



CalAIM: California Advancing and Innovating Medi-Cal

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CaAIM

- Overview and Goals
- Review of CaAIM Proposals
- From Medi-Cal 2020 to CaAIM: A Crosswalk
- Advancing Key Priorities
- Stakeholder Engagement



CaAIM Overview

DHCS has developed a comprehensive and ambitious framework for the upcoming waiver renewals that encompasses a broader delivery system, and program and payment reform across the Medi-Cal program, called CaAIM: California Advancing and Innovating Medi-Cal.

Includes initiatives and reforms for:

- Medi-Cal Managed Care
- Behavioral Health
- Dental
- Other County Programs and Services



CaAIM Overview

- Medi-Cal has significantly expanded and changed over the last ten years
- Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems
- As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care.



CaAIM Overview

- Offers solutions to reinforce the stability of the Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded.
- Seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life.



CaAIM Overview

Advances several key priorities of the Newsom Administration by leveraging Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as:

- homelessness,
- increasing behavioral health care access,
- children with complex medical conditions,
- growing number of justice-involved populations who have significant clinical needs, and
- growing aging population.



CaAIM Overview

The CaAIM package presented here is an initial set of proposals intended to drive discussion and consideration through proposed stakeholder workgroups as well as the legislative process.

Funding for CaAIM will be determined through the budgetary process which will affect which reforms proceed as well as the timeline and scope of such reforms.



CaAIM Goals

CaAIM has three primary goals:

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



High Level Overview of CalAIM Proposals with Detail on BH Specific Proposals



Identify and Manage Member Risk and Need

The following proposals fall under this goal as well as incorporate the third goal of improved quality outcomes:

- Population Health Management
- Enhanced Care Management
- Mandatory Medi-Cal Application & Behavioral Health Coordination
- In Lieu of Services and Incentives
- Mental Health IMD Waiver (SMI/SED)
- Full Integration Plans
- Long-Term Plan for Foster Care



Population Health Management

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

The plan shall include, at a minimum, a description of how it will:

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



Enhanced Care Management

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



Enhanced Care Management

DHCS is proposing statewide implementation of the enhanced care management benefit on January 1, 2021 for most mandated target populations and January 1, 2023 for individuals transitioning from incarceration.

Administered by the Medi-Cal managed care plan which will have direct responsibility for establishing model of care and contracting with public and private providers.



Mandatory Medi-Cal Application & Behavioral Health Coordination

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



In Lieu of Services

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



Incentive Payments

- DHCS is proposing to establish plan incentive payments linked to delivery system transformation through an investment in enhanced care management and in lieu of services infrastructure.
- The incentive payments would also be based on quality and performance improvements and reporting in areas such as care coordination, long-term services and supports and other cross-delivery system metrics.
- The purpose of incentive payments is to drive change all the way down to the provider level
- Medi-Cal managed care plans would need to partner and share the incentive dollars with providers in the community, including our critical safety net systems such as Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital systems, and county behavioral health systems and providers



Mental Health IMD SMI/SED Waiver

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

Allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease.

Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries.



IMD SMI/SED Waiver

DHCS would like to collaboratively assess through the stakeholder process whether California should pursue this serious mental illness/serious emotional disturbance via a Section 1115 demonstration.

Similar to the State's existing 1115 demonstration to provide residential and other substance use disorder treatment services under Medi-Cal, county participation would be on an opt-in basis.



IMD SMI/SED Waiver

Below is a summary of key requirements that may pose feasibility challenges:

- Average Length of Stay
- Maintenance of Effort
- Readiness Requirements
- Data Collection and Required Measures
- Health Information Technology
- Staffing Considerations

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



Full Integration Plans

- Currently, Medi-Cal beneficiaries must navigate multiple complex delivery systems in order to meet all of their health care needs.
- This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries.



Full Integration Plans

- DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity.
- Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around:
 - eligibility criteria for entities,
 - administrative requirements across delivery systems,
 - provider network requirements,
 - quality and reporting requirements, and
 - complex financial considerations including current sources of non-federal share, county/state financing and realignment/Prop 30
- Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024.



Long Term Plan for Foster Care

- DHCS proposes convening a workgroup, in 2020, of interested stakeholders to consider whether a different model of care should be implemented for children and youth in foster care, including the former foster youth program and transitions out of foster programs and services at age 26.
- DHCS would invite and encourage participation from key partners including but not limited to: the Department of Social Services; the Department of Education; child welfare county representatives and State level associations; Medi-Cal managed care plans; behavioral health managed care plans; juvenile justice and probation; foster care consumer advocates; regional centers; and judicial entities involved with matters pertaining to children who are placed into the foster care system.
- The goal of the workgroup would be to develop one or more recommendations regarding changes to the delivery systems and models of care for this population that could then be implemented in order to improve outcomes for this population



Moving Medi-Cal to a Consistent and Seamless System

The following proposals fall under this goal as well as incorporate the third goal of improved quality outcomes:

- Standardize the Managed Care Benefit
- Standardize Managed Care Enrollment
- Transition to Statewide MLTSS
- Annual Medi-Cal Health Plan Open Enrollment
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Rates for Medi-Cal Managed Care
- Behavioral Health Proposals
 - Payment Reform
 - Revisions to Medical Necessity
 - Administrative Integration Statewide
 - Regional Contracting
 - SUD Managed Care Renewal (DMC-ODS)
- Future of Dental Transformation Initiative Reforms
- Enhancing County Oversight and Monitoring
- Improving Beneficiary Contact and Demographic Information



Standardize Managed Care Benefit and Populations

- Currently Medi-Cal beneficiaries experience differences regarding which services are provided through and which populations are serviced via the Medi-Cal managed care plan vs fee-for-service or another delivery system, depending on their county of residence
- CalAIM proposes to standardize the benefits that are provided through Medi-Cal managed care plans statewide, effective January 1, 2021
- CalAIM also proposes to standardize the populations enrolled in Medi-Cal managed care plans statewide:
 - Non-Dual populations will be standardized January 1, 2021
 - Dual populations will be standardized January 1, 2023



Behavioral Health Payment Reform

- As a part of CalAIM, DHCS proposes to reform the Medi-Cal behavioral health payment methodologies via a multi-phased approach
- A change is required in order to allow for the possibility to incentivize outcomes and quality as well as potential to increase reimbursement
- The first step in payment reform would be to shift away from the cost-based Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county non-federal share.



Behavioral Health Payment Reform

DHCS proposes to implement the shift in methodology in two initial phases:

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



Behavioral Health Payment Reform

The shift from Certified Public Expenditure to other methodologies will allow DHCS, in collaboration with county partners, to:

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



Behavioral Health Payment Reform

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



Revisions to Behavioral Health Medical Necessity

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

- Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.
- Allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.



Revisions to Behavioral Health Medical Necessity

- Identify an existing or develop a new statewide, standardized level of care assessment tool – one for beneficiaries 21 and under and one for beneficiaries over 21 – that would be used by all entities to determine a beneficiary’s need for mental health services and which delivery system is most appropriate to cover and provide treatment.
- Revise the existing intervention criteria to clarify that specialty mental health services are to be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are medically necessary and provided in accordance with the Medi-Cal State Plan instead of the existing state service criteria.
- Align with federal requirements by allowing a physician’s certification/recertification to document a beneficiary’s need for acute psychiatric hospital services.
- Other technical corrections.



Revisions to Behavioral Health Medical Necessity

- As a part of this change, CalAIM proposes that eligibility criteria, largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which someone should receive services.
- Each delivery system would then provide services in accordance with an individualized beneficiary plan, as recommended by a physician or other licensed mental health professional.



Revisions to Behavioral Health Medical Necessity

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



Administrative Behavioral Health Integration Statewide

- DHCS is proposing administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program.
- The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care.
- An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the State.
- The result would be, by 2026, a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder treatment services for all Medi-Cal beneficiaries in that county or region.
- Substance use disorder fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.



Administrative Behavioral Health Integration Statewide

Clinical Integration

- Access Line
- Intake, Screening and Referrals
- Assessment
- Treatment Planning
- Beneficiary Informing Materials

Administrative Functions

- Contract
- Data Sharing/Privacy Concerns
- Electronic Health Record Integration
- Cultural Competence Plans

DHCS Oversight Functions

- Quality Improvement
- External Quality Review Organization
- Compliance Reviews
- Network Adequacy
- Licensing and Certification



Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations and encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries.

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



Substance Use Disorder Managed Care Renewal

- The 30 counties that have implemented the substance use disorder managed care program (also known as DMC-ODS) have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with substance use disorder treatment needs.
- Implementation has yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.
- However, for many counties, the substance use disorder managed care model of care is still very new or hasn't been able to be implemented.



Substance Use Disorder Managed Care Renewal

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

- Residential treatment length-of-stay requirements
- Residential treatment definition
- Recovery services
- Additional medication assisted treatment
- Physician consultation services
- Evidence-based practice requirements
- Provider appeals process
- Tribal services
- Treatment after incarceration
- Billing for services prior to diagnosis



Improving Beneficiary Contact and Demographic Information

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



From Medi-Cal 2020 to CalAIM: A Crosswalk



From Medi-Cal 2020 to CalAIM: A Crosswalk

The State is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for States interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years.

- The federal government no longer considers the “savings” generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers.
- CMS, in recent guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

The following slides outline the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements.



From Medi-Cal 2020 to CalAIM: A Crosswalk

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Timeline
Medi-Cal Managed Care	Transition to new 1915(b) waiver.	January 1, 2021
Whole Person Care Pilots	Transition to new 1915(b) waiver.	January 1, 2021
PRIME	Transition to managed care directed payment under the Quality Incentive Program (QIP).	QIP 2.0 – July 1 – December 31, 2020 QIP 3.0 – January 1, 2021
Health Homes Program	Transition to new 1915(b) waiver.	January 1, 2021
Coordinated Care Initiative and Cal MediConnect	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	1915(b)/1115A to continue current CCI program with end date of December 31, 2022 January 2021 - Carve out MSSPs; LTC carved in January 2023 – full transition all duals into managed care statewide; all Medi-Cal managed care plans to operate DSNPs



From Medi-Cal 2020 to CalAIM: A Crosswalk

Medi-Cal 2020 Waiver Component	Planned for CalAIM	Timeline
Global Payment Program	1115 waiver renewal.	GPP program year ends June 30, 2020; renewal request to begin GPP extension on July 1, 2020.
Drug Medi-Cal Organized Delivery System (DMC-ODS)	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	Implementation continues; transition to 1915(b) waiver in January 2021
Dental Transformation Initiative	Transition authority to Medi-Cal State Plan.	January 1, 2021
Community-Based Adult Services (CBAS)	Transition to new 1915(b) waiver.	January 1, 2021
1115 Eligibility and Population Authorities	1115 waiver renewal.	January 1, 2021
Rady CCS Pilot	Not included.	Pilot expires on December 31, 2020
Designated State Health Programs (DSHP)	Not included.	Expires December 31, 2020
Tribal Uncompensated Care	Not included.	Expires December 31, 2020



Advancing Key Priorities



Advancing Key Priorities

CalAIM aligns with and advances several key priorities of the Newsom Administration.

At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings.

CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care, and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission

The following slides provide an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed



Advancing Key Priorities

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



Advancing Key Priorities

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



Advancing Key Priorities

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



Advancing Key Priorities

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



Advancing Key Priorities

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



Advancing Key Priorities

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



Advancing Key Priorities

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



Stakeholder Engagement



Stakeholder Engagement

Throughout 2019 and 2020, DHCS will conduct extensive stakeholder engagement for both CalAIM and the renewal of the 1115 and 1915b waiver(s).

DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.



Stakeholder Engagement

DHCS is undertaking a robust CalAIM workgroup process that will cover key issue areas:

- Requiring Medi-Cal managed care plans to submit **Population Health Management** strategies and moving to annual Medi-Cal managed care plan open enrollment
- Adding a new **Enhanced Care Management** benefit and a set of **In Lieu of Services**
- **Behavioral Health** payment reform and delivery system transformation
- Requiring **National Committee on Quality Assurance (NCQA) accreditation** for Medi-Cal managed care plans
- Considerations for creation of **Full Integration Plans** where one entity would be responsible for the physical, behavioral and oral health needs of their members



CalAIM Workgroups

Each CalAIM workgroup will be open to the public, so DHCS encourages interested parties to attend and/or submit written comments. Workgroup schedules, agendas, materials, and other CalAIM updates will be made available on the [CalAIM webpage](#).

DHCS will also use the Stakeholder Advisory Committee (SAC) and Behavioral Health SAC to provide critical updates on the CalAIM initiatives on an ongoing basis. While most aspects of CalAIM will be discussed through workgroups, it will not be possible to cover all of the topics for which we have CalAIM proposals. Updates on those proposals that are not presented in the workgroups will be provided during SAC and BH-SAC meetings in early 2020.



Stay Informed

Please [subscribe](#) to DHCS' stakeholder email service to receive CalAIM updates.

Listen-in on all workgroup meetings and attend the SAC and BH-SAC meetings.

For any other comments, questions, or concerns, please contact CalAIM@dhcs.ca.gov.



Committee Discussion

