>1341</i>
<i>Total across waiver period</i>	<i>1025</i>	<i>5548</i>	<i>6573</i>

Problems identified:

There is a high level of compliance with the Medi-Cal certification requirements and no significant trends have been identified. In most cases the provider is able to correct any identified issue(s) while the reviewer is still onsite or within just a few days, such as updating a policy or placing additional informing materials in the lobby.

Corrective action (plan/provider level):

Any corrective action plans issued as a result of an onsite review for identified deficiencies must be resolved prior to certifying and/or recertifying a provider's eligibility to claim Medi-Cal for reimbursement of SMHS.

Program change (system-wide level):

N/A

M. Performance Improvement Projects (required for MCO/PIHP)

DHCS Response

Strategy 1: Performance Improvement Projects

Confirmation it was conducted as described:

 X Yes

 No. Please explain:

Summary of results:

Each County MHP is required to conduct two PIPs. One PIP must be one in a clinical area and the other in a non-clinical area. Clinical PIPs usually focus on outcomes of care, while non-clinical PIPs are geared toward improving service delivery, such as access to and availability of services. During the last waiver reporting period, DHCS increased its efforts in monitoring County MHP performance, including the development and implementation of their PIPs.

The EQRO ensures compliance with PIP submission requirements and the validity of County MHP PIPs. PIP findings are summarized in quarterly PIP reports and one annual technical report. Each report is posted on the EQRO's website. The EQRO also provides DHCS with information regarding PIPs, including topics, activity levels, and status.

The EQRO reports to DHCS on County MHP compliance with PIP requirements. In the FY 2018-19 annual technical report, the EQRO noted that due to the increased monitoring, the EQRO was able to provide technical assistance more frequently. As a result, County MHPs were better able to develop, implement, and complete PIPs, and support continuous quality improvement activities in both clinical and non-clinical aspects of mental health care. Central PIP themes in FY 2018-19 included access to care (24 percent); timeliness to care (17 percent); quality of care (24 percent); and outcomes of care (35 percent). For example, in the fiscal quarter that ended December 31, 2020, one clinical PIP and one non-clinical PIP focused on improving timeliness of services for beneficiaries.

County MHPs also focused on areas such as improvement on maintaining appointments, timeliness to appointments, and follow-up appointments after hospitalization. In addition, the County MHPs' PIPs addressed the well-being of beneficiaries and improvements in their care rather than simply improving MHP processes. The EQRO encouraged County MHPs to continue the trend with a focus

on direct interventions that enhance the quality of life of beneficiaries. The EQRO provided significant technical assistance to County MHPs. The EQRO provides technical assistance in person and via conference calls and webinars. The EQRO's website also contains resources that County MHPs can access when needed, including examples of successful PIPs.

Finally, as required by the 2015-2021 Section 1915(b) SMHS waiver STCs, DHCS submitted to CMS the EQRO quarterly and annual reports regarding the required PIPs.

Problems identified:

N/A

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

N. Performance Measures (required for MCO/PIHP)

DHCS Response

Strategy 1: Measurements of Indicators of Mental Health System Performance on an Ongoing and Periodic Basis

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

During the 2015-2021 Section 1915(b) SMHS waiver, DHCS implemented the following activities and initiatives regarding system performance:

DHCS continued to implement the consumer perception surveys, which collect descriptive information from each beneficiary and include questions about beneficiary satisfaction with services and whether the services improved their ability to function across several domains. Consumer perception survey results are included above (see Monitoring Results item #1).

In addition, in compliance with 42 CFR § 438.202(a), DHCS prepared its Medi-Cal Managed Care Quality Strategy report, which includes quality strategies across all of California's Medi-Cal managed care delivery systems, including County MHPs.

DHCS also continued its efforts to identify data sources and data collection methodologies for additional quality measures, which have been defined through the POS for SMHS provided to children and youth and SMHS Performance Dashboard stakeholder processes.

The POS, required by CA WIC § 14707.5, and the 2015-2020 Section 1915(b) SMHS waiver STCs, have driven quality improvement efforts for the SMHS program. Through these efforts, both involving collaborative stakeholder processes, DHCS is defining quality domains and measures and has developed and published MHP performance data.

DHCS considered the following objectives, among others, in developing the POS:

- 1. High-quality and accessible mental health services for eligible children and youth, consistent with federal law;*
- 2. Information that improves practice at the individual, program, and system levels;*
- 3. Minimization of costs by building upon existing resources to the fullest extent possible; and*
- 4. Reliable data that are collected and analyzed in a timely fashion.*

The Performance Measurement Paradigm is a conceptual framework for the POS, which was built on the Mental Health Services Act measurement paradigm. DHCS developed the paradigm in collaboration with a wide array of stakeholders. In the paradigm there are four levels for outcomes measurement: individual, provider, system, and community. There are seven domains of measures and indicators in the paradigm, which cross the four levels of outcomes measurement. These domains reflect domains used by SAMHSA. Following are the seven domains selected for the POS measurement paradigm:

- Access;*
- Engagement;*
- Service Appropriateness to Need;*
- Service Effectiveness;*
- Linkages;*
- Cost Effectiveness; and*
- Satisfaction.*

DHCS publishes three types of POS reports on the DHCS website.

- Statewide Reports;*
- Population-Based Reports (Small Rural, Small, Medium, Large, Very Large); and*
- County-Level Reports.*

Furthermore, the 2015-2021 Section 1915(b) SMHS waiver STCs required DHCS to develop and publish an SMHS Performance Dashboard for each County MHP. The SMHS Performance Dashboards include County MHP performance in the following areas: quality, access, timeliness, and translation/interpretation capabilities.

The Statewide Aggregate SMHS Performance Dashboard and the County-Level SMHS Performance Dashboards are accessible on the DHCS website [here](#).

Benchmarks and performance targets for SMHS are evolving areas, and DHCS continues efforts to determine appropriate benchmarks and performance targets related to SMHS.

The quality indicators currently reported for SMHS are outlined below:

- *Access*
 - *Number of children and adults that received SMHS*
- *SMHS Penetration Rate*
 - *Received one or more SMHS visits: proportion of beneficiaries eligible for SMHS who received one or more SMHS visits*
 - *Received five or more SMHS visits: proportion of beneficiaries eligible for SMHS who received five or more SMHS visits*
- *Time to Step Down*
 - *Time between Inpatient Discharge and Step Down Service*
- *Utilization: Approved SMHS*
 - *Expenditures and Service Quantity per Beneficiary: service utilization in minutes by unique beneficiary and service type*
- *Satisfaction*
 - *General Satisfaction (youth and adult surveys)*
 - *Perception of Participation in Treatment Planning (youth and adult surveys)*
 - *Perception of Access (youth and adult surveys)*
 - *Perception of Cultural Sensitivity (youth and adult surveys)*
 - *Perception of Quality and Appropriateness (adult surveys)*
 - *Perception of Outcomes of Services (youth and adult surveys)*
 - *Perception of Functioning (youth and adult surveys)*
 - *Perception of Social Connectedness (youth and adult surveys)*

Finally, the EQRO also reviews and validates performance measures as part of their external quality review of County MHPs. The performance measures reviewed by the EQRO include the following:

- *Total beneficiaries served by each County MHP*
- *Penetration rates in each County MHP*

- *Total costs per beneficiary served by each County MHP*
- *Penetration rates for vulnerable and underserved populations*
 - *Stratified by race/ethnicity Foster Care*
- *Approved claims for vulnerable and underserved populations*
 - *Stratified by race/ethnicity Foster Care*
- *High-Cost Beneficiaries (HCBs), incurring approved claims of \$30,000 or higher during a calendar year (CY)*
- *Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the four percent Emily Q. benchmark*
- *Psychiatric inpatient hospital seven-day and 30-day rehospitalization rates*
- *Post-psychiatric inpatient hospital seven-day and 30-day SMHS follow-up service rates*
- *Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS)*
- *Beneficiary counts by diagnostic groups*
- *Approved claims by diagnostic groups*
- *Affordable Care Act (ACA) analysis:*
 - *Eligibles and beneficiaries served*
 - *Penetration rates*
 - *Approved claims per beneficiary (ACB)*
 - *Beneficiary counts by diagnostic groups*
 - *Approved claims by diagnostic groups*

The FY 2019-20, EQRO performance measures report may be accessed [here](#).

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 2: Implementation Plans

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

The Implementation Plan is required by State regulations when a County MHP begins operation. The State has approved the Implementation Plans for all current County MHPs. State regulations require County MHPs to submit proposed changes to their Implementation Plans to the State in writing, prior to the implementation of the proposed changes. There were no new County MHPs started during this reporting period, therefore all implementation plans submitted were updates. The State approved twelve submitted Implementation Plan updates received during the 2015-2021 Section 1915(b) SMHS waiver period. Updates included updates to point of contact information or to bring the implementation plan into compliance with newly issued guidance.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 3: Onsite Triennial System Review: County MHPs Quality Improvement (QI) Program

Confirmation it was conducted as described

☒ Yes

☐ No. Please explain:

Summary of results:

County MHPs are required to have a QI program. The purpose of the QI program is to review and improve the quality of SMHS provided to beneficiaries. The QI Program must have active participation by the County MHP's providers, as well as beneficiaries and family members. During the triennial system reviews, DHCS reviewed each County MHP's QI work plan for evidence of QI activities that the County MHP has engaged in, including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The County MHPs also provided evidence of mechanisms in place to evaluate the effectiveness of the QI program and how QI activities have contributed to improvements in clinical care and beneficiary services. The County MHPs are required to review the QI

work plan and revise as appropriate on an annual basis. During the triennial system review, DHCS reviewed both the QI work plan itself and evidence that activities identified in the work plan were implemented.

Average compliance ratings related to the County MHPs' QI activities are reflected in the table below:

Table 23: Area of Compliance: Quality Improvement Activities

<i>Fiscal Year</i>	<i>Number of County MHPs Reviewed</i>	<i>Average Percent Compliance</i>
<i>FY 2014-2015</i>	<i>20</i>	<i>92%</i>
<i>FY 2015-2016</i>	<i>17</i>	<i>100%</i>
<i>FY 2016-2017</i>	<i>19</i>	<i>100%</i>
<i>FY 2017-2018</i>	<i>20</i>	<i>96%</i>
<i>FY 2018-2019</i>	<i>17</i>	<i>97%</i>
<i>AVERAGE LAST THREE-YEAR CYCLE</i>		<i>98%</i>

Problems identified:

There is a high level of compliance across County MHPs in the area of Quality Improvement activities. No significant issues or trends were identified.

Corrective action (plan/provider level):

County MHPs were required to submit a corrective action plan to inform DHCS of actions taken to resolve noncompliance with these requirements. DHCS' staff follows up with the County MHPs to monitor implementation of the corrective action plans and to provide technical assistance between triennial onsite reviews.

Program change (system-wide level):

N/A

O. Periodic Comparison of Number and Types of Medicaid Providers Before and After Waiver

Strategy 1: Provider Comparison Before/After Waiver

Confirmation it was conducted as described:

- ☐ Yes
- ☒ No. Please explain:

Summary of results:

DHCS does not have information regarding the number of providers that existed prior to the implementation of the first Section 1915(b) SMHS waiver – which was implemented in the mid-1990s. As a result, DHCS is not able to conduct a comparison between the number of current SMHS providers with the number of providers prior to the implementation of the first waiver. DHCS is discontinuing this monitoring activity, as data on the number of providers prior to the waiver is not available.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

P. Profile Utilization by Provider Caseload (looking for outliers)

N/A

Q. Provider Self-Report Data

N/A

R. Test 24 Hours/7 Days a Week PCP Availability

N/A

S. Utilization Review (e.g. ER, non-authorized specialist requests)

DHCS Response

Strategy 1: MHP Utilization Review Management Program (UMP): Payment Authorization System

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

County MHPs are required to have utilization management programs that evaluate medical necessity, appropriateness and efficiency of services provided to beneficiaries. All County MHP's Utilization Management Plans reviewed during the waiver period contained requirements related to consistent application of medical and service necessity in payment authorization systems.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

T. Other (please describe)

DHCS Response

Strategy 1: External Quality Reviews (EQRs)

Confirmation it was conducted as described:

 X Yes

 No. Please explain:

Summary of results:

As required by 42 CFR § 438, Subpart E, DHCS contracts with an EQRO. The EQRO conducts annual reviews of County MHPs to analyze and evaluate information related to quality, timeliness, and access to SMHS provided by County MHPs and/or their subcontractors to Medi-Cal beneficiaries.

EQRO reviews consist of site visits, consumer (beneficiary) and family member focus groups, County MHP and provider staff focus groups, data analysis and reporting, information system reviews, and the evaluation of County MHP Performance Improvement Projects.

Each EQRO review is summarized in an individualized MHP report. Information included in individualized County MHP reports is also included in an annual statewide summary report. In addition to individualized MHP reports and the annual statewide summary report, BHC publishes quarterly PIP reports. The Medi-Cal Specialty Mental Health EQR, FY 2018-19 Statewide Report can be found [here](#).

In addition, in accordance with the 2015-2021 Section 1915(b) SMHS Waiver STCs, DHCS submitted EQRO's quarterly PIP reports and annual summary report to CMS.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 2: Cultural Competence Plans (CCPs)

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

County MHPs are required to develop and implement CCPs that include objectives for reducing disparities by tailoring best practices in mental health services to beneficiaries' cultural and ethnic backgrounds and language preferences. County MHPs must update their CCPs and submit those updates to DHCS for review and approval annually.

During the 2015-2021 Section 1915(b) SMHS waiver, DHCS worked with subject matter experts in the field of cultural competence to incorporate the enhanced national standards published in 2013 by the U.S. Department of Health & Human Services Office of Minority Health into the statewide CCPRs. The CCPRs offer a strong framework for tailoring mental health services to the beneficiaries' culture and language preferences as well as the provision of high-quality mental health care. The CCPRs address the entire public mental health delivery system by focusing on the following eight domains:

- Organizational commitment to cultural competence;*
- Assessment of population and service needs;*
- Strategies and efforts for reducing disparities;*
- Participation of client, family, and community members in the delivery system;*
- Culturally competent training activities;*
- Commitment to growing a multicultural workforce;*
- Language capacity; and*
- Adaptation of services to meet the needs of beneficiaries.*

During FY 2018-19, DHCS conducted an analysis of County MHPs' CCP updates to identify strategies that County MHPs are using to reduce disparities, and to determine common mental health disparities and/or strategies for addressing them among County MHPs. The CCPs addressed social determinants of health, including family dynamics and living arrangements, which influence mental health risk and outcomes, particularly for children and youth in the foster care system.

The CCP findings for FY 2017-18 and 2018-19 indicate that factors such as culture, ethnicity, and language influence mental health risk and outcomes. The availability of bilingual clinicians, and clinicians that are familiar with or share the same cultural

background as the beneficiaries they serve, can help beneficiaries engage in and benefit from mental health services, leading to improved outcomes. There is also a growing trend at some County MHPs to use trauma-informed care as a cultural competence component to provide trauma-informed services. These services focus on recovery and are strength based, client and family driven, and culturally competent.

Finally, during FY 2018-19, an analysis of CCP information found that County MHPs use community-informed and culturally competent practices that meet the needs of their diverse communities in accessing SMHS.

Problems identified:

No County MHPs were out of compliance with the CCP requirement. However, County MHPs have not met all of DHCS' equity goals. DHCS is in the process of revamping CCPRs to increase expectations of the plans related to culturally responsive care and achieving equitable outcomes.

Corrective action (plan/provider level):

TBD as new standards are developed.

Program change (system-wide level):

DHCS has contracted with an expert consultant, the Center for Applied Research Solutions, to work with counties to identify and address disparities in care and to improve their delivery of culturally responsive care.

Strategy 3. A.: Compliance Advisory Committee (CAC)

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

The Compliance Advisory Committee (CAC) offers stakeholders an invaluable opportunity to provide feedback and recommendations relative to DHCS' compliance protocol and review process. This ongoing relationship between DHCS and the CAC ensures stakeholders have a significant voice in how quality and access are monitored.

During the Section 1915(b) SMHS waiver period from 2015-2021, annual CAC meetings were held on the following dates:

Fiscal Year	CAC Meeting Date
FY 2014-2015	August 8, 2014
FY 2015-2016	July 30, 2015
FY 2016-2017	July 26, 2016

<i>FY 2017-2018</i>	<i>August 14, 2017</i>
<i>FY 2018-2019</i>	<i>August 31, 2018</i>
<i>FY 2019-2020</i>	<i>July 29, 2019</i>

Certain revisions to the compliance protocol and review process recommended by the CAC were implemented. For example, one major revision during the five-year waiver period included adding an indication of partial compliance in FY 2014-15, as appropriate, for select items on the protocol, which allows the State, as well as the County MHP, to have a more complete understanding of the level of compliance in these areas. Other changes during this period have included the addition of the new requirements related to the Managed Care Rule. The CAC's feedback and recommendations help shape the discussion around proposed changes to the protocol and help determine the process for implementing the recommended changes.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 3. B.: Cultural Competence Advisory Committee (CCAC)

Confirmation it was conducted as described:

☐ Yes

☒ No. Please explain: DHCS did not implement a CCAC, as originally planned, and instead formed a broader Behavioral Health Stakeholder Advisory Committee (BH-SAC), which includes a focus on cultural competence.

Summary of results:

DHCS formed the BH-SAC in 2019 to facilitate stakeholder input on behavioral health policy, including culturally responsive care and health equity. The BH-SAC consists of leaders from County MHPs, providers, associations, advocates, consumer representatives, and others. The October 2020 meeting, for example, was predominantly devoted to collecting input from BH-SAC members on how to improve the delivery of culturally responsive care and how to eliminate health inequities. In addition, DHCS convenes ad hoc stakeholder workgroups to develop input on issues related to culturally responsive care, such as a project launching that launched in early 2021 to provide training and technical assistance to counties on culturally

responsive care and health equity. DHCS held a workgroup to collect input on the design of the program and scope of work for the contractor. In this effort, DHCS will be working collaboratively with the California Department of Public Health Office of Health Equity to enhance County MHPs' cultural competence and quality improvement programs, increase provider capacity, engage community-based organizations to become Medi-Cal-certified providers, and achieve population-specific approaches to reduce disparities in access to mental health services.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

DHCS Response

Strategy 3. C.: California Mental Health Planning Council (CMHPC)

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

DHCS continued to work with its federal- and State-mandated California Behavioral Health Planning Council (CBHPC, previously known as the Mental Health Planning Council; name was changed to include SUD), which is a majority consumer and family member advisory body to State and local government, the Legislature, and residents of California on mental health services in California. The CBHPC is designed to advocate for children with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

The vision and mission of the CBHPC guides its evaluation of California's system of behavioral health care through targeted committee studies, community site visits, and General Session forums and presentations. The CBHPC informs the Administration and the Legislature on priority issues and provides feedback on behavioral health policy and regulations and on legislative actions based on our Policy Platform. The Administration regularly attends the Council's quarterly meetings and shares key policy initiatives, including but not limited to the development of behavioral health policy in CalAIM, the development of the proposed SMI/SED IMD 1115 demonstration, the department's response to public health emergencies, and [CalHOPE](#). The Council provides feedback during committee meetings, formally through written feedback, and through representatives on the BH-SAC.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 4: Provider Appeals

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

Strategy 4.1.: Inpatient Service Treatment Authorization Requests (TAR) State Appeals: Fee for Service (FFS) Hospitals

County MHPs are required to have a provider problem resolution process. When an appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, providers may appeal to the State if the County MHP denies the appeal in whole or in part. Such appeals to the State are generally referred to as "State/second-level TAR appeals."

- In FY 2015-16, DHCS received 131 State/second level TAR appeals from providers.*
- In FY 2016-17, DHCS received 72 State/second level TAR appeals from providers.*
- In FY 2017-18, DHCS received 284 State/second level TAR appeals from providers.*
- In FY 2018-19, DHCS received 214 State/second level TAR appeals from providers*
- As of March 1, FY 2019-20, DHCS received 103 State/second level TAR appeals from providers.*

A majority of second-level TAR appeals were filed by small individual providers. DHCS upheld the County MHP's decision for 92 percent of days appealed through the State/second-level TAR appeal process.

The high percentage of second-level TAR appeal denial decisions is primarily based upon the failure of providers to meet documentation standards related to medical necessity criteria for acute and administrative days, such as failure to

document the required number of phone calls to facilities to allow step-down to a lower level of care.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 4.2.: Appeals Regarding Specialty Mental Health Services

Summary of results:

Overall, the number of provider appeals have been low within the 2015–2020 Section 1915(b) SMHS waiver period. During this period, 12 inpatient appeals were filed, 23 outpatient appeals were filed, and ten EPSDT informal appeals were filed; the resolution of one informal appeal is still pending. These results likely are due in large part to DHCS technical assistance, policy clarifications, and trainings on clinical documentation.

Problems identified:

None

Corrective action (plan/provider level):

N/A

Program change (system-wide level):

N/A

Strategy 5: County Support Unit

Confirmation it was conducted as described:

☒ Yes

☐ No. Please explain:

Summary of results:

DHCS has dedicated staff that function as the central point of contact for County MHPs. Staff provides resources and technical assistance to support counties in the provision of SMHS. There is an assigned DHCS liaison to each county.

DHCS staff provided technical assistance to County MHP contact staff on the development of the corrective action plans in response to triennial review items that were out of compliance with standards.

Prior to upcoming system reviews, DHCS staff contacted County MHPs to request updates on evidence of correction from the previous triennial review. Based on MHP status, DHCS staff offered consultation and technical assistance as the MHP prepared for the review. DHCS staff continued to regularly follow up with MHP staff until the time of the system review.

After submission of the corrective action plans, DHCS staff worked with County MHPs to obtain evidence of correction for corrective action plans in priority areas including Access, Beneficiary Protection, Quality Improvement, Program Integrity, and any repeat corrective action plan items from the previous review. After evidence of correction was submitted, DHCS staff continued to interact with County MHPs and request evidence of continued correction as needed to confirm continued implementation of corrective action plans.

DHCS staff determined that the following were of the highest priority for follow-up: 24/7 access lines, grievance and appeal processes, timeliness of access to services, as well as quality improvement activities. DHCS staff tracked County MHP progress in these specific areas.

Problems identified:

DHCS identified 24/7 access line requirements as statewide compliance concerns.

Corrective action (plan/provider level):

DHCS staff participated in one focused review for one county that needed additional assistance to meet state requirements analogous to reports of similar issues from other counties. The technical assistance, in the form of regularly scheduled contacts, continued for several months and DHCS staff worked with the county to obtain evidence of correction and ensure that requirements were met. The County MHP has made significant improvement.

Based on DHCS staff analysis of statewide trends from the system reviews during the last three years, we have identified 24/7 access line requirements as an area for focused statewide technical assistance. As a result, County MHPs' internal test call frequency and scripts are reviewed by DHCS staff on a quarterly basis.

Program change (system-wide level):

N/A

In addition to the above monitoring results, DHCS also implemented the following STCs as requested by CMS:

- 1. The State made available to beneficiaries, providers, and other interested stakeholders a mental health plan dashboard that is based on performance data of each County MHP included in the annual CalEQRO technical report and/or other appropriate resources. Each County MHP dashboard is posted on the State's and the County MHP website.*

2. *The State required each County MHP to commit to having a system in place for tracking and measuring timeliness of care, including wait times to assessments and wait time to providers.*
3. *The State provided the CalEQRO's quarterly and annual reports regarding the required PIPs to CMS, and discussed these findings during monthly monitoring calls.*
4. *The State published on its website the County MHPs' Plan of Correction as a result of the State compliance reviews. The State and County MHPs published the county mental health QI Plan. The intent was to be able to identify the County MHP's goals for quality improvement and compliance.*
5. *The State and the County MHPs provided to CMS the annual grievance and appeals reports by November 1 of each year.*
6. *All information required to be published pursuant to these STCs is placed in a standardized and easily accessible location on the State's website.*
7. *The State, within the timeframes specified in law, regulation, or policy statement, came into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occurred during this waiver period.*

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
 - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual

- Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
Lindy Harrington
- c. Telephone Number: **(916) 322-4831**
- d. E-mail: **Lindy.Harrington@dhcs.ca.gov**
- e. The State is choosing to report waiver expenditures based on
☒ X date of payment (*Applies to SMHS, DMC-ODS*).
☒ X date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter. (*Applies to MCMC, Dental MC*)

DHCS Response

DHCS is reporting base and projected waiver expenditures on a date of payment basis for SMHS and DMC-ODS and a date of service basis for MCMC and Dental MC. The date of payment basis is consistent with existing and previous reporting for SMHS and DMC-ODS due to the cost-based financing and payment methodology for behavioral health services. Under CalAIM, DHCS aims for further delivery system integration and administrative simplification. When DHCS moves to a rate-based financing and payment methodology for behavioral health services, DHCS will be able to align waiver expenditure reporting for MCMC, Dental MC, SMHS, and DMC-ODS on a date of service basis.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- a. ☒ X The State provides additional services under 1915(b)(3) authority. (*Applies to DMC-ODS*)

- b. ☒ The State makes enhanced payments to contractors or providers. *(Applies to MCMC, Dental MC)*
- c. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.
- d. ☐ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b.**

- a. ☒ MCO *(Applies to MCMC)*
- b. ☒ PIHP *(Applies to SMHS, DMC-ODS)*
- c. ☒ PAHP *(Applies to Dental MC)*
- d. ☐ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers *[NOT APPLICABLE]*

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a. ____ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
 1. ____ First Year: \$ ____ per member per month fee
 2. ____ Second Year: \$ ____ per member per month fee
 3. ____ Third Year: \$ ____ per member per month fee
 4. ____ Fourth Year: \$ ____ per member per month fee
- b. ____ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ____ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ____ Other reimbursement method/amount. \$ ____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: *[NOT APPLICABLE]*

- a. ____ Population in the base year data
 1. ____ Base year data is from the same population as to be included in the waiver.
 2. ____ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ____ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. ____ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- d. ____ [Required] Explain any other variance in eligible member months from BY to P2: ____
- e. ____ [Required] List the year(s) being used by the State as a base year: ____.

If multiple years are being used, please explain: _____

- f. _____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.
- g. _____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
-

For Conversion or Renewal Waivers:

- a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver. *(Applies to MCMC, Dental MC, SMHS, DMC-ODS)*
- b. X For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period. (Applies to MCMC, Dental MC, SMHS, DMC-ODS)*

DHCS Response

DHCS adjusted the formulas to calculate the annualized trend rates correctly.

- c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

DHCS Response

MCMC and Dental MC: The base year member months include all Medical managed care populations under the waiver enrolled in State Fiscal Year (SFY) 2018-19. Although total member months in P1 are anticipated to be higher due to the moratorium on eligibility redeterminations during the public health emergency, with subsequent decreases anticipated in P2 and P3 due to the resumption of eligibility determinations, at this time DHCS is not projecting an increase or decrease in member months over the term of the waiver for purposes of the cost-effectiveness calculation, with one exception in P2 (described further below). Due to the high number of programmatic/policy/pricing change adjustments applicable to MCMC and Dental MC, DHCS believes that holding member months constant facilitates the identification and review of the impact of changes applicable during each year of this waiver. DHCS will continue to monitor caseload and may, in the future, work with CMS to amend the cost-effectiveness calculation to reflect an updated projection – especially if any changes to caseload are anticipated to materially change the per-capita expenditure level projected for an eligibility grouping.

A caseload increase is assumed in P2 for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., County Organized Health System (COHS) and Coordinated Care Initiative (CCI) counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).

SMHS and DMC-ODS: *DHCS is projecting an increase in member months in P1 due to the moratorium on eligibility redeterminations during the public health emergency. It is likely to take a year to bring current all redeterminations. Member months decrease in P2 and P3 due to the resumption of eligibility determinations and is consistent with California's decline in Medi-Cal enrollment prior to the COVID-19 Public Health Emergency (PHE). The base year member months data includes all Medi-Cal beneficiaries enrolled in State Fiscal Year 2018-19, which includes quarter ending September 30, 2018 through quarter ending June 30, 2019.*

- d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2:

DHCS Response

MCMC and Dental MC: *In P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.*

SMHS and DMC-ODS: *No other changes.*

- e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

DHCS Response

MCMC, Dental MC, SMHS, and DMC-ODS: *BY/R1/R2 are SFY. BY reflects SFY 2018-19 (June 1, 2018 through September 30, 2019).*

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers: *[NOT APPLICABLE]*

- a. ____ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

- a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

DHCS Response

The previous 1915(b) waiver only included mental health services. This renewal waiver includes:

- most components of the physical health and dental managed care delivery systems, which transitioned from the 1115 demonstration authority to the 1915(b) waiver; and*
- substance use disorder services provided through DMC-ODS counties, which also transitioned from 1115 demonstration authority to the 1915(b) waiver.*

MCMC and Dental MC: *The Actual Waiver Cost in Appendix D3 represents expenditures under the 1115 demonstration that, with a few exceptions, align with services and populations under this renewal waiver. To address these exceptions, notably the carve-out or carve-in of certain services in P1 or P2, DHCS applied program adjustments to the P1 and P2 projected expenditures as described in Section D.I.J.b.2.vi.D below.*

SMHS and DMC-ODS: *The State Plan costs reported in Appendix D5 for the base year includes expenditures for mental health services assigned to the 1915(b) waiver and expenditures for substance use disorder services assigned to the DMC-ODS 1115 demonstration reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019. DHCS also included a program adjustment in Prospective Year 2 to account for 10 new counties starting to provide substance use disorder services through the 1915(b) PIHP delivery system.*

Beginning January 1, 2022, Medi-Cal will begin a 27-month pilot of contingency management treatment of stimulant use disorders in the DMC-ODS under 1915(b)(3) authority. These costs are accounted for in the 1915(b)(3) service trend adjustment.

- b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:

DHCS Response

MCMC and Dental MC: *DHCS has excluded from the cost-effectiveness analysis the following: 1) services delivered through the Medi-Cal managed care delivery system but not included in this waiver, such as Community-Based Adult Services (included in 1115 demonstration authority) and services for Out-of-State Former Foster Care Youth; and 2) services carved out of the Medi-Cal managed care delivery system, such as In-Home Supportive Services and 1915(c) waiver HCBS services.*

SMHS and DMC-ODS: *All Medi-Cal mental health service costs and substance use disorder service costs, except for the following costs, are accounted for in this waiver: 1) the cost of substance use disorder services provided by prepaid inpatient health plans (PIHP) in an Institution for Mental Disease (IMD), and 2) the cost of specialty mental health and substance use disorder services provided by PIHPs to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims. The cost of state plan substance use disorder services provided to beneficiaries residing in counties that do not provide substance use disorder services through a PIHP delivery system are excluded from this waiver. DHCS included a program adjustment in Prospective Year 2 to account for the cost of 10 new counties to begin providing substance use disorder services through a PIHP delivery system. The cost of substance use disorder services provided to beneficiaries in an IMD and the cost of substance use disorder services provided to AI/AN beneficiaries is separately accounted for in the State's 1115 demonstration and it is not included in the State's 1915(b) renewal waiver. California included a program adjustment in Prospective Year 1 to remove the cost of specialty mental health and substance use disorder services provided to Medi-Cal beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims.*

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers: **[NOT APPLICABLE]**

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

The allocation method for either initial or renewal waivers is explained below:

- a. ____ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. ____ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. **X** Other (Please explain).

DHCS Response

MCMC and Dental MC: DHCS is directly identifying administrative costs associated with this waiver. Reported amounts are based on actual or estimated program administration costs for State staff, related overhead/support costs, and administrative contractors (e.g., actuarial, Information Technology) dedicated to the Medi-Cal managed care delivery system. Unlike SMHS and DMC-ODS, Managed Care Plan administrative costs are a component of their capitated payments and considered service costs for the purpose of the waiver.

SMHS and DMC-ODS: DHCS directly identifies DHCS' costs associated with this waiver. DHCS costs are based on actual percentages of time spent by State staff on this waiver. County-operated PIHPs Administration costs for: i) PIHP administration; ii) quality assurance and utilization review (QA-UR); and iii) Medi-Cal Administrative Activities (MAA), are also included as part of the State administrative costs.

H. Appendix D3 – Actual Waiver Cost

- a. **X** The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver. *(Applies to DMC-ODS)*

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

DHCS Response:

CMS confirmed that California's long history on the SMHS waiver would enable the State to support Section 1915(b)(3) services in the first year of the renewal with savings accrued from the SMHS waiver. DHCS has annotated the chart below to reflect accrued savings and is reflecting the .

DMC-ODS: DHCS is seeking to cover contingency management as a Section 1915(b)(3) service effective January 1, 2022.

1915(b)(3) Service	Savings projected accrued in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Contingency Management:	SMHS PMPM saving from prior waiver		\$ 7,275,335 in P1 \$ 22,448,600 in P2 \$ 7,878,838 in Q1 P3

Contingency Management pilot program for the treatment of stimulant use disorder January 1, 2022 through March 31, 2024	totals \$6,461,730,963. For state fiscal year 2019-20 \$2,371,550,449 was saved and will be used to fund Contingency Management		PMPMs vary between .01 and 1.04 for P1, P2 and P3
Total	(PMPM in Appendix D5 Column T x projected member months should correspond)		\$37,602,773 (PMPM in Appendix D5 Column W x projected member months should correspond)

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections *[NOT APPLICABLE]*

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	\$1,751,500 or \$.97 PMPM R1 \$1,959,150 or \$1.04 PMPM R2 or BY in Conversion	8.6% or \$169,245	\$2,128,395 or 1.07 PMPM in P1 \$2,291,216 or 1.10 PMPM in P2

Total	(PMPM in Appendix D3 Column H x member months should correspond)		(PMPM in Appendix D5 Column W x projected member months should correspond)
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- b. X The State is including voluntary populations in the waiver (*Applies to MCMC, Dental MC*).

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

DHCS Response

MCMC and Dental MC: Voluntary populations in the waiver were voluntary prior to the waiver including the base year. DHCS has no knowledge of or reason to anticipate material changes in selection between the base year and years under the waiver. Examples of voluntary populations include: 1) beneficiaries in San Benito County choose between a single commercial plan and FFS, and enrollment in managed care is voluntary; 2) Foster Youth in non-COHS counties; and 3) dually eligible beneficiaries except in COHS and CCI counties in P1 only (January 1, 2022 through December 31, 2022), after which they will be mandatorily enrolled in managed care statewide.

- c. ____ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

- 1.____ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
- 2.____ The State provides stop/loss protection (please describe):

DHCS Response

This question appears out-dated. Per 42 CFR § 438.6(b), the State is not required to provide or require reinsurance or stop-loss.

- d. Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:
 1. [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
 - 2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and
 - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP **[NOT APPLICABLE]**

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments):

States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
 1. ____ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as

changes in technology, practice patterns, and/or units of service PMPM.

- ii. ____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

- b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1. ____ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ **Determine adjustment for Medicare Part D dual eligibles.**
 - E. ___ Other (please describe): _____
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe): _____
 For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe): _____
 - iv. ___ Changes in legislation (please describe): _____
 For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe): _____
 - v. ___ Other (please describe): _____
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe): _____

- c. **Administrative Cost Adjustment***: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.
1. ☐ No adjustment was necessary and no change is anticipated.
 2. ☐ An administrative adjustment was made.
 - i. ☐ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ☐ Other (please describe):
 - ii. ☐ FFS cost increases were accounted for.
 - A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ☐ Other (please describe):
 - iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. ☐ Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

- B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
- 1.____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 - 2.____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.I.a.** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.
- 1.____ We assure CMS that GME payments are included from base year data.
 - 2.____ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
 - 3.____ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. ___ GME adjustment was made.
 - i. ___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ___ No adjustment was necessary and no change is anticipated.

Method:

1. ___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine GME adjustment based on a pending SPA.
3. ___ Determine GME adjustment based on currently approved GME SPA.
4. ___ Other (please describe):

- g. Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3. ___ The State had no recoupments/payments outside of the MMIS.

- h. Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.

4.____ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

- 1.____ No adjustment was necessary and no change is anticipated.
- 2.____ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

- 1.____ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
- 2.____ Determine copayment adjustment based on pending SPA.
- 3.____ Determine copayment adjustment based on currently approved copayment SPA.
- 4.____ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

- 1.____ No adjustment was necessary
 - 2.____ Base Year costs were cut with post-pay recoveries already deducted from the database.
 - 3.____ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
 - 4.____ The State made this adjustment:*
- i.____ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
 - ii.____ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment :** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

- 1.____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States

may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5**.

- 2.____ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
- 3.____ Other (please describe):

k. Disproportionate Share Hospital (DSH) Adjustment: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

- 1.____ We assure CMS that DSH payments are excluded from base year data.
- 2.____ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
- 3.____ Other (please describe):

l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

- 1.____ This adjustment is not necessary as there are no voluntary populations in the waiver program.
- 2.____ This adjustment was made:
 - a. ____ Potential Selection bias was measured in the following manner:
 - b. ____ The base year costs were adjusted in the following manner:

m. FQHC and RHC Cost-Settlement Adjustment: Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

- 1.____ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
- 2.____ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3. ____ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4. ____ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ____ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ____ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

***[NOT APPLICABLE]* Special Note for initial combined waivers (Capitated and PCCM) only:**

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM

Adjustment	Capitated Program	PCCM Program
	administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*
- 1.____ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 - 2.____ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 - 3.____ Other (please describe):
- o. **[NOT APPLICABLE] PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.
- 1.____ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 - 2.____ This adjustment was made in the following manner:
- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only

include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
1. No adjustment was made.
 2. This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

DHCS Response

DHCS anticipates additions or revisions to adjustments as we advance in implementation of CalAIM initiatives (e.g., behavioral health payment reform), expand on state budget initiatives, and receive further Legislative direction. DHCS will engage with CMS to amend these adjustments and cost effectiveness calculations as necessary.

- a. **X State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as

percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*)

The actual trend rate used is:

DHCS Response

MCMC and Dental MC: 4.95 percent annually

SMHS and DMC-ODS: 6.3 percent annually (*applies to SMHS, DMC-ODS*).

Please document how that trend was calculated:

DHCS Response

MCMC and Dental MC: The State's actuaries reviewed the Medi-Cal managed care program experience trend with a focus on the major rate categories over a four-year period (CY 2016 to CY 2019) and the national per capita trend for the four major Medicaid categories of aid (Child, Adult, ACE OE, and SPD) as projected by CMS through CY 2026 in its most recent 2018 actuarial report (<https://www.cms.gov/files/document/2018-report.pdf>). Based on the review and internal discussion, the actuaries recommended the State use a single PMPM trend of 4.95 percent across all eligibility groups. In developing this single MEG-wide PMPM trend, the actuaries considered the program experience, national PMPM trend for Medicaid populations, CY 2021 capitation rate development trend assumptions, and consideration given the length of the projection period (5-year waiver period). For P1, the State applied a compounded trend factor of 18.42 percent, calculated by compounding the 4.95 percent annual trend over 3.5 years from the midpoint of the base year (January 1, 2019) to the midpoint of P1 (July 1, 2022).

SMHS and DMC-ODS: The retrospective year of data includes actual expenditures reported on the CMS 64 for quarters ending September 30, 2018, December 31, 2018, March 31, 2019, and June 30, 2019 for mental health services assigned to the 1915(b) waiver (CA17.R09) and substance use disorder services assigned to the DMC-ODS 1115 demonstration.

DHCS reduced these actual expenditures by the amount it identified as costs incurred to provide services to beneficiaries with unsatisfactory immigration status excluding pregnancy related allowable claims; the amount it spent on substance use disorder services provided to beneficiaries in an IMD; and the amount it spent on substance use disorder services provided to American Indian and Alaskan Native beneficiaries. DHCS trended the result to Prospective Year 1 using the percentage change in the Home Health Agency Market Basket Index to account for inflation.

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
- i. X State historical cost increases (*Applies to MCMC, Dental MC*).

Please indicate the years on which the rates are based: **CY 2016 through CY 2019**

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). **The mathematical method used is year over year exponential smoothing.**

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. **Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.**

- ii. X National or regional factors that are predictive of this waiver's future costs. (*Applies to MCMC, Dental MC, SMHS, DMC-ODS*)

Please indicate the services and indicators used:

DHCS Response

MCMC and Dental MC: A five-year annualized prospective PMPM trend (FY2021 to FY2026) as projected by CMS for each major category of aid (Aged, Disabled, Child, Adults, and Expansion Adults) in its 2018 Actuarial Report On The Financial Outlook For Medicaid. The categories of aid encompass a comprehensive level of Medicaid services.

SMHS and DMC-ODS: Home Health Agency Market Basket Index

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs:

DHCS Response

MCMC and Dental MC: The prospective PMPM trend as projected by CMS for Medicaid on a national basis is considered to be an excellent indicator of future trends over a similar five-year projection period for this waiver's future costs given the large program size and similar types of covered populations and services.

SMHS and DMC-ODS: DHCS has found the Home Health Agency Market Basket Index produced by CMS as the most relevant and available predictor of future costs and is used in current payment processes for the SMHS and DMC-ODS delivery systems. CMS uses the Office of the Actuary (OACT) staff on a variety of market basket topics, including index development and construction, theoretical update frameworks, and wage studies which produce actuarially sound indexes.

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

DHCS Response

MCMC and Dental MC: Yes, the trend includes both the utilization trend (changes in technology, practice patterns, and units of services including service mix changes) component and the unit cost trend (price increase) component.

SMHS and DMC-ODS: The PMPM costs per MEG are trended for P1, P2, P3, P4 and P5 utilizing the percentage change in the CMS' Home Health Agency Market Basket (HHAMB) Index for each PY.

3. X The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2. (Applies to SMHS, DMC-ODS)

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).

DHCS Response

SMHS and DMC-ODS: *DHCS estimated that it would spend an additional \$11 million on SUD services provided through a PIHP delivery system to beneficiaries in 10 additional counties in prospective year. DHCS estimated \$11 million based upon State Fiscal Year 2019-20 actual expenditures in counties that currently provide SUD services through a PIHP delivery system with populations similar to the 10 counties projected to begin providing SUD services through a PIHP delivery system.*

- ii. Please document how the utilization did not duplicate separate cost increase trends.

DHCS Response

SMHS and DMC-ODS: *DHCS's estimated cost increase due to change in utilization does not duplicate the inflation cost increase described above. DHCS used the percentage change in the HHAMB index from P1 (CY 2022) to P2 (CY 2023) to estimate the increase in the PMPM due to inflation. California separately calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 (\$4,130,795,712*1.0256).*

b. X State Plan Services Programmatic/Policy/Pricing Change Adjustment:

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. X An adjustment was necessary and is listed and described below:
(Applies to MCMC, Dental MC, SMHS, DMC-ODS)

i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
- B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
- D. ___ Determine adjustment for Medicare Part D dual eligible,
- E. ___ Other (please describe):

ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

- iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe): _____
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe): _____
- vi. X Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. X Other (please describe): _____

DHCS Response

MCMC and Dental MC: *The State applied the following programmatic adjustments:*

- 1) *Reducing P1 and P2 projected expenditures for the carve-out (from Medi-Cal managed care) of specialty mental health services for a subset of beneficiaries in Sacramento County and Solano County, effective July 1, 2022. Note, these services and populations are included in this waiver under the behavioral health eligibility groups. The impact of the reduction is \$16.7 million distributed across applicable eligibility groups and both projection years.*
- 2) *Increasing P1 projected expenditures for the carve-in (to Medi-Cal managed care) of dental services in San Mateo County,*

effective January 1, 2022. The impact of the increase is \$10.7 million distributed across applicable eligibility groups.

- 3) Reducing P1 projected expenditures for the carve-out of pharmacy services billed on a pharmacy claim, effective January 1, 2022. The impact of the reduction is \$6,904.0 million distributed across applicable eligibility groups. The projected carve-out date is consistent with the [Governor's May Revision budget](#), which assumes a transition will take place January 1, 2022. As noted previously, the Medi-Cal Rx transition has been delayed and a revised timeline for the pharmacy benefit transition has not yet been determined as of this writing. If the date is later than January 1, 2022, then DHCS will amend the cost-effectiveness calculation to reflect the actual date.
- 4) Reducing projected expenditures to account for the application of two new rate-setting efficiency adjustments in the waiver period that were not present in the base year. The impact of the reduction is \$203.0 million distributed across applicable eligibility groups.
- 5) Increasing P1 projected expenditures for new or expanded covered services such as Major Organ Transplant, Community Health Worker services, Remote Patient Monitoring, Continuous Glucose Monitors, and Dyadic Behavioral Health services, effective January 1, 2022. The impact of the increase is \$751.3 million distributed across applicable eligibility groups.
- 6) Increasing P1 projected expenditures for anticipated rate increases associated with addition of Enhanced Care Management as a benefit and the sunset/transition of Whole Person Care Pilots under the CalAIM framework, effective January 1, 2022. The impact of the increase is \$565.0 million allocated across applicable eligibility groups.
- 7) Increasing P1 projected expenditures to reflect the ramp-up of the Whole Child Model program, which was not fully phased in during the base year. The impact of the increase is \$326.5 million distributed across applicable eligibility groups.
- 8) Increasing P1 projected expenditures for new directed payments pursuant to 42 CFR § 438.6(c) that did not exist in the base year, and for increases to directed payments above and beyond annual Consumer Price Index-linked growth. The impact of the increase is \$3,509.3 million distributed across applicable eligibility groups.
- 9) Increasing P1 projected expenditures for new, time-limited incentive payments pursuant to 42 CFR § 438.6(b) that did not exist in the base year. The impact of the increase is \$1,424.8 million distributed across applicable eligibility groups.
- 10) Reducing P2, P3, and P4 projected expenditures for the end of the time-limited incentive payments described above. The

impact of the reduction is \$38.0 million in P2, \$809.3 million in P3, and \$577.4 million in P4, distributed across applicable eligibility groups.

11) Increasing P2 for the carve-in of long-term care services statewide, effective January 1, 2023. The impact of the increase is \$2.817.0 million distributed across applicable eligibility groups.

The cumulative, weighted-average impact of these adjustments is -0.95 percent in P1, +4.70 percent in P2, -0.60 percent in P3, and -0.88 percent in P4.

Note, for P2, the State applied a -100.0 percent adjustment to the CCI Dual (non-CMC) and CMC eligibility groups, shifted the member months to the SPD Dual eligibility group, and calculated new, weighted-average P1 PMPMs for State Plan Service Costs and Administrative Service Costs.

SMHS and DMC-ODS: *California included two policy adjustments. In Prospective Year 1, California included a policy adjustment to remove non-pregnancy related services provided to Medi-Cal beneficiaries with unsatisfactory immigration status which were reported on the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports. California removed those expenditures in the September 2020 and December 2020 CMS 64 quarterly reports. In Retrospective Year 2, California included a policy adjustment of .26 percent in to account for 10 counties starting to provide substance use disorder services through the PIHP delivery system. The base data calculated the percentage change in the PMPM in P1 as the ratio of total estimated increased costs for the 10 additional counties using SFY 2019-20 claims data to the R2 costs increased by the percentage change in the HHAMB index from 2018 Q2 to 2019 Q 2 (\$4,130,795,712*1.0256).*

- c. **X Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the*

managed care program, then the State needs to estimate the impact of that adjustment. *(Applies to MCMC, Dental MC)*

1. ☐ No adjustment was necessary, and no change is anticipated.
2. ☒ An administrative adjustment was made. *(Applies to MCMC, Dental MC)*
 - i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - ii. ☒ Cost increases were accounted for. *(Applies to MCMC, Dental MC)*
 - A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ☐ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
 - D. ☒ Other (please describe) *(Applies to MCMC, Dental MC)*:

DHCS Response

DHCS calculated a 5.39 percent trend rate based on the average of annual salary cost increases over a two-year period (SFY 2017-18 and SFY 2018-19) for program areas within DHCS that are directly responsible for the operation of the Medi-Cal managed care delivery system. For P1, the State applied a compounded trend factor of 20.17 percent, calculated by compounding the 5.39 percent annual trend rate over 3.5 years from the midpoint of the base period (January 1, 2019) to the midpoint of P1 (July 1, 2022).

- iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

- B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. _____ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
2. _____ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
 - i. State historical 1915(b)(3) trend rates
 1. Please indicate the years on which the rates are based: base years _____
 2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.): _____
 - ii. State Plan Service Trend
 1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____
2. List the Incentive trend rate by MEG if different from **Section D.I.J.a.** _____
3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State

with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

g.____ Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

- 1.____ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
- 2.____ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
- 3.____ Other (please describe):
- 4.____ No adjustment was made.
- 5.____ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

DHCS Response

MCMC and Dental MC: *In P2, the State is projecting an increase in member months for the SPD and SPD Dual eligibility groups due to the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. In the base year and in P1, dually eligible beneficiaries are mandatorily enrolled, with certain exceptions, into the Medi-Cal managed care delivery system in 27 of California's counties, i.e., COHS and CCI counties. The increase to P2 projected member months consists of 205,000 additional members months in the SPD eligibility group (roughly equivalent to 17,000 partial-dually eligible members per month) and 3,660,000 additional member months in the SPD Dual eligibility group (equivalent to 305,000 full-dually eligible members per month).*

Also in P2, to align with the transition of CCI to a statewide aligned enrollment structure, the State is ending the CCI Dual (non-CMC) and CMC eligibility groups. Members in these eligibility groups are projected to shift to the SPD Dual eligibility group.

No additional caseload changes are projected for purposes of the cost-effectiveness calculation, as described in Section D, Part I.E. Appendix D1 – Member Months.

SMHS and DMC-ODS: *The rate of change identified in Column I is due to inflation adjustments, program policy change and Section 1915(b)(3) service trend adjustments. The rate of change from R2 to P1 is 4.5 percent. This is due to an inflation adjustment of 6.3 percent and policy change adjustment of related to the removal of non-pregnancy claims for beneficiaries with unsatisfactory immigration status. The inflation adjustment of 6.3 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending June 30, 2019, which is the last quarter in Retrospective Year 2 (Fiscal Year 2018-19), to the quarter ending March 31, 2022, which is the first quarter of Prospective Year 1 (Calendar Year 2022). The program policy change adjustment is equal to the amount of non-pregnancy claims for beneficiaries with unsatisfactory immigration status (\$58,985,535.98) divided by the expenditures for mental health and substance use disorder*

services reported in the September 2018, December 2018, March 2019, and June 2019 quarter CMS 64 reports (\$4,130,795,712.28). The Section 1915(b)(3) service trend adjustment in P1 is \$7,275,335 for the use of contingency management in DMC-ODS.

The rate of change from P1 to P2 is 3.2 percent. This is due to an inflation adjustment of 2.6 percent, program policy change adjustment of .26 percent and Section 1915(b)(3) service trend of \$22,448,600. The inflation adjustment of 2.6 percent is equal to the percentage change in the Home Health Agency Market Basket Index from the quarter ending March 31, 2022 (1st quarter of Calendar Year 2022) to the quarter ending March 22, 2023 (1st quarter of Calendar Year 2023). The program policy change adjustment of .26 percent accounts for 10 additional counties starting to provide substance use disorder services through a PIHP delivery system. California estimated the cost of those additional 10 counties would be \$11 million based upon costs incurred by counties with similar populations in Fiscal Year 2019-20. California divided \$11 million by the R2 expenditures trended forward to Fiscal Year 2019-20 using the percentage change in the Home Health Agency Market Basket Index. The Section 1915(b)(3) service trend adjustment in P2 is \$22,448,600 for the use of contingency management in DMC-ODS. The increase in costs from P1 to P2 is based on increased utilization in the second year of the pilot.

The change from P2 to P3 is due to an inflation adjustment and Section 1915(b)(3) service trend adjustment. The service trend adjustment in P3 is for the final three months of the contingency management pilot and is anticipated to cost \$7,878,838.

The rate of change from P3 to P4, and P4 to P5 is entirely due to an inflation adjustment. The inflation adjustment for each year is equal to the percentage change in the Home Health Agency Market Basket Index from the 1st quarter of the base year to the 1st quarter of the prospective year.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

DHCS Response

MCMC and Dental MC: The State refers to the descriptions of the State Plan Services trend in Section D.I.J.a, the State Plan Services programmatic adjustments in Section D.I.J.b, and the Administrative Cost adjustment in Section D.I.J.c.

SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes an inflation adjustment. The inflation adjustment captures anticipated changes in unit costs.*

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

DHCS Response

MCMC and Dental MC: *The State refers to the descriptions of the State Plan Services trend in Section D.I.J.a and the State Plan Services programmatic adjustments in Section D.I.J.b.*

SMHS and DMC-ODS: *As explained above, the overall annualized rate of change in Appendix D7, Column I includes three program policy change adjustments. These three program policy change adjustments capture anticipated changes in utilization.*

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.