State of California

Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

Mark A. Ghaly, MD, MPH
SECRETARY
Health and Human Services

RICHARD FIGUEROA
ACTING DIRECTOR
Health Care Services

October 28, 2019

Dear Colleagues,

Enclosed for your review and consideration is a comprehensive set of proposals that encompass the Department of Health Care Services' (DHCS) approach to the California Advancing and Innovating Medi-Cal (CalAIM) initiative. The primary goals of the CalAIM initiative are to:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

These proposals outline DHCS' initial thinking about the best ways to achieve these goals through the Medi-Cal program and were developed based on extensive input DHCS has received over the past few years, and in particular from the Care Coordination Advisory Committee and Stakeholder Advisory Committee. We look forward to the robust stakeholder engagement effort that is now underway; and we expect the discussions that occur over the next several months to inform the final approach to each element of the CalAIM initiative.

We welcome input from all stakeholders and perspectives, and also caution that the ultimate outcome of the various components of CalAIM are contingent on the discussions that will occur through the state budgeting process as well as the availability of state funding resources and/or other sources of the non-federal share of Medi-Cal funds.

We are undertaking a robust CalAIM workgroup process that will cover key issue areas:

- Requiring Medi-Cal managed care plans to submit **Population Health Management** strategies and moving to annual Medi-Cal managed care plan open enrollment.
- Adding a new **Enhanced Care Management** benefit and a set of **In Lieu of Services**, designed to focus on critical populations such as children, high-cost/high-need populations, and the homeless, among others.

1600 Ninth Street, Room 460
Sacramento, CA 95814
Telephone (916) 654-3454
Fax (916) 654-3343

1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Phone (916) 440-7400

- **Behavioral Health** payment reform and delivery system transformation, with particular emphasis on how to improve critical needs for children.
- Requiring the **National Committee on Quality Assurance (NCQA) accreditation** for Medi-Cal managed care plans.
- Considerations for creation of **Full Integration Plans** where one entity would be responsible for the physical, behavioral, and oral health needs of their members.

These workgroup discussions will take place between November 2019 and February 2020 and will provide multiple opportunities for stakeholders and members of the public to give feedback and input into the policy development process. More information is available on our CalAIM website.

DHCS will also use the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC to provide critical updates on the CalAIM initiatives on an ongoing basis. While most aspects of CalAIM will be discussed through workgroups, it will not be possible to cover all of the topics for which we have CalAIM proposals. Updates on those proposals that are not presented in the workgroups will be provided during SAC and BH SAC meetings in early 2020. In addition to these specific workgroups, DHCS will also be developing a workgroup focused on how to better serve the foster care population in Medi-Cal that we will seek to begin to convene in early 2020 in order to develop a proposal for this important and vulnerable population.

Please subscribe to DHCS' stakeholder email service to receive CalAIM updates. For any other comments, questions, or concerns, please contact CalAIM@dhcs.ca.gov.

We look forward to your participation in this important effort to shape the future of the Medi-Cal program.

Sincerely,

Mark A. Ghaly, MD, MPH
Secretary
Health and Human Services Agency

Richard Figueroa
Acting Director
Health Care Services

State of California—Health and Human Services Agency
Department of Health Care Services

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

October 28, 2019

This page is left intentionally blank.

Table of Contents

1. Executive Summary 6

1.1 Background and Overview 6
1.2 Guiding Principles 7
1.3 Key Goals 8
1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health 8
Population Health Management 9
Enhanced Care Management 9
In Lieu of Services & Incentive Payments 10
Institutions for Mental Disease (IMD) Expenditure Waiver 10
Mandatory Medi-Cal Application Process upon Release from Jail 11
Full Integration Plans 11
Develop a Long-Term Plan for Foster Care 12
1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility 12
Managed Care 13
Behavioral Health 15
Dental 17
County Partners 17
1.6 Advancing Key Priorities 18
1.7 From Medi-Cal 2020 to CalAIM 20
1.8 CalAIM Stakeholder Engagement 21
1.9 Conclusion 22

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health 23

2.1 Population Health Management Program 23
2.2 Enhanced Care Management Benefit 37
2.3 In-Lieu-of Services 45
2.4 Shared Risk, Shared Savings, and Incentive Payments 48
2.5 Institutions for Mental Disease; Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver 50
2.6 Full Integration Plans 53
2.7 Long Term Plan for Foster Care 55

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility 56

Managed Care 57
3.1 Managed Care Benefit Standardization 57
3.2 Mandatory Managed Care Enrollment 59

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans 61
3.4 Annual Medi-Cal Managed Care Plan Open Enrollment 64
3.5 NCQA Accreditation of Medi-Cal Managed Care Plans 67
3.6 Regional Managed Care Capitation Rates 69
Behavioral Health 71
3.7 Behavioral Health Payment Reform 71
3.8 Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services 74
3.9 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services 80
3.10 Behavioral Health Regional Contracting 86
3.11 Substance Use Disorder Managed Care Program Renewal and Policy Improvements 87
Dental 93
3.12 New Dental Benefits and Pay for Performance 93
County Partners 95
3.13 Enhancing County Eligibility Oversight and Monitoring 95
3.14 Enhancing County Oversight and Monitoring: CCS and CHDP 98
3.15 Improving Beneficiary Contact and Demographic Information 100

4. Conclusion 102

5. From Medi-Cal 2020 to CalAIM: A Crosswalk 103

5.1 Transition of PRIME to Quality Incentive Program 107
5.2 Global Payment Program Extension 110

6. APPENDICES 113

Appendix A: CalAIM Implementation Timeline 113
Appendix B: Targeted Case Management 116
Appendix C: County Inmate Pre-Release Application Process sample contracting Models 119
Appendix D: Menu of In Lieu of Service Options 120
Housing Transition Navigation Services 121
Housing Deposits 126
Housing Tenancy and Sustaining Services 130
Short-term Post-Hospitalization Housing 135
Recuperative Care (Medical Respite) 139
Respite Services 142
Day Habilitation Programs 145
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult and Adult Residential Facilities 148
Community Transition Services/Nursing Facility Transition to a Home 151
Personal Care and Homemaker Services 154

Environmental Accessibility Adaptations (Home Modifications)..... 156
Meals/Medically Tailored Meals..... 159
Sobering Centers..... 161
Appendix E: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones..... 163
Appendix F: CalAIM Benefit Changes Chart..... 167
Appendix G: Managed Care Enrollment Proposed Aid Code Group Coverage 168
Appendix H: Global Payment Program Extension Timeline..... 174
7. Glossary..... 175

1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care.

Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles. For the purposes of CalAIM DHCS built off and refined those principles to guide the work we intended to pursue.

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities or inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.

- Improve plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A** for the CalAIM Implementation Timeline.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the State's health care delivery system aimed at achieving better care, better health and reduced expenditures in Medi-Cal programs. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following recommendations that focus on a whole-person care approach that addresses the needs of our beneficiaries across the board – looking at physical and behavioral as well as social determinants of health, with the overarching goals of improving quality of life and reducing the overall costs for the Medi-Cal population.

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.

- Evaluate particiapation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.
- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots, and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;

- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or Care Management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the State must use its ability to provide our Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

Institutions for Mental Disease (IMD) Expenditure Waiver

Currently, federal Medicaid funding cannot be used for institutional services provided to individuals with serious mental illness or severe emotional disturbance (known as the IMD exclusion). However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to these populations. Through extensive stakeholder engagement, DHCS will assess state and county interest in pursuing the IMD expenditure waiver, as well as readiness of our systems to achieve the required goals and outcomes. Such a proposal must be budget neutral and would allow counties to “opt-in.” The main elements of any proposed waiver would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail

Justice involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs are met like housing, transportation and overall integration back into the community. Studies have shown, such coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. In an effort to ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2022. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to realignment and Prop 30 implications. Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024, as DHCS and our managed care plans and county partners work together to develop the most appropriate delivery systems for this purpose.

Develop a Long-Term Plan for Foster Care

In 2020, DHCS would like to form a group of stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. Based on the recommendations from such workgroup, DHCS, California Department of Social Services, and other sister departments would work to implement such changes based on timelines developed in the stakeholder process.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services are different depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental and other county based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

Managed Care

Managed Care Enrollment

By January 2021, DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries and by January 2023 requiring all dual beneficiaries, statewide to be enrolled mandatorily in a managed care plan, with the exception of those for whom managed care enrollment does not make sense due to limited scope of benefits or limited time enrolled. This will eliminate variation of managed care enrollment practices that currently vary by aid code, population, or geographical location.

Standardize Managed Care Benefit

By January 2021, DHCS proposes to standardize managed care plans benefits, so that all Medi-Cal managed care plans provide the same benefit package. Some of the most significant changes are the carving-in of institutional long-term care and major organ transplants into managed care statewide and, per Executive Order, the carving out of pharmacy.

Transition to Statewide Managed Long-Term Services and Supports

In order to achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative to standardized mandatory enrollment of dual eligibles into a Medi-Cal managed care plan for Medi-Cal benefits and integration of long-term care into managed care for all Medi-Cal populations statewide. This will be done in two phases:

January 2021: The Coordinated Care Initiative proceeds as today, however Multipurpose Senior Services Programs will be carved out and all institutional long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement the voluntary in lieu of services benefit at this time.

January 2023: Full transition of the Coordinated Care Initiative to mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Medicare Dual-Special Needs

Plans, in order to offer dual eligible members the ability to have coordinated managed care plans for both their Medi-Cal and Medicare benefits.

The purpose of these transitions and phases is to target a long-term goal of implementing managed long term services and supports (MLTSS) statewide in Medi-Cal managed care beginning in 2026 by providing enough time and incentive to develop the needed infrastructure. This will allow beneficiaries to receive needed MLTSS and home and community based services statewide through their managed care plan, instead of a variety of 1915(c) waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be National Committee for Quality Assurance (NCQA) accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

Annual Medi-Cal Health Plan Open Enrollment

Effective for plan enrollment as of January 1, 2022, DHCS proposes to implement an Annual Health Plan Open Enrollment process for all managed care plan enrollees. Enrollees would generally only be allowed to change their managed care plan during the Annual Health Plan Open Enrollment period which is consistent with health care industry practice. The Annual Health Plan Open Enrollment period would first begin in November 2021. However in recognition of the concerns previously raised by stakeholders, DHCS has developed this proposal to include a consumer-friendly exemption process that will allow members who have a real need to change plans mid-year to do so in a streamlined way. Enrollment into Medi-Cal coverage would still be allowed throughout the year. This proposal provides the stability required to do effective care and case management of the plan members, while still allowing a simplified process to allow a plan change when it is needed.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model, this also coincides with a shift of the rating period from the state fiscal year to the calendar year beginning in 2020. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with goal of allowing DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates will allow cost

averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging rather than just the experience of plans within the county. This change is fundamental to the ability of DHCS to implement the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps forward to invest in and improve access to mental health and substance use disorder services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS, and we recognize that the full needs of the Medi-Cal population are not being met, particularly with respect to improving services and access for children and other vulnerable populations. In order to achieve true reform, DHCS believes that an important first step is undergoing behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. Such a shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation and engage in value-based payment arrangements with their health plan partners in order to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to further build a high quality continuum of care for mental health and substance use disorder services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide.

Administrative Behavioral Health Integration Statewide

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from

integrated treatment. The State provides Medi-Cal covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide substance use disorder and specialty mental health services through one delivery system.

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. Finally, DHCS is exploring

opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

Dental

The Department has set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress towards achieving that goal, and based on our lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new Dental Benefits based on the outcomes and successes from the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high risk and institutional populations; and
- Continue and expand Pay for Performance Initiatives initiated under the Dental Transformation Initiative that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office as identified in a recent audit. This proposal will also ensure that DHCS is compliant with federal and State requirements. These enhancement will be done in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 child beneficiaries. The State delegates certain responsibilities for these high-risk children to California's 58 counties. The State needs to enhance the oversight of counties to ensure they comply with legislation, regulations, and State issued guidance. Enhancing monitoring and oversight will eliminate disparities in care and

reduce vulnerabilities to the State, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

These reforms are interdependent and build off one another; without one, the others are neither possible or powerful.

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other. These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value based and integrated delivery of care are significantly harder and potentially impossible to achieve. These fundamental financing changes themselves would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Therefore, carving out prescription drugs from managed care (Medi-Cal Rx) and the other carve-in/carve-outs detailed in the Medi-Cal managed care proposals are necessary and serve as the foundation for DHCS to institute the concepts around not only regional rate setting, but also nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots). The Medi-Cal program has evolved over the multiple decades since inception and has relied upon ever-increasing system and fiscal complexity in order to operate and serve the Californians who rely upon it. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess

what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be the most effective with respect to the funding utilized to most efficiently operate the program.

Furthermore, CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly,

the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred

15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. In addition, given that California has significant learnings from our past 1115 Waivers, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with new federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The proposal outlines all elements of the Medi-Cal 2020 waiver and how they will be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or abilities to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes under this federal authority approach. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care. We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS' intention in the release of these proposals is to garner important input from the many key stakeholders and partners that help us to improve upon these concepts and align them with the expertise and experience of our partners. As previously outlined, DHCS will be undertaking a significant stakeholder engagement effort that begins with the release of this document and continues through the CalAIM workgroups scheduled for November through February, the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC meetings, Medi-Cal Health Advisory Panel (MCHAP) and other convenings. We recognize that CalAIM contains many significant proposals and changes to the Medi-Cal program, aimed at ultimately improving the beneficiary experience and outcomes. However, these represent DHCS' initial proposals and thinking and we look forward to working to refine and modify these proposals relying on the expertise of our stakeholder partners through this engagement process. DHCS plans to finalize all proposals for submission to CMS in the May to July period of 2020 based on the input we will receive from our partners through this process, but also dependent on the funding availability through the state budget process.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively impact our beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how Californians (adults and children) will access mental health and substance use disorder services including administration of, eligibility for, and access to integrated behavioral health care.
- Provides access to enhanced care management for medically complex children and adults to ensure they get their physical, behavioral, developmental and oral health needs met.
- Builds capacity in clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and will be a critical component on the State's Master Plan on Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- IMD Expenditure Waiver
- Full Integration Plans
- Long Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement that Medi-Cal managed care plans maintain a population health management program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care coordination – including screenings, health assessments, case management, data collection and monitoring, care transitions, communications, governance, training, and other issues. Additionally, Medi-Cal managed care plans will develop predictive analytics about which patients, communities or populations are emerging as high risk, as well as, identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a beneficiary-centered population health management program, in accordance with NCQA and DHCS

requirements. The population health management program description must be filed with the state annually and shall address all NCQA population health management elements. The plan must also address all DHCS requirements noted in this document which are intended to align with, and augment, the NCQA requirements.

Each managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

The population health management program description shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize initial and ongoing assessments of data to identify groups and individuals within groups;
- Ensure access to physical and behavioral health while providing assistance for Members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs to mitigate social determinants of health issues; and partner with appropriate community based providers to support individual members, families and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a Person-Centered and Family-Centered approach for care planning; and
- Continually evaluate and improve on the strategic plan on an ongoing basis through meaningful quality measurement.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Assessment of Risk and Need

1. **Initial Risk Assessment**

   The Medi-Cal managed care plan shall conduct an initial assessment of each new member's risk and need, including emerging risk, by assessing behavioral, developmental, physical, and oral health status, and social determinants of health within 90 days of the effective date of plan enrollment. The Medi-Cal managed care plan must also ensure that existing members who have not already received an initial risk assessment, or an acceptable alternative, have one completed within one year of population health management program implementation. The population health management program plan shall include a description of the Medi-Cal managed care plan's process for identifying and completing the assessment for existing members, which may include a phased-in approach in the first year of implementation.

   The initial assessment of risk and need includes two parts: 1) use of all available data sources and data analytics; and 2) a member-contact and evidence-based screening appropriate to the age of the member. An initial assessment of each member's risk and need shall be required for all aid codes. The standardized population health management initial assessment and risk stratification will replace the assessments below:

   - Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
   - Health information form/member evaluation tool (HIF/MET)
   - Health risk stratification and assessment survey for seniors and people with disabilities

   In redesigning current member assessments, DHCS will separate Medi-Cal managed care plan-level risk assessments from those that are more appropriate to be delivered in the clinical setting, such as screenings conducted by providers during the initial health assessment visit. Prior to contacting the member, Medi-Cal managed care plans shall conduct a data and analytics assessment that considers at least the following sources:

   - Previous screening or assessment data;

- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;
- Pharmacy data;
- Laboratory data;
- Electronic health records; and
- Results of Medi-Cal managed care plan predictive modeling or specific algorithms.

The member-contact screening may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. The Medi-Cal managed care plan shall make at least three (3) attempts to contact a member using available modalities.

The member-contact screening shall include, but is not limited to, the following elements:

- Behavioral, developmental, physical, and oral health needs;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Ability to function independently and organize his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of support/caregiver;
- Access to private and/or public transportation;
- Social or geographic isolation;
- Housing and housing instability assessment; and
- Use of community-based services and supports.

2. Risk Stratification

In preparation of the population health management plan, Medi-Cal managed care plans will risk stratify the population to determine the level of intervention that members require based on all available data sources, as well as the results of the member-contact screening. The plan will use risk stratification to assign members to tiers or subsets that address all care needs and intensities. The population health management program description will identify what actions the Medi-Cal managed care plan expects to take for members based on the results of the assessment and risk stratification process.

Based on the individual assessment, the Medi-Cal managed care plan will link the member with the appropriate services, including, but not limited to wellness and prevention, general case management, complex case management, enhanced care management, external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below. In addition, Medi-Cal managed care plans should include in their population health management program a description of any additional programs and services that are needed to ensure that the program is comprehensive. Medi-Cal managed care plans will be responsible for reporting the beneficiary's level of risk (low, medium, high) to the department in an electronic format to enable better tracking and assessment of the impacts of this proposed structure.

3. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including emerging risk, of all members annually through an approved data-driven risk stratification process. Members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what triggers the re-evaluation process. Members newly identified as requiring case management or other services through the annual risk stratification must be contacted within 30 calendar days to assess their needs. In the population health management program description, the Medi-Cal managed care plan must inform the department what minimum risk groups or triggers would call for regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as the minimum in the program description.

4. Provider Referrals

The Medi-Cal managed care plan must establish a process by which providers may make referrals for members to receive case management. Referrals for case management should lead to a reassessment of risk and need. Medi-Cal managed care plans must consider and integrate information received through those referrals when determining the member risk stratification

Actions to Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate, including, but not limited to: member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and substance use disorder treatment referrals, developmental services referrals, dental referrals and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24 hours a day, seven (7) days a week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The population health management program shall integrate wellness and prevention services for all members according to the benefits outlined in the managed care contract:

- Provide preventive health visits and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Emerging Risks

The population health management program shall:

- Ensure that providers are able to refer members to Medi-Cal managed care plan services when the providers identify emerging risk or needs outside the Medi-Cal managed care plan risk assessment process;
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs, including preventive care, care for chronic conditions, and referrals to long-term services and supports, social services and community-based organizations, as appropriate;
- Refer members identified as needing care coordination to the member's case manager for follow-up care and needed services within thirty (30) calendar days; and
- Assess individual needs and deploy appropriate community resources and strategies to mitigate impacts of social determinants of health.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk, as well as identify and address the needs of outliers with more specific services and supports.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems, acquiring self-care skills to improve functioning and health outcomes, and slowing the progression of disease or disability. Case management services are intended for members who are medium- or high-risk or may have emerging risks that would benefit from case management services. Members determined to be low-risk should continue to receive wellness and prevention services, as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Documentation in an electronic format of the individual care plan and assigned case manager for each member.
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact.
- Access to person-centered planning, including education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, developmental, and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement social determinant interventions (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.

- Assisting members in relapse/crisis prevention planning that includes development and incorporation of recovery action plans and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting the requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.
Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who have a medium- to high-risk level, or emerging risk, and require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include a documented individual care plan; an assigned case manager (located with the Medi-Cal managed care plan, provider, or community-based); assignment to a certified patient-centered medical home; participation in a Medi-Cal managed care plan disease management program; or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that

requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** Enhanced care management is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, including behavioral health conditions, and multiple social needs, as well as utilization of multiple service types and delivery systems (similar to the current Whole Person Care or Health Home Programs in intensity). See the separate CalAIM enhanced care management proposal for more details, including proposed member eligibility and model of care requirements.

  The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management program. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, Health Homes, Coordinated Care Initiative, etc.), as well as inform the development of future statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot Program that are not covered as State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically-tailored meals, supplemental personal care services, and housing tenancy navigation and sustaining services. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See the separate CalAIM in lieu of services proposal for more details.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The plan must coordinate with competent external entities to provide all necessary services and resources to the beneficiary. These entities should be listed as part of the population health management plan identifying specific services each named entity will provide plan members.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The plan shall work with appropriate staff at any hospital that provides services to its members (whether contracted or non-contracted in the case of emergency services), to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission. The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions.

The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, in order to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services required for the member within two (2) business days. Such services shall include

authorizations for therapy, home care services, equipment, medical supplies or pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services requiring pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and shall ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes but is not limited to prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional services requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;

- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and
- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis, or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including All plan Letters, Policy Letters, and Dual plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would be reviewed and approved by the State.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making and case management. An overarching goal of population health management is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value based payment models and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans and Advance Directives necessary to coordinate service delivery, and care management for each member in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal Managed Care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans, including changes to our audit procedures and our imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that through this and the other proposals contained within CalAIM that the responsibility of the Medi-Cal Managed Care plans is increasing, and therefore DHCS oversight to hold the plans accountable must also grow and change in conjunction with these proposals. To assist with such large change, DHCS is committed to providing Medi-Cal managed care plans technical assistance through such changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plan development of their population health management program, DHCS will provide submission templates and "best practice" examples of current Medi-Cal managed care plan population health management programs from California and other States. DHCS will also solicit stakeholder feedback on the idea of creating a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. DHCS, in consultation with stakeholders, will continue thinking about the best methods to advance promising practices in the areas of specific tools and requirements for:

- The initial assessment to gather information for risk assessment and stratification. Implementation will occur at a later date after the population health management program is initially implemented. In the interim, Medi-Cal managed care plans will utilize current required assessments and data collected at their option, to risk stratify the population;
- Coordination with external entities;
- Transition coordination, including a discharge risk assessment tool;
- Use or develop of a general beneficiary medical record release consent allowing plans and providers to share data broadly for the purposes of care coordination;
- Submission of social determinants of health data to DHCS via ICD-10 coding;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes; and
- Data exchange protocols and the development of health information technology/health information exchange policies.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan

outcomes. DHCS may also standardize certain requirements after research and consultation with stakeholders.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while also reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** provides a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers in order to maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2021. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).

Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence. Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Both the Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management program within Medi-Cal managed care.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. It is the State's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment of the Whole Person Care entities in building the capacity for these services and intends to build on those investments and infrastructure in order to continue the positive outcomes achieved by the pilots.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, enhanced care management will identify target populations, share data between systems, and coordinate care in real time. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care for beneficiaries and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and

- Decreasing inappropriate utilization.

Target populations for enhanced care management may include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

Enhanced Care Management Design and Services

Enhanced care management will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

Enhanced care management involves principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely and cost-effective manner. Enhanced care management shall emphasize prevention, health promotion, continuity and coordination of care which advocates for, and links members to, services as necessary across providers and settings and emphasizes the least restrictive and most integrated setting.

The role of enhanced care management is, through face-to-face visits, coordinating all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for

coordination of all the member's physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management is provided at a level dictated by the complexity and required needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Care managers are encouraged to develop relationships with members and their families, engage members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

Care managers are the members' primary point of contact and are responsible for ensuring that all physical, behavioral, long term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services to beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health, identify, and access helpful resources; identify and coordinate in lieu of services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services and follow-up to help ensure that beneficiaries are connected to the services they need; and helping beneficiaries obtain and maintain housing, as appropriate.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing enhanced care management programs and criteria for their members and contracting with public and private providers to deliver such services. DHCS intends that, as appropriate, Medi-Cal managed care plans build upon the expertise and infrastructure of the existing program within Whole Person Care and Health Homes to achieve these outcomes. In addition, DHCS expects that plans will work in coordination and collaboration with, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that plans determine service

design and intensity based on the parameters established by DHCS. Contingent on available funding for this proposal, DHCS will build funding into the capitation rates for Medi-Cal managed care plans to operate their enhanced care management programs. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposed to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the State that their program is community based and such plan component would be submitted to both medical and financial audits.

For individuals with a primary serious mental illness diagnosis, children with serious emotional disturbance, or substance use disorder, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, so long as they agree to coordinate all the services (physical, developmental, oral or long-term care) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that these beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Furthermore, due to duplication of services and target populations and concerns from CMS regarding duplication of federal funding, DHCS will no longer allow participating Local Governmental Agencies to provide Targeted Case Management to Medi-Cal beneficiaries enrolled in managed care after January 1, 2021. DHCS would look to Medi-Cal managed care plans to partner with Local Governmental Agencies currently providing these services as likely partners to provide services under the plan's responsibilities for case management. The Targeted Case Management Program provides specialized case management services to Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See Appendix B for which counties currently participate in the Targeted Case Management program. Local Governmental Agencies would still be able to provide Targeted Case Management services to Medi-Cal fee-for-service and non-Medi-Cal populations, and as noted would be looked to contract with the Medi-Cal managed care plans for the managed care population.

The CalAIM enhanced care management workgroup will need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of funding.

Transition Plan

Since DHCS is looking to build on the infrastructure from the Health Homes Program, parts of the Whole Person Care pilots and Targeted Case Management, Medi-Cal managed care plans will be required to submit a transition plan to the State by July 1, 2020 demonstrating how they will transition such existing programs into their enhanced care management and in lieu of services programs; and demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services, with such health homes providers, Whole Person Care entities and Local Governmental Agencies already providing such services. Additionally, if the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to agreement.

Implementation

By January 1, 2021, all Medi-Cal managed care plans will need to submit to DHCS an Enhanced Care Management Model of Care proposal as a part of their population health management plan and complete readiness for the following mandatory target populations:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis); and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

By January 1, 2023, all Medi-Cal managed care plans would need to submit to DHCS an Enhanced Care Management Model of Care proposal for reentry for individuals transitioning from incarceration. Reentry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these type of arrangements take significant coordination between the managed care plan, counties, sheriff, probation and other key stakeholders. Conversely,

DHCS would consider whether the post incarceration/reentry bundles that were created in Whole Person Care pilots could continue in those counties on January 1, 2021, but would to give other counties more time to build such relationships and programs. DHCS is also looking to leverage H.R. 6 SUPPORT Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. Lastly, these efforts will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre or post booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management bundle, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022. *See the Mandated County Inmate Pre-Release Application Process section below for more details.*

Medi-Cal managed care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations listed above.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for State inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (i.e. Community-Based Organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals

at the county Jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. Appendix C includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration. Additionally, DHCS is proposing to mandate all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health providers, prior to or upon release from jail.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the State's health care delivery system and is working with health promotion partners to achieve better care, better health outcomes, at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants to health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions.

Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts effective on January 1, 2021 for most mandated target populations and January 1, 2023 for individuals transitioning from incarceration.

DHCS is proposing an effective date of January 1, 2022 for counties to implement a County inmate/juvenile pre-release application process. To ensure the necessary data sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2020:** Establish workgroup with County Welfare Director's Association and Counties to develop and vet implementation plan
- **July 1, 2020:** All county guidance development
- **October 1, 2020:** County and stakeholder feedback process
- **January 1, 2021:** Publish All County Welfare Director Letter
- **January – December 2021:** County implementation planning and technical assistance
- **January 1, 2022:** Implementation of county inmate pre-release application process

2.3 In-Lieu-of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes. However, the implementation of these programs has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State

Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The State determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for beneficiaries; they are not required to use the in lieu of services; and
- The in lieu of services are authorized and identified in the State's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs and avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use.

2.3.2 Proposal

DHCS is proposing to cover the following thirteen (13) distinct services as in lieu of service under Medi-Cal managed care. Details regarding each proposed set of services are provided in Appendix D:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Supportive Services) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

The use of in lieu of services is voluntary to both beneficiaries and Medi-Cal managed care plans. Each service will have defined eligible populations, code sets, providers, restrictions, and limitations. However, individual in lieu of services may be used together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. In lieu of services should not replace existing State, federal or community efforts to address the social determinants of health, but used to fill in gaps to address the needs of particularly vulnerable members and avoid more costly services.

Transition Plan

Since DHCS is looking to build on the infrastructure from the Health Homes Program, parts of the Whole Person Care pilots and Targeted Case Management, Medi-Cal managed care plans will be required to submit a transition plan to the State by July 1, 2020 demonstrating how they will transition existing programs into their enhanced care management and in lieu of services programs. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services, with Health Homes providers, Whole Person Care entities, and Local Governmental Agencies providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to provide these services. Finally, if the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to agreement.

2.3.3 Rationale

If ultimately approved, adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the State, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as, identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care plans to be prepared for an integrated long-term services and supports managed care program by 2026.

Stakeholder feedback will be critical to ensuring that the services we have identified will adequately be able to address the critical needs of beneficiaries. Input on strategies for building the necessary service infrastructure in a cost-effective manner will also be critical. DHCS is also interested in feedback on the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2021: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services allows for a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2026 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the State to be equipped with the needed managed long-term services and supports and housing infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. The State could provide Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu off services capacity, and achieve improvements in quality performance that can inform future policy decisions. Ultimately the size and availability of incentive payments will be dependent on funding made available through the State budget process.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate for seniors and persons with disabilities and long-term care beneficiaries. The rate would be subject to a rate blend update to align with actual plan membership, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.
- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years -- 2021, 2022 and 2023.
- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach for calendar years 2024 and 2025. DHCS would utilize historical cost and utilization experience that would reflect the implementation experience of providing in lieu of services, managed long-term care services, and enhanced care management benefits statewide.
- Establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments would also be based on quality and performance improvements and reporting in areas such as long-term services and supports and other cross-delivery system metrics. The target of incentive payments is to drive change at the provider level and so DHCS would be looking for plans to partner and share the incentive dollars with on the ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of in lieu of services, long-term care, and enhanced care management benefits statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as the State and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the State and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;
- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program by 2026; and
- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2020:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2021:** Implement a seniors and persons with disabilities/long-term care blended rate and plan incentives.

2.5 Institutions for Mental Disease; Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness and children with serious emotional disturbance who are enrolled in Medicaid.

This serious mental illness/serious emotional disturbance Section 1115 demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (i.e., psychiatric hospitals or health facilities that have more than 16 beds, or skilled nursing facilities with special treatment programs that have more than 50 percent of the total beds designated for patients who are institutionalized due to their mental health condition). Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS seeks input from stakeholders regarding whether California should pursue this serious mental illness/serious emotional disturbance Section 1115 demonstration to receive federal financial participation for services provided to Medi-Cal beneficiaries in an institution for mental disease. If California decides to pursue this waiver opportunity, DHCS must submit an application to CMS using the usual process for submitting an 1115 application. Similar to the State's existing 1115 demonstration to provide residential and other substance use disorder treatment services under Medi-Cal, county participation would be voluntary.

In considering applying for this Section 1115 demonstration opportunity, DHCS would need to consult with CMS to ensure that the "costs not otherwise matchable" under the mental illness waiver would be considered a pass-through of State and federal funds in the same manner as the substance use disorder treatment waiver. Because DHCS will not have budget neutrality savings to apply to an 1115 waiver moving forward, this determination is critical to the feasibility of pursuing this demonstration opportunity.

2.5.3 Rationale

If California is approved to participate in the waiver opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an institution for mental disease. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings including permanent supportive housing and board and care facilities. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

While appealing, this Section 1115 demonstration opportunity comes with many federal milestones and requirements. As of August 2019, only Washington DC has submitted an 1115 waiver application to CMS. Below is a summary of key requirements that may pose feasibility challenges:

- **Average Length of Stay:** The State would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in institutions for mental disease. CMS is said to be developing guidance regarding calculations of average length of stay; but this will be an important consideration for implementation of the waiver.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the State's commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and is encouraging States to provide an

assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The State would need to report on a common set of measures and agree to additional measures and concepts specific to the State's demonstration parameters.
- **Health Information Technology:** The State would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.
- **Staffing Considerations:** Since DHCS does not currently pay for institution for mental disease services, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration. For example, more robust case management and utilization management services within IMD settings will be required at the county level.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the Appendix E of this proposal.

2.5.4 Proposed Timeline

The timeline for this 1115 waiver proposal is to be determined. The first step is to engage stakeholders to assess interest in pursuing the demonstration and determine if participation is feasible for California given the rigorous implementation, data and monitoring requirements. If there is sufficient interest from counties and support of the Administration, state legislature and stakeholders, the next step would be to identify counties interested in participating and to discuss how to meet the requirements. If it is determined that California will pursue the demonstration, a proposed approach, metrics, and timeline would need to be included in a waiver application. A formal implementation plan would need to be completed and submitted to CMS.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems in order to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health from their Medi-Cal managed care plan, care for serious mental illness/serious emotional disturbance and substance use disorders from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The long known longevity gap among individuals with serious and persistent mental illness and the fact that this group suffers and dies from un- or under-treated chronic physical health conditions demonstrates the need to pilot such full integration delivery systems.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, substance use disorder managed care, and dental) would be consolidated under one contract with DHCS. In order to develop this concept, DHCS is engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems In addition, integration will improve access to health data/ data sharing among providers and between plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

DHCS will seek stakeholder feedback on the following questions in order to explore ideas around Full Integration Plans:

- What delivery systems should be a part of the Full Integration Plan?
- What criteria would an entity need to meet in order to participate in a Full Integration Plan?
- What are the challenges in implementing a plan that provides medical, dental, specialty mental health and substance use disorder services?
- What are the opportunities for implementing a program that provides medical, dental, specialty mental health and substance use disorder services?
- What policy discussions/decisions need to occur before moving forward with a fully integrated delivery system?
- How much time is needed to build a fully integrated delivery system?
- What impact would a fully integrated Medi-Cal delivery system have on non-Medi-Cal program mandates (e.g., Mental Health Services Act, SAMHSA block grants)?
- What challenges and opportunities are there of blending existing separate and complex funding streams (e.g. realignment and Prop 30)?
- What other considerations should be accounted for when looking to implement a fully integrated delivery system?
- What are the best ways to utilize and hold accountable the various delivery systems that have expertise and will act as providers of the services in this type of plan?

2.6.4 Proposed Timeline

DHCS is proposing the following implementation timeline:

- **January 2020:** Full Integration Plan workgroup meetings
- **January** – **December 2021:** Build full integration plan contract and request for proposal
- **January – July 2022:** Request for proposal posted; DHCS evaluates responses
- **July 2022:** Full Integration Plan contracts awarded
- **July 2022 – December 2023:** Readiness activities and implementation planning

- **January 2024:** Full Integration Plans go live in counties that have opted in to participate

2.7 Long Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences; therefore, navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, enrolled beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children Services, regional centers, dental managed care/fee-for-service, mental health managed care, and substance use disorder managed care/fee-for-service. While children and youth in foster care have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses and the judicial system; many challenges remain in navigating the various Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the Continuum of Care Reform along with the development of short-term residential treatment providers and coordinated efforts to implement the new federal Families First Prevention Services Act at the State level.

2.7.2 Proposal

In assessing the challenges faced by foster care children and youth, DHCS proposes convening a workgroup in 2020 of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth program and transitions out of foster programs and services at age 26. To facilitate this discussion and develop meaningful recommendations, DHCS would invite and encourage participation from key partners including but not limited to: the Department of Social Services; the Department of Education; child welfare county representatives and State level associations; Medi-Cal managed care plans; behavioral health managed care plans; juvenile justice and probation; foster care consumer advocates; regional centers; and judicial entities involved with matters pertaining to children who are placed into the foster care system.

2.7.3 Proposed Timeline

DHCS is proposing that a workgroup be formed during the 2020 calendar year which would develop policy recommendations and a proposed timeline for implementation.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

- **Managed Care**
  - Managed Care Benefit Standardization
  - Mandatory Managed Care Enrollment
  - Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
  - Annual Medi-Cal Managed Care Plan Open Enrollment
  - NCQA Accreditation of Medi-Cal Managed Care Plans
  - Regional Managed Care Capitation Rates

- **Behavioral Health**
  - Behavioral Health Payment Reform
  - Medical Necessity Criteria for Specialty Mental Health Services and Substance Use Disorder Services
  - Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
  - Behavioral Health Regional Contracting
  - Substance Use Disorder Managed Care Program (Drug Medi-Cal) Renewal and Policy Improvements

- **Dental**
  - New Dental Benefits and Pay for Performance

- **County Partners**
  - Enhancing County Eligibility Oversight and Monitoring
  - Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
  - Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental managed care and substance use disorder managed care/fee-for-service. Most full-scope Medi-Cal beneficiaries receive their physical health services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

Effective January 1, 2021 the following benefits that are currently within the scope of some or all of the Medi-Cal managed care plans will be carved out from their responsibility:

- All prescription drugs and/or pharmacy services billed on a pharmacy claim (pursuant to the Governor's Executive Order from January 2019);
- Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and
- The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.
- Effective January 1, 2020, Medi-Cal will provide the fabrication of optical lenses statewide through the fee-for-service system (currently CenCal Health and Health Plan of San Mateo provide these services within their managed care delivery systems).

Carved In Benefits

Effective January 1, 2021 the following benefits that are currently not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan:

- All institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities); and
- All major organ transplants.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long term care and transplant providers accept and require the Medi-Cal Managed Care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan enter into a mutually agreed upon alternative payment methodology. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

With this proposal all Medi-Cal managed care plans will provide the same standardized set of services across the State as of January 1, 2021.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they have to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

With the small exception of the fabrication of optical lenses (January 2020), the benefit standardization will be effective and included in Medi-Cal managed care plan contracts on January 1, 2021. See Appendix F for more details.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment verses mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost. These are just a few of examples of data analytics completed to inform this policy.

DHCS is proposing implementation of this change in two phases, transitioning all non-dual populations in 2021 and dual populations in 2023. The two-phased approach is to coincide with the discontinuation of the Cal MediConnect component of the Coordinated Care Initiative and the transition to future statewide managed long-term services and support structure. See below for a summary of changes and Appendix G for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that not only are current requirements being met but that the additional layers of benefits and requirements contained in CalAIM are truly being achieved statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2021:

- Individuals eligible for long-term care services (includes long-term care share of cost populations)
- 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-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage
- Beneficiaries living in rural zip codes
- All dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment:

- Omnibus Budget Reconciliation Act: This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of cost: beneficiaries in County organized health systems (COHS) and Coordinated Care Initiative counties

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, County compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth status quo until the proposed foster care workgroup make recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations of beneficiaries to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2021:** Non-Dual and pregnancy related aid code group, and population based transitions
- **January 1, 2023:** Dual aid code group transition

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2021 for all Medi-Cal members. CMS recently approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer. DHCS is considering a new approach in order to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

DHCS leveraged the significant learnings from implementation of Cal MediConnect in developing a statewide policy for dual eligible beneficiaries that aligns with the CalAIM goals of reducing variation and complexity, implementing population health management strategies, improving quality outcomes, and driving delivery system transformation. DHCS is proposing to discontinue the Cal MediConnect component of the Coordinated Care Initiative and begin a transition to a statewide managed long-term services and supports and Dual Eligible Special Needs Plan structure. Dual Eligible Special Needs Plans are Medicare Advantage health care plans that provide specialized care and wrap-around services to dual eligibles.

This effort will build on the successes and learnings from Cal MediConnect and the Coordinated Care Initiative, as well as promising practices from innovative managed long-term services and supports and Dual Eligible Special Needs Plan models in other States. Following are the key elements of the proposal:

- Discontinue Cal MediConnect on December 31, 2022;
- Transition the concepts of the Coordinated Care Initiative by requiring statewide mandatory enrollment of dual eligibles in a Medi-Cal managed care plan by 2023 and statewide integration of long-term care into managed care for all Medi-Cal populations by 2021;
- All Medi-Cal health plans would be required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan as of January 1, 2023. Dual Eligible Special Needs Plans differ from Cal MediConnect in that they are permitted to enter into Medicare Improvements for Patients and Providers Act of 2008-compliant contracts with DHCS.
    - DHCS will recommend and provide sufficient time for Cal MediConnect plans to either continue their existing Dual Eligible Special Needs Plan or apply for the operation of a new Dual Eligible Special Needs Plan. Dual Eligible Special Needs plans would have to be operational before Cal MediConnect ends in order to ensure a seamless transition of beneficiaries from Cal MediConnect to the new system.

- For health plans not currently participating in Cal MediConnect, DHCS may provide some flexibility in the timeline for the continuation and/or development of a new Dual Eligible Special Needs Plan.
- DHCS will explore pathways to encourage enrollment of dual eligibles into their Medi-Cal Dual Eligible Special Needs Plan for true alignment of care. Passive or default enrollment options are under discussion.

3.3.3 Rationale

This initiative will help address some of the challenges the Cal MediConnect program has faced over the years, including:

- **Program Structure:** Cal MediConnect was envisioned as an integrated partnership between DHCS and CMS, offering seamless care and administration of Medicare and Medicaid coverage. However, Cal MediConnect plans were never able to integrate the full range of Medicaid benefits, primarily due to delivery system carve-outs. As a result, the Cal MediConnect plans focused on managing Medicare benefits, although some plans targeted improvements in delivering Medicaid benefits such as long-term care. Despite their best efforts, the result is that Cal MediConnect plans operate very similar to Dual Eligible Special Needs Plans (a Medicare managed care program with Medicaid enhancements) without the flexibility and lower regulatory burden of the Dual Eligible Special Needs plan model.
- **Enrollment:** Statewide enrollment in Cal MediConnect is low and declining. Cal MediConnect enrollment has decreased consistently from 111,631 in September 2018 to 108,154 in March 2019. A new approach may provide additional flexibility and innovation in plan efforts to enroll beneficiaries in more integrated products.
- **Inefficiency:** Cal MediConnect is a complex and costly program to administer, despite being only available to dual eligibles in seven counties. DHCS has been unable to efficiently focus efforts and resources across the State. In many parts of the State, dual eligible Californians have limited access to integrated care models.
  - Significant numbers of staff and contracting resources have gone into developing, communicating, and monitoring compliance with a third set of policies and requirements that needed to be created in order to resolve discrepancies between Medicare and Medi-Cal.
  - DHCS operates two sets of eligibility systems, one for the non-county operated health systems counties that participate in the Coordinated Care Initiative and one for those not participating the Coordinated Care Initiative. This further complicates an already complex system. The amount of resources used to manage several different eligibility systems would be better spent by streamlining enrollment rules across all non-county operated health system counties.

- The bifurcation within the managed care delivery system has further exacerbated the complexity of California's managed care rate setting related to the Coordinated Care Initiative.

3.3.4 Proposed Timeline

In order to take a more standardized approach to comprehensive care coordination for all Medi-Cal populations, DHCS is proposing to discontinue the Cal MediConnect program at the end of calendar year 2022. DHCS envisions a phased-in approach to achieving these goals, providing enough time and incentives to develop the needed infrastructure. The target for complete statewide implementation of all project elements is 2026.

- **January 2021:** Coordinated Care Initiative and Cal MediConnect proceed as today, however Multipurpose Senior Services Program will be carved out of both; and all long-term care services will be carved into managed care for all populations enrolled in plans around the state. DHCS will also implement enhanced care management and voluntary in lieu of services at this time.
- **December 31, 2022:** Coordinated Care Initiative and Cal MediConnect end.
- **January 1, 2023:** Full transition of Coordinated Care Initiative with discontinuation of Cal MediConnect and full implementation of mandatory managed care enrollment of dual eligibles into managed care in all counties/plan models. In addition, require Medi-Cal managed care plans to operate Dual Eligible Special Needs Plans.

3.4 Annual Medi-Cal Managed Care Plan Open Enrollment

3.4.1 Background

Currently, in counties with more than one Medi-Cal managed care plan, enrollees may change their Medi-Cal managed care plan every month. This activity often limits the plans' ability to provide adequate and appropriate care coordination to their members. An annual Medi-Cal managed care plan open enrollment process would allow enrollees to change their Medi-Cal managed care plan only during a specified open enrollment period, unless a specific reason for a change exists that is based on a consumer-friendly process that recognizes true needs for a change in plan. An annual enrollment period would be consistent with health care industry practices and align with best practices for quality health care delivery.

3.4.2 Proposal

DHCS proposes to establish an annual Medi-Cal managed plan open enrollment process for all enrollees in counties where two or more Medi-Cal managed care plans operate. Members would only be allowed to change their Medi-Cal managed care plan during the annual open enrollment period.

A consumer-friendly exception process would also be established to ensure all beneficiary needs are being met. At a minimum, the following enrollees would have the option to change their initially selected Medi-Cal managed care plan once (with or without cause):

- During the first year of enrollment for a beneficiary newly enrolled in Medi-Cal managed care and whose plan was assigned through the default enrollment process;
- During the first year of enrollment for a newborn that is automatically assigned to their mother's Medi-Cal managed care plan;
- During the first year of enrollment for a beneficiary moving from one county to another, whose plan in the new county was assigned through the default enrollment process;
- An enrollee for whom their primary care provider (includes physician extenders) and/or specialists, has terminated his/her contract with the Medi-Cal managed care plan that they are enrolled in, but that provider is available in the other Medi-Cal managed care plan in the county or another provider that is preferred by the beneficiary is available in a different network than their existing plan for whom their current provider has terminated his/her participation; and
- At any time, for "good cause" as defined in Title 42 C.F.R 438.56(d)(2) defining "cause." Examples include, but are not limited to:
    - Transgender services not available in network;
    - HIV/AIDS services not available in network;
    - Lack of access to services covered under the contract; and
    - Conditions whose management requires coordination of multiple specialties.

Note: The option to change the initially selected Medi-Cal managed care plan would not apply to an enrollee upon a termination and reinstatement of their Medi-Cal, if such reinstatement is made within one year or is retroactive to the date of termination of their Medi-Cal eligibility.

3.4.3 Rationale

In alignment with the goals of CalAIM, the annual Medi-Cal health plan open enrollment proposal reduces variation and creates standardization for beneficiaries who stay enrolled with one Medi-Cal managed care plan during the year. It reduces member risk by enhancing patient care management and supports the population health management strategies. Annual open enrollment would also help to improve quality outcomes by allowing the beneficiary to develop long-lasting, positive relationships with their Medi-Cal managed care plans and providers. However, DHCS also acknowledge the concerns raised previously regarding this type of structure and has proposed a consumer-friendly

streamlined exemption process that seeks to address any specific need for a change in plan that has been discussed and shared through the recent years. DHCS specifically request input on these exemptions to ultimately have a process that is most appropriate for the Medi-Cal populations.

With annual Medi-Cal managed plan open enrollment:

- Medi-Cal managed care plans would be accountable for providing enrollees with a medical home, care coordination, and case management over the entire calendar year, which will lead to increased continuity of care, higher quality of care, and ultimately better health outcomes.
- Continuous enrollment in a Medi-Cal managed care plan will help better facilitate coordination of care with carved-out services such as specialty mental health, substance use disorder treatment, and home and community-based services;
- Medi-Cal managed care plans would be better positioned to identify member risk and need through population health management strategies, which will in turn lead to better health outcomes and greater motivation for enrollees and Medi-Cal managed care plans to work together through possible health issues or concerns; and
- DHCS would be able to gather more comprehensive beneficiary level data over an entire calendar year to track Medi-Cal managed care plan performance.

DHCS would notify enrollees 90 days prior to the end of the calendar year of their option to change Medi-Cal managed care plans during the annual open enrollment period. If enrollees do not elect to change their Medi-Cal managed care plan, they would be required to remain in their existing plan for one calendar year until the next annual Medi-Cal managed plan open enrollment period, unless they meet one of the exceptions listed above. Enrollment into Medi-Cal coverage would still take place throughout the year. This proposal only impacts movement from one Medi-Cal managed care plan to another outside of the annual open enrollment period.

Through stakeholder feedback, DHCS would create the annual Medi-Cal health plan open enrollment materials to communicate to beneficiaries about their plan choices, timing of the open enrollment period, enrollment allowances, and other important details.

3.4.4 Proposed Timeline

DHCS proposes implementing the first annual Medi-Cal health plan open enrollment period from November 1, 2021 to December 31, 2021 for enrollment effective January 1, 2022. Each year thereafter, the annual health plan open enrollment period would occur from November 1 through December 15. Medi-Cal managed care plan enrollment would be effective on January 1 of each year.

3.5 NCQA Accreditation of Medi-Cal Managed Care Plans

3.5.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, member rights and responsibilities, and member connections. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 States require NCQA accreditation for their contracted Medicaid health plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the State to deem this information.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the State, 14 plans currently have NCQA accreditation; one has interim accreditation; and two are pending an accreditation visit. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.5.2 Proposal

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their subcontractors (delegated entities) to be NCQA accredited by 2025. DHCS would use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain State and federal Medicaid requirements.

DHCS is also considering requiring Medi-Cal managed care plan NCQA accreditation to include the Long Term Services and Supports Distinction Survey. This would align with the State's effort to carve-in long-term care services and expand in lieu of services in order to make managed long-term services and supports a statewide benefit. DHCS is also interested in discussing the addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as this could potentially maximize the opportunity for streamlining state compliance and deeming. The Medicaid module would ensure that NCQA accreditation complies with federal Medicaid regulations, in addition to the best practices included in the base health plan accreditation process. Finally, DHCS is also considering requiring Medi-Cal managed care plans to ensure any subcontractors to

whom certain contractual elements are delegated are NCQA accredited for that function. At a minimum, DHCS is considering plan-to-plan delegation would likely require NCQA accreditation.

DHCS would not accept accreditation from entities other than NCQA (e.g. URAC) except for specific plans for which NCQA does not offer accreditation, due to the limited population (e.g. population-specific plans). In these cases, DHCS would allow for an alternate accreditation entity, but would hold the population-specific plan to the same requirements as Medi-Cal managed care plans

3.5.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. If DHCS requires NCQA accreditation of its managed care plans and follows the NCQA framework, it could potentially increase standardization throughout the State and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation could assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of categories in which DHCS could consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the Long-Term Services and Supports Distinction Survey aligns with DHCS' goal of making long-term services and supports a statewide benefit. However, DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so a phased in approach may be necessary.

Similarly, while DHCS is interested in maximizing the deeming potential of NCQA accreditation, DHCS is open to a discussion of whether the MED module would truly increase deeming; and if so, what would be a reasonable timeframe to expect Medi-Cal managed care plan compliance with that module.

Requiring NCQA accreditation of Medi-Cal managed care plan subcontractors, such as larger independent practice associations or medical groups, would further the goal of reducing variation across the statewide benefit, as well as reducing Medi-Cal managed care plan burden of subcontractor oversight. However, requiring NCQA accreditation for only one or two standards may not be administratively feasible for many subcontractors. DHCS is interested in stakeholder feedback on this topic.

3.5.4 Proposed Timeline

DHCS would require all Medi-Cal managed care plans to be NCQA accredited by 2025.

- DHCS could consider implementing deeming sooner than 2025 for Medi-Cal managed care plans that already have NCQA accreditation.

- DHCS would align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following seven NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2025:
  - Quality Improvement;
  - Population Health Management;
  - Network Management;
  - Utilization Management;
  - Credentialing;
  - Member Rights and Responsibilities; and
  - Member Connections.

Timelines for utilizing the Long-Term Services and Supports Distinction Survey and the MED module, as well as potentially requiring accreditation of subcontractors, are up for discussion, and a phased-in approach may be necessary.

3.6 Regional Managed Care Capitation Rates

3.6.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each rate for a total of more than 4,000 rating components on an annual basis as of state fiscal year 2018-19. The number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. The excessively large number of rate components also limits DHCS' ability to advance value-based and outcomes focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes to our Medi-Cal beneficiaries.

3.6.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

In order to ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2021 and 2022 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2023, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.6.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permitting DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.
- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region; and
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.6.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input;
- **January 1, 2021:** Implement Phase I for targeted counties and Medi-Cal managed care plans;
- **Calendar Year 2022:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide;
- **No sooner than January 1, 2023:** Fully Implement regional rates statewide; and
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.7 Behavioral Health Payment Reform

3.7.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Certified Public Expenditure methodologies. Under Certified Public Expenditure methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor- intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit Certified Public Expenditures to the State in order for the State to draw down eligible federal matching funds. In accordance to the CMS approved Certified Public Expenditure protocol, mental health managed care plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the State on an annual basis for approved units of service for allowable procedure codes. The State completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each State fiscal year. The final cost reconciliation of mental health managed care plan interim Medicaid payments occurs within 36 months after the certified, reconciled, State-developed cost report are submitted.

Substance use disorder fee-for-service (previously referred to as Drug Medi-Cal State Plan) and substance use disorder managed care plan services (previously referred to as the Drug Medi-Cal Organized Delivery System), establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer the substance use disorder fee-for-service or managed care programs. After the fiscal year ends, DHCS performs a cost settlement with counties for their costs of administering the substance use disorder services (either through state plan fee-for-service or through substance use disorder managed care). These cost reconciliations occur years after the close of the State fiscal year in order to allow time for claims run out as well as the completion of cost reconciliation audits by DHCS.

In order to incentivize additional investment in the delivery systems and reduce overall burden on counties and the State, DHCS is proposing to reform behavioral health payment methodologies for both managed care and fee-for-service systems. Under the current Certified Public Expenditure methodology, counties are not able to retain revenue when implementing cost-reduction efforts thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.7.2 Proposal

The State is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilized intergovernmental transfers to fund the county non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and substance use disorder services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal and State share being provided by counties via intergovernmental transfer instead of Certified Public Expenditures, eliminating the need for reconciliation to actual costs.

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Additionally, DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services. Further discussion needs to be had between DHCS and counties regarding changes to administrative cost claiming or methodology changes.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS will look to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The State will discuss with counties the appropriate time to transition from monthly to quarterly payments.

3.7.3 Rationale

Under Certified Public Expenditure-based methodologies, all reimbursement is limited to the actual cost of providing services which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from Certified Public Expenditure to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce State and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate

county readiness and develop a strategy to support them in making this transition. However, the earliest the shift would occur would be January 1, 2021.

The transition from cost-based reimbursement to an established rate schedule would follow after adoption of the HCPCS Level I coding. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.8 Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

DHCS contracts with counties to deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries who meet medical necessity criteria for the programs. Today, for specialty mental health and substance use disorder services, the medical necessity criteria for each program specifies requirements that beneficiaries must meet to be eligible for such services. The medical necessity criteria for each program also delineates service and intervention requirements that must be met.

With the CalAIM initiative, DHCS aims to design a cohesive plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. DHCS is interested in discussing the concept of developing new approaches to care delivery and system administration that could improve beneficiary experience, increase efficiency, and ensure cost effectiveness. As part of this discussion, we are interested in exploring opportunities to improve the specialty mental health and substance use disorder programs by updating and making clearer the corresponding eligibility and medical necessity criteria, which will lead to improved treatment planning and documentation and help beneficiaries better understand the criteria that must be met in order to access specialty mental health and substance use disorder services.

Therefore, DHCS is proposing to modify the existing medical necessity criteria for both outpatient and inpatient specialty mental health services in order to align with State and federal requirements and more clearly delineate and standardize the benefit statewide.

3.8.2 Proposal

To ensure beneficiary behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties for providing behavioral health services, DHCS is proposing to:

- Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.

- Allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.
- Identify an existing or develop a new statewide, standardized level of care assessment tool – one for beneficiaries 21 and under and one for beneficiaries over 21 – that would be used by counties, Medi-Cal managed care plans, and providers to determine a beneficiary's need for mental health services, if any, and which delivery system is most appropriate to cover and provide treatment.
- Revise the existing intervention criteria to clarify that specialty mental health services are to be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are medically necessary and provided in accordance with the Medi-Cal State Plan instead of the existing state service criteria.
- Align with federal requirements by allowing a physician's certification/recertification to document a beneficiary's need for acute psychiatric hospital services.
- Make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-4), rather than the more current DSM-5, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

DHCS is proposing that eligibility criteria, being largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which someone should receive services; either Medi-Cal managed care plans for mild to moderate mental health services or through the mental health managed care plans for specialty mental health services. Each delivery system should then provide services in accordance with an individualized beneficiary plan, as recommended by a physician or other licensed mental health professional.

Outpatient Specialty Mental Health Services

The existing medical necessity criteria for outpatient specialty mental health services includes three components: covered diagnoses, functional impairment, and intervention criteria. These three components represent two distinct concepts: 1) whether a beneficiary meets eligibility criteria for the specialty level of care (i.e., covered diagnoses and functional impairment); and, 2) whether the services are medically necessary (i.e., intervention criteria).

These existing criteria have led to confusion and inconsistent treatment of beneficiaries across the State depending on how a county and the behavioral health providers interpret the requirements. Under CalAIM, DHCS would like to pursue distinguishing the beneficiary eligibility criteria (i.e., covered diagnosis and impairment criteria) for receiving specialty mental health services and the service intervention criteria (i.e., whether the service itself is medically necessary).

Beneficiary Eligibility

Covered Diagnosis

Under the existing requirements, Medi-Cal beneficiaries are eligible to receive outpatient specialty mental health services if the beneficiary has been diagnosed with a covered mental health condition and, as a result of that condition, meets specified impairment criteria. DHCS requires counties use the criteria sets in the DSM-5, as the clinical tool to make diagnostic determinations. Not all diagnoses are covered under the mental health managed care plans, as other delivery systems are better suited to provide treatment for the certain conditions. For example, mental health managed care plans do not have the appropriate expertise to treat autistic disorders; therefore, regional centers and Medi-Cal managed care plans provide care and treatment for autistic disorders.

However, sometimes when a new beneficiary presents for an assessment, a diagnosis is not immediately known. Today, mental health managed care plans are reluctant to provide treatment services to someone without a defined diagnosis due to existing criteria or the county is providing such services using other county funds when the services should be eligible for Medi-Cal funding. Given this, DHCS is proposing that a county should be able to provide and be paid for treatment services to meet a beneficiary's mental health needs prior to the mental health provider determining whether the beneficiary has a covered diagnosis. Once a diagnosis is determined, and level of impairment has been determined, the beneficiary would be referred to the appropriate delivery system.

Impairment Criteria

As stated above, DHCS is interested in exploring the concept of shifting the focus from diagnosis to level of impairment rather than continuing to let diagnoses drive delivery system and funding decisions. As a means of accomplishing this goal, DHCS is seeking stakeholder input regarding the implementation of a statewide, standardized level of care assessment tool that could be used across delivery systems to determine level of impairment for beneficiaries with mental health conditions. Many counties are currently using a variety of level of care assessment tools, such as the Level of Care Utilization System or Child and Adolescent Level of Care Utilization System, to determine the appropriate level of care within the county's delivery system. Developed by members of

the American Association of Community Psychiatrists, each of these assessment tools is "a level of care assessment tool being widely used by behavioral health managers and clinicians throughout the country to support level of care recommendations" (American Association of Community Psychiatrists website, 2019).

DHCS is proposing the identification of an existing, or development of a new, statewide, standardized level of care assessment tool – one for beneficiaries 21 and under and one for beneficiaries over 21 – that would be used by counties, Medi-Cal managed care plans, and providers to determine a beneficiary's need for specialty mental health services, if any, and/or which delivery system is most appropriate to cover and provide treatment. DHCS would like to engage with stakeholders on any special considerations DHCS should make concerning foster children with such assessment.

Service Criteria

Current regulatory language specifies that interventions (i.e., services) must meet the following criteria:

- The focus of the proposed intervention is to address the beneficiary's covered mental health condition;
- The expectation that the proposed intervention will: 1) significantly diminish the impairment; 2) prevent significant deterioration in an important area of life functioning; 3) allow a child to progress developmentally as individually appropriate; or 4) for a child, meet the requirements laid out in state regulations; and
- The condition would not be responsive to physical health care-based treatment.

DHCS is proposing to revise the existing intervention criteria to clarify that specialty mental health services should be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are provided in accordance with the Medi-Cal State Plan. Rehabilitative mental health services (i.e., specialty mental health services) are services recommended by a physician or other licensed mental health professional, within the scope of his or her practice, under State law for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level.

Specialty mental health services must also meet the following criteria:

- Allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention;

- Provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency; and
- Provided based on medical necessity criteria, in accordance with an individualized client plan, and approved and authorized according to State requirements.

The State Plan incorporates concepts of recovery and resiliency into the definition of specialty mental health services, as well as the service definitions for each category of specialty mental health services. DHCS believes that it is appropriate to expand the concept of medical necessity to ensure that services are reimbursable if provided in accordance with these service definitions.

The only exception to that recommendation is for beneficiaries under the age of 21 because in accordance with federal law, beneficiaries under the age of 21 are allowed EPSDT service protections, which must also "…correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Therefore, for beneficiaries under the age of 21, each delivery system should provide mental health services according to the broader EPSDT guidelines.

DHCS is also proposing a no wrong door approach with children under the age of 21. Essentially, whether the child presents first in the Medi-Cal managed care plan or the mental health managed care plan, each system is responsible for providing services to the child, assessing the child and either providing ongoing treatment, as necessary, or referring the child to the appropriate delivery system. Both the Medi-Cal managed care plan and mental health managed care plan would be reimbursed for all medically appropriate services provided to a child, even if the child ultimately moves to the other delivery system.

Inpatient Specialty Mental Health Services for Adults and Children/Youth

With respect to inpatient specialty mental health services, to better align with federal requirements, DHCS is proposing that a physician's certification/recertification is required to document a beneficiary's need for acute psychiatric hospital services and that services are provided at the appropriate level of care. Federal regulations require the completion of a certification by a physician (and recertification by a physician or nurse practitioner or physician assistant under the supervision of a physician) to authorize inpatient care. Current State and federal regulations further require the completion of medical, psychiatric and social evaluations, as well as a written plan of care, before admission to a mental hospital or before authorization for payment.

DHCS also is interested in the concept of providing mental health managed care plans with guidance to address inconsistencies in the mechanisms for authorization and

reauthorization of inpatient mental health services. The goal is to set forth a consistent approach that is amenable to the State, mental health managed care plans, and the hospitals as the statewide policy regarding implementation of concurrent review (i.e., authorization) of inpatient psychiatric hospital services.

Substance Use Disorder Services

Since substance use disorder services are only provided via the carved out substance use disorder delivery system and are not covered by Medi-Cal managed care plans, the need to differentiate coverage responsibilities across delivery systems is not applicable. In addition, under substance use disorder managed care, counties are already required to utilize an assessment tool based on the American Society of Addiction Medicine criteria for substance use disorder treatment services.

However, as with the current specialty mental health services medical necessity criteria, the current Section 1115 waiver and regulations for substance use disorder services require a beneficiary to be diagnosed with a substance use disorder to meet criteria for reimbursement. The existing rules limit the counties' ability to be reimbursed for services that are provided prior to the completion of an assessment based on the American Society of Addiction Medicine criteria.

DHCS is proposing, similar to specialty mental health, that a county should be able to provide services to meet a beneficiary's substance use disorder needs prior to the substance use disorder provider determining whether the beneficiary has a covered diagnosis and be paid for such services.

3.8.3 Rationale

The medical necessity criteria for specialty mental health and substance use disorder services, as currently defined, is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services.

3.8.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder eligibility and medical necessity criteria, as applicable, effective January 1, 2021 with the approval of the 1115 and 1915(b) waivers.

3.9 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.9.1 Background

California's mental health managed care plan operates under the authority of a Section 1915(b) waiver, substance use disorder managed care plans operate under the authority of a Section 1115 demonstration waiver, and substance use disorder fee-for-service program is authorized through California's Medicaid State Plan.

For the mental health and substance use disorder managed care plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and substance use disorder treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the substance use disorder managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health managed care plans administer the specialty mental health services program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For substance use disorder services, 30 counties administer the substance use disorder managed care program, covering 93 percent of the Medi-Cal population. The remaining 28 counties provide less robust substance use disorder treatment services through the fee-for-service delivery system. Eight of these counties are working with a local Medi-Cal managed care plan to implement an alternative regional model for substance use disorder managed care.

Medi-Cal specialty mental health and substance use disorder treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and substance use disorder services needs must navigate multiple systems to access care. Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both substance use disorders and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For substance use disorder managed care counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.9.2 Proposal

DHCS is proposing administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the State.

For counties participating in substance use disorder managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health managed care plan structure. The result would be a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet State and federal requirements and significantly decrease their administrative burden.

Additionally, substance use disorder fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health and substance use disorder managed care. Some substance use disorder fee-for-service counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental health and substance use disorder treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or substance use disorder services.

2. Intake/Screening/ Referrals

Processes for intake, screening and referral, particularly to managed care plans, vary by county. Optimally, counties would have standardized and streamlined processes that are timely, emphasize a positive beneficiary experience, and consider a “no wrong door” approach to helping beneficiaries access services. Integrated screening would allow counties to be able to promptly initiate an integrated treatment path for

beneficiaries that screen positive for both mental health conditions and substance use disorder services.

3. Assessment

Assessment processes and tools for specialty mental health and substance use disorder services also vary by county. For example, the American Society of Addiction Medicine placement tool is utilized to make level of care determinations for substance use disorder managed care. However, an assessment tool is not required in substance use disorder fee-for-service counties. For specialty mental health services, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. Due to these variances, it would be beneficial to have a uniform, standardized assessment for use across the behavioral health delivery system. More research will be needed to determine which aspects, authorities, or requirements need to be addressed in order to achieve a uniform and standardized assessment. As mentioned under the medical necessity proposal, there would be one assessment for beneficiaries 21 and under and one for beneficiaries over 21.

4. Treatment Planning

Currently, treatment planning for specialty mental health and substance use disorder treatment services is conducted separately and is not integrated. For beneficiaries receiving both types of services, this can result in having multiple treatment plans that include different documentation requirements. To improve efficiency, counties would implement a standardized and streamlined treatment plan for both specialty mental health and substance use disorder services. These plans would also have aligned documentation requirements that are less burdensome on the counties, providers and beneficiaries. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to standardize treatment plan requirements across the specialty mental health and substance use disorder delivery systems. Additionally, DHCS will provide counties with complete Medi-Cal services data, such as managed care and pharmacy encounter data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive specialty mental health services and substance use disorder services through substance use disorder managed care receive two beneficiary handbooks. The handbooks are not exactly the same, but both address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials in order to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in substance use disorder fee-for-service counties, since they are not currently required to have a beneficiary handbook.

Integration of Prepaid Inpatient Health Plans/Fee-for-Service Functions

1. Contracts

Currently, there are three separate contracts between DHCS and counties. DHCS contracts with mental health managed care plans for the provision of specialty mental health services, and also with substance use disorder managed care plans and fee-for-service counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both specialty mental health and substance use disorder services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for specialty mental health services and substance use disorder services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records or maintain differently configured and completely separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health managed care plans are required to have a cultural competence plan for specialty mental health services. Substance use disorder managed care plans are also

required to have a cultural competence plan. Under an integrated system, counties would have only one integrated cultural competence plan instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in substance use disorder fee-for-service counties since they are currently not subject to these same requirements.

Administrative Integration

1. **Quality Improvement**
   Some counties have integrated quality improvement and performance measurement programs for specialty mental health services and substance use disorder managed care. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. **External Quality Review Organizations**
   Pursuant to federal Medicaid managed care requirements, an external quality review is required for both specialty mental health and substance use disorder managed care. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization report for each county. Since an external quality review is not required for substance use disorder fee-for-service counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. **Compliance Reviews**
   Current compliance reviews conducted by DHCS for specialty mental health services, substance use disorder managed care, and substance use disorder fee-for-service counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on documentation requirements. Reducing duplicative documentation requirements and mitigating audit/compliance risk that stems from the need to meet disparate requirements for the specialty mental health and substance use disorder programs are critical changes that must be made if California wants to

incentivize more behavioral health providers to offer effective, evidence-based models for integrated care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health and substance use disorder managed care, and there are currently no network adequacy requirements for substance use disorder fee-for-service counties. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.9.3 Rationale

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit from integrated treatment. Since the State provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in both substance use disorder and mental health managed care plans are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the substance use disorder service separately from the mental health service. The purpose of this proposal is to make necessary State and county changes that would provide substance use disorder treatment and specialty mental health services through one behavioral health managed care delivery system.

3.9.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the next 1915(b) waiver in 2026. Both State-level and county-level activities will be required to achieve

this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.10 Behavioral Health Regional Contracting

3.10.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating substance use disorder managed care plans are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.10.2 Proposal

DHCS recognizes that some counties have resource limitations. Therefore, DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

3.10.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region, allow for increased county administrative efficiencies, and improve compliance with state and federal requirements. Although regional contracting is currently allowed under State law, only a few counties have taken advantage of this opportunity. This has resulted in a mental health and substance use disorder delivery systems that must compete for scarce resources (e.g., workforce), and that are unnecessarily costly, since each county must individually invest in administrative infrastructure (e.g., electronic health records, billing and claiming systems, oversight/quality assurance and quality improvement). In addition, county policies and procedures related to access, eligibility,

provider contracting, and available treatment services vary significantly, creating challenges for both providers and beneficiaries.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in counties with a limited provider and county workforce. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For substance use disorder fee-for-service counties, regionalization could potentially enable smaller counties to participate in substance use disorder managed care, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in substance use disorder managed care, these counties could then create a single, integrated behavioral health managed care plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans must meet the full array of State and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.10.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.11 Substance Use Disorder Managed Care Program Renewal and Policy Improvements

3.11.1 Background

One of the key goals of the substance use disorder managed care demonstration program (previously known as the Drug Medi-Cal Organized Delivery System) was to treat more people more effectively by reorganizing the delivery system for substance use disorder treatment through Medi-Cal. California's substance use disorder managed care program

was the nation's first substance use disorder treatment demonstration project under a Medicaid Section 1115 waiver, approved by CMS in 2015. Since then, more than 20 other States have received approval for similar substance use disorder treatment waivers. The program has established a continuum of care modeled after the American Society for Addiction Medicine criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the substance use disorder managed care plan include all of the standard substance use disorder treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple American Society for Addiction Medicine levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the authority to allow federal Medicaid reimbursement for short-term residential substance use disorder treatment stays in an Institution for Mental Disease. The Institution for Mental Disease exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and substance use disorder treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This policy exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential substance use disorder treatment services through the Medi-Cal program, with no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, substance use disorder managed care is not a statewide benefit, since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 30 counties participating in the substance use disorder managed care demonstration, providing access to substance use disorder treatment services for 93 percent of the Medi-Cal population. Eight other counties are working with a local managed care organization to implement an alternative regional model. Medi-Cal beneficiaries in the 20 counties not participating in the program provide their substance use disorder treatment services through fee-for-service as authorized through the State Plan. The fee-for-service benefit is more limited than the substance use disorder managed care benefit in terms of covered services and that it is not a managed care program.

3.11.2 Proposal

DHCS proposes to incorporate the Drug Medi-Cal Organized Delivery System into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for

Mental Disease will continue to be authorized through Section 1115 waiver authority. DHCS also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewideness. While participation in the substance use disorder managed care program will not be mandatory for counties, DHCS would like to work with counties not currently participating in the substance use disorder managed care program to explore ways to encourage the remaining counties to opt-in.

Finally, DHCS is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' substance use disorder treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 30 counties that have implemented the substance use disorder managed care program have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with substance use disorder treatment needs. Implementation across 30 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the substance use disorder managed care model of care is still very new, since implementation was phased in over several years.

Accordingly, DHCS would like input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level:

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential substance use disorder treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent

with the clinical understanding of relapse and recovery from substance use disorders, DHCS proposes to remove this limitation and base treatment on medical necessity, reimbursing services up to the maximum number of authorized days, as agreed upon with CMS, in a 365-day period. DHCS further proposes that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain permission from CMS regarding all components of the Section 1115 waiver renewal. CMS is currently only approving substance use disorder 1115 waivers with a residential benefit average length-of-stay of 30 days. While some States may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those substance use disorder managed care enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that takes into account the increased clinical needs of individuals utilizing stimulants.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these particular requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the American Society for Addiction Medicine criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposes to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term "after completing their course of treatment," to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorder treatment.

DHCS proposes keeping the additional medication assisted treatment services as an optional benefit but clarifying the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to, medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Physician Consultation Services

Physician consultation services include substance use disorder managed care physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. They are designed to assist with seeking expert advice on designing treatment plans for beneficiaries. Physician consultation services can only be billed and reimbursed by substance use disorder managed care providers.

DHCS proposes to make this benefit optional, and to clarify the terms of physician consultation, particularly with regard to how and who can claim this activity. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five current evidence-based practices, and at least add Contingency Management (and potentially more evidence-based practices) to the waiver renewal proposal.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements.

Tribal Services

Attachment BB was included in the Section 1115 waiver in order to further define services provided for American Indians and Alaska Natives. Negotiations with Tribal 638 and Urban clinics were not completed during the current waiver period; however, new federal requirements pertaining to the American Indian and Alaska Native populations have been implemented. DHCS will provide clarification regarding policies to increase access to substance use disorder treatment services for American Indians and Alaska Natives. For the waiver renewal, DHCS plans to seek an allowance for specific cultural practices for Tribal 638 and urban clinics, reimbursement for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

Treatment after Incarceration

The current language requiring the American Society of Addiction Medicine criteria, may be under estimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS proposes exploring solutions to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for substance use disorder services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and oftentimes finds that the presenting symptoms are due to a combination of mental illness, substance use disorder, or both,

DHCS proposes clarifying the waiver Special Terms and Conditions to allow reimbursement for substance use disorder assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Note: For specialty mental health services, there is no limit on the number of visits needed to conduct an assessment; counties can receive reimbursement for assessment while the beneficiary's diagnosis is being determined.

3.11.3 Proposed Timeline

The changes would go into effect on January 1, 2021.

Dental

3.12 New Dental Benefits and Pay for Performance

3.12.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 waiver;
- Proposition 56 supplemental provider payments; and
- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time limited.

3.12.2 Proposal

The Department has set a goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. In order to progress toward achieving that goal, and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide:

- Add new dental benefits based on the successes of the Dental Transformation Initiative that will provide better care and align with national dental care standards. The proposed new benefits include a Caries Risk Assessment Bundle for young

children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand pay for performance Initiatives that reward increasing the use of preventive services and establishing/maintaining continuity of care through a Dental Home. These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Carries Risk Assessment bundle would include associated codes to educate and influence behavior change, including nutritional counselling. Additionally, based on risk level associated with each individual Medi-Cal dental member ages 0 to 6, allow the following frequency of services:

- Low – comprehensive preventive services 2x/year
- Moderate – comprehensive preventive services 3x/year
- High – comprehensive preventive services 4x/year

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and adults living in a skilled nursing facility/intermediate care facility or part of the Department of Developmental Services population. The Silver Diamine Fluoride benefit would provide two visits per member per year, four to ten teeth per visit, at a per tooth rate.

Pay for Performance

In an effort to increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location. The performance payment would be made at the same time the approved claim is paid.

Additionally, the state would provide a flat rate performance payment to a service office location for each paid claim for Current Dental Terminology exam codes D0120, D0150, or D0145, for the same Medi-Cal member for two or more years in a row. Payments to the corresponding service office location(s) would only take place annually.

3.12.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP

children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative.

For example, in the Dental Transformation Initiative Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data between a control group in the Dental Transformation Initiative counties who received no Carries Risk Assessment and those that did over two calendar years are staggering. The Medi-Cal children who had a Carries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Carries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Carries Risk Assessment had a 263 percent increase in restorative services while the control group with no Carries Risk Assessment had a 475 percent increase in restorative services.

3.12.4 Proposed Timeline

January 1, 2021:

- **New Dental Benefit**: Caries Risk Assessment Bundle for ages 0 to 6 and Silver Diamine Fluoride for children ages 0 to 6 years and adults living in a skilled nursing facility/intermediate care facility or part of the Department of Developmental Services population
- **Pay for Performance**: Increase statewide utilization of preventive services and establish and maintain continuity of care through a dental home.

County Partners

3.13 Enhancing County Eligibility Oversight and Monitoring

3.13.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal eligibility program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted

statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, State, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified a number of issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS). Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the State to repay the federal matching funds that were claimed as a result of erroneous Medi-Cal eligibility determinations.

3.13.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under State law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving

and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.13.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal eligibility services are provided in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and State requirements.

3.13.4 Proposed Timeline

- **January 1 – March 31, 2020**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.
- **April 1 – June 30, 2020:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.
- **January 1 – March 31, 2021:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
- **April 1 – June 30, 2021:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
- **July 1 – September 30, 2021:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **October 1 – December 31, 2021:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.14 Enhancing County Oversight and Monitoring: CCS and CHDP

3.14.1 Background

The California Children's Services program serves as an agent of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high quality standard of care is compliant with federal and State guidelines for all beneficiaries. In an effort to remain

proactive with emerging trends, technology, medical advances and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are foundational to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across counties within the programs. The information gathered will be the cornerstone for future efforts, and the genesis for the development of the strategic compliance program.

County variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties are providing the necessary provider oversight and the medical and dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop and create county and program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties from annual hardcopy submission of plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. The more rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

A vehicle to manage this population's health care and ensure targeted interventions are implemented, the county and State will enter into a Memorandum of Understanding. The Memorandum of Understanding, in conjunction with other supportive policies, will detail how the State will monitor county activities, policies and procedures, conduct audits, and implement corrective action plans. This Memorandum of Understanding will be developed

utilizing information obtained during the audits with the intent of having signed agreements with all counties.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue this robust strategic compliance oversight in order to preserve and improve the overall health and well-being of these vulnerable populations.

3.14.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the State, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.14.4 Proposed Timeline

- **Phase I: July – September 2020**
  - Review of current standards, policies, and guidelines
  - Development of goals, performance measures, and metrics
- **Phase II: April – June 2021**
  - Development of auditing tools
- **Phase III: April – June 2022**
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines
  - Shift to an automated PFG submission

3.15 Improving Beneficiary Contact and Demographic Information

3.15.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS

to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems to support and maintain Medi-Cal enrollment processes. The Statewide Automated Welfare Systems, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the State-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the State-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible for ensuring the data maintained in the local county eligibility system is accurate and up-to-date. Under current State law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.15.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable State and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.15.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.15.4 Proposed Timeline

DHCS proposes to engage with key partners during 2020-21 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-ter vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other State-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the State is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for States interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals			
Medi-Cal 2020 Waiver Component	**Planned for CalAIM**	**Description**	**Timeline**
Medi-Cal Managed Care	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needed waiver approval and Whole Child Model.	January 1, 2021
Whole Person Care Pilots	Transition to new 1915(b) waiver.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via participating Medi-Cal managed care plans, and can be expanded to participating Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2021
PRIME	Transition to managed care directed payment under the Quality Incentive Program (QIP).	The existing PRIME funding structure would be extended from July 1 to December 31, 2020. Beginning in January 2021, network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	QIP 2.0 – July 1 – December 31, 2020 QIP 3.0 – January 1, 2021
Health Homes Program	Transition to new 1915(b) waiver.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing or contracting with counties or other providers to cover a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2021

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multi-purpose Senior Services Programs will be carved out; long-term care will be carved in. All Medi-Cal managed care plans will be required to offer coverage through DSNPs for care coordination and integration of benefits.	1915(b)/1115A to continue current CCI program with end date of December 31, 2022 January 2021 - Carve out MSSPs; LTC carved in January 2023 – full transition all duals into managed care statewide; all Medi-Cal managed care plans to operate DSNPs
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS), or what is also known as, substance use disorder managed care, provides a continuum of care for substance use disorder treatment.	Implementation continues; transition to 1915(b) waiver in January 2021
Global Payment Program	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	GPP program year ends June 30, 2020; renewal request to begin GPP extension on July 1, 2020.

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, nursing facility, and disability population • Pay for Performance incentives for preventive services and establishing continuity of care through Dental Homes	January 1, 2021
Community-Based Adult Services (CBAS)	Transition to new 1915(b) waiver.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization. Shifting benefit and managed care authority from 1115 waiver to 1915(b).	January 1, 2021
1115 Eligibility and Population Authorities	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2021
Rady CCS Pilot	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Pilot expires on December 31, 2020
Designated State Health Programs (DSHP)	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2020

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program builds on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 35 District and Municipal Public Hospitals participate in PRIME. PRIME is designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program – a managed care directed payment program – for the State's Designated Public Hospitals. The State directs Medi-Cal managed care plans to make Quality Incentive Program payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The Quality Incentive Program measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The Quality Incentive Program is anticipated to promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning State, Medi-Cal managed care plan, and hospital system goals. The Quality Incentive Program also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the State to pay for quality and build capacity.

5.1.2 Proposal

Subject to obtaining the necessary federal approvals, DHCS proposes transitioning the quality improvement work and a portion of the funding that has been available through PRIME into the Quality Incentive Program and permitting the District and Municipal Public Hospitals to begin participating in the program. The goal is to enable hospitals to continue quality improvement efforts that have been underway at all 52 PRIME entities after PRIME expires on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes, Additionally, DHCS proposes to align PRIME entities' transition to the Quality Incentive Program with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to-Quality Incentive Program transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020
- **Phase II:** Merge to Quality Incentive Program, January 1 through December 2021, and beyond

Phase I: Alignment with Calendar Year Rating Period

Subject to obtaining the necessary federal approvals, when PRIME ends on June 30, 2020, all 52 PRIME entities will transition into a six-month program called the Quality Incentive Program 2.0. This six-month period will calibrate the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ends on December 31, 2020. For performance on both the original Quality Incentive Program quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 35 District and Municipal Public Hospitals) during this period, the 52 entities will be paid through Medi-Cal managed care plans, via State-directed Medi-Cal managed care plan payments.

In order to earn funds for PRIME transition metrics, all 52 PRIME entities will continue to report to DHCS on the quality improvement projects and measures currently underway in PRIME. The six-month transition will use the twelve-month measurement period of January-December 2020 to ensure that performance can be fairly compared to benchmarks set by DHCS. Performance assessments will use PRIME Demonstration Year 15 mid-year data as a baseline. This will ensure that PRIME entities have a full twelve-month period to close a ten percent gap from baseline performance. Metric benchmarks will remain unchanged from benchmarks used in PRIME Demonstration Year 15. The Designated Public Hospitals will also continue their complementary activities on the original Quality Incentive Program quality metrics during this six-month period.

Phase II: Merge to Quality Incentive Program

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of Quality Incentive Program Year 4 and will include the Designated Public Hospitals and 35 District and Municipal Public Hospitals, totaling 52 Quality Incentive Program entities. Similar to Phase I, payments to the 52 Quality Incentive Program entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to the Quality Incentive Program. DHCS will review all prior PRIME Policy Letters and Quality Incentive Program Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS will work with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, increased capacity for primary and specialty care services and other nationally vetted and endorsed measures, or measures in wide use across Medicare and Medicaid quality initiatives. The measures will align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set will meaningfully reflect the goals and priorities of CalAIM.

5.1.3 Rationale

The Quality Incentive Pool is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning State, Medi-Cal managed care plan, and hospital system goals. The PRIME to Quality Incentive Pool transition and merge will engage both Designated Public Hospitals and 35 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics merged into Quality Incentive Pool from the PRIME measures. As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through standardizing data collection to health plan requirements.

5.1.4 Proposed Timeline

July 1 – December 31, 2020: Transition from PRIME to QIP 2.0 for Designated Public Hospitals and District and Municipal Public Hospitals using previous PRIME metrics and methodologies

QIP 3.0 – January 1, 2021: Complete transition from PRIME to QIP 3.0 for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital allotment with uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program funding is authorized through June 30, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 6 will begin on July 1, 2020, and end on June 30, 2021. Since the current waiver ends on December 31, 2020, but the Global Payment Program is only approved through June 30, 2020, DHCS proposes to begin operating under the new program protocol for Global Payment Program Year 6 on July 1, 2020 but postpone payment to hospitals for quarters one and two, until the waiver renewal is approved. The quarters and corresponding dates of the Global Payment Program payments to be postponed until the waiver is approved are Program Year 6 quarter one, July 1, 2020 - September 30, 2020, and quarter two October 1, 2020 - December 31, 2020.
- The Global Payment Program will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver.;

- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS will recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in this waiver period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public hospital systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in Appendix H.

6. Appendices

Appendix A: CalAIM Implementation Timeline

Date	Implementation Activity
2019	
November-December 2019	**Stakeholder Engagement Process:** • Population health management/ Annual enrollment • Enhanced care management/ In lieu of services • Behavioral health proposals
2020	
January 2020	**Stakeholder Engagement Process:** • Population health management/Annual open enrollment • Enhanced care management/In lieu of services • Behavioral health proposals • Full Integration Plans • NCQA **Regional Rates:** Develop rate setting methodologies and seek managed care plan input **County Oversight:** DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide **Benefit standardization:** Fabrication of optical lenses carve-out effective **Long-Term Plan for Foster Care:** Internal planning and selection of workgroup members
February 2020	**Stakeholder Engagement Process:** • Population health management/Annual open enrollment • Enhanced care management/In lieu of services • Behavioral health proposals • Full Integration Plans • NCQA
March 2020	**County Inmate Pre-Release Application Process:** Establish workgroup
April 2020	**County Oversight:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards
July 2020	**County Inmate Pre-Release Application Process:** Develop guidance • **County Oversight (CCS, CHDP):** Review of current standards, policies, and guidelines, and development of goals, performance measures, and metrics • **Global Payment Program:** Extended through December 31, 2025 • **Long Term Plan for Foster Care:** Workgroup meetings to inform policy recommendation (implementation timeline will be determined through stakeholder process)
October 2020	**County Inmate Pre-Release Application Process:** Stakeholder process

Date	Implementation Activity
December 31, 2020	**Medi-Cal 2020 1115 waiver expires along with**: Whole Person Care, PRIME, the Health Homes Program, California Children's Services pilot, designated state health programs, safety-net care pool, tribal uncompensated care
2021	
January 1, 2021	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Population health management • Enhanced care management/In lieu of services • Shared savings and incentive payments • PRIME transitions to Quality Improvement Program • Dental benefits and pay for performance • Managed care benefit standardization • Non-dual managed care enrollment standardization** • Long-term care integration • Regional rates Phase I • Behavioral health payment reform (at the earliest for HCPCS Level I code implementation) • Substance use disorder managed care renewal and policy improvements • Changes to behavioral health medical necessity **Behavioral Health Administrative Integration:** Begin in 2021 and continue over the five years of the waiver **County Inmate Pre-Release Application Process:** Begin technical Assistance (through December 2021) **Full Integration Plans:** Begin building managed care contract and request for proposal **County Oversight:** Begin assessing County Performance Standards **Long-Term Plan for Foster Care:** Policy work based on workgroup recommendations
April 2021	**County oversight:** Implementation of the "county performance monitoring dashboard" **County oversight (CCS, CHDP):** Development of auditing tools
July 2021	**County oversight:** Publication of the county performance monitoring dashboard on the CHHS Open Data Portal.
November-December 2021	First Medi-Cal managed care plan open enrollment period
2022	
January 1, 2022	**County Inmate Pre-Release Application Process:** Implementation **Full Integration Plan:** Post RFP (6 months) **Annual Open Enrollment:** Effective date of enrollment into Medi-Cal plans selected during first open enrollment period

Date	Implementation Activity
April 2022	**County Oversight (CCS, CHDP):** Evaluate and analyze findings and trends, identify gaps and vulnerabilities
July 2022	**Full Integration Plans:** Contracts awarded; establish readiness (18 months)
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, shift to an automated PFG submission
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Duals:** • Require statewide mandatory enrollment of dual eligibles in a Medi-Cal managed care** • All Medi-Cal health plans required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan **Regional Rates:** Implement Phase II regional rates statewide (at the earliest)
2024	
January 2024	**Full Integration Plan:** Go Live
2025	
January 2025	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2026	
January 2026	**Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Behavioral Health Managed Care:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver

*TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

**Mandatory Managed Care enrollment: See Appendix G

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X	X	
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X	X	X	X	
Imperial County	X	X	X	X	X	
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X	X		X	X	

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County						X
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County						X
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County		X	X			
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**25**	**17**	**28**	**17**	**31**

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Menu of In Lieu of Service Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF)
- Nursing Facility Transition to a Home
- Personal Care (beyond In Home Services and Supports) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8 or Section 202, etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [1]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Ensuring that the living environment is safe and ready for move-in.
10. Communicating and advocating on behalf of the client with landlords.

[1] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

11. Assisting in arranging for and supporting the details of the move.
12. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[2]
13. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
14. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Medi-Cal managed care plans must assure housing options identified for members are safe and appropriate for the member's health status.

The services may involve coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care (CoCs) through Coordinated Entry System; and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

[2] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[3] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 as:

[3] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and cost-effective substitute or setting for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the Medi-Cal managed care plan contracts.

Housing Transition/Navigation services are available once in an individual’s lifetime. Housing Transition/Navigation services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Transition/Navigation services would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual’s individualized housing support plan and are available only if the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- Mental health or substance use disorder treatment providers;
- Supportive housing providers; and
- Federally qualified health centers.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services they should be provided by one entity whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) to be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[4] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

[4] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

B. By the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least four (4) separate occasions in the last three (3) years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. An in lieu of service can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual’s lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

The entity that is coordinating an individual's Housing Navigation/Transition Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.)

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, and skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance us, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assistance with the annual housing recertification process.
8. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
9. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
10. Health and safety visits, including unit habitability inspections.
11. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).
12. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.

Individuals who are matched to a permanent supportive housing unit or rental subsidy resource through the Coordinated Entry System or similar system designed to use clinical information to identify highly vulnerable individuals with multiple chronic conditions and/or serious mental illness and/or serious substance use disorder.

Individuals who meet the Housing and Urban Development (HUD) definition of homeless[5] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness and/or serious substance use disorders. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder

[5] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

Individuals who meet the definition of a Chronically Homeless Individual either as defined:

A. In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
B. By the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:
    1. A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least four (4) separate occasions in the last three (3) years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
    2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other

similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically appropriate and cost-effective substitute or setting for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Many individuals will have also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other state, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- Mental health or substance use disorder treatment providers

- Supportive housing providers
- Federally qualified health centers

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, they should be provided by one entity whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric), substance abuse or mental health treatment facility, custody facility, or recuperative care.[6]

This setting provides individuals with ongoing supports necessary for recuperation such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition/Navigation.[7]

This setting may include supported housing in an individual or shared interim housing setting.

Beneficiaries must also receive Housing Transition/Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting.

Eligibility (Population Subset)

Individuals exiting recuperative care.

Individuals exiting an inpatient hospital stay (either acute or psychiatric), substance abuse or mental health treatment facility, or custody facility and who meet any of the following criteria:

- Individuals who meet the HUD definition of homeless[8] (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management. For the purpose of this service,

---

[6] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.

[7] Housing Transition/Navigation is a separate in-lieu service.

[8] Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

- Individuals who meet the HUD definition of homeless (including those exiting institutions but not including any limits on the number of days in the institution) and who have multiple chronic conditions and/or serious mental illness. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery bridge housing, Institutes for Mental Disease and State Hospitals.

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness" which includes persons exiting institutions who were homeless prior to entering the institutions and Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system and have a serious mental illness and/or a child or adolescent with serious emotional disturbance.

- Individuals who meet the definition of Chronically Homeless Individual either:

    a. As defined in W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

    b. As defined by the Department of Housing and Urban Development (HUD) in 24 C.F.R. 91.5 as:

        1. A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

            i. Lives in a place not meant for human habitation, a safe haven or in an emergency shelter; and

            ii. Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least

four (4) separate occasions in the last three (3)years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

In addition to meeting one of these criteria at a minimum, individuals must:

- Have medical/behavioral health needs such that experiencing homelessness upon discharge from hospital, substance abuse or mental health treatment facility, correctional facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission; and
- Participate in a housing assessment and individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[9]

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

[9] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs).

The service is only available if enrollee is unable to meet such expense or when the services cannot be obtained from other sources.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Supportive Housing Providers

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, post-acute care, Emergency Department services, Emergency Transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with activities of daily living
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are homeless or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to clients onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Are homeless or are at imminent risk of being homeless;
- Live alone with no informal supports; or
- Face housing insecurity or have housing that would jeopardize their health and safety without modification. [10]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Examples of facilities include:

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[10] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home.

- County directly operated or contracted recuperative care facilities

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, skilled nursing facility, and Emergency Department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite benefit services are provided to the participant in his or her own home.

The Facility Respite benefit services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State

Plan. An in lieu of service can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Benefit limit is up to 336 hours per calendar year. The benefit is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336 hour annual limit.

This benefit is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Licensing/Allowable Providers

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children
- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home (AFH)/Family Teaching Home(FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, and Skilled Nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For homeless participants receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [11]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [12]
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising and dismissing personal attendants;

[11] Refer to the Housing Transition/Navigation Services In Lieu of Services
[12] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support.
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are homeless or formerly homeless including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 12 months, and individuals at risk of homelessness whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is only provided to individuals age 21 and over. All medically-necessary case management services for children under the age of 21 are covered in the State Plan pursuant to the EPSDT benefit.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- Non-Profit Agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, skilled nursing facility, Emergency Department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs) Instrumental ADLs (IADLs), meals, transportation, medication administration and skilled nursing, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADL). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[13]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF in order for the client to be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

Eligibility (Population Subset)

[13] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Individuals are directly responsible for paying their own living expenses.

Licensing/Allowable Providers

- Case management agencies
- Home Health agencies
- Managed care plans
- ARF/RCFE Operators

Medi-Cal managed care plan may utilize other providers but must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home assists individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[14]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[15]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [16]

---

[14] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[15] Refer to Home Modification In Lieu of Services for additional details.
[16] Refer to Housing Deposits In Lieu of Services for additional details.

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Community Transition Services are furnished only to the extent that they are reasonable and necessary.
- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $X, 000.00. The only exception to the $X,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Licensing/Allowable Providers

1. Case management agencies
2. Home Health agencies

3. Managed care plans

Medi-Cal managed Care plan may utilize other providers but must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal Managed Care plans shall monitor the provision of all the services included above.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services), up to a maximum of 30 days, if required for immediate member need.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Similar services available through In-Home Supportive Services should always be utilized first. These PCA and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility
- Individuals with functional deficits and no other adequate support system
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This benefit cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member has any change in their current condition, they must be referred to In-Home Supportive Services for assessment and determination of additional hours before the plan can begin to cover via in lieu of services.

Licensing/Allowable Providers

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision.

The services are available in a home that is owned, rented, leased or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for the modifications.

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document:

1. The participant's current primary care physician's order specifying the requested equipment or service;
2. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:
    A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;
4. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor and applicable warranties; and
5. That a home visit has been conducted to determine the suitability of any requested equipment or service.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- This benefit is not meant to replace any other State Plan service. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- Bathroom and bedroom modifications are limited to one of each of those types of rooms in a given house, and entryway modifications are limited to one entryway.

- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of the modification, the MCO must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the participant ceases to reside at the residence.
- Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- The Medi-Cal managed care plan may manage these services directly or may coordinate with an existing Medi-Cal provider to manage the service.
- All EAAs must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.
- Area Agency on Aging (AAA) can provide these services.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home: immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.

Eligibility (Population Subset)

1. Individuals with chronic conditions: diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, and chronic or disabling mental health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with intensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Three medically-tailored meals per day for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Reimbursement to address food insecurities is not covered.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

- Licensing/Allowable Providers
- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly-intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services.

- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. An in lieu of services can only be covered if: 1) the State determines it is medically-appropriate and a cost-effective substitute or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This benefit is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally-funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

- Sobering Centers, or other appropriate and allowable substance use disorder facilities
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and Outpatient Hospital services, Emergency Department services, Emergency Transportation services.

Appendix E: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a State's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the State's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that States' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with States to determine the feasibility of their budget neutrality models and suggest changes as necessary;
- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;

- Written documentation of the State's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix F: CalAIM Benefit Changes Chart

Benefit Changes Effective January 1, 2020	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Category/Benefit	**Impact**
Fabrication of Optical Lenses	Currently only covered by CenCal and Health plan of San Mateo in managed care
Benefit Changes Effective January 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Category/Benefit	**Impact**
Pharmacy	All drugs or pharmacy claims billed by a pharmacy. Including HIV/AIDS and Psychotherapeutic Drugs currently carved into some county operated health systems and AIDS Healthcare Foundation
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In Managed Care Statewide	
Category/Benefit	**Impact**
Long Term Care Umbrella • ICF-DD Disabled, Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services	Currently full benefit in county operated health systems and/or CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside), in non-county operated health systems/Non- CCI counties Medi-Cal managed care plans are responsible for the month of admission and the month following
Major Organ Transplant	Currently full benefit in county operated health systems counties, non-county operated health systems counties currently only cover kidney transplants

Appendix G: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2021			2023		
Aid Code Group	Aid Codes	Non-Dual/ Dual	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[17], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[17], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Aged	10[18], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[17] Aid code can have a SOC or no SOC
[18] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.
*Light blue colored cells indicate a change from current enrollment.

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2021			2023		
Aid Code Group	**Aid Codes**	**Non-Dual/ Dual**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 63	Non-Dual	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U, 4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[17], 83, 85, 87, 89, 02[17], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[17], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[17], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2021			2023		
Aid Code Group	Aid Codes	Non-Dual/ Dual	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P, 7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[17], 83, 85, 87, 89, 02[17], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2021			2023		
Aid Code Group	Aid Codes	Non-Dual/ Dual	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G, 7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				Non-Citizen		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2021**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian	COHS	Non-COHS	N/A	All Models[19]	N/A	N/A	All Models[3]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[3]	N/A	N/A	All Models[3]	N/A	N/A
Beneficiaries in Rural Zip Codes[4]	COHS	Non-COHS	Non-COHS	All Models[3]	N/A	N/A	All Models[3]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[3]	N/A	N/A

[3] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[4] The following zip codes are currently excluded from enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 93592

Appendix H: Global Payment Program Extension Timeline

GPP PY	SFY	FFY	Service Period Dates	DY	Periods for DY
6	2020-21	2021	July 1, 2020 – June 30, 2021	16 and 17	July 1, 2020 - Dec 31, 2020 Jan 1, 2021 - June 30, 2021*
7	2021-22	2022	July 1, 2021 – June 30, 2022	18	July 1, 2021 - June 30, 2022*
8	2022-23	2023	July 1, 2022 – June 30, 2023	19	July 1, 2022 - June 30, 2023*
9	2023-24	2024	July 1, 2023 – June 30, 2024	20	July 1, 2023 - June 30, 2024*
10	2024-25	2025	July 1, 2024 – June 30, 2025	21	July 1, 2024 - Dec 31, 2025*

**Program Year (PY), State Fiscal Year (SFY), Federal Fiscal Year (FFY), Demonstration Year (DY)*

7. Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Annual Medi-Cal Managed Care Plan Open Enrollment: A specified period in which Medi-Cal enrollees would be able to change their Medi-Cal managed care plan once per year. Exceptions would be allowed based on a consumer-friendly process that ensures beneficiary needs are being met, particularly as it comes to access to providers.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: Formerly referred to as a prepaid inpatient health plan (PIHP), including county mental health plans responsible for specialty mental health services and DMC-ODS counties (now referred to as substance use disorder managed care) responsible for substance use disorder services. Under the CalAIM proposal, behavioral health managed care plans would be responsible for managing all Medi-Cal services related to behavioral health, including arranging inpatient care. A behavioral health managed care plan would provide services to consumers under a contract with DHCS through prepaid capitation payments and would not have a comprehensive risk contract.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

1. Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2013 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and

supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently contracted with CMS to be authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all counties to implement warm handoffs from county jail release to county behavioral health departments, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children. DTI is authorized under the Medi-Cal 2020 Section 1115 waiver and expires at the end of 2020.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 waiver expires.

Enhanced Care Management: A collaborative and interdisciplinary approach to providing intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficairies.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, substance use disorder managed care, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care

funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on June 30, 2020 and is part of the Medi-Cal 2020 Section 1115 waiver.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for state plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform Waiver in 2010. PRIME funding is authorized under the Medi-Cal 2020 Section 1115 waiver and is currently set to expire on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals would also be able to participate in the QIP once PRIME expires.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 Waivers that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 Section 1115 waiver.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to waive the institution for mental disease (IMD) exclusion, which in turn enables them to use federal funding to pay for short-term residential treatment services in IMDs. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Substance Use Disorder Fee-for-Service: Formerly referred to as Drug Medi-Cal State Plan Services, substance use disorder fee-for-service pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Substance Use Disorder Managed Care: Formerly referred to as the Drug Medi-Cal Organized Delivery System, substance use disorder managed care is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the 2010 Medi-Cal 1115 Waiver and was reauthorized in the current Medi-Cal 2020 1115 Waiver.

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 Section 1115 waiver and expires on December 31, 2020.