



**State of California
Department of Health Care Services**

***Medicaid Section 1115 Waiver Demonstration
Extension Request***

***DRAFT for PUBLIC COMMENT
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Section 1 – Introduction

The California Department of Health Care Services (DHCS) is requesting a 12-month extension of the Medi-Cal 2020 Section 1115 waiver demonstration, which is scheduled to expire on December 31, 2020. Although California has conducted significant planning for a transition away from the Section 1115 waiver authority for many aspects of the Medi-Cal program, the final development of our approach and the preparation of our health care delivery system has been delayed by the impact of the COVID-19 pandemic. It is essential for the stability of the state's health care systems, particularly during the pandemic, that the current Medi-Cal 2020 Section 1115 waiver provisions be extended for one year to December 31, 2021.

Delivery System Transformation Planning

DHCS has been working for over two years to re-imagine, modernize, and align its Medi-Cal (Medicaid) delivery system with three key goals:

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, reduce health disparities, and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

This plan, known as "California Advancing and Innovating Medi-Cal (CalAIM)" will be a multi-year initiative to improve quality of life and health outcomes for California residents by implementing broad delivery system, program, and payment reform across the Medi-Cal program. The major components of CalAIM will build on successful programs piloted in California's previous federal waivers and result in better health outcomes for Medi-Cal members and long-term cost savings and avoidance. The authority for CalAIM would be established through a combination of a comprehensive Section 1915(b) waiver (for the affected managed care delivery systems) and a narrower Section 1115 demonstration waiver (for the programs and initiatives for which approval is not available under Section 1915(b)).

Starting in the fall of 2019, DHCS developed and refined the elements of CalAIM through a robust stakeholder and public engagement process involving five major policy Workgroups represented by stakeholders across the health care delivery system and consumer advocacy organizations. The state hosted 20 Workgroup meetings between November 2019 and the end



of February 2020. Each meeting also included an opportunity for participation by phone and webinar, as well as an in-person public comment period as part of the agenda. The agreed upon goal, based on discussions with the Centers for Medicare & Medicaid Services (CMS), had been to submit the CalAIM proposals to CMS for review by June 2020, and to receive federal approval in time for the expiration of the Medi-Cal 2020 Section 1115 waiver demonstration on December 31, 2020.

COVID-19 Impact

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one of the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training to address COVID, such as infection control measures. While the stay-at-home order and related delivery system changes significantly slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 1115 waiver. In addition, the economic impact of the stay-at-home order in California and other states has been significant. This confluence of events has prevented the state from moving ahead with the implementation of CalAIM. The Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. Based on initial conversations with CMS leadership and staff indicating support for an extension given the circumstances, DHCS is proposing a 12-month waiver extension request.

12-Month Extension Request

DHCS is requesting a 12-month extension of the Medi-Cal 2020 Section 1115 waiver demonstration. A full description of the elements of the extension request is provided below.

It is important to note that the **Public Hospital Re-Design and Incentives in Medi-Cal (PRIME)** program is not included in this extension request. DHCS has been working closely with the



public hospital system to transition the PRIME program over to the Quality Incentive Program (QIP) directed payment initiative approved under the 2016 Medicaid managed care final rule, and we anticipate that transition can occur with an effective date of July 1, 2020, subject to CMS approval of the required preprint.

However, keeping all other elements of the Medi-Cal 2020 waiver intact for an additional year is critical to maintaining the current delivery system until the CalAIM initiative can proceed:

- Medi-Cal Managed Care
- Whole Person Care pilots
- Global Payment Program and Safety Net Care Pool
- Drug Medi-Cal Organized Delivery System
- Low-Income Pregnant Women
- Out of State Former Foster Care Youth
- Community-Based Adult Services
- Coordinated Care Initiative
- Dental Transformation Initiative and Designated State Health Programs
- Tribal Uncompensated Care
- Rady's California Children's Services Pilot
- PACE as an Alternative Delivery System in Select COHS

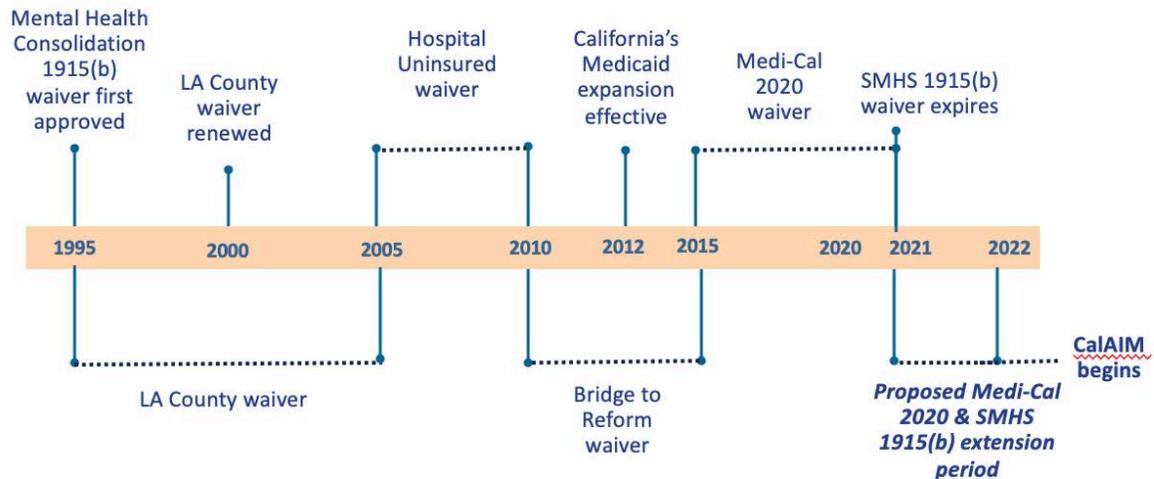
Section 2 provides a description of the history of California's use of the Medicaid Section 1115 waiver authority, followed by an outline of the proposed elements of the 12-month extension in Section 3.

Section 2 – Medi-Cal Section 1115 Waiver History and Background

California's relationship with the Medicaid Section 1115 waiver authority dates back to 1995, when the state became one of the first to leverage the flexibility provided under the law. The first approved waiver was designed to provide needed financial relief to Los Angeles County in the wake of an economic downturn. Through the waiver, the Los Angeles County Department of Health Services sought to reduce its traditional emphasis on emergency room and inpatient care by building an integrated system of community-based primary, specialty, and preventive care. Although the demonstration did not ultimately achieve all of its stated goals, it established Section 1115 as the key authority for and pathway to Medicaid innovation in California for the next 25 years.



Medi-Cal 1115 Waiver History: 1995-2021



Medi-Cal Hospital Uninsured Care Waiver (2005)

California’s “Medi-Cal Hospital Uninsured Care” waiver under Section 1115 was approved in 2005. The waiver and expenditure authorities enabled California to improve the condition of its state and county budgets by making new federal matching funds available to cover uncompensated care costs and expand coverage of the uninsured. Specifically, the waiver established a Safety Net Care Pool (SNCP) that made federal matching funds available to the state’s designated public hospitals (DPHs) to help offset the losses they sustain in providing medically necessary health care services to the uninsured. The SNCP also included a pool of funds to help finance the expansion of health care coverage options for low-income individuals in certain counties in the state. Under the waiver, California also shifted the state source of its Medicaid payments to hospitals from intergovernmental transfers (IGTs) to certified public expenditures (CPEs).

California Bridge to Reform Waiver (2010)

In 2010, California’s 2005 demonstration was renewed and renamed “California Bridge to Reform.” In the Bridge to Reform waiver the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for full implementation of the Affordable Care Act (ACA). The Bridge to Reform waiver was initially designed to support the following primary initiatives:



- *Coverage Expansion*: Provided phased-in coverage for individual counties for adults aged 19-64 with incomes up to 200% of the federal poverty level (FPL) through the Low Income Health Program (LIHP).
- *Managed Care for Seniors and Persons with Disabilities*: Improved care coordination for vulnerable populations by mandatorily enrolling seniors and persons with disabilities (SPDs) into Medi-Cal managed care.
- *DSRIP*: Supported California's public hospitals in their effort to improve quality of care by providing payment incentives through the Delivery System Reform Incentive Pool (DSRIP) Program for projects that support infrastructure development, innovation and redesign of the delivery system, population-focused improvements, and urgent improvements in care.
- *Uncompensated Care*: Supported the ongoing provision of services to otherwise uninsured individuals through the Safety Net Care Pool (SNCP) Uncompensated Care Component and federal funding of Designated State Health Programs (DSHP).
- *California Children's Services (CCS) Pilots*: The waiver included provisions to test alternate health care delivery models for children enrolled in CCS, through several pilot programs. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with certain medical conditions, such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, CCS also provides medical therapy services that are delivered at public schools. The CCS program is authorized and funded as one of the Designated State Health Programs (DHSPs).

In addition, several amendments to the waiver were approved during the demonstration period that further advanced the waiver's goals. These included:

- *Community-Based Adult Services (CBAS)*: An amendment approved on March 30, 2012 authorized California to establish the Community-Based Adult Services (CBAS) Program, which offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting in order to restore or maintain their optimal capacity for self-care and delay or prevent unnecessary institutionalization. CBAS services include an individual assessment; professional nursing services; physical, occupational, and speech



therapies; mental health services; personal care; nutritional counseling; and transportation, among others. The CBAS waiver amendment was renewed on November 28, 2014.

- *Managed Care for the Newly-eligible Population*: Effective January 1, 2014, adults newly eligible for Medi-Cal with incomes up to 133 percent of the FPL were added as a state plan eligibility category pursuant to the Affordable Care Act, and were transitioned from the Low-Income Health Program (LIHP) to the Medi-Cal managed care delivery system.
- *Coordinated Care Initiative (CCI)*: Through a further amendment to the waiver, DHCS received approval to establish the Coordinated Care Initiative (CCI) with coverage commencing on April 1, 2014. The state also received separate Section 1115(a) demonstration authority for the Cal MediConnect program. The CCI was designed to provide integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community. It has been implemented in seven counties and is comprised of two parts: (1) Cal MediConnect, a demonstration project that combines 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; and (2) mandatory Medi-Cal managed care enrollment for dual eligible individuals for all Medi-Cal benefits, including managed long-term services and supports.
- *Drug Medi-Cal Organized Delivery System (DMC-ODS)*: As part of its ongoing effort to treat and prevent SUD, California received approval in August 2015 to implement a new delivery system for SUD treatment known as the Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS Program provided California counties the opportunity to provide their resident Medicaid beneficiaries with a range of evidence-based SUD treatment services not available under the Medi-Cal state plan. In connection with the DMC-ODS Program, the state was first in the nation to receive approval for federal Medicaid funding for residential treatment of SUDs in institutes for mental disease (IMDs). To date, 37 counties have implemented the DMC-ODS Program providing access to more than 90 percent of the Medi-Cal population. As described in more detail in Section 5 below, the University of California Los Angeles (UCLA) 2019 evaluation of the DMC-ODS Program concluded that it has met its stated goals of improving access, quality, and coordination of care for SUD services in implementing counties.



Medi-Cal 2020 Waiver (2015)

In December 2015, the Federal government approved a five-year extension of the state’s Section 1115 waiver. The new waiver, entitled “Medi-Cal 2020,” retained and advanced many of the initiatives established under its predecessor Bridge to Reform waiver, and established new programs designed to expand access and improve quality, particularly for individuals with complex health and social needs, including individuals with substance use disorders (SUDs) and individuals experiencing homelessness. Through the Medi-Cal 2020 waiver, the state received financial support and legal authority to extend the operation of and federal financial support for programs in the prior waiver and also established the following new programs:

- *Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)*: Under the Medi-Cal 2020 waiver, California received authority to extend and improve its DSRIP Program—renamed the Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)—to provide additional incentives to its safety net hospitals to improve the way they deliver care. Specifically, the PRIME Program provides incentive funding for California’s 21 DPHs and 39 District/Municipal Public Hospitals (DMPHs) to support delivery system reform, including through adoption of alternative payment models (APMs), with the ultimate goal of increasing quality and efficiency and improving population health and health outcomes, particularly for high-utilizers and individuals with co-occurring physical and behavioral health conditions. To receive funding, participating hospitals must report on progress toward and achievement of specified metrics.
- *Whole Person Care (WPC)*: The state received authority and up to \$1.5 billion in federal funds to pilot an innovative new approach to engaging and treating Medicaid beneficiaries who are high-utilizers of the health care system or present complex physical, behavioral, or social needs. Under this initiative, California counties and other local entities were provided the opportunity to develop and implement their own pilot programs within certain parameters established by the waiver and state guidelines. The pilots must be designed to coordinate physical health, behavioral health, and social services (e.g., housing supports for one or more of the designated target populations, which include high utilizers with two or more chronic conditions, individuals who are homeless or at risk of homelessness, or individuals with a behavioral health condition or substance use disorder.)



- *Global Payment Program (GPP) & Safety Net Care Pool*: Although the expansion of Medi-Cal significantly reduced the state’s uninsured rate, 9 percent of the state’s population remained uninsured in 2015. To support and improve ongoing care for the uninsured, California received authority in the Medi-Cal 2020 waiver to establish the Global Payment Program (GPP). Through the GPP, the state is able to make value-based payments to California’s public health care systems (PHCS) that are designed to further two aims. First, the payments offset some of the losses the PHCSs sustain in providing medically necessary services to California’s remaining uninsured population. And second, the payments are structured to spur improvements in the quality and value of the care provided by PHCSs by, for example, rewarding care that is appropriately provided in less intensive and less expensive outpatient settings, rather than in the emergency room or hospital inpatient setting.
- *Coverage of Low-Income Pregnant Women*: Under the Medi-Cal 2020 waiver, the state received authority to cover pregnant women with incomes from 109 percent of the FPL up to and including 138 percent of the FPL (including all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL).
- *Dental Transformation Initiative (DTI)*: Under the Dental Transformation Initiative (DTI), the state developed a critical new mechanism for improving dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

Amendments

In addition to the programs authorized under the initial Medi-Cal 2020 waiver, as described above, several amendments to the waiver approved during the demonstration period contributed to achievement of the waiver’s goals. Key amendments were for the following new initiatives:

- *Health Homes Program (HHP)*: Federal authority for California’s HHP was provided through an amendment to California’s State Plan, as well as an amendment to the Medi-Cal 2020 waiver, both of which were approved on December 19, 2017. The 1115 waiver authority enables the state to waive freedom of choice of providers, statewide, and comparability for the counties participating in the HHP. Eligibility for the HHP is limited to individuals who are: (1) enrolled in a Medi-Cal managed care organization (MCO); (2)



have certain chronic health or mental health conditions, such as diabetes, asthma, SUD, or serious mental illness, among others; and (3) meet certain acuity/complexity criteria, one of which is chronic homelessness. As of March 2020, more than 25,000 people have enrolled in HHP.

- *Coverage of Out-of-State Former Foster Youth:* On August 18, 2017, CMS approved an amendment to the Medi-Cal 2020 waiver that authorized California to provide Medicaid State Plan coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they “aged out” of foster care at age 18 (or such higher age as elected by the state) and were enrolled in Medicaid at that time.
- **(Pending)** *Global Payment Program Extension:* On February 28, 2020, DHCS submitted a proposed waiver amendment to allow DHCS to operate the Global Payment Program (GPP) for an additional six-month period, from July 1, 2020 to December 31, 2020. This amendment would also allow Medi-Cal beneficiaries in Orange County, at their election, to be disenrolled from CalOptima, a county-organized health system (COHS) including CalOptima PACE, to be enrolled in a Program of All Inclusive Care for the Elderly (PACE) organization not affiliated with CalOptima, if eligible. DHCS requested an effective date of July 1, 2020 for this amendment, although the amendment is still pending CMS review.

Section 3 – Medi-Cal 2020 Extension Request

As described above, the COVID-19 emergency has prevented the State of California and its local health care delivery system partners from being able to work with Medi-Cal managed care plans, county public health agencies, and other key stakeholders to prepare for implementation of the CalAIM initiative by December 31, 2020. Therefore, the state is requesting a 12-month extension – to December 31, 2021 – of the existing Medi-Cal 2020 waiver demonstration in order to bridge the gap and keep the current delivery system intact. Following are the elements of the Medi-Cal 2020 demonstration that are proposed to continue under the 12-month extension:

- **Managed Care Delivery System** – The Medi-Cal managed care delivery system provides high-quality, accessible, integrated, and cost-effective care for beneficiaries, and is the



core delivery system for most services. As of March 2020, approximately 80% of the state's Medi-Cal beneficiaries across 58 counties received their health care through managed care.

- **Whole Person Care (WPC) pilots** – There are 25 WPC pilots in operation across the state. As discussed in more detail in below, a 2019 study by UCLA evaluating care coordination by the WPC pilots found that they have made significant progress in establishing essential care coordination processes and delivering cross-sector care coordination services.
- **Global Payment Program (GPP) and Safety Net Care Pool** – The GPP plays a vital role in sustaining and improving care for the uninsured, and its continuation is critical to achieving California's goal of increasing population health statewide. The GPP established a statewide pool of funding for California's remaining uninsured by allocating over \$2 billion of combined federal Disproportionate Share Hospital (DSH) allotment and uncompensated care funding to Public Health Care Systems (PHCS). These funds support PHCS 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. This amendment is necessary to continue GPP payments, using the federal DSH allotment funds for the relevant time period and a continued Uncompensated Care Pool, to eligible PHCSs through an additional 12 months of the Medi-Cal 2020 Demonstration period.
- **Drug Medi-Cal Organized Delivery System (DMC-ODS)** – Authority for the state to continue to authorize participant counties to provide the expanded continuum of DMC-ODS benefits, including residential SUD treatment services in settings that are considered IMDs. DMC-ODS is now available in 37 counties, providing access to more than 90% of the Medi-Cal population.
- **Low-Income Pregnant Women** – The state requests authority to continue to provide coverage to pregnant women with incomes from 109 percent up to and including 138 percent of the FPL (including all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL).
- **Out-of-State Former Foster Care Youth** – The Medi-Cal 2020 waiver authorizes Medi-Cal coverage for former foster care youth under age 26, who were in foster care under the responsibility of another state or a tribe when they aged out.



- **Community-Based Adult Services (CBAS)** – CBAS offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting in order to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.
- **Coordinated Care Initiative (CCI)** – The state seeks to continue CCI until December 31, 2022 (previously approved by CMS) at which point the state intends to fully transition all dual-eligible beneficiaries into Medi-Cal managed care statewide. The separate Cal MediConnect authority also needs to be extended under this request to ensure alignment of the program transition to CalAIM.
- **Dental Transformation Initiative (DTI)** – This initiative is designed to improve dental health for children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.
- **Tribal Uncompensated Care (TUCCWA)** – The proposed extension would permit DHCS to make uncompensated care payments for certain optional services previously eliminated from the state plan that are provided by Indian Health Service (IHS) tribal health programs operating under the authority of Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries.
- **Rady Children’s Hospital of San Diego California Children’s Services (CCS) Pilot** – The 12-month extension would permit the state to continue to test this effective health care delivery model for children with complex medical needs.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE is a fully integrated Medicare and Medicaid delivery model that coordinates and provides all needed preventive, primary, acute and long-term care services for eligible participants to continue living in the community. Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. In order for a PACE organizations to operate a third party PACE organization in a COHS county, the PACE organization must seek county board of supervisor, DHCS and CMS approval, as approved through the 1115 waiver. DHCS currently has one PACE organization approved to operating in Humboldt County, and a pending request with CMS for Orange County.



Following are detailed descriptions of the programs listed above, along with the rationale for including them in the 12-month extension request.

Section 3.1 – Whole Person Care Pilots

Under the Whole Person Care pilot program, California counties and other local entities developed and implemented programs tailored to their communities' needs, within certain parameters established by the waiver and state guidelines. The WPC pilots are designed to coordinate physical health, behavioral health, and social services (e.g., housing supports, food assistance, etc.) for one or more of the designated target populations, which include high utilizers with two or more chronic conditions, individuals who are homeless or at risk of homelessness, or individuals with a behavioral health condition or substance use disorder.

Each WPC pilot determined the services that were appropriate for its target populations, which could include services not otherwise covered by Medi-Cal such as medical respite, recuperative care, sobering center services, and mobile or street-based services. Pilots were able to use program funds to develop program infrastructure, collaborate with community partners, and improve data sharing between entities. Payments to the pilots can be fee-for-service, per-member-per-month (PMPM) capitation, and/or incentives based on numbers enrolled, services provided, and milestones achieved.

Each pilot developed its own payment structure based on its selected services and goals. For example, some WPC pilots receive PMPM payments for providing “bundles” of care coordination or supportive housing services. Others receive FFS payments for services provided to enrollees at respite centers, separate funding to build data sharing infrastructure, and incentive payments for achieving pilot-specific outcomes or milestones. Currently, there are 25 pilots in operation across 26 counties in the state. As discussed in more detail in Section 4 below, a 2019 study by UCLA evaluating the WPC pilots found that they have made significant progress in establishing essential care coordination processes and delivering cross-sector care coordination services.

Under this 12-month extension request, the WPC pilots would continue as currently structured. Additional federal matching funds in the amount of \$300 million would be needed in order to sustain the program at the current expenditure level. In addition, given the COVID-19 emergency, the state proposes to include individuals impacted by COVID-19 as a target population. DHCS also proposes that the WPC pilots be permitted to modify their budgets for in



response to COVID-19, and requests that the pilots be permitted to opt out of participating in this 12-month extension due to budget constraints or other extenuating circumstances.

Section 3.2 – Supporting California’s Safety Net – The Global Payment Program

California has a long history of providing services to Medi-Cal beneficiaries and uninsured individuals through its public health care systems (PHCSs), which consist of 15 county-owned and operated health care systems and five University of California Medical Centers. California’s PHCSs are committed to delivering high-quality care to those in need, regardless of ability to pay or insurance status. The PHCSs include only six percent of California’s hospitals but provide more than 40 percent of the hospital care delivered to California’s remaining uninsured.

The evidence continues to suggest that improvements in access to outpatient services, including primary care, can reduce health care costs and improve health outcomes. However, many of California’s remaining uninsured continue to receive most of their care in emergency departments or other hospital settings. Moreover, the funding programs previously available to PHCSs to provide compensation for care to the uninsured, while important, were not designed to promote value-based care or delivery system reform. In addition, the funding formulas associated with these programs made it difficult for the PHCSs to predict how much funding they would receive, making long-term financial planning and investments more difficult.

The GPP established a new method of compensating PHCSs for caring for the uninsured that promotes delivery system reform in care for the uninsured and incentivizes value, not volume, in the provision of services.

The stated goals of the GPP are to:

- Move away from payments restricted to hospital settings;
- Encourage the use of primary and preventive services and create access to services like telehealth, group visits, and health coaching by expanding the settings in which PHCSs can receive payments;
- Emphasize coordinated care and care provided outside of the hospital and emergency room; and
- Recognize the value of services that have not typically been reimbursable through Medicaid, but that substitute or compliment services that are reimbursable.



The GPP achieves these goals by compensating PHCSs through a value-based point methodology that awards points based on services provided and is designed to encourage primary and preventive care and the delivery of care in appropriate settings. Over the course of the waiver, the points attributed to high-value services, such as primary or preventive care delivered in an outpatient setting, has increased relative to the points attributed to services provided in an emergency room or inpatient setting.

Importantly, the GPP also provides PHCSs with federal matching funds for a much wider range of services than was previously allowed under past waivers, including low-cost high-value services such as visits to a health coach, nutrition education, and email provider consultations. In addition, under the GPP, PHCSs benefit from the greater predictability of funding, and a quarterly payment schedule, both of which are designed to facilitate PHCS planning for service delivery reform and other infrastructure investments.

As discussed in Section 4 below, an independent evaluation of the GPP found that it has been successful in rewarding and incentivizing value-based cost-effective care, not volume of services, in care for the uninsured. For this reason, the state seeks federal approval to continue the GPP and the Safety Net Care Pool to December 31, 2021 as currently structured, to preserve and build on the delivery-system improvements achieved in the expiring waiver period. The program would continue the modification to the point values as outlined in Attachment FF of the Medi-Cal 2020 Special Terms and Conditions. Point thresholds would be established dependent on the final budget amounts.

Section 3.3 – Advancing the DMC-ODS Program

Medi-Cal has long provided coverage for some substance use disorder (SUD) treatment benefits through the state plan authorized Drug Medi-Cal program that the counties administered, but services were limited and quality was variable. To improve its SUD delivery system, the state created the Drug Medi-Cal Organized Delivery System (DMC-ODS) program under Section 1115 waiver authority to expand access to treatment and provide a greater continuum of high-quality, evidenced-based SUD treatment services. Since the DMC-ODS pilot program began in 2015, California counties have had the opportunity to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services not available under the Medi-Cal State Plan. To date, 37 of California's 58 counties have implemented DMC-ODS providing access to more than 90 percent of the Medi-Cal population statewide.



As described in Section 4 below, UCLA's most recent evaluation of DMC-ODS revealed that the program has been successful in improving access, quality, and coordination of care for SUD services in implementing counties.

Delivery System

Counties that wish to participate in DMC-ODS must submit an implementation plan to the state and participate in a readiness review. After the state approves the implementation plan and concludes that the county is ready to proceed, the state and county execute an intergovernmental agreement (IA) governing the county's participation in DMC-ODS. Under the IA, the county agrees to provide or reimburse Drug Medi-Cal certified providers for providing DMC-ODS services through a Prepaid Inpatient Health Plan (PIHP) as defined in 42 CFR § 438.2. Counties may contract with a managed care plan to arrange for the provision of services. Counties can also request state approval to develop regional delivery systems for one or more of the DMC-ODS modalities or receive additional flexibility in delivery system design. Importantly, under the program, counties are not required to offer providers state plan rates.

Eligibility and Enrollment

In order to receive services through the DMC-ODS program, a Medicaid beneficiary must be enrolled in Medi-Cal, reside in a participating county, and have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or have received such a diagnosis prior to being incarcerated.

Any determination that the DMC-ODS program medical necessity criteria is satisfied must be based on a face-to-face or telehealth encounter with a medical director, licensed physician, or licensed practitioner of the healing arts (LPHA). If a qualifying diagnosis is established or confirmed, the ASAM Criteria is applied to determine the appropriate level of services.

Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process; except for Narcotic Treatment Program (NTP) which require annual reauthorization.

Beneficiaries may receive a referral to treatment under DMC-ODS from any source, including a physical or mental health care provider, law enforcement agency, school, other county department, or family member. Individuals may also self-refer to the DMC-ODS Program. Participating counties must have a toll-free number available for beneficiaries to call 24 hours a



day, seven days a week, to access DMC-ODS services. Oral language interpretation must be available.

Covered Services

In the standard Drug Medi-Cal program, benefits include outpatient and intensive outpatient SUD services, perinatal residential SUD treatment (limited to facilities with 16 beds or fewer), and narcotic (opioid) treatment programs. DMC-ODS benefits include all the standard services plus case management, multiple levels of residential SUD treatment (not limited to perinatal or to facilities with 16 beds or fewer), withdrawal management, recovery services, physician consultation, and, if the county chooses, additional medication-assisted treatment (MAT) and partial hospitalization. Tables displaying all the services currently covered under DMC-ODS are provided below.

Extension Request

To enable DMC-ODS to continue to grow and mature, the state is requesting an extension of the Section 1115 waiver authority to provide residential SUD treatment for individuals in IMDs, among other settings and services (see Table 1). As noted above, the program has been successful over the past five years, but the opioid crisis continues to persist and DHCS requests this extension to continue its efforts to expand access to life-saving treatment and prevention services.

Given the 12-month extension request, DHCS requests authority to make several technical changes to the current DMC-ODS program that will increase efficiency, improve access, and align more closely with CMS policy regarding SUD waivers. These changes, which are outlined in more detail later in this proposal, are intended to be a part of the transition to a future five-year waiver and will not have a budget neutrality impact for the federal government:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period;
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined;
- Clarify the recovery services benefit;
- Expand access to MAT; and
- Increase access to SUD treatment for American Indians and Alaska Natives



Table 1 – DMC-ODS Benefits

ASAM Level of Care	Service	Service Definition	Provider Type	Current Coverage Authority
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment	Managed Care Plans and Fee-For-Service Providers	State Plan
1	Outpatient Services	Counseling services for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities	State Plan / 1115 waiver
2.1	Intensive Outpatient Services	Counseling services to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities	State Plan / 1115 waiver
2.5	Partial Hospitalization Services	Services for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities	1115 waiver
3.1	Clinically Managed Low-Intensity residential Services	24-hour structure with available trained personnel; 20 hours of care with at least 5 hours of clinical service/week and prepare for outpatient treatment.	ASAM Designated Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	1115 waiver
3.3	Clinically Managed Population-Specific High Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive impairments.	DHCS Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	1115 waiver
3.5	Clinically Managed High Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	ASAM Designated Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	1115 waiver
3.7	Medically Monitored	24-hour nursing care with physician	Chemical Dependency Recovery Hospitals;	1115 waiver



ASAM Level of Care	Service	Service Definition	Provider Type	Current Coverage Authority
	Intensive Inpatient Services	availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Hospital, Freestanding Acute Psychiatric Hospitals	
4.0	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital; Freestanding Acute Psychiatric Hospitals	1115 waiver
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed Narcotic Treatment Programs	State Plan / 1115 waiver
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, Licensed Prescriber; or OTP for Opioids.	1115 waiver
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; Physician; Licensed Prescriber; or OTP.	1115 waiver
3.2-WM	Clinically managed residential withdrawal management	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Services; Chemical Dependency Recovery Hospitals; Freestanding Acute Psychiatric Hospitals; Physician; or Licensed Prescriber.	1115 waiver
3.7-WM	Medically Managed Inpatient	Severe withdrawal, needs 24-hour nursing care and physician	General Acute Care Hospital; Chemical Dependency Recovery	1115 waiver



ASAM Level of Care	Service	Service Definition	Provider Type	Current Coverage Authority
	Withdrawal Management	visits; unlikely to complete withdrawal management without medical monitoring.	Hospitals; Freestanding Acute Psychiatric Hospitals	
4-WM	Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	General Acute Care Hospital, Chemical Dependency Recovery Hospitals; Freestanding Acute Psychiatric Hospitals	1115 waiver
Other	Physician Consultation	Consultation services to assist DMC clinicians with seeking expert advice on designing treatment plans for DMC-ODS beneficiaries.	DHCS Certified Physicians consulting with Addiction Medicine Physicians, Addiction Psychiatrists, or Clinical Pharmacists.	1115 Waiver
Other	Case Management	Coordination of SUD care, including assisting the beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, and other community services.	DHCS Certified Providers	1115 Waiver
Other	Additional MAT	Ordering, prescribing, administering, and monitoring of all medications for SUDs not covered under the State Plan.	DHCS Certified Providers	1115 Waiver
Other	Recovery Services	Services provided after completing treatment based on self-assessment or provider assessment of relapse.	DHCS Certified Providers	1115 Waiver

Model of Care



The DMC-ODS Program uses a continuum of care modeled after the ASAM Criteria. These criteria, first developed in 1991, are the most widely used set of guidelines for assessing SUD patient needs and are used to create comprehensive, individualized patient treatment plans. The ASAM Criteria provide a matrix for matching severity and level of function with type and intensity of treatment needs.

DMC-ODS Pilot Program counties must require their network providers to implement at least two evidence-based treatment practices per service modality. Currently, the state recognizes the following five evidence-based practices: motivational interviewing, cognitive behavioral therapy, relapse prevention, trauma-informed treatment, and psycho-educational groups. Under the IA, counties must ensure that providers have effectively implemented the required evidence-based practices. The state additionally ensures provider compliance with these standards through its monitoring and review process.

[Proposed Changes to the DMC-ODS Program](#)

The state seeks federal approval for the following technical, no cost changes to the DMC-ODS program as part of this 12-month extension request.

1. Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period

Under current Program rules, a maximum of two non-continuous residential stays may be reimbursed in a one-year period. California proposes to revise this policy to remove the limitation on the number of treatment episodes that can be reimbursed in a one-year period. In accordance with CMS State Medicaid Director Letter #17-0003, California will aim for a statewide average length of stay of 30 days. Counties will adhere to the monitoring requirements set forth by DHCS and the performance measure(s) set by the external quality review organization.

2. Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined

The state seeks to clarify that reimbursement is available for SUD assessment and appropriate treatment before a definitive diagnosis is determined, even if requiring multiple visits. This includes services for beneficiaries under age 21 pursuant to the terms of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Beneficiaries under the age of 21 are entitled to any necessary services needed to treat



conditions that are covered under Medicaid, even if they do not meet criteria for a SUD, including treatment for risky substance use.

3. Clarify the recovery services benefit

California proposes to clarify: (1) the allowable components of recovery services (e.g., individual, group, recovery focused events and activities, alumni groups, education sessions, and assessment); (2) when and how beneficiaries, including justice-involved individuals, may access recovery services; and (3) the availability of recovery services to individuals receiving MAT. This change is requested to clarify the current language, which has been inconsistently interpreted in different counties. In addition, some counties have interpreted that justice-involved patients or patients on opioid maintenance treatments are not eligible for recovery services.

4. Expand access to MAT

California proposes to require counties to mandate that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer, or have effective referral mechanisms to, MAT. The state also seeks to maintain the option for counties to elect to cover additional MAT services, including ordering, prescribing, administering, and monitoring of MAT. Additionally, California proposes to add naltrexone in the Narcotic Treatment Program setting to align with the pending State Plan Amendment and clarify that this benefit can be utilized for all medication assisted treatment not covered under the State Plan.

5. Increase access to SUD treatment for American Indians and Alaska Natives

California has prepared an Information Notice to counties to provide guidance regarding their current obligations pursuant to existing contractual requirements towards Indian Health Care Providers for Tribal and Urban Health Clinics as established in Title 42, Code of Federal Regulations, Section 438.14.

Additionally, the state proposes to take a number of actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.



- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based SUD treatment.

Complimentary State Efforts to Address SUDs

The DMC-ODS Program is one critical element of a larger state strategy for treating and preventing substance use disorders. In addition to piloting the DMC-ODS Program, the state is also implementing two grants from SAMHSA, a State Targeted Response (STR) Grant and State Opioid Response (SOR) Grant, which are designed to expand access to SUD treatment and in particular, MAT.

Through the STR, California received \$89.4 million from FY 2017 to FY 2018 (\$44.7 million in each year) to implement the Hub and Spoke System, piloted in Vermont. The Hub and Spoke System consists of central “Hubs,” which are dedicated SUD treatment programs with expertise in treating SUD and, around them, “Spokes,” or office-based treatment settings that provide ongoing care and maintenance treatment. The California Hub and Spoke System is composed of 18 Hub and Spoke networks and over 200 Spoke locations. California also used its STR funding to establish the Tribal MAT Project, which promotes opioid safety, improves the availability and provision of MAT, and facilitates wider access to naloxone for the Tribal and Urban Indian populations.

In FY 2018 and 2019, California received an SOR grant, totaling \$176 million over two years. The state used this grant to further support the Hub and Spoke System and Tribal MAT Project, and to develop more than 30 new projects to expand access to and the quality of SUD treatment. Many of these projects focused on improving access to and the quality of SUD treatment in SUD-specific treatment programs, clinical settings, and county and state criminal justice systems. A full list of the state’s STR and SOR-funded projects is available [here](#).

California has seen promising outcomes from the STR and SOR projects. So far, more than 22,000 individuals have received treatment for opioid use disorder with MAT. Through the naloxone distribution project, more than 12,000 overdose reversals have been reported. More than 2,000 providers have received training on MAT as a result of the project. In addition, the



project has expanded the number of locations statewide where individuals can access treatment. In addition to traditional MAT settings like opioid treatment programs, provider offices and federally qualified health centers, MAT is now available in hospital emergency rooms and county jails. The STR and SOR grants have provided California the funding to expand access to MAT statewide, while training providers and educating the public about the importance of treatment and recovery. With the extension of the DMC-ODS, California can continue and sustain this important work.

Section 3.4 – Low-Income Pregnant Women

Numerous studies have demonstrated the positive impact on health outcomes for mothers and children of providing pregnant women with medically necessary care, including prenatal care. To expand access to prenatal care for low-income women, the state sought and received authority under the Medi-Cal 2020 waiver to cover pregnant women with incomes from 109 percent up to and including 138 percent of the FPL (including all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL). Eligible pregnant women are required to enroll in a Medi-Cal managed care plan unless they opt to remain with their physician in fee-for-service throughout their pregnancy and postpartum period. In this extension application, the state seeks authority to extend this important coverage initiative to continue to provide necessary health benefits to low-income pregnant women.

Section 3.5 – Out-of-State Former Foster Care Youth

Young adults who have “aged out” of foster care often present with complex medical, behavioral, oral and developmental health problems rooted in a history of childhood trauma and adverse childhood experiences. To ensure access to medically necessary care for such adults, in 2017 California sought to amend the Medi-Cal 2020 waiver to provide Medicaid State Plan coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they “aged out” of foster care at age 18 (or such higher age as elected by the state) and were enrolled in Medicaid at that time. CMS approved the amendment on August 18, 2017, and authority for coverage was effective as of that date. In this extension application, California seeks authority to extend coverage of this population for an additional 12 months and through December 31, 2021.

Section 3.6 – Community-Based Adult Services

Through an amendment to the California Bridge to Reform demonstration approved on March 30, 2012, California established the Community-Based Adult Services (CBAS) Program, which



offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting in order to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CBAS services include an individual assessment; professional nursing services; physical, occupational, and speech therapies; mental health services; personal care; nutritional counseling; and transportation, among others. The CBAS waiver amendment was renewed on November 28, 2014 and is now included in the Medi-Cal 2020 demonstration. The state requests that the authority for the program be extended along with the other elements of the Medi-Cal 2020 demonstration.

Section 3.7 – The Coordinated Care Initiative (including Cal MediConnect)

The Coordinated Care Initiative (CCI) began on April 1, 2014 as part of the CMS Federal Alignment Initiative. The CCI was designed to provide integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community. It has been implemented in seven counties and is comprised of two parts: (1) Cal MediConnect, a Section 1115(a) demonstration project that combines 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; and (2) mandatory Medi-Cal managed care enrollment for dual eligible for all Medi-Cal benefits under the Section 1115 demonstration, including managed long-term services and supports.

The CCI has been an important initiative in providing integrated, coordinated care for elderly and disabled beneficiaries through Medi-Cal managed care. More than 107,000 dually eligible Californians are enrolled in Cal MediConnect and have access to the care coordination and enhanced services provided through CMC and the CCI. A 2018 study showed that 90 percent of CMC enrollees were satisfied with their health coverage and 83 percent of enrollees found the quality of their care to be good or excellent.

The federal authority for CMC has been extended multiple times and is scheduled to expire on December 31, 2022.

Section 3.8 – Dental Transformation Initiative

Under the Dental Transformation Initiative (DTI), the state developed a critical new mechanism for improving oral health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. The state proposes to continue Domains 1-3 of the DTI for an additional 12-months.



Domain 1 has exceeded its annual utilization goals to date, with DHCS earning additional spending authority to apply to DTI efforts. Domain 2 had underperformed prior to expanding to additional, more populous – provider and population – counties. However, since expansion implementation as of January 1, 2019, the number of participating providers has increased significantly.

Domain 3 has also demonstrated success, as there have been large numbers of Medi-Cal children returning to the same dental office, establishing continuity of care, over the duration of the demonstration. The Department anticipates ongoing success in this Domain in future PY reports, and inclusive of expansion county and increased incentive payment data.

Domain 4 was designed to test innovative local dental pilot projects (LDPPs) to support and further the goals of Domains 1 -3. Thirteen LDPP applications have been approved to date. However, the LDPPs have had difficulty meeting the project and reporting goals. It took longer than anticipated to stand up the project, many of which were not operational until mid-late 2018, and the majority have not met self-selected performance metrics. While many LDPPs have emphasized inserting grassroots level knowledge through culturally adept dental personnel, the results have not yet netted a positive return on investment.

The LDPPs faced many unforeseen challenges, many of which are attributed to member and provider behavior that are echoed in surveys conducted by the Department’s independent evaluator. It is for these reasons that Domain 4 will not continue in the waiver extension.

With the additional 12 months for Domains 1-3, the state proposes to use rollover federal funds for Program Year (PY) 6. The state proposes to add the seventh (7th) continuous period under program criteria and performance metrics (*i.e., two (2), three (3), four (4), five (5), six (6) and seven (7) year continuous periods*) for Domain 3.

Section 3.9 – Tribal Uncompensated Care Waiver Amendment (TUCWA)

DHCS is requesting a 1 year extension of the TUCWA. The proposed extension would permit DHCS to continue to make uncompensated care payments for certain optional services previously eliminated from the state plan provided by Indian Health Service (IHS) tribal health programs operating under the authority of Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries. This proposal is similar to the current



section 1115 Waiver amendment approved by the Centers for Medicare and Medicaid Services in 2015. The extension would continue the arrangement for uncompensated care payments to be administered through a contract with the California Rural Indian Health Board, Inc. (CRIHB).

The CRIHB is a tribal organization contracting under the ISDEAA that provides medical assistance as a facility of the IHS through a subcontracting process with seven Tribal health programs. Additionally, the CRIHB serves as the central administrator for the Tribal Medicaid Administrative Activities program through contracts with 11 Tribal health programs and for 20 Tribal health programs participating in the current 1115 TUCWA.

The proposed extension would include a new requirement for CRIHB to contract with any willing Tribal health program enrolled in Medi-Cal. It would provide uncompensated care payments for Medi-Cal optional services eliminated from the state plan using the IHS encounter rate.

Section 3.10 – Rady’s California Children’s Services Pilot

In 2016, Rady Children’s Hospital of San Diego (RCHSD) and its affiliated physicians, in collaboration with the county CCS Program, establish an ACO that is jointly designed, implemented, and managed. The target population for the ACO model includes children with chronic medical conditions, anticipated to last twelve (12) months or more, and whose needs are best met by hospital-based outpatient Special Care Centers. The program is known as California Kids Care. Children and youth residing in the designated geographic service area, who have a CCS medical condition eligible for the ACO and who meet all of the CCS Program eligibility requirements are enrolled into the ACO. Additionally, children and youth who develop a CCS medical condition eligible for the ACO can be referred to the health care organization for care and be enrolled into the ACO. The medical conditions for RCHSD include: Cystic Fibrosis, Hemophilia, Sickle Cell, Acute Lymphoblastic Leukemia; and Diabetes Types I and II (ages 1 – 10 years of age). The program has capacity to serve 600 children in San Diego county.

Section 3.11 – Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a fully integrated Medicare and Medicaid delivery model that coordinates and provides all needed preventive, primary, acute and long-term care services for eligible participants to continue living in the community. There are 22 PACE programs in operation across California. The PACE model of care is designed to provide a comprehensive medical/social service delivery system using an interdisciplinary team



approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. In order for a PACE organizations to operate a third party PACE organization in a COHS county, the PACE organization must seek county board of supervisor, DHCS and CMS approval, as approved through the 1115 waiver. DHCS currently has one PACE organization approved to operate in Humboldt County.

As outlined in the state's pending February 28, 2020 waiver amendment request, a new third party PACE organization is being proposed in Orange County. This amendment is necessary to allow for the enrollment of Medi-Cal beneficiaries in PACE not operated or subcontracted by CalOptima, the Orange County COHS. The amendment will increase beneficiary access to PACE services in Orange County and is supported by CalOptima.

Section 4 – Demonstration Evaluation Results to Date

As required under the terms and conditions of the Medi-Cal 2020 Waiver, California engaged independent research organizations to evaluate the performance of a number of Medi-Cal 2020 programs, including PRIME, WPC, the GPP, DMC-ODS, Out-of-State Former Foster Care youth, SPD, DTI, and CCS. The overall results of these evaluations demonstrate that Medi-Cal 2020 has experienced significant success in achieving its stated aims, including driving delivery system reform, and improving access and quality of care, particularly for high-need beneficiaries.

PRIME and WPC

An interim evaluation of the PRIME Program, conducted by the UCLA Center for Health Policy Research and published in August 2019, found that during the demonstration period, hospitals participating in PRIME achieved advancements in reporting on their quality improvement metrics across the board. In addition, they achieved success in administrative capacity and personnel, electronic health record (EHR) content and functioning, use of tools such as registries and telehealth to manage patients and increase access, coordination with external providers, and synergies with other initiatives and programs that were concurrently implemented, such as WPC.

The state engaged the UCLA Center for Health Policy to conduct an evaluation of the WPC program as well. In an interim evaluation, published in September 2019, the researchers found



that in the two years since the Program’s inception in January 2017, the WPC Pilots had already made progress in improving data sharing infrastructure, including through establishing or obtaining tools to track enrollees, take notes during interactions with enrollees, and record services delivered from anywhere and in real-time. Due to effective outreach, communication, and service delivery, Pilots saw significant growth in WPC enrollment with limited churn and high levels of retention of enrollees. Between January 1, 2017 and December 2018, Pilots collectively enrolled 108,667 unique individuals and experienced limited churn, with nearly half (49 percent) of enrollees staying continuously enrolled and only 7 percent of enrollees enrolling and disenrolling multiple times.

There were positive findings with respect to service delivery as well: all the Pilots provided care coordination and housing services and the researchers found that the services delivered by the Pilots were frequently aligned with the needs of the target population. To deliver care coordination, the Pilots had successfully formed care coordination teams, standardized protocols to foster consistency in care coordination activities, and at times, incorporated financial incentives to promote a high level of performance from external partners. Most importantly, the researchers found that the services the Pilots delivered were positively impacting care for enrollees, as evidenced by improved rates of follow-up after hospitalization for mental illness, initiation and engagement in alcohol and SUD treatment, timely provision of comprehensive care plans, and use of suicide risk assessments.

The positive results from the PRIME and WPC interim evaluations suggest that providing the core benefits of PRIME and WPC—including intensive care coordination, case management, and linkage to social supports—on a statewide basis through integration on the enhanced care management and in lieu of services benefits into the managed care delivery system, as the State proposes under CalAIM, is likely to improve care and health outcomes for beneficiaries, particularly those with complex physical, behavioral, and social needs.

GPP Evaluation

As required under California’s Medi-Cal 2020 Demonstration, DHCS engaged an independent evaluator (the Rand Corporation) to conduct a midpoint and final evaluation of the GPP in accordance with the CMS-approved evaluation plan. In addition, the state has successfully produced the required [Uncompensated Care Reports](#) as specified in the Medi-Cal 2020 STCs.



In its final evaluation report, released in 2019, the Rand Corporation found that the GPP has been successful in incentivizing a shift toward more value-based cost-effective care for the uninsured.

Key findings include:

- *Improvements in infrastructure.* Since the commencement of the GPP, PHCSs reported implementing a range of the Program’s designated improvement strategies to enhance their system infrastructures to achieve Program goals. All 49 health system improvement strategies were used by at least one PHCS and most PHCSs implemented at least one improvement strategy from each of the seven domains. The report noted that the GPP’s quarterly payment schedule has provided greater predictability for PHCSs, enabling the delivery system and infrastructure investments the researchers observed.
- *Shift toward high-value care.* Trends in utilization show that over the demonstration, PHCSs shifted care from inpatient medical and surgical services and emergency room visits toward outpatient non-emergent services. For non-behavioral health services, there was an increase in points earned for outpatient non-emergent services overall (12% increase) and for nine of the twelve PHCSs individually. There was a concomitant decrease in points earned for both inpatient medical and surgical services (15% decrease overall and for seven of the twelve PHCSs individually) and emergency room visits (14% decrease overall and for eight of the twelve PHCSs individually). The researchers found unexpected changes in utilization of behavioral health services—specifically a 4% decrease in outpatient mental health and SUD treatment services and a 21% increase in inpatient behavioral health—but also a favorable decrease of 14% in the use of mental health emergency room and crisis stabilization services.
- *Increases in care for the uninsured.* There was a more than six-percent increase in the number of uninsured patients served by the PHCSs, suggesting that the GPP is increasing access to care for the uninsured.
- *PHCSs report progress.* The PHCSs reported that their participation in the GPP has led to improvements in patient experience, care coordination, tailoring of patient care to the clinically appropriate setting, and wise allocation of resources. In addition, PHCS leaders were consistent in reporting a moderate to substantial association between strategy use and the third assessed outcome, “now being a part of your overall culture,” across six of the seven health strategy domains.



Overall, the researchers found that the GPP is a promising and sustainable program that has been effective in promoting value-based cost-effective care for the uninsured in California.

DMC-ODS Evaluation

As required under California's Medi-Cal 2020 demonstration, DHCS also engaged the UCLA Center for Health Policy to assess the DMC-ODS Program in accordance with the CMS-approved evaluation plan. The evaluation report was issued on September 16, 2019 based on data collected in 2018 and early 2019, with earlier periods used for comparison purposes where available.

In the report, the UCLA researchers find that the DMC-ODS Program has increased access to and improved the quality of SUD treatment services in implementing counties and in Calendar Year 2018, more than 107,000 patients accessed DMC-ODS services. In the first five months after counties launched their DMC-ODS programs, the number of patients accessing DMC-ODS services increased on average by 20 percent (after standardizing by county implementation date). More than 80 percent of county administrators reported the DMC-ODS waiver increased access to SUD services in their county. The change in the number of patients accessing services varied by county and while some counties showed little change, 12 of the 19 counties included in the UCLA evaluation had clear increases—doubling the number of patients accessing services in one county.

With respect to quality, DMC-ODS patients rated the quality of services as high and county administrators reported that implementing the evidence-based criteria associated with DMC-ODS was getting easier over time and that the DMC-ODS had positively impacted quality improvement efforts. The researchers found that most patients (84.7 percent) were referred to the level of care indicated by their ASAM criteria screenings or assessments, and most of the referred patients (72.3 percent) went on to receive treatment at the providers to which they were referred within 30 days of their initial screening or assessment. Both providers (78.2 percent) and patients (87.2 percent) suggested that patients participated in the development of their treatment plans and goals, indicating that the Program is achieving its goal of providing patient-centered care.

County administrators reported that the DMC-ODS Program has improved collaboration and communication across the physical, mental health, and SUD treatment systems. That said, their survey responses indicated that integration was occurring only "somewhat well," indicating an opportunity for further progress in this area. DHCS expects that during the next demonstration



period, county programs will continue to build on the progress they made in cross-system integration during the expiring waiver period. As described in Section 7 below, DHCS has developed a robust plan for monitoring performance in this area and will continue to support county pilots in their efforts to increase cost-system collaboration.

In addition to cross-system integration, the report identified a number of areas to target for improvement going forward including continuing to increase the pool of qualified SUD treatment providers, addressing provider difficulties in billing and receiving payment for prescribing MAT, and expanding youth treatment and withdrawal management services. As part of CalAIM, DHCS has developed a strategy for driving improvements in these areas that will include:

- The provision of additional billing guidance to providers, including guidance related to billing for MAT services;
- Minor fixes to the program, described above (and proposed to be amended in the year-long waiver extension period);
- New initiatives designed to expand youth treatment and withdrawal management services; and
- Broad system reforms, including payment reform, streamlining medical necessity criteria and behavioral health integration for specialty mental health and substance use disorder treatment.

DTI Evaluation

As required under California's Medi-Cal 2020 Demonstration, DHCS engaged an independent evaluator (Mathematica) to conduct a midpoint and final evaluation of the DTI in accordance with the CMS-approved evaluation plan. Due to unanticipated delays, the Mathematica contract was executed August 2018 instead of late 2017. The scope of the evaluation centered around conducting qualitative interviews as well as collecting DHCS provided survey data from Medi-Cal dental providers, beneficiaries, and stakeholders, as well as providing impact analyses on program metrics.

Mathematica submitted its interim report in September 2019 which was published in January 2020. It contained interviews conducted with stakeholders in Spring 2019 as well as DHCS datasets covering January 2017 – June 2019. Data findings were incomplete due to the expansion of Domain 2 and Domain 3 to additional pilot counties effective January 1, 2019, and the timing of the report. The final evaluation report will include findings from Mathematica's



analysis of Medi-Cal administrative data on trends in utilization of prevention services among the target population, forming a multivariate analysis on the impacts of DTI on Domain 1-3 outcomes. Some of the preliminary findings are:

- Domain 1, a statewide initiative, had 12 counties where no payments were made in Program Year (PY) 2. There were two counties where payments were less than \$2,000.
- Domain 2 had lower than anticipated provider participation, with 163 total opt-in providers with the majority of providers operating in three counties.
- Domain 3 had 70 percent of dental offices earning incentive payments for approximately 260,000 beneficiaries.

The second part of the interim evaluation component involved obtaining perceptions and experiences of stakeholders and providers, which yielded mixed results. Mathematica was challenged with locating participating providers for the survey despite a DHCS sponsored letter and managed to secure only 10 providers of the desired 47 during the data collection timeframe. Researchers used standardized interview protocols that were primarily open-ended questions, specifically tailored for the varied roles within the dental space such as providers, provider associations, the state, Dental Managed Care plans, and other stakeholders.

The feedback was varied, with some of the constructive feedback echoing past sentiments such as low reimbursement rates, administrative burdens, and lack of cultural education on oral health as well as socioeconomic factors. The encouraging feedback cited parallel initiatives such as various incentive payment programs that supplement base payments and encourage provider enrollment as well as Smile, California and Local Oral Health Programs. Furthermore, stakeholders appreciated the focused approach on children's preventive services, citing how mandatory procedures for specific domains such as nutritional and motivational counseling was critical to change behaviors.

As an overall policy, Mathematica noted that stakeholders interviewed during the period leading up to the interim report viewed DTI as a promising valued-based model, however, cited areas needing improvement including expanding focused statewide outreach and program administration. Stakeholders voiced that the state could benefit from partnering with medical providers and other organizations to help with outreach efforts as well having targeted outreach to families, specifically pregnant women, to immediately foster parent/child awareness. Stakeholders also voiced concerns regarding administrative burdens associated with provider enrollment applications and treatment authorization request requirements.



While the evaluation work to date was completed before the increased utilization that occurred as a result of the expansion, Mathematica’s final evaluation report will provide a thorough analysis on all-encompassing DTI data, and will identify innovative approaches to oral health care delivery. .

Other Evaluations

Because the many waiver programs included in California’s 1115 demonstration have different timeframes, structures, and funding streams, the evaluation designs and timelines for the programs also vary. There are a number of programs for which the Interim Evaluation Reports have been provided, but the majority are still in the evaluation design phase, so the ability to identify and synthesize outcomes and results is limited. All of the state’s evaluation materials are available on the [DHCS website](#).

Section 5 – Medi-Cal 2020 Demonstration Extension Evaluation

The state proposes to continue its current evaluation of the Medi-Cal 2020 1115 waiver demonstration into the 12-month extension period and extend the deadline for the final evaluation to December 31, 2022. This includes the ongoing evaluations for all program components, including DMC-ODS. Adjustments will be made to the DMC-ODS evaluation design to comport with more recent CMS guidance released after California’s evaluation design was complete at the conclusion of the extension period. The state is not requesting to extend the evaluation period for Seniors and Persons with Disabilities (SPD) or PRIME, as those programs are being discontinued.

Section 6 – Demonstration Financing and Budget Neutrality

Whole Person Care Pilot Funding

In order to sustain the WPC program at current levels, \$300 million in federal matching funds would be needed for the 12 month extension period. DHCS requests the authority to retain the right to distribute rollover funds among the pilots for an additional 12 months.

GPP Funding

The state’s existing DSH funding for PHCS is allocated to make payments to participating PHCS that incur costs for services to the remaining uninsured. During the additional GPP PY, the state is requesting that FFP be available for such GPP payment expenditures up to the amount



equal to the state’s entire DSH allotment as set forth in section 1923(f) of the Act and adjusted as described in subparagraphs (a) and (b) below (“Adjusted DSH”). In order to align DSH amounts with each SFY, the state’s DSH allotment for the federal fiscal year that commences in the SFY will be used.

(a) A portion of California’s DSH allotment shall be set aside for those California DSH facilities that do not participate in the GPP. The methodology for the set aside is identified in Attachment NN (DSH Coordination Methodology).

(b) If reductions to California’s DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to GPP in the additional PY shall be reduced consistent with CMS guidelines.

The total computable annual limits for GPP PYs 6B & 6C payments will not exceed the limit set forth below:

- GPP PY 6B (CY 2021) – Adjusted DSH = approximately \$2.5 billion

GPP Budget Neutrality

GPP is currently funded by the Adjusted DSH methodology and uncompensated care Safety Net Care Pool funding outlined in Attachment NN and STC 170. DHCS is proposing to continue to fund GPP in the extension with using the Adjusted DSH methodology and uncompensated care Safety Net Care Pool funding. To maintain budget neutrality, the state will not make DSH payments to hospitals authorized to participate in the GPP.

DMC-ODS Financing Structure

Financing for the DMC-ODS Program is currently governed by a certified public expenditure (CPE) protocol approved under California’s Medi-Cal 2020 waiver.

DTI Continuation

The state is requesting an extension of the Designated State Health Programs (DSHP) authority in order to continue operation of the Dental Transformation Initiative for an additional 12 months.

Budget Neutrality Calculation



The current budget neutrality reporting requirements and eligibility groups for reporting are defined in STC 182 and rules around budget neutrality reporting, including categories that are not subject to the budget neutrality cap are contained within STCs 183-193. The budget neutrality calculation is defined in STCs 194-203 and Attachment K.

DHCS is proposing to continue to exempt the current categories that are not subject to the budget neutrality calculation as stated as hypothetical populations in STCs 182, 183, and 197. This includes, CBAS, the new adult group, DMC-ODS, Health Homes, and Out-of-State Former Foster Youth. DHCS also seeks to continue the removal of the Private Hospital Directed Payment and Hospital Quality Assurance Fee pass-through from the budget neutrality calculation.

DHCS is proposing to continue the growth trends in the without waiver calculation stated in STC 197(a)(v.) for purposes of the budget neutrality calculation and continuing the Limit B Total Computable IP Unspent Public Hospital amount of \$863,054,068 defined in STC 197(b) for an additional year. DHCS also proposes to freeze the savings phase-out percentages at the levels they were in DY 5 stated in STC 197(f) and the authority to rollover any unspent allocation from WPC, GPP, DTI/DSHP, and IHS uncompensated care from DYs 1-5 to the extension year.

DHCS also requests additional changes to the budget neutrality calculation for the extension period. DHCS requests not to be subject to the Duals Demo Savings reduction defined in STC 198. DHCS also requests to be able to remove expenditures from DY 1-5 and continue in the extension year related to costs for managed care directed payments that were not included in the original 1115 Waiver STCs since they were not established until after waiver approval and these expenditures are captured in the with waiver budget neutrality calculation. This will allow directed payments to be treated as pass-throughs and not subject to budget neutrality.

Finally, the state projects that the overall budget impact of this 12-month waiver demonstration extension will not be significant to the federal government. The state is implementing a pharmacy benefit carve-out that is expected to result in a net decrease in managed care expenditures due to intended changes to the capitated benefits schedule for Medi-Cal managed care. The projected savings is estimated to be \$5.5 to \$6 billion due to the pharmacy benefit carve-out, clearly offsetting any additional funding provided to sustain the Whole Person Care pilots, the DMC-ODS, and the GPP/SNCP and the Dental Transformation Initiative. In addition, while the PRIME activities that are currently funded under Medi-Cal 2020 are transitioning to the QIP authority, the dedicated funds for these activities are also offset by the pharmacy benefit carve-out. In sum, we expect federal expenditures to decrease, rather than increase, during the course of the 12-month extension period.

Section 7 – List of Proposed Waivers and Expenditure Authorities



For the duration of the proposed one-year extension, DHCS intends to maintain the relevant waiver and expenditure authorities approved under the Med-Cal 2020 demonstration (last updated December 22, 2017), as described below. Please note that the expenditure authority for the PRIME program has been removed based on the proposed changes described herein, effective July 1, 2020.

Waiver Authorities

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act), the following waivers shall enable California to continue operating the Medi-Cal 2020 demonstration through December 31, 2021.

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

To enable the State to require participants to receive benefits through certain providers and to permit the State to require that individuals receive benefits through managed care providers who could not otherwise be required to enroll in managed care.

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

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

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

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

3. Statewideness – Section 1902(a)(1)

To enable the State to operate the demonstration on a county-by-county basis and to provide managed care plans only in certain geographic areas.

To enable the State to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services to individuals on a geographically limited basis.



To enable the State to authorize Whole Person Care (WPC) pilots and to provide WPC services to individuals on a geographically limited basis.

To enable the State to authorize Dental Transformation Incentive (DTI) program pilots and to provide DTI services to individuals on a geographically limited basis.

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

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

To enable the State to authorize WPC pilots which may make available certain services, supports or interventions to certain high-risk, vulnerable populations targeted under an approved WPC pilot program that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to provide certain services, supports and other interventions to eligible individuals with substance use disorders under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group.

To enable the State to provide certain services, supports and other interventions to eligible individuals under the DTI program that are not otherwise available to all beneficiaries in the same eligibility group.

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by California for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the State's title XIX plan. The expenditure authority period of this demonstration extension is from the effective date identified in the extension approval letter through December 31, 2021.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:



- Expenditure authorities 1, 2, 3, and 4 promote the objectives of title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the State.
- Expenditure authorities 1 and 4 promote the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks to support better integration, improved health outcomes, and increased access to health care services.
- Expenditure authorities 3, 4, 5, 6, 7, and 8 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the State.

The following expenditure authorities shall enable California to implement the one-year extension of the Medi-Cal 2020 Demonstration. All Medicaid requirements apply to expenditure authority 4, 5, 6, and 7 (except as inconsistent with those authorities or except as provided herein or as set forth in the extension STCs).

1. Global Payment Program for Public Health Care Systems.

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

2. Designated State Health Care Programs (DSHP).

Expenditures for costs of designated programs which are otherwise state-funded, subject to the terms and limitations set forth in the STCs for the following programs:

- AIDS Drug Assistance Program (ADAP)
- Breast & Cervical Cancer Treatment Program (BCCTP)
- California Children Services (CCS)
- Department of Developmental Services (DDS)
- Genetically Handicapped Persons Program (GHPP)
- Medically Indigent Adult Long Term Care (MIA-LTC)
- Prostate Cancer Treatment Program (PCTP)
- Song Brown Health Care Workforce Training
- Mental Health Loan Assumption Program (MHLAP)
- Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)



3. Uncompensated Care for Indian Health Service (IHS) and tribal facilities.

Expenditures for supplemental payments to support participating IHS and tribal facilities that incur uncompensated care costs associated with services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by these providers to individuals enrolled in the Medi-Cal program.

4. Delivery System Transformation and Alignment Payments.

Expenditures for the following payments for Delivery System Transformation and Alignment.

- A. **Whole Person Care (WPC) Pilots.** Expenditures for payments to entities operating an approved WPC pilot program. Such expenditures may include payments for services, supports, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such services, supports, infrastructure and interventions are authorized as part of an approved WPC pilot program.
- B. **Dental Transformation Incentive Program.** Expenditures for incentive payments to eligible dental providers that achieve dental transformation objectives set forth in the STCs.

5. Expenditures Related to Community Based Adult Services (CBAS).

Expenditures for CBAS services furnished to individuals who meet the level of care or other qualifying criteria.

6. Expenditures Related to Low Income Pregnant Women.

Expenditures to provide post-partum benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the Federal Poverty Level (FPL), that includes all benefits that would otherwise be covered for women with incomes below 109 percent of the FPL.

7. Expenditures Related to the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Expenditures for services not otherwise covered that are furnished to otherwise eligible individuals who are DMC-ODS beneficiaries, including services for individuals who are short-term residents in facilities that meet the definition of an Institution for Mental Disease. These facilities include, but are not limited to, Free Standing Psychiatric treatment centers, Chemical Dependency Recovery Hospitals, and DHCS licensed residential facilities for residential treatment, and withdrawal management services.

8. Expenditures Related to Out-of-State Foster Care Youth.



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



Section 8 – Stakeholder Engagement and Public Notice

[PLACEHOLDER FOR SUMMARY OF PUBLIC COMMENTS]