State of California
Department of Health Care Services

Medicaid Section 1115 Demonstration
Five-Year Renewal and Amendment Request:
CalAIM Demonstration

DRAFT FOR PUBLIC COMMENT
April 2021

Table of Contents

Section 1 – Introduction

The California Department of Health Care Services (DHCS) is requesting a five-year renewal of components of the Medi-Cal 2020 Section 1115 demonstration, which is scheduled to expire on December 31, 2021, along with new authorities to continue advancing the State's goal of improving health outcomes for Medicaid and other low-income populations in the State under the California Advancing & Innovating Medi-Cal (CalAIM) initiative. This five-year Section 1115 demonstration amendment and renewal will rename California's Medi-Cal 2020 demonstration as the CalAIM demonstration.

DHCS also will request a renewal and amendment to expand its Section 1915(b) waiver, which will further integrate California's Medi-Cal managed care system. The State's Specialty Mental Health Services (SMHS) program is already authorized under a 1915(b) waiver. California is proposing to transition Medi-Cal managed care delivery systems from Section 1115 demonstration authority to 1915(b) waiver authority; these systems are Medi-Cal managed care, dental managed care, and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The consolidated 1915(b) waiver will be the primary authority that the State uses to authorize its managed care delivery system, including core components of the CalAIM initiative. This transition will streamline California's managed care programs, while continuing key Section 1115 demonstration initiatives, in order to meet the physical, behavioral, developmental, long term services and supports (LTSS), oral health, and health-related social needs of all Medi-Cal beneficiaries in an integrated, patient-centered, whole person fashion.

Collectively, the Section 1115 CalAIM demonstration and consolidated 1915(b) waiver, along with related contractual and State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high-need, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the state. CalAIM recognizes the opportunity to adopt California's whole person care approach—first authorized by the Medi-Cal 2020 demonstration—statewide, with a clear focus on improving health and reducing health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the State to take a population health, person-centered approach to providing services, with the goal of improving health outcomes for Medicaid and other low-income populations.

CalAIM implementation was originally scheduled to begin in January 2021 but was delayed due to the impact of the COVID-19 public health emergency. The Centers for Medicare & Medicaid Services (CMS) granted the State's request for a temporary extension, extending most components of the Medi-Cal 2020 demonstration through December 31, 2021. DHCS is proposing a new CalAIM start date of January 1, 2022. Other elements of the CalAIM initiative do not require federal approval and will be implemented by the State. Additional information is available at https://www.dhcs.ca.gov/calaim.

CalAIM Goals and Guiding Principles

The CalAIM framework encompasses broad delivery system, program, and payment reform across the Medi-Cal program. It advances several key priorities of Governor Newsom's administration by more fully addressing the complex challenges facing California's most vulnerable residents, such as the growing number of justice-involved populations who have significant clinical needs, the growing aging population, and individuals experiencing and at risk of experiencing homelessness. CalAIM has three primary goals:

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

Currently, depending on their needs, some Medi-Cal beneficiaries may have to access six or more separate delivery systems to get the care they need (e.g., managed care for physical health needs, fee for service, specialty mental health, substance use disorder (SUD), dental, developmental, In Home Supportive Services (IHSS)). As one would expect, the risk of service gaps and the need for care coordination increases with greater system fragmentation, clinical complexity, deeper social needs, and/or decreased patient capacity for coordinating their own care. In order to meet the physical, behavioral, developmental, and oral health needs of all members in an integrated, patient-centered, whole person fashion, DHCS is seeking to—over time—integrate delivery systems and align funding, data reporting, quality, and infrastructure to mobilize, incentivize, and support care delivery toward common goals. Transitioning Medi-Cal's managed care programs to a single, consolidated 1915(b) waiver, while continuing key 1115 demonstration initiatives, is an important step forward along this path.

Through CalAIM, DHCS seeks to advance the coordination and delivery of quality care for all Medi-Cal beneficiaries. A key feature of CalAIM that builds off the success of the Medi-Cal 2020 Whole Person Care (WPC) pilots and the State's Health Homes Program (HHP) is the introduction of Enhanced Care Management (ECM) statewide, as well as a new menu of in lieu of services (ILOS), which, at the option of a Medi-Cal Managed Care Plan (MCP) and a member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering both ECM and ILOS by contracting with local, community-based providers. California will leverage MCP contracts to authorize and establish expectations and parameters for these services. In conjunction with the launch of ECM, DHCS plans to sunset the WPC

pilots and the HHP. The populations being served through these two programs will be transitioned to ECM. Together, ECM and ILOS will provide a whole person approach to care—addressing the clinical and nonclinical needs of Medi-Cal beneficiaries—translating the successes of the Medi-Cal 2020 Section 1115 demonstration into the new CalAIM program.

Stakeholder Engagement

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 approximately two dozen workgroup meetings between November 2019 and the end of February 2020, as well as ongoing targeted stakeholder engagements throughout 2020 to review and refine proposal language. Further, in June 2020, DHCS and the California Department of Social Services (CDSS) launched the Foster Care Model of Care Workgroup, and in February 2021, DHCS launched the Managed Long-Term Services and Supports and Duals Integration Workgroup. DHCS will have ongoing stakeholder engagement through these groups, as well as through topic-specific materials posted for feedback, such as documents posted in February 2021 for ECM and ILOS. DHCS will also continue stakeholder discussions regarding various CalAIM topics in the quarterly Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee meetings.

The California Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

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

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

DHCS also is seeking public comment on this Section 1115 CalAIM demonstration proposal.

Five-Year Renewal Request

DHCS is requesting a five-year renewal of some of the waiver and expenditure authorities contained in the Medi-Cal 2020 Section 1115 demonstration as well as certain new authorities to enable the State to complete the transition to the new structure contemplated under CalAIM. New requests include:

- Section 1115 demonstration authority to provide targeted Medi-Cal services to eligible justice-involved populations 30 days pre-release from incarceration. As described in more detail below, this request is designed to ensure continuity of health coverage and care for justice-involved populations who experience disproportionately higher rates of physical and behavioral health diagnoses. These Medi-Cal services include ECM and limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for use post-release into the community.
- Additionally, to continue advancing the State's progress in addressing the complex needs of beneficiaries with SUDs, this renewal requests waivers needed to provide new peer support specialist services, to be authorized in the Medi-Cal State Plan, in Drug Medi-Cal (DMC) counties that opt in to participate. (DHCS also seeks to provide peer support specialist services in DMC-ODS and SMHS counties that opt in to participate. These changes are encompassed in the consolidated 1915(b) waiver.)

The table below provides an overview of the Medi-Cal 2020 Section 1115 demonstration programs that DHCS is requesting to renew, new demonstration proposals, current demonstration initiatives that DHCS is seeking to continue via alternate authority, and Section 1115 demonstration initiatives that have or will sunset. California's negotiations with the federal government and any changes required by State legislation and/or the State budget could lead to refinements in this list as DHCS works with CMS to move the CalAIM initiative forward.

Table 1. Crosswalk of Medi-Cal 2020 Demonstration Initiatives and Requested Cal-AIM Demonstration Initiatives

Initiative	Duration of Authority Requested in Renewal/Alternate Authorities
Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Seeks to Renew	
Global Payment Program (GPP)	January 1, 2022–December 31, 2026
DMC-ODS – Institutions for Mental Disease (IMD) Authority *DHCS is seeking a renewal of Section 1115 expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs receiving DMC-ODS services.*	January 1, 2022–December 31, 2026
Low-Income Pregnant Women (109%–138% of the Federal Poverty Level (FPL))	January 1, 2022–December 31, 2026
Out-of-State Former Foster Care Youth	January 1, 2022–December 31, 2026[1]
Community-Based Adult Services (CBAS)	January 1, 2022–December 31, 2026
DMC-ODS Certified Public Expenditure (CPE) Protocols	January 1, 2022–at least July 1, 2022[2]
Designated State Health Care Programs (DSHP)	January 1, 2022–December 31, 2026

[1] Out-of-State Former Foster Care Youth: DHCS seeks authority to continue Medi-Cal coverage for out-of-state former foster care youth during the renewal period, subject to alternative guidance from CMS pursuant to new coverage requirements created by Section 1002 of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (P.L. 115-271), which requires State Plan coverage for out-of-state former foster care youth who attain 18 years of age on or after January 1, 2023.

[2] DMC-ODS CPE Protocols: Beginning no sooner than July 1, 2022, DHCS plans to transition behavioral health financing from CPE-based methodologies to a fee schedule structure to better align payment methodologies across the Medi-Cal delivery systems.

Initiative	Duration of Authority Requested in Renewal/Alternate Authorities
CalAIM Initiatives for Which DHCS Requests New Section 1115 Demonstration Authority	
Peer Support Specialists (Drug Medi-Cal) *Waivers of statewideness and comparability for new Medi-Cal State Plan services in Drug Medi-Cal (DMC) counties that opt in; similar waivers for peer support specialist services for SMHS and the DMC-ODS will be included in the 1915(b) waiver.*	January 1, 2022–December 31, 2026
Services for Justice-Involved Populations 30-Days Pre-Release	January 1, 2023–December 31, 2026
Providing Access and Transforming Health (PATH) Supports	January 1, 2022–December 31, 2026
DMC-ODS Traditional Healers and Natural Helpers	January 1, 2022–December 31, 2026
Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Seeks to Continue Under Alternate Authorities	
Medi-Cal Managed Care[3] and Dental Managed Care	January 1, 2022–December 31, 2026
DMC-ODS *As noted above, DHCS is seeking a renewal of its expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs receiving DMC-ODS services and other programmatic changes described in the 1115 renewal application. The remainder of the DMC-ODS will be transitioned from the 1115 demonstration to the 1915(b) waiver authority and corresponding State Plan Amendments (SPAs).*	January 1, 2022–December 31, 2026

[3] The consolidated 1915(b) waiver will authorize the Medi-Cal managed care delivery system, including the Coordinated Care Initiative (CCI) program and Program of All-Inclusive Care for the Elderly (PACE) as an alternative delivery system in select County-Organized Health Systems (COHSs).

Initiative	Duration of Authority Requested in Renewal/Alternate Authorities
Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Plans to/Has Sunset	
Tribal Uncompensated Care (UCC) *DHCS implemented Tribal Federally Qualified Health Centers (FQHCs), obviating the need for these UCC payments.*	N/A
WPC Pilots and HHP *DHCS seeks to continue the majority of WPC and HHP services under the managed care delivery system via ECM and ILOS.*	N/A N/A
Dental Transformation Initiative (DTI) *DHCS is establishing a new, statewide dental benefit for children and certain adults and expanded pay-for-performance initiatives under the State Plan.*	N/A
Rady California Children's Services (CCS) Pilot	N/A
PRIME *Applicable performance measures were transitioned to, and public hospitals may now qualify to receive managed care directed payments through, the Quality Incentive Program (QIP).*	N/A

Additional details about all these initiatives and authorities are described in this renewal request as follows:

- Section 3 describes the proposed elements of the Section 1115 demonstration renewal request for all initiatives DHCS seeks to continue or newly establish under Section 1115 demonstration authority.
- Section 4 describes the initiatives authorized under the Medi-Cal 2020 demonstration that have been or will be discontinued or will be transitioned to either the consolidated 1915(b) waiver or Medi-Cal State Plan authority.

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

California's Medicaid Section 1115 demonstrations date back to 1995, when the State became one of the first to leverage this flexibility. The first approved California demonstration was designed to provide needed financial relief to Los Angeles County in the wake of an economic downturn. Through the demonstration, 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.

Medi-Cal Hospital Uninsured Care Demonstration (2005)

California's "Medi-Cal Hospital Uninsured Care" Section 1115 demonstration was approved in 2005. The waiver and expenditure authorities made new federal matching funds available to reimburse public hospital UCC costs and expanded coverage of the uninsured. Specifically, the demonstration established a Safety Net Care Pool (SNCP) that made federal matching funds available to the State's designated public hospitals 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. Under the demonstration, California also shifted the nonfederal source of its Medicaid payments to designated public hospitals from intergovernmental transfers (IGTs) to CPEs.

California Bridge to Reform Demonstration (2010)

In 2010, California's 2005 demonstration was renewed and renamed "California Bridge to Reform." In the Bridge to Reform demonstration, 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 demonstration was initially designed to support the following primary initiatives:

- *Coverage Expansion:* Provided phased-in coverage in individual counties for adults aged 19–64 with incomes up to 200 percent of the FPL through the Low-Income Health Program (LIHP).
- *Managed Care for Seniors and Persons With Disabilities (SPDs):* Improved care coordination for vulnerable populations by mandatorily enrolling SPDs into Medi-Cal managed care.
- *Delivery System Reform Incentive Payment (DSRIP):* Supported California's public hospitals in their efforts to improve quality of care by providing payment incentives through the DSRIP program for projects that support infrastructure development, innovation and redesign of the delivery system, population-focused improvements, and urgent improvements in care.

- *UCC:* Supported the ongoing provision of services to uninsured individuals through the SNCP UCC component and federal funding of DSHPs.
- *CCS Pilots:* The demonstration 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, and traumatic injuries. CCS also provides medical therapy services that are delivered at public schools. The CCS program was also authorized and funded as one of the DSHPs.

In addition, several amendments to the demonstration were approved during the 2010–15 demonstration period that further advanced the State's goals. These included:

- *CBAS:* An amendment approved on March 30, 2012, authorized California to establish the 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. The CBAS demonstration amendment was renewed on November 28, 2014.
- *Managed Care for the Newly Eligible ACA 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 ACA and were transitioned from the LIHP to the Medi-Cal managed care delivery system.
- *Coordinated Care Initiative (CCI):* Through a further amendment to the demonstration, DHCS received approval to establish the CCI with coverage commencing on April 1, 2014. The State also received separate Section 1115A demonstration authority for the Cal MediConnect program (which is one component of the CCI). 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 composed 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 Medicaid-eligible individuals who are fully or partially eligible for Medicare; and (2) mandatory Medi-Cal managed care enrollment for dual-eligible individuals.[4]

[4] DHCS also carved into managed care the Multipurpose Senior Services Program (MSSP) and IHSS in CCI counties. IHSS was subsequently excluded from the managed care carve-in, and the MSSP is proposed to be excluded from the carve-in beginning January 1, 2022.

- *DMC-ODS:* As part of its ongoing effort to treat and prevent SUDs, California received approval in August 2015 to implement a new delivery system for SUD treatment known as the Drug Medi-Cal Organized Delivery System. The DMC-ODS program provided California counties the opportunity to offer 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 the first in the nation to obtain expenditure authority to receive federal Medicaid funding for reimbursable services provided to short-term residents of IMDs receiving DMC-ODS services. To date, 37 of California's 58 counties have implemented the DMC-ODS program, providing access to 96 percent of the Medi-Cal population.

Medi-Cal 2020 Demonstration (2015–21)

In December 2015, the federal government approved a five-year extension of the State's Section 1115 demonstration titled "Medi-Cal 2020" to advance the State's objectives to improve health outcomes for Medicaid and other low-income populations in the state, to increase efficiency, quality, and access to care , and to stabilize and strengthen providers and provider networks available to serve those populations. In December 2020, the demonstration was extended for another year, in substantially the same form (subject to the amendments noted below).

Medi-Cal 2020 retained and advanced many of the initiatives established under its predecessor, the Bridge to Reform demonstration. It also established new programs designed to expand access and improve quality, particularly for individuals with complex health and social needs, including individuals with SUDs and individuals experiencing homelessness. This section describes the history of the Medi-Cal 2020 demonstration and provides an overview of how the overall objectives set forth in the demonstration have been met.

Section 3 describes the elements of the Medi-Cal 2020 demonstration that California is requesting to continue as well as new requests, and Section 4 outlines elements of the Medi-Cal 2020 demonstration that the State has discontinued or does not plan to continue. Section 5 reviews findings to date, which demonstrate the success of Medi-Cal 2020 and provide grounds for this renewal.

The Medi-Cal 2020 demonstration includes the following:

- *Public Hospital Redesign and Incentives in Medi-Cal (PRIME):* Under the Medi-Cal 2020 demonstration, California received authority to extend and improve its DSRIP program—renamed PRIME—to provide additional incentives to its safety net hospitals to improve the way they deliver care. Specifically, PRIME provided incentive funding for California's 21 designated public hospital systems and 39 district/municipal public hospitals to support delivery system reform, including

through adoption of alternative payment models, with the ultimate goal of increasing quality and efficiency and improving population health and health outcomes, particularly for frequent users and individuals with co-occurring physical and behavioral health conditions. To receive funding, participating hospitals were required to report on progress toward and achievement of specified performance metrics.

- *WPC Pilots:* 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 users of the health care system or who 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 WPC pilot programs within certain parameters established by the demonstration and State guidelines. The pilots, which have been operating in 23 localities (including a small county collaborative), are 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 users with two or more chronic conditions, individuals who are experiencing or at risk of experiencing homelessness, and individuals with a behavioral health condition or SUD.
- *GPP and SNCP:* Although the expansion of Medi-Cal significantly reduced the uninsured rate, 9 percent of California's population remained uninsured in 2015. To support and improve ongoing care for the uninsured, California received authority in the Medi-Cal 2020 demonstration to establish the GPP. Through the GPP, the State has been able to make value-based payments to California's public health care systems (PHCSs) 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. 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 demonstration, 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 pregnant women with incomes below 109 percent of the FPL).
- *DTI:* Under the DTI, the State developed a critical new payment mechanism for improving dental health for Medi-Cal-enrolled children by focusing on high-value care, improved access, and use of performance measures to drive delivery system reform.

Medi-Cal 2020 Amendments

In addition to the initiatives authorized under the initial Medi-Cal 2020 demonstration, CMS approved several amendments during the demonstration period that have contributed to the achievement of the State's goals. Key amendments authorized the following new initiatives:

- *HHP:* Federal authority for California's HHP was provided through an amendment to the Medi-Cal State Plan, as well as an amendment to the Medi-Cal 2020 demonstration, both of which were approved on December 19, 2017. The combination of these two approvals enabled the State to provide HHP services to managed care-enrolled beneficiaries residing in the counties participating in the HHP. Eligibility for the HHP is limited to individuals who: (1) are enrolled in a Medi-Cal managed care organization (MCO) and residing in a participant county; (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 27,000 people have enrolled in HHP across 12 counties.
- *Coverage of Out-of-State Former Foster Care Youth*: On August 18, 2017, CMS approved an amendment to the Medi-Cal 2020 demonstration that authorized California to provide Medi-Cal 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.
- *PACE:* On August 3, 2020, CMS approved a demonstration amendment to allow, effective July 1, 2020, Medi-Cal beneficiaries in Orange County, at their election, to be disenrolled from CalOptima, a COHS including CalOptima PACE, and to be enrolled in a PACE organization not affiliated with CalOptima, if eligible.

Medi-Cal 2020 Temporary Extension and Pending Amendments

On December 29, 2020, CMS approved a 12-month temporary extension to continue the Medi-Cal 2020 demonstration through December 31, 2021. The demonstration was extended in substantially the same form, but CMS declined to extend DSHP expenditure authority, which expired on December 31, 2020. The State also sunset the PRIME program; applicable performance measures were transitioned to, and public hospitals may now qualify to receive managed care directed payments through, the Quality Incentive Program (QIP).

CMS is still considering several amendment requests that were submitted as part of the temporary extension; DHCS is requesting to continue these changes, if approved, into the renewal period.

- *GPP Extension:* On August 3, 2020, CMS approved a demonstration amendment to allow DHCS to operate the GPP for an additional six-month period, from July 1, 2020, to December 31, 2020. DHCS is currently negotiating with CMS amendments to continue GPP payments until December 31, 2021; reestablish Safety Net Care Pool funding for that time period; and modify the Special Terms and Conditions (STCs) to allow DHCS, during a period of public health emergency, to adjust the GPP thresholds without modifying the applicable total GPP payments, based on the estimated impact to usage rates.
- *DMC-ODS:* DHCS is currently negotiating with CMS amendments to make the following DMC-ODS programmatic changes in 2021: (1) remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period; (2) clarify criteria for services (including determination by a licensed provider and treatment post-incarceration) while reimbursing treatment prior to diagnosis in residential settings; (3) clarify the allowable components of recovery services, including when and how beneficiaries, including justice-involved individuals, may access recovery services, and the availability of recovery services to individuals receiving medication-assisted treatment (MAT); and (4) require counties to mandate that all DMC-ODS providers demonstrate they either directly offer or have effective referral mechanisms for MAT.

Goals & Objectives of the Medi-Cal 2020 Demonstration

As noted above, Medi-Cal 2020 included multiple objectives. It sought not only to improve health outcomes for Medi-Cal and other low-income populations in the state generally but also to improve access, quality and coordination of care for SUD services in particular and to generally move to a whole-person care model. Other elements of the demonstration sought to encourage delivery system transformation. The demonstration included initiatives to increase efficiency and quality of care by transforming service delivery networks to support better integration, improved health outcomes, and increased access to health care services. It also included initiatives to increase access to, stabilize, and strengthen providers and provider networks available to serve Medi-Cal and other low-income populations.

Over the demonstration period, the state succeeded in meeting these objectives. Several elements of Medi-Cal 2020 have improved both access to health coverage as well as health outcomes for Medi-Cal beneficiaries. For example, California has provided comprehensive coverage to pregnant and postpartum women; doing so plays a critical role in improving maternal and infant health outcomes. Similarly, by providing out-of-state former foster care youth with Medicaid coverage, DHCS has achieved the demonstration goals to maintain continuous health insurance coverage, improve and ensure positive health outcomes, and improve health care service utilization and access among this population. As described in Section 5 below, the DTI initiative improved statewide access to dental preventive services for children. An independent evaluation of DMC-ODS demonstrated that the program increased access to SUD treatment

services and found high patient satisfaction and use of evidence-based practices for SUD treatment, increased follow-up for SUD treatment services following a referral, and enhanced patient-centered care in SUD treatment services. Importantly, county administrators reported improved collaboration and communication across the physical, mental health, and SUD treatment systems. Similarly, an independent, interim evaluation of the Whole Person Care Pilots found significant progress in the establishment of needed infrastructure and processes to support effective care coordination, including the development health information technology and the establishment of partnerships for managing care and better care outcomes; these interim findings provide the basis for the State's CalAIM initiative, which seeks to apply a whole person model of care to continue promoting the health of Medi-Cal beneficiaries.

The demonstration also made significant progress in achieving its specific delivery system transformation goals. For example, GPP has resulted in improvements in infrastructure and resulted in greater predictability for PHCSs, thereby enabling delivery system and infrastructure investments; shifts in care from inpatient medical and surgical services and emergency room visits toward outpatient non-emergent visits; a more than six percent increase in uninsured care provided by PHCSs; and reported improvements in patient experience, care coordination, tailoring of patient care, and appropriate allocation of resources. Similarly, the results of the PRIME interim evaluation indicated establishment of needed infrastructure such as health information technology and protocols, delivery of care according to evidence-based guidelines, and regular monitoring of efforts to ensure these efforts led to the desired results.

More details about how the goals and objectives of the Medi-Cal 2020 demonstration have been met are included in Section 5.

Anticipated Future Demonstration Request

In the future, and subject to stakeholder consultation, DHCS plans to request Section 1115 demonstration authority to provide short-term residential treatment services in IMDs for adults with serious mental illness (SMI) and children with serious emotional disturbances (SEDs), in conjunction with the existing SMHS program. This authority would allow DHCS to improve service delivery and outcomes across a well-developed and robust continuum of care, from inpatient to community-based settings. Counties would voluntarily opt in to participate. DHCS plans to submit the Section 1115 demonstration request no sooner than July 1, 2022.

Section 3 – Medi-Cal Five-Year Renewal Request

As outlined above, DHCS is requesting a five-year renewal of Section 1115 demonstration waiver and expenditure authorities to continue operating a discrete set of program elements that generally cannot be approved under, or are otherwise incompatible with, the Medi-Cal State Plan or 1915(b) waiver authorities. Following are

the elements of the Medi-Cal 2020 Section 1115 demonstration that DHCS proposes to continue under the five-year renewal, with modifications as noted:

- **GPP** – 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. The GPP provides a pool of funding for value-based payments to participating designated public hospital systems providing care for California's uninsured by allocating federal Disproportionate Share Hospital (DSH) and UCC funding. These payments support designated public hospital systems' efforts to provide health care services for the uninsured while promoting the delivery of more cost-effective and higher-value care. This Section 1115 demonstration renewal is necessary to continue and expand GPP payments, using a portion of California's federal DSH allotment for the relevant time period and enhanced SNCP funding. DHCS seeks to make GPP a stronger tool for addressing health inequities by expanding SNCP funding to establish an equity sub-pool through which eligible designated public hospital systems earn points (and thereby receive payments) for services and activities designed to address health inequities and social determinants of health.
- **DMC-ODS** – The DMC-ODS is now available in 37 (out of 58) counties, providing access to 96 percent of the Medi-Cal population. DHCS aims to expand the program statewide, contingent on additional counties opting in. In the Section 1115 demonstration proposal, the State is seeking a renewal of its expenditure authority allowing federal reimbursement for Medi-Cal services provided to short-term residents of IMDs receiving DMC-ODS services as well as several program modifications. Other current elements of the DMC-ODS that do not require Section 1115 demonstration authority, including the expanded continuum of services currently available through the Medi-Cal 2020 Section 1115 demonstration, will remain in place, with authority transitioned to Medi-Cal State Plan authority and the consolidated CalAIM Section 1915(b) waiver.
- **Low-Income Pregnant Women** – The State requests authority to continue to provide full-scope Medi-Cal coverage to pregnant women with incomes from 109 percent up to and including 138 percent of the FPL (including all benefits that would be available for pregnant women with incomes below 109 percent of the FPL). California is not requesting any changes as part of the Section 1115 demonstration renewal request.
- **Out-of-State Former Foster Care Youth** – The Medi-Cal 2020 demonstration 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. DHCS requests a renewal of this coverage authority pending further guidance from CMS regarding implementation of the SUPPORT Act requirement that states extend State Plan coverage to this population. California is not

requesting any changes as part of the Section 1115 demonstration renewal request.

- **CBAS** – CBAS offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization. California is requesting technical changes as part of this Section 1115 demonstration renewal to align with MCP contract changes, Medi-Cal Provider Manual updates, and provider enrollment requirements, and to clarify both eligibility and medical necessity criteria.

In addition to renewal of the above authorities, DHCS is requesting new authorities, effective January 1, 2022 unless otherwise noted, including:

- **Peer Support Specialists** – To enhance DMC services, and consistent with State legislation,[5] peer support specialist services will be added to the Medi-Cal State Plan through a State Plan Amendment, beginning no sooner than January 2022. As required by State legislation, peer support specialist services will be provided at county option, and the State is, therefore, seeking waivers of statewideness and comparability. (DHCS is seeking similar waiver authority in the 1915(b) waiver for SMHS and the DMC-ODS.)
- **Services for Justice-Involved Populations 30 Days Pre-Release (effective January 1, 2023)** – To ensure continuity of health coverage and care for justice-involved populations—who experience disproportionately higher rates of physical and behavioral health diagnoses—DHCS requests authority to provide targeted Medi-Cal services to eligible justice-involved populations 30 days pre-release. These Medi-Cal services include ECM and limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for use post-release into the community.
- **Providing Access and Transforming Health (PATH) Supports** – As California implements the CalAIM initiative statewide, the State is requesting expenditure authority to support services and capacity building, including payments for supports, infrastructure, interventions, and services to complement the array of care that will be authorized in the consolidated 1915(b) waiver delivery system. This expenditure authority will support California's efforts to shift delivery systems in furtherance of its objectives to advance the coordination and delivery of quality care for all Medi-Cal beneficiaries. California also is requesting federal funding of DSHPs to support CalAIM implementation, including efforts to strengthen the effectiveness of Medi-Cal in addressing the significant gaps in health outcomes across beneficiaries based on race and ethnicity. This request reflects the same

[5] See Sections 14045.14(a) and 14045.19 of the California Welfare & Institution Code, as amended by Senate Bill 803.

DSHPs authorized in the initial five-year period of the Medi-Cal 2020 demonstration, although at a reduced level.

These new authorities will promote the objectives of the Medicaid program by ensuring high-risk individuals have access to needed coverage and health care services, and by addressing health disparities for underserved populations.

Following are detailed descriptions of the programs listed above, along with the rationale for renewal or establishment (whichever applies) of each. DHCS requests to continue the majority of existing programs and seeks some programmatic and technical changes to selected programs, including the DMC-ODS and CBAS.

Section 3.1 – The Global Payment Program

California has a long history of providing services to Medi-Cal beneficiaries and uninsured individuals through its designated public hospital systems. California's public hospitals are committed to delivering high-quality care to those in need, regardless of ability to pay or insurance status, but the provision of such care imposes significant costs on California's safety net hospitals. California's designated public hospital systems account for only 6 percent of California's hospitals but provide more than 40 percent of the hospital care delivered to California's remaining uninsured.

Prior to the GPP, many of California's uninsured received most of their care in emergency departments or other hospital settings. Moreover, the UCC funding previously available to designated public hospitals to provide care to the uninsured, while important to defray costs, was not designed to promote value-based care or delivery system reform. In addition, the funding formulas associated with these pre-GPP initiatives made it difficult for designated public hospital systems to predict how much funding they would receive, making long-term financial planning and investments more difficult.

In line with evidence suggesting that improvements in access to outpatient services, including primary care, can reduce health care costs and improve health outcomes, the GPP combined the demonstration-authorized UCC funding with DSH funds and established a new method of compensating participating designated public hospital systems for caring for the uninsured that promotes delivery system reform and incentivizes the value, rather than the volume, of services.

Importantly, the GPP also provides participating designated public hospital systems with federal matching funds for additional low-cost, high-value services such as visits to a health coach, nutrition education, and email provider consultations. In addition, under the GPP, participating systems benefit from the greater predictability of funding and a quarterly payment schedule, both of which are designed to facilitate planning for service delivery reform and other infrastructure investments.

Objective

The objective of the GPP is to compensate designated public hospital systems through a value-based methodology that awards points based on services provided and encourages primary and preventive care and the delivery of care in appropriate settings. Over the course of the demonstration, the points attributed to high-value services, such as primary or preventive care delivered in an outpatient setting, have increased relative to the points attributed to services provided in an emergency room or inpatient setting. The 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 designated public hospital systems 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 complement services that are reimbursable.

DHCS seeks to build on these goals and the achievements of GPP to date, by continuing the existing GPP program and establishing a new, separate GPP sub-pool (the “Equity Sub-pool”) that specifically addresses social needs and responds to the impacts of racism and inequities on the uninsured populations these hospital systems serve. Akin to the approach established under the current GPP, the Equity Sub-pool, if approved by CMS, will allow participating designated public hospital systems to receive payments based on providing services and completing activities designed to address the social determinants of health. Participants’ point allocations in GPP and in the Equity Sub-pool would be distinct; in other words, participant systems would achieve Equity Sub-pool points based on completing activities unique to the Equity Sub-Pool.

The GPP promotes the objectives of Title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations while increasing efficiency, equity, and quality of care.

Renewal Request

As discussed in Section 5 below, the independent evaluation of the GPP found that the program has been successful in rewarding and incentivizing value-based, cost-effective care rather than volume of services. For this reason, the State seeks federal approval to continue the GPP using Medicaid DSH and SNCP dollars through the five-year renewal period (ending December 31, 2026).

Additionally, DHCS seeks to establish the Equity Sub-pool described above, using

Safety Net Care Pool dollars. Acknowledging that the Equity Sub-Pool will provide participant hospital systems with funding for providing services that were not contemplated when establishing the current Safety Net Care Pool, DHCS seeks to include the cost of providing these additive, social determinants of health services to its current Safety Net Care Pool allotment, as described in Section 7 below.

These changes would preserve and build on the delivery system improvements achieved in the expiring demonstration period. The program would continue the modification to the point values as outlined in Attachment FF of the Medi-Cal 2020 STCs (pending negotiations with CMS regarding adjustments for the 2021 calendar year), while establishing new and separate point values for the equity sub-pool. For both the existing GPP and the proposed new equity sub-pool, point thresholds would be established dependent on the final budget amounts.

Section 3.2 – DMC-ODS

Medi-Cal has long provided coverage for certain SUD treatment benefits through its DMC program, which is authorized through the State Plan and administered by the counties. To improve its SUD delivery system, the State created the DMC-ODS program under the Section 1115 demonstration authority to expand access to treatment, standardize service delivery across participant counties, 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 option to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services beyond what was historically available under the Medi-Cal State Plan. To date, 37 of California's 58 counties have implemented the DMC-ODS, providing access to 96 percent of the total Medi-Cal population across the state. DHCS is actively engaging with prospective new counties to participate by opting into the DMC-ODS, with the goal to expand to eventual statewide access to comprehensive SUD services for Medi-Cal beneficiaries.

The DMC-ODS program is a critical component of the State's comprehensive strategy for treating SUDs; that strategy includes using the Substance Abuse and Mental Health Services Administration's State Targeted Response (STR) and State Opioid Response (SOR) grants to implement its Hub and Spoke system of care and expand access to MAT, including for the tribal and urban Indian populations. 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, sustain, and bolster this important work.

Objective

The objective of the DMC-ODS demonstration is to improve access, quality, and coordination of care for SUD services in participating counties. As described in Section 5 below, University of California Los Angeles' (UCLA) most recent evaluation demonstrates that the program has been successful in all three of these areas; now, DHCS seeks to build upon DMC-ODS program successes by continuing the initiative and making targeted program improvements, described below.

Renewal Request

To enable the DMC-ODS to continue to grow and mature, the State is requesting a five-year renewal of the Section 1115 demonstration expenditure authority allowing federal reimbursement for Medicaid services provided to short-term residents of IMDs receiving DMC-ODS services as part of the comprehensive continuum of SUD care. California will continue to provide all the DMC-ODS benefits currently authorized under Medi-Cal 2020, but will transition the delivery system authority for the DMC-ODS to a consolidated 1915(b) waiver and the coverage authority for most DMC-ODS benefits to its State Plan. DHCS will request 1915(b)(3) authority for Contingency Management services or pursue other necessary authority as advised by CMS.

In this renewal, DHCS also requests authority to make several improvements to the current DMC-ODS program that will increase efficiency, improve access, and align more closely with CMS policy regarding SUD demonstrations, described below.

DHCS is seeking expenditure authority to allow federal reimbursement for all DMC-ODS services that are provided by traditional healers and natural helpers. The purpose of this request is to provide culturally appropriate options and improve access to SUD treatment for American Indians and Alaska Natives receiving SUD treatment services through Indian health care providers (IHCPs). For American Indians and Alaska Natives, traditional healing practices are a fundamental element of Indian health care that helps patients achieve wellness and healing and restores emotional balance and one's relationship with the environment. Medi-Cal recognizes that reimbursement for these services to address SUD in a manner that retains the sanctity of these ancient practices is critical.

As noted above, the DMC-ODS has been successful over the past five years, but the opioid crisis continues to persist—and given the pandemic, even deepen—and California is seeing growing rates of overdose deaths from stimulants. DHCS requests this extension in order to continue its efforts to expand access to lifesaving treatment.

Proposed Improvements to DMC-ODS Requested in This Renewal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation, in order to improve beneficiary care and administrative efficiency. Many of these changes will be encompassed in the

consolidated 1915(b) waiver; however, a targeted set of program modifications relate to the authorities DHCS seeks to continue under Section 1115 demonstration authority. Those proposals are outlined here:

1. **Transition From a CPE/Cost-Based Financing Methodology to Rate-Based Financing**
   California plans to shift reimbursement for all inpatient and outpatient SUD services from a CPE- or cost-based financing methodology to rate/fee schedule-based financing and payment methodologies. These changes will help DHCS and counties realize the following objectives: incentivize quality and value; create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal MCPs and counties; and reduce state and county administrative burdens by eliminating the cost-reconciliation process. The State will work with CMS to update the STCs and related protocols to make this change, which would go into effect no earlier than July 2022. Until those updates are made, the existing methodology will remain in place.
2. **Increase Access to SUD Treatment for American Indians and Alaska Natives**
   DHCS seeks to improve access to SUD treatment for American Indians and Alaska Natives through IHCPs and to promote access to culturally appropriate and evidence-based SUD treatment for American Indians and Alaska Natives. To achieve these objectives, DHCS seeks expenditure authority for DMC-ODS services provided by traditional healers and natural helpers, using culturally specific, evidence-based practices. DHCS also plans to require IHCPs 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 Indian partners.

Proposed Improvements to DMC-ODS DHCS Seeks to Establish in 2021

DHCS is currently negotiating program modifications to take effect in 2021. Pending CMS approval of these modifications, DHCS seeks to continue the following programmatic features using appropriate federal authorities:

- Removal of the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarification of criteria for services requirements (including determination by a licensed provider and treatment post-incarceration) and reimbursement for nonresidential services prior to diagnosis
- Clarification of the allowable components of recovery services, describing when and how beneficiaries, including justice-involved individuals, may access recovery services and the availability of recovery services to individuals receiving MAT

- Requirement for counties to mandate that all DMC-ODS providers demonstrate they either directly offer or have effective referral mechanisms for MAT

DHCS also intends to make technical DMC-ODS program modifications or clarifications that may necessitate updates to the 1115 demonstration STCs or attachments related to the DMC-ODS; others may be documented in SPAs and/or the consolidated 1915(b) waiver, which will become the vehicle for other portions of the DMC-ODS program.

DMC-ODS Benefits

Through a combination of State Plan, 1915(b) waiver, and 1115 demonstration authorities, DHCS plans to continue to offer the following DMC-ODS services. (The table below describes the continuum of DMC-ODS services and the coverage authorities DHCS is seeking as it transitions the majority of DMC-ODS services currently authorized under the Medi-Cal 2020 Demonstration to State Plan and 1915(b) waiver authority.

Table 2. DMC-ODS Benefits Under CalAIM[6]

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
0.5	Screening, brief intervention, referral to treatment (SBIRT) and Early Intervention services	SBIRT by primary care providers is a service in FFS and managed care. SBIRT by DMC-ODS providers represent components of assessment and treatment services in DMC-ODS. Early intervention services include individual counseling, group counseling, and education services	FFS and managed care primary care providers DMC and DMC-ODS providers	Medicaid State Plan	Fee-for-service, 1915(b)

[6] This table reflects the proposed state of DMC-ODS benefits, much of which is simply a continuation of existing policy. In some instances, however, DHCS is working with CMS to secure appropriate authority for adding selected services.

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
		without the requirement of an SUD diagnosis, available in DMC-ODS and DMC for beneficiaries under age 21			
1	Outpatient Services	Counseling, education and other service components	DHCS Certified Outpatient Facilities	Medicaid State Plan	Fee-for-service, 1915(b)
2.1	Intensive Outpatient Services	Counseling services to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities	Medicaid State Plan	Fee-for-service, 1915(b)
2.5	Partial Hospitalization Services	Services for multidimensional instability not requiring 24-hour care, but requiring more clinical hours than intensive outpatient	DHCS Certified Intensive Outpatient Facilities	Medicaid State Plan (Contingent on SPA approval[7])	1915(b)
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; 20 hours of care/week with at least 5 hours of clinical services/week	DHCS-Licensed Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	Medicaid State Plan (Contingent on SPA approval)	1915(b)

[7] As previously noted, DHCS is shifting the coverage authority for many existing DMC-ODS benefits that are authorized under the 1115 demonstration to the Medicaid State Plan.

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
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-Licensed Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	Medicaid State Plan (Contingent on SPA approval)	1915(b)
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger	DHCS-Licensed Residential Providers, Chemical Dependency Recovery Hospitals, Freestanding Acute Psychiatric Hospitals	Medicaid State Plan (Contingent on SPA approval)	1915(b)
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability and 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Freestanding Acute Psychiatric Hospitals	Medicaid State Plan	Fee-for-service, 1915(b)
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems, including counseling services	Chemical Dependency Recovery Hospitals, Hospital; Freestanding Acute Psychiatric	Medicaid State Plan	Fee-for-service, 1915(b)

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
			Hospitals		
NTP	Narcotic Treatment Program	Medications and counseling for opioid and alcohol use disorders	DHCS-Licensed Narcotic Treatment Programs	Medicaid State Plan	Fee-for-service, 1915(b)
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Management of mild withdrawal with daily or less than daily outpatient supervision	DHCS Certified Outpatient Facility with Detox Certification; Physician, Licensed Prescriber; or NTP for Opioids	Medicaid State Plan (Contingent on SPA approval)	1915(b)
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Management of moderate withdrawal with daytime withdrawal management and support and supervision (not residential)	DHCS Certified Outpatient Facility with Detox Certification; Physician; Licensed Prescriber; or NTP	Medicaid State Plan (Contingent on SPA approval)	1915(b)
3.2-WM	Clinically managed residential withdrawal management	24-hour support for moderate withdrawal symptoms not manageable in outpatient setting	DHCS Licensed Residential Facility with Detox Services; Chemical Dependency Recovery Hospitals; Freestanding Acute Psychiatric Hospitals; Physician; or Licensed Prescriber.	Medicaid State Plan (Contingent on SPA approval)	1915(b)
3.7-	Medically Managed	24-hour care for severe	General Acute Care	Medicaid State	Fee-for-service,

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
WM	Inpatient Withdrawal Management	withdrawal symptoms requiring 24-hour nursing care and physician visits	Hospital; Chemical Dependency Recovery Hospitals; Freestanding Acute Psychiatric Hospitals	Plan	1915(b)
4-WM	Medically managed intensive inpatient withdrawal management	Management of severe, unstable withdrawal requiring 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	Medicaid State Plan	Fee-for-service, 1915(b)
1-4 1-WM – 4-WM	Clinician Consultation	Consultation services to assist DMC clinicians with seeking expert advice for treating DMC-ODS beneficiaries	DHCS-Certified LPHAs consulting with Addiction Medicine Physicians, Addiction Psychiatrists, or Clinical Pharmacists	Medicaid State Plan	1915(b)
1-4 1-WM – 4-WM	Case Management (component of existing services; can be provided as part of	Coordination of SUD care, including assisting the beneficiary to access needed medical, educational, social,	DHCS-Certified Providers	Medicaid State Plan (Contingent on SPA approval)	1915(b)

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
	services listed above)	prevocational, vocational, rehabilitative, and other community services			
1-4	MAT (component of existing services; provided as part of services listed above)	Requirement that all providers must provide MAT prescribing, administration, and monitoring on-site, or have a referral process in place to refer to MAT prescribers (the medications are covered through the pharmacy Fee for Service Benefit)	DHCS-Certified Providers	Medicaid State Plan (Contingent on SPA approval)	Fee-for-service, 1915(b)
1-4	Additional MAT	MAT when medications are bought and billed by non-NTP providers as a medical benefit administered or provided on-site or in the community	DHCS-Certified Providers	Medicaid State Plan	Fee-for-service, 1915(b)
1	Recovery Services	Services to prevent relapse	DHCS-Certified Providers	Medicaid State Plan (Contingent on SPA approval)	1915(b)
1	Peer Support Specialist Services	Services include therapeutic activities, outreach and engagement, and educational	DHCS-Certified Providers	Medicaid State Plan (Contingent on SPA approval)	Fee-for-service, 1115, 1915(b)

ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
		groups			
1-2.5	Contingency Management (provided as component of outpatient services)	Motivational incentives combined with counseling	DHCS-Certified providers (the incentives may be delivered through an independent third-party application, to be determined)	1915(b)(3)	1915(b)

Section 3.3 – Peer Support Specialist Services

Leveraging the Medi-Cal State Plan, DHCS is establishing a peer support specialist pilot program to expand the use of certified peer support specialists in counties that opt in to participate in the pilot project. Under this pilot program, peer support specialists will be established as a distinct provider type in participant counties under DMC, Medi-Cal SMHS, and/or DMC-ODS programs. Under the pilot programs, certified peer support specialists will provide covered peer support services, as defined herein, to Medi-Cal beneficiaries in participating counties. DHCS will establish statewide requirements for peer support specialist certification for participating counties to use to certify their peer support specialists.

Peer support specialist services are culturally competent services that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and educate beneficiaries and their families about their conditions and the process of recovery. Participating counties will provide supervision of their peer support specialists by competent behavioral health professionals trained in the peer recovery model.

Peer support specialist services may include the following evidence-based activities when medically necessary:

- Therapeutic activity: any structured, nonclinical activity whose purpose is to augment treatment and provide additional internal foundations for beneficiaries to attain and maintain recovery within their communities. These activities may include advocacy, resource usage, and/or collaboration with the beneficiaries and others providing care or support to the client, family members, or significant support persons.

- Engagement: includes peer-led activities, such as motivational interviewing, that encourage beneficiaries to enter, remain in, and complete behavioral health treatment programs and maintain recovery.
- Educational groups: provide a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups should promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Objective

The objective of the combined behavioral health peer support specialist pilot program is to improve recovery outcomes and prevent relapses and symptoms of behavioral disorders. Since a substantial percentage of beneficiaries have co-occurring mental health and SUDs, cross-training the workforce will allow peer support specialists to be able to recognize and refer when a beneficiary needs care in the other corresponding systems. This effort also furthers integration between local mental health and SUD delivery systems and supports administrative efficiencies. Implementing peer support specialists on a pilot basis in counties that opt in will enable the State to gain experience with the new services and consider improvements over time.

Renewal Request

Consistent with State legislation, to implement the peer support services pilot in the DMC program, DHCS seeks waiver authority to offer these services at county option and specifically to individuals who meet the criteria for services.

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 and postpartum care. To expand access to prenatal and postpartum care for low-income women, the State sought and received authority under the Medi-Cal 2020 demonstration 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 pregnant women with incomes below 109 percent of the FPL).

Objective

To improve health outcomes for Medi-Cal enrollees who are pregnant or have recently given birth.

Renewal Request

In this renewal 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 August 2017, California received CMS approval 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.

Objective

To improve health outcomes by extending Medi-Cal coverage to former foster youth who may not otherwise be eligible for coverage.

Renewal Request

In this renewal application, California seeks authority to extend coverage of this population through the Section 1115 demonstration until states are able to provide Medicaid eligibility for out-of-state former foster care youth through the Medicaid State Plan, as outlined in the SUPPORT Act.[8]

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 CBAS program, which offers services to eligible older adults and adults with disabilities in an outpatient facility-based setting. CBAS 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 demonstration amendment was renewed on November 28, 2014, and was included in the Medi-Cal 2020 demonstration.

[8] P.L. 115-271.

Objective

To offer services that restore or maintain optimal capacity for self-care and that delay or prevent institutionalization, thereby improving health outcomes, access to health care services, and integration of care for Medicaid beneficiaries.

Renewal Request

Given the medical eligibility criteria and available services and supports provided to this vulnerable population, the state is seeking to continue CBAS. CBAS has matured into a functional and key part of the State's approach to delivering long-term services and supports. The State requests that the authority for the CBAS program be extended in this renewal. DHCS also seeks to make technical amendments to the program, including to align portions of the STCs and Standards of Participation with the Medi-Cal Provider Manual and Managed Care Contract Language.

Section 3.7 – Services for Justice-Involved Populations 30-Days Pre-Release

California is requesting approval to authorize federal Medicaid matching funds for the provision of a set of targeted Medicaid services to be provided in the 30-day period immediately prior to release for eligible justice-involved populations. These Medicaid services include ECM and limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for use post-release into the community. All Medicaid-eligible groups—including adults, youth under 19, pregnant women, the aged, and the disabled—would be eligible for these benefits. Authority to cover these services is requested for persons incarcerated in State prisons, county jails, and youth correction facilities.

Ensuring continuity of health coverage and care for justice-involved populations is a high priority for California. This group of low-income adults is disproportionately people of color who have considerable health care needs but who are often without care and needed medications upon release. Some 28.5 percent of male prisoners are Black, as compared to 5.6 percent of the state's adult male residents; for Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of

other races.[9] Over the course of a year, 36,000[10] people are released from California prisons, with millions more going in and out of jails.

Individuals leaving incarceration are particularly at risk for poor health outcomes—justice-involved individuals experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of violence, overdose, and suicide than are people who have never been incarcerated.[11] Inmates who have a behavioral health disorder are more likely than those without a disorder to have been homeless in the year prior to their incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse.[12] Nearly 70 percent of individuals reoffend within three years after release from prison.[13] While the factors contributing to recidivism are complex, effective treatment for mental health conditions and substance use disorders can interrupt the cycle of reoffending.

In 2017, 66 percent[14] of inmates assessed through California's Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) were identified as having a high or moderate need for SUD treatment. From 2009 to 2019, the proportion of incarcerated people in California jails with an active mental health case rose 63 percent; in 2019, 15,500 out of 80,000 individuals in jail custody had an active mental health case.[15] The California correctional health care system drug overdose death rate for

---

[9] California's Prison Population, Public Policy Institute of California, 2017. Available at https://www.ppic.org/publication/californias-prison-population/#:~:text=African%20Americans%20remain%20overrepresented%20in,the%20state's%20adult%20male%20residents.

[10] From Corrections to Community: Reentry Health Care, California Health Care Foundation, 2018. Available at https://www.chcf.org/project/corrections-community-reentry-health-care/.

[11] Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison — A High Risk of Death for Former Inmates," *New England Journal of Medicine*, January 2007.

[12] Gates, A., Artiga, S., Rudowitz, R., "Health Coverage and Care for the Adult Justice Population, Kaiser Family Foundation, September 5, 2014, available https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/

[13] National Institute of Justice Fact Sheet, "Recidivism is a Core Criminal Justice Concern," October 2008, available at https://nij.ojp.gov/topics/corrections/recidivism

[14] Improving In-Prison Rehabilitation Programs, Legislative Analyst's Office, 2017. Available at https://lao.ca.gov/Publications/Report/3720.

[15] The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019, California Health Policy Strategies,

individuals in the system is 12.6 per 100,000, more than three times the total rate in the United States, which is 3.7.[16]

Evidence suggests that improving health outcomes for this high-needs group of people requires focused, high-touch care management to assess needs and strengths and connect them to the services they need when released into their communities.[17] In-reach ECM is needed to ensure the medical, behavioral, and social needs that are tied so closely to health—including housing and transportation—are met. ECM pre-release coupled with targeted Medi-Cal services, including limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for use post-release, will contribute to improved health and longer-term treatment and medication adherence upon release from incarceration.

By working to ensure justice-involved populations have a stable network of health care services and supports upon discharge, California believes it will be able to demonstrate a reduction in emergency department use, hospitalizations, and other medical expenses associated with relapse, as well as improvements in health outcomes, including a reduction in overdose rates and deaths.

California Efforts to Support Justice-Involved Populations

California has notable experience with justice-involved populations. Nine of the WPC pilots authorized under the Medi-Cal 2020 demonstration[18] specifically target formerly incarcerated individuals. This includes the Los Angeles County WPC,[19] which focuses on pre-release and post-release medical, behavioral, and social support services for justice-involved individuals (lasting, on average, three months post-release), with a separate program for juvenile aftercare (lasting, on average, six months post-release). These pilots will be leveraged to provide valuable lessons as California brings these efforts to scale.

2020. Available at https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

[16] Analysis of 2017 Inmate Death Reviews in the California Correctional Healthcare System, 2018. Available at https://cchcs.ca.gov/wp-content/uploads/sites/60/MS/2017-Inmate-Death-Reviews.pdf.

[17] "How Strengthening Health Care at Reentry Can Address Behavioral Health and Public Safety: Ohio's Reentry Program." Available at https://cochs.org/files/medicaid/ohio-reentry.pdf.

[18] DHCS. "Whole Person Care Pilots." Available at https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.

[19] Health Services – Los Angeles County. Whole Person Care – Los Angeles (WPC-LA). Available at https://dhs.lacounty.gov/whole-person-care/.

This demonstration proposal largely builds on legislative initiatives already passed and implemented in California that are focused on ensuring continuity of coverage through Medi-Cal pre-release enrollment and suspension strategies. In 2014, California passed Assembly Bill 720,[20] requiring all counties upon learning of incarceration status to suspend Medi-Cal benefits for up to one year rather than terminate coverage. Additionally, California requires counties to suspend Medi-Cal eligibility, rather than terminate, for individuals under age 21 who were Medi-Cal beneficiaries at the time they became an inmate of a public institution consistent with the federal SUPPORT Act requirements and recently released CMS guidance.[21] California has had long-standing suspension processes in place in its prison system.

DHCS is mandating all counties implement an inmate pre-release Medi-Cal application process by January 1, 2023, to ensure all eligible inmates in county jails, including those who are not in suspended status, receive timely access to Medi-Cal services upon release from incarceration.[22] The State has also made efforts to improving continuity of coverage and care for its juvenile detainees. California law requires County Welfare Departments to determine Medi-Cal eligibility of juvenile inmates who are incarcerated for 30 or more days.[23]

California's approach to serving justice-involved individuals is very much aligned with federal priorities. In October 2018, Congress passed the SUPPORT Act, which creates a new opportunity for states to apply for an 1115 demonstration to provide Medicaid coverage in the 30 pre-release days. Section 5032 of the SUPPORT Act requires the Department of Health & Human Services to issue a state Medicaid director letter regarding opportunities to design Section 1115 demonstration projects that allow for Medicaid coverage for inmates 30 days pre-release. Consistent with the SUPPORT Act, California is seeking authority to develop an innovative demonstration program that will promote justice-involved adults and juveniles receiving needed coverage and health care services pre- and post-release into the community.

Eligibility for Services

This demonstration proposal will provide limited Medi-Cal benefits for eligible beneficiaries, including adults, youth under 19, pregnant women, the aged/blind/disabled, and former foster care youth who are inmates in State prisons,

[20] Assembly Bill No. 720. Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB720.

[21] Available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[22] AB-720 Inmates: health care enrollment. Available at http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201320140AB720&showamends=false.

[23] Available at http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1451-1500/sb_1469_cfa_20060501_142757_sen_comm.html.

county jails, and youth correction facilities (pretrial or post-conviction) during the 30-day period before their release (or fewer days for people who may be released from incarceration earlier) who meet any of the following criteria:

- Adult health care needs:
  - Chronic mental illness
  - SUD
  - Chronic disease (e.g., hepatitis C, diabetes)
  - Intellectual or developmental disability
  - Traumatic brain injury
  - HIV
  - Pregnancy
- All youth who are inmates of a corrections setting

See Table 3 for more information on Medicaid eligibility groups affected by a 30-day pre-release demonstration.

Table 3. Medicaid Eligibility Groups Affected by 30-Day Pre-Release Demonstration

Eligibility Group	Federal Citations	Income Level
Adults	42 CFR § 435.119	0%–138% FPL
Parents/Caretaker Relatives	42 CFR § 435.110	0%–109% FPL
Children Under 19	42 CFR § 435.926	0%–266% FPL
Pregnant Women	42 CFR § 435.116	0%–213% FPL
Aged/Blind/Disabled	42 CFR §§ 435.120-435.138	0%–138% FPL
Former Foster Care Youth	42 CFR § 435.150	N/A

If CMS approves this demonstration proposal, California projects that approximately 250,000 individuals each year will receive Medi-Cal coverage 30 days pre-release. This estimate is based on data indicating that approximately 400,000 people are released from county, state and federal prisons and youth correctional facilities each year and assumes that approximately two thirds of that group will qualify for Medi-Cal and have a complex health care need, substance use, or mental health diagnosis that would qualify them for coverage 30 days pre-release.

Justice-Involved Initiative Benefits and Cost Sharing

Eligible Medi-Cal enrollees will receive ECM pre-release coupled with targeted Medicaid services, including limited community-based clinical consultation services provided via

telehealth or e-consultation and a 30-day supply of medication for reentry into the community.

The scope of in-reach ECM will include but not be limited to the following:

- Conducting an initial care needs assessment to evaluate medical, mental, SUD, and social needs
- Developing a transition plan for community-based health services
- Screening and providing referrals to community-based health, developmental disabilities, mental health, SUD, and social needs appointments post-release, including peer mentorship to help provide positive social support
- Identifying housing and preparing individuals for securing and maintaining stable housing, using housing-related ILOS as appropriate
- Developing a medication management plan, in consultation with clinical providers
- Linking individuals to in-lieu of services and other critical supports that address social determinants of health
- Providing culturally and linguistically appropriate education to individuals, families, caretakers, and other circles of support regarding the member's health care needs and available supports
- Supporting members as they navigate reentry

The ECM benefit will be delivered by Medi-Cal MCPs and their contracted community-based providers with particular expertise working with justice-involved individuals. Delivery of services during the 30 days pre-release will require close coordination with the State prisons, county jails, and youth correction facilities, including probation, courts, and the local county jail system to both identify/refer members and ensure connections to care once individuals are released from incarceration.

No cost sharing shall be applied during the 30 days pre-release. The full range of medically necessary services under Medi-Cal, including ongoing ECM, will be available as appropriate in the community.

Demonstration Implementation

California is seeking to implement Medi-Cal coverage 30 days pre-release by January 1, 2023. Recognizing the need for system and operational changes, the State may consider a phased rollout, commencing first with State prisons and counties that elect to opt in to the first phase.

Objective

This demonstration will address the health care needs of California's justice-involved population and promote the objectives of the Medicaid program by ensuring justice-involved individuals with high physical or behavioral health risks receive needed coverage and health care services pre- and post-release into the community. By bridging relationships between community-based Medi-Cal providers and justice-involved populations prior to release, California seeks to improve the chances that individuals with a history of substance use, mental illness, and/or chronic disease receive stable and continuous care. By working to ensure justice-involved populations have a ready network of health care services and supports upon discharge, this demonstration will seek to:

- Improve physical and behavioral health outcomes of justice-involved populations post-release
- Reduce the number of justice-involved people being released into homelessness by, prior to their release, connecting them to enhanced care management and In Lieu of Services
- Reduce emergency department visits, hospitalizations, and other avoidable services by connecting justice-involved individuals to ongoing, community-based physical and behavioral health services
- Promote continuity of medication treatment for individuals receiving pharmaceutical treatment
- Reduce health care costs by ensuring continuity of care and services upon release into the community

Section 3.8 – Providing Access and Transforming Health Supports

To move beyond WPC pilots and address SDOH and health equity statewide through Medi-Cal managed care, it is important that plans, counties, public hospital systems and community-based organizations have the tools and resources needed to work together, including ability to exchange data, establish payment relationships, measure value and outcomes, and ensure that beneficiaries remain at the center of care. Although some plans, counties, public hospital systems and community based organizations (CBOs) already have such experience, California is seeking federal support to broaden and scale such arrangements.

The Medi-Cal 2020 demonstration includes expenditure authority to authorize expenditures for Providing Access and Transforming Health (PATH); California is requesting this expenditure authority to take California's system transformation to the next phase, while refocusing its uses to achieve the CalAIM vision. As California implements the CalAIM initiative statewide, expenditure authority is necessary to support services and capacity building, including payments for supports, infrastructure

and interventions to strengthen the delivery and efficacy of care otherwise available in the Medi-Cal program.

The expenditure authority would tie directly to the CalAIM initiatives that are the focus of this Section 1115 demonstration and the related, consolidated 1915(b) waiver. The funding would support services for Medi-Cal beneficiaries that are not otherwise authorized under the Medi-Cal State Plan, including but not limited to services that could be provided under the Medi-Cal State Plan as well as capacity building, infrastructure or IT systems for community-based ECM and ILOS providers. The expenditure authority also will support capacity building for effective pre-release care for justice-involved populations, to enable coordination with justice agencies and Medi-Cal for coverage of services 30 days pre-release.

Implementation of this expenditure authority is contingent upon California identifying adequate non-federal share funding. Therefore, California is also requesting DSHP expenditure authority during this five-year renewal period to cover a portion of the non-federal share; the remainder of non-federal share could come from counties through intergovernmental transfers or certified public expenditures. This authority, which was previously provided but which is not now in place under the one-year temporary extension, will support the CalAIM initiative; including by supporting delivery system reform aimed at providing holistic care, addressing inequities in outcomes by race and ethnicity, and continuing and strengthening key Medi-Cal initiatives that have been supported by DSHP in the past. California will work with CMS to update the approved Special Terms and Conditions and DSHP funding and reimbursement protocols for the renewal period to reflect new demonstration goals and funding levels.

Objective

This expenditure authority will support California's efforts to shift delivery systems in furtherance of its objectives to advance the coordination and delivery of quality care for all California Medicaid beneficiaries and will help improve health outcomes for Medicaid and other low-income populations in the State. The expenditure authority further promotes the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks to increase access to health care services, support better integration, and improve health outcomes, including across racial and ethnic groups.

Renewal Request

California is requesting expenditure authority coupled with resumption of DSHP expenditure authority at reduced levels for PATH supports.

Section 4 – Initiatives Being Discontinued or Transitioned Under CalAIM

As noted in the introduction, CalAIM represents a fundamental shift in the Medi-Cal delivery system, benefits, and financing structure. As such, several authorities in the

Medi-Cal 2020 Section 1115 demonstration will be transitioned to the consolidated 1915(b) waiver or the Medi-Cal State Plan, and some are no longer needed. In sunsetting or transitioning these programs, the State seeks to build upon their successes to date and take an important step toward a more integrated, whole person-oriented Medicaid delivery system.

Medi-Cal Managed Care

DHCS will not continue Medi-Cal managed care delivery system authority under a Section 1115 demonstration; rather, the authority will be transitioned to a consolidated 1915(b) waiver, which will be the vehicle to authorize Medi-Cal managed care for current beneficiaries, including CCI, which was previously authorized by the Medi-Cal 2020 Section 1115 demonstration. DHCS also will seek 1915(b) waiver authority to standardize Medi-Cal managed care enrollment statewide. Additional aid code groups—Trafficking and Crime Victims Assistance Program (except share of cost); Individuals participating in accelerated enrollment; Child Health and Disability Prevention infant deeming; and Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)—will be required to enroll in Medi-Cal managed care in all counties starting in 2020. Some American Indians and Alaska Natives may be eligible for Medi-Cal coverage in these additional aid code groups. As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of mandatory Medi-Cal managed care enrollment for fee-for-services. In non-COHS counties, beneficiaries with other health coverage and beneficiaries in rural zip codes will no longer be excluded and will be subject to mandatory Medi-Cal managed care enrollment. Finally, all dual eligibles will be required to enroll in Medi-Cal managed care in 2023. As of March 2020, approximately 80 percent of the State's Medi-Cal beneficiaries across 58 counties received their health care through managed care.

Whole Person Care (WPC) and Health Homes Program (HHP)

Building on the successes of the WPC pilots and HHP, California intends to seamlessly transition beneficiaries served by these two programs to ECM and targeted ILOS. ECM and ILOS will be delivered through Medi-Cal managed care and by community providers under contract with MCPs. DHCS plans to phase in ECM beginning in 2022 to align with the phase-out of the WPC pilots and HHP, now that California has tested and validated the approach embodied by these programs. State-approved ILOS will be available beginning in 2022.

As a result of this transition, California is not requesting the renewal of authorities related to the WPC pilots and HHP during this renewal period. Instead, ECM will build

on both the design and learning from the WPC pilots and HHP and, with ILOS,[24] will replace both models. The combination of ECM and ILOS within CalAIM represents an opportunity for MCPs to work with providers, counties, and community-based organizations to knit together a stronger set of supports for those who need it most, supported entirely within the managed care delivery system.

DHCS will continue to support the WPC pilots and MCPs as they work to ensure a seamless transition for enrollees receiving pilot services. Careful planning and handoffs will be required to ensure continuity of coverage, and stakeholder engagement will remain critical as the ILOS and ECM services launch. California intends to make robust investments in provider capacity to deliver these services; in addition, the PATH Supports expenditure authority described above will enable the State to ensure that providers, plans, and the State have the resources necessary to support services and build capacity in order to strengthen the delivery and efficacy of care otherwise available in the Medi-Cal program, promoting seamless, high-quality care.

Oral Health Services

The DTI authorized under Medi-Cal 2020 was designed to improve dental health for children by focusing on high-value care, improved access, and incentivizing performance. Building upon the DTI, and in acknowledgement of the State legislature's charge that DHCS achieve a 60 percent dental usage rate for Medi-Cal-eligible children, DHCS plans to establish a new, statewide dental benefit for children, encompassing the services included in domains 1 through 3 of the DTI. The State's approach aligns with the CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and Children's Health Insurance Program children ages 1 to 20 who receive a preventive dental service) and lessons learned from the DTI.

DHCS also will offer new dental benefits statewide for children and certain adult enrollees, as well as expanded pay-for-performance initiatives. These include:

- A Caries Risk Assessment Bundle for young children
- Silver diamine fluoride for young children and for adults in specified high-risk and institutional populations, including those living in a skilled nursing facility/intermediate care facility or who are part of the Department of Developmental Services population

[24] Consistent with federal regulations (42 CFR § 438.3(e)(2)), DHCS will encourage MCPs to offer a menu of ILOS to comprehensively address the needs of members with the most complex health challenges, including social determinants of health.

- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home

These services and payment initiatives will be included in forthcoming amendments to the Medi-Cal State Plan.

Managed Care for Seniors and Persons With Disabilities (SPDs)

Beginning in 2011, California transitioned its SPD population from the Medi-Cal fee-for-service (FFS) delivery system into the managed care delivery system (i.e., enrolled them in Medi-Cal managed care health plans between June 2011 and May 2012). The transition occurred in Two-Plan and Geographic Managed Care (GMC) plan model counties—16 counties total—across California. Under CalAIM, the authority to enroll the SPD population into managed care will transition out of Section 1115 demonstration authority and into the consolidated 1915(b) waiver.

Tribal Uncompensated Care

DHCS made uncompensated care payments for certain optional services previously eliminated from the Medi-Cal State Plan that are provided by Indian Health Service (IHS) tribal health programs operating under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries. DHCS implemented tribal FQHCs, obviating the need for these uncompensated care payments.

Rady Children's Hospital of San Diego California Children's Services (CCS) Pilot

DHCS will sunset the CCS pilot.

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 COHS are the sole source for Medi-Cal services in that county. In order 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 in the Medi-Cal 2020 demonstration. DHCS currently has approval through the 1115 demonstration to allow Medi-Cal beneficiaries to enroll in a Program of All-Inclusive Care for the Elderly (PACE) independent of the COHS MCP in two COHS counties: Humboldt and Orange. The State will shift authority to the consolidated 1915(b) waiver

to continue to allow for Medi-Cal beneficiaries to enroll in PACE in selected COHS counties.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

The PRIME program was replaced by the State's QIP managed care direct payment program as of July 1, 2020.

Coordinated Care Initiative (CCI)

CCI is a Medi-Cal managed care program in seven counties that is designed to provide integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community

The CCI is composed of two parts: (1) Cal MediConnect (CMC), a Section 1115A demonstration project under the federal Financial Alignment Initiative that combines acute, primary, institutional, and home and community-based services into a single benefit package for Medicaid eligible individuals who are fully or partially eligible for Medicare; and (2) mandatory Medi-Cal managed care enrollment for dual-eligibles for most Medi-Cal benefits and Medi-Cal managed care carve-in for long-term care and some managed long-term services and supports (MLTSS).

DHCS is proposing to transition both components of the CCI into a statewide aligned enrollment structure, in which dual eligible beneficiaries will enroll in a Medi-Cal Managed Care Plan and have the option to enroll in a dual eligible special needs plan (D-SNP) operated by the same parent company to allow for greater integration and coordination of care. This will be an important step to achieving integration of long-term services and supports (LTSS) into Medi-Cal Managed Care Plans for dual eligible beneficiaries in all counties. DHCS plans to begin this transition in CCI counties starting in 2023, and will expand this approach statewide by 2025. DHCS seeks this managed care authority (now provided under the Section 1115 demonstration) via the consolidated 1915(b) waiver and will work with the CMS Medicare-Medicaid Coordination Office to effectuate necessary changes to the Section 1115A Financial Alignment Initiative.

Section 5 – Demonstration Evaluation Results to Date

As required under the STCs of the Medi-Cal 2020 Section 1115 demonstration, California engaged independent research organizations to evaluate the performance of Medi-Cal 2020 programs, including the GPP, the DMC-ODS, out-of-state former foster care youth, SPDs, the DTI, PRIME, the WPC pilots, and the CCS. The overall results of these evaluations demonstrate that Medi-Cal 2020 has had significant success in achieving its stated aims, including driving delivery system reform and improving access and quality of care, particularly for high-need beneficiaries.

Because the many programs included in the Medi-Cal 2020 demonstration have different time frames, structures, and funding streams, the evaluation designs and timelines for the programs also vary. For initiatives where interim evaluation reports, rather than final evaluation reports, have been completed, work on the final evaluations is continuing and will be provided to CMS as required by the demonstration STCs. All of the State's evaluation materials are available on the DHCS website.

GPP Evaluation

Consistent with the STCs of California's Medi-Cal 2020 Section 1115 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 its final evaluation report, released in June 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 the following:

- **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 usage show that over the demonstration, PHCSs shifted care from inpatient medical and surgical services and emergency room visits to nonemergent outpatient services. For nonbehavioral health services, there was an increase in points earned for nonemergent outpatient services overall (12 percent increase) and for nine of the 12 PHCSs individually. There was a concomitant decrease in points earned for both inpatient medical and surgical services (15 percent decrease overall and for seven of the 12 PHCSs individually) and emergency room visits (14 percent decrease overall and for eight of the 12 PHCSs individually). The researchers found unexpected changes in the usage of behavioral health services—specifically, a 4 percent decrease in outpatient mental health and SUD treatment services and a 21 percent increase in inpatient behavioral health treatment services—but also a favorable decrease of 14 percent in the use of mental health emergency room and crisis stabilization services.
- **Increases in care for the uninsured.** There was a more than 6 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

Consistent with the STCs of the Medi-Cal 2020 Section 1115 demonstration, DHCS engaged the UCLA Integrated Substance Abuse Programs to assess the DMC-ODS program in accordance with the CMS-approved evaluation plan. DHCS has partnered with UCLA to evaluate the DMC-ODS program since 2016, focusing on measures of treatment access, quality, and coordination of care. The 2020 evaluation report was issued in March 2021 based on data collected in 2019 and early 2020, with earlier periods used for comparison purposes where available. On July 1, 2020, seven additional counties participating in a regional model under the Partnership Health Plan of California (PHC) went live in the DMC-ODS program.

The evaluation report relies on statewide data collected by UCLA through stakeholder surveys, key informant interviews, client treatment perception interviews, a unique American Society of Addiction Medicine (ASAM) screening and assessment database created for the DMC-ODS, and "secret shopper" calls to beneficiary access lines. UCLA also conducted analyses of administrative data received from DHCS, including Medi-Cal claims and treatment episode data.

In the report, the UCLA researchers explained that the DMC-ODS program has increased access to and improved the quality of SUD treatment services in implementing counties.

- **Increased access to SUD treatment services.** Seven or more months after the introduction of the DMC-ODS pilots, the number of patients using DMC-ODS services increased on average by nearly 30 percent. More than 80 percent of county administrators reported the DMC-ODS pilots increased access to SUD services in their counties. Although there has been great variation between counties, with some increasing services immediately and others showing little change, the UCLA researchers found that in at least 13 of the 30 counties there was a clear increase in the number of beneficiaries using DMC-ODS services following the county's implementation of the DMC-ODS.
- **Increased quality of SUD treatment services.** Data suggests that the DMC-ODS is improving treatment quality, with overall patient satisfaction high, and county administrators continuing to report that the DMC-ODS pilots positively

influenced quality improvement efforts. Counties and SUD treatment providers report meeting and, in many cases, surpassing use of two evidence-based practices, the minimum requirement under the DMC-ODS pilots. They also report widespread use of ASAM criteria-based assessment tools to help determine level-of-care placement.

- **Increased follow-up for SUD treatment services following a referral.** The researchers found that most patients (83 percent) were referred to the level of care indicated by their ASAM criteria screenings or assessments, and most of the referred patients (80 percent) went on to receive treatment at the providers to which they were referred within 30 days of their initial screening or assessment.
- **Enhanced patient-centered care in SUD treatment services.** Both providers (67 percent) and patients (87 percent for adults; 85 percent for youth) 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.

The report also suggests the DMC-ODS had a positive impact on coordination of 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. The lower ratings seem to reveal a better understanding of challenges the county administrators were not aware of before implementing the DMC-ODS pilots. Some of these challenges include barriers to sharing patient information, separate billing silos, lack of alignment between Medi-Cal requirements and certifications (specifically with mental health), and continued stigma toward SUD patients (especially in physical health care settings). DHCS expects that during the renewal demonstration period, county programs will continue to build on the progress they made in cross-system integration during the expiring demonstration period. As described in Section 6 below, DHCS has developed a robust plan for evaluating performance in this area and will continue to support county pilots in their efforts to increase cross-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 medications for addiction treatment (or MAT), and expanding youth treatment and withdrawal management services. UCLA sought to address the DMC-ODS challenges by producing case studies on stakeholders overcoming common challenges, recommending training topics based on stakeholder input, and filling specific needs such as developing free screening and assessment tools.

The COVID-19 pandemic caused a rapid shift from in-person services to telehealth. Of note is that in response to COVID-19, providers in DMC-ODS-participating counties made a number of changes to their services provided. The UCLA researchers found

that nearly all DMC-ODS counties expanded services by telehealth. Prior to COVID-19, only 27 percent of DMC-ODS counties had offered treatment by telehealth. Both counties and patients reported high satisfaction with its use. Overall, UCLA found that the DMC-ODS has been successful at improving treatment access, quality, and coordination/integration of care for the 96 percent of Medi-Cal enrollees DMC-ODS covers (with the remaining 4 percent living in the 21 mostly small, rural counties that have not opted in to the DMC-ODS as of early 2021). The researchers' findings support the CalAIM initiatives DHCS is currently proposing to improve the DMC-ODS, including the following:

- Removing the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarifying that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined;
- Clarifying the recovery services benefit
- Expanding access to MAT
- Increasing access to SUD treatment for American Indians and Alaska Natives
- Expanding access to Contingency Management for treatment of stimulant use disorder

Out-of-State Former Foster Care Youth Evaluation

As required under California's Medi-Cal 2020 Section 1115 demonstration, DHCS is evaluating how the expansion of Medi-Cal coverage for former foster care youth who aged out of foster care under the responsibility of another state or tribe strengthened coverage and improved health outcomes for these youth. The interim evaluation published in September 2020 compared data from out-of-state former foster care youth in 2017 to those in 2018 and found that the coverage expansion achieved the demonstration goals aiming to maintain continuous health insurance coverage, improve and ensure positive health outcomes, and improve health care service usage and access among this population.

- **Improved continuous coverage.** Out-of-state former foster care youth with continuous health insurance coverage increased to 16,590 enrollees in 2018, up from 14,442 enrollees in 2017.
- **Increased service usage.** Out-of-state former foster care youth received or had access to emergency and hospital services more often than did their peers. In 2018, 40 percent of youth in this population used emergency departments (down from 41 percent in 2017); 4 percent used inpatient hospitalizations (up from 3 percent in 2017); and 13 percent used behavioral health visits (down from 14 percent in 2017). The same percentage of this population—44 percent—used ambulatory care visits in both 2017 and 2018.
- **Consistent chlamydia and cervical cancer screenings and initiation of treatment for SUD.** In 2018, 69 percent of youth in this population were

screened for chlamydia (up from 68 percent in 2017) and 31 percent received initiation and engagement of alcohol and other drug treatment (up from 27 percent in 2017); this is consistent with their peers. Cervical cancer screening remained the same in both 2017 and 2018, with 43 percent of this population having received a screening.

- **Improvement needed for medication measures and follow-up after hospitalization for mental illness.** Compared to their peers, out-of-state former foster care youth did not do as well on medication management measures, including: antidepressant medication management (13 percent in 2018, up from 10 percent in 2017); asthma medication ratio for people with asthma (36 percent in 2018, down from 42 percent in 2017); and annual monitoring for patients with persistent medication (73 percent in both 2017 and 2018). For follow-up after hospitalization for mental illness, youth in this population receiving this service in 2018 was 63 percent (down from 64 percent in 2017).

Overall, the interim evaluation report results show increasing and strengthening coverage of former foster care youth and improving health outcomes for these youth, indicating that this demonstration is on a trajectory to achieve its objectives over the full five-year demonstration period.

SPD Evaluation

As noted above, beginning in 2011, California transitioned its population of SPDs from the Medi-Cal fee-for-service delivery system into the managed care delivery system. Consistent with the STCs of the Medi-Cal 2020 Section 1115 demonstration, DHCS engaged UCLA to assess the SPD program in accordance with the CMS-approved evaluation plan. The SPD evaluation examines the impact of the transition on beneficiary experience and the impact of the State's administration of the program overall using measures describing three specific content areas: (1) access to care; (2) quality of care; and (3) costs of coverage (care).

The evaluation leverages existing patient-level and supplemental data, specifically enrollment and claims/encounters supplemented with other patient-level data, collected by the State to assess the three content areas for the SPD population in the period surrounding the transition and the maintenance of performance in the post-transition period. The vast majority of SPDs across the entire state were in managed care by 2016.

The interim evaluation activities found—through a review of metrics in the approved protocol and candidate claims-based quality metrics that can be implemented with available data—that the explicitly approved measures for the evaluation require greater granularity and scope in order to measure access, quality, and cost. Additionally, heterogeneity of data across the evaluation period requires the inclusion of external data sources for the validation and construction of alternative measures. Finally, the interim results must focus on the period with the greatest data consistency while

external data sources are being compiled. Additional analysis is being conducted to address these initial findings to ensure that the targets of the consolidated 1915(b) waiver are addressed.

Based on the initial assessment of the data, the interim evaluation finalized in December 2019 was able to conclude the following:

- **Expansion of managed care.** Medi-Cal has successfully transferred most nondual SPDs into managed care, with 90 percent of the SPD population enrolled in managed care by 2018, covering 975,233 individuals. This transition greatly expanded care delivery for SPDs among plans.
- **Improved access to managed care in rural areas.** In difficult-to-reach rural areas, DHCS implemented two Medi-Cal managed care delivery models to improve coverage access in rural counties: COHSs in eight counties and the regional model (a single, commercial managed care model) in 21 Central Sierra counties.
- **Stable mortality for SPD population.** Overall, mortality appears to be stable, with an increase in mortality in the managed care population reflecting adverse selection for fee-for-service, with healthier SPD patients opting for optional managed care enrollment prior to the transition period. In 2018, the mortality rate for the SPD population enrolled in managed care was 19.2 per 1,000 patients, compared to 18.6 per 1,000 patients in 2017. The rate remained relatively stable in the fee-for-service SPD population, at 29.4 per 1,000 patients in 2018 and 29.8 per 1,000 patients in 2017.
- **Improved data quality and reporting uniformity.** The data quality and consistency appear to have substantially improved since the introduction of the Post Adjusted Claims & Encounters System. This data quality improvement enforced uniform reporting standards and audit procedures, which makes the evaluation, following the waiver extension, more robust.

DHCS is no longer requesting authority to mandatorily enroll SPDs in Medicaid managed care via Section 1115 authority. Under CalAIM, the authority to enroll the SPD population into managed care will transition out of Section 1115 authority and into the consolidated 1915(b) waiver; additionally, DHCS is, over time, implementing several changes to improve care for dual-eligibles, described in the CalAIM proposal. The State will use the findings from this evaluation and the future final evaluation to inform delivery system design and implementation in order to ensure that SPDs continue to have access to high-quality care.

These early results from the evaluation point to general programmatic successes for the mandatory SPD transition to managed care in terms of moving enrollees to managed care across the entire state and toward managing costs. The findings for the SPD evaluation thus far indicate that the program is on a trajectory to meet the targets for the

consolidated 1915(b) waiver. The final report will address further analysis for access to care and quality of care and an analysis for cost of coverage, which was not fully addressed in the SPD interim report. The final report is on schedule for a timely submission to CMS on December 31, 2021.

DTI Evaluation

Consistent with the STCs of the Medi-Cal 2020 Section 1115 demonstration, DHCS engaged Mathematica to assess the DTI in accordance with the CMS-approved evaluation plan. The interim evaluation published in September 2019 identified that the DTI did improve Medi-Cal participation due to the increased statewide outreach efforts during the DTI demonstration period with two large public awareness campaigns for oral health care.

- **Domain 1: Incentive payment for increasing preventive care.** The State aims to meet its goal of increasing statewide usage of preventive dental services among Medi-Cal-eligible children (up to age 20) by 10 percentage points over the five-year demonstration period. The interim evaluation concluded that in Program Year 2, 63 percent of dental providers statewide earned incentive payments for increasing by at least two percentage points the number of children who received preventive care in their practice. As a result, DHCS provided more than $54.3 million to 4,070 dental offices.
- **Domain 2: Incentive payment for assessing caries risk and managing disease.** In all, 11 counties participated in Domain 2 in Program Year 2, with dental providers statewide having received incentive payments for emphasizing preventive care and noninvasive approaches for children (up to age 6) identified as high or moderate risk for caries, as well as having provided nutritional counseling and motivational interviewing. About 54 percent of dental providers in the 11 participating counties received incentive payments for Domain 2. DHCS provided approximately $5.5 million in incentive payments to 163 dental providers.
- **Domain 3: Incentive payment for promoting continuity of care.** In Program Year 2, 17 counties participated in Domain 3, in which dental providers received incentive payments for promoting continuity of care, with children (up to age 20) enrolled in Medi-Cal returning to the same practice for an annual dental exam. In 2017, this translated to 259,590 unduplicated pediatric beneficiaries returning to the same office location as [was used in] 2016 for their annual dental exam. DHCS provided over $11.9 million to 742 dental providers, or 70 percent of dental providers, in the participating counties.
- **Domain 4: Community-based supports for children's oral health.** Starting in 2017 and continuing through 2018, DHCS supported 13 programs across the state that tested strategies to advance one or more of the goals of domains 1, 2, or 3. The programs were diverse, including county and city governments, local

First 5 county commissions, universities, and the California Rural Indian Health Board. Common strategies reported by these programs included implementing care coordination and oral health education, improving communication and messaging with target populations, using virtual dental homes, partnering with primary care providers, and implementing quality improvement. DHCS provided over $25 million total to all 13 programs between 2017 and 2018.

Mathematica's findings suggest that transitioning many components of the DTI demonstration into a statewide program, as the State proposes under CalAIM, is likely to continue to improve outcomes for beneficiaries. Building upon the DTI, and in acknowledgement of the State legislature's charge that DHCS achieve a 60 percent dental usage rate for Medi-Cal-eligible children, DHCS plans to establish a new, statewide dental benefit for children, encompassing the services included in Domains 1 through 3 of the DTI.

PRIME Evaluation

For the PRIME program, the UCLA Center for Health Policy Research conducted an interim evaluation (DHCS submitted to CMS September 2019 and finalized March 2020) and a preliminary summative evaluation (DHCS submitted to CMS December 2020 and finalized February 2021), with a draft Final Summative Evaluation Report due to CMS on August 31, 2021. These evaluations tested the five main goals of PRIME, which were to: (1) increase provision of patient-centered, data-driven, team-based care; (2) improve the provision of point-of-care services, complex care management, population health management, and culturally competent care; (3) improve population health and patient experience in Medi-Cal; (4) integrate physical and behavioral health services and coordinate care for vulnerable populations; and (5) transition public hospitals to value-based care through the adoption of alternative payment methods.

The interim evaluation comprehensively analyzed the PRIME program from baseline Demonstration Year (DY) 11 through two years of program implementation, through DY 13. It used both qualitative and quantitative data gathered from the participating PRIME entities (17 designated public hospital systems and 35 district municipal hospitals (DMPHs)) as well as Medi-Cal enrollment and claims data and hospital discharge data from the Office of Statewide Health Planning and Development (OSHPD). The preliminary summative evaluation was cumulative through DY 14 and focused on qualitative data only, which UCLA defined as entity survey results and self-reported metric data. UCLA performed a rigorous Difference-in-Differences (DID) quantitative analysis for the interim evaluation, and will do so again for the final summative evaluation. The comprehensive DID analysis will include rigorous comparison of metric trends based on state-level data before and during PRIME, comparing patients of PRIME hospitals to those of non-PRIME hospitals. Additionally, the final summative evaluation will include a cost analysis based on all five years of the PRIME program.

For the two evaluations finalized to date, key findings include the following:

- **Goal 1: Increase provision of patient-centered, data-driven, team-based care.** The findings for this goal are mainly positive. In the interim evaluation DID analysis, UCLA identified five metrics to gauge the success of this goal. All pertained to projects involving the redesign of ambulatory care and showed improvements for PRIME patients in areas such as primary care follow-up rates for hypertension and primary care visits per 1,000 Medi-Cal enrollees, as compared to non-PRIME patients. (Please see Interim Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Exhibit 376, page 878, for details).
- **Goal 2: Improve the provision of point-of-care services, complex case management, population health management, and culturally competent care.** The findings for this goal are mainly positive. In the interim evaluation DID analysis, UCLA identified 11 metrics to gauge the success of this goal. Overall, nine metrics showed significant improvement among PRIME designated public hospital patients, including increased rates of breast cancer screening and cervical cancer screening, reduced rates of Cesarean section, increased rates of perinatal care, and increased rates of follow-up visits within seven days of hospitalization, as compared to non-PRIME patients. Among DMPHs, five metrics showed improvement, including higher rates of outpatient follow-up visits within seven days of hospitalization and avoidance of antibiotic treatment in adults with acute bronchitis, as compared to non-PRIME patients.
- **Goal 3: Improve population health and patient experience in Medi-Cal.** The interim evaluation DID analysis findings for this goal did not show improvement for designated public hospital and DMPH patients versus comparison patients. The Prevention Quality Indicator (PQI) metric (which evaluates preventable hospitalization rates) was expected to decrease but actually increased among PRIME patients when compared to non-PRIME patients. Similarly, the All-Cause Readmission rates did not improve and increased for DMPHs. (Please see Interim Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Exhibit 376, page 878, for details). Although the quantitative analysis did not show positive results, the qualitative self-reported hospital data in the preliminary summative evaluation supports the conclusion that some progress has occurred for specific hospitals for both the PQI and All-Cause Readmission measures. We look forward to the DID analysis in the final summative evaluation and hope to see improvement in some of these outcomes.
- **Goal 4: Integrate physical and behavioral health services and coordinate care for vulnerable populations.** This goal was extensively evaluated through survey results and self-reported metric data, which showed that entities increased screening for depression, rates for depression remission and follow-up, and tobacco assessment and counseling within the primary care setting.

Additionally, a central focus of PRIME was to improve documentation of and stratification by patient demographics, particularly race, ethnicity, and language (REAL) and sexual orientation and gender identity (SOGI), which were used to focus on improving disparities in care. These efforts can be found in Exhibit 183 of the Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program.

- **Goal 5: Transition public hospitals to value-based care through the adoption of alternate payment methodologies.** In PRIME, all hospitals reported metric data and were paid based on achievement of improvement targets in project metrics, targets which became more difficult over time. By DY 14, designated public hospital systems achieved 76 percent–92 percent of their pay-for-performance quality targets (depending on metric type) and DMPHs achieved 60 percent–77 percent (see the Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, exhibits 30 and 31). Additionally, starting in 2018, all designated public hospital systems were required to establish alternative payment methodology (APM) arrangements (including capitation, risk pool payments, and other risk-sharing arrangements) with Medi-Cal Managed Care Plans. An analysis of these APMs will be presented in the final summative evaluation currently being prepared.

Looking Forward

The interim evaluation concluded that the full impact of PRIME on patient outcomes will be more accurately assessed at the end of PRIME, when efforts to fully implement all projects and to address the challenges to achieving metrics are finalized. All demonstration years of PRIME, from DY 11 to DY 15, will be included in the forthcoming final summative evaluation.

Transition to QIP

The lessons learned from PRIME supported expanding the program statewide. The PRIME funding structure was transitioned into directed QIP payments effective July 2020. Through QIP, designated public hospital systems and DMPHs have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal Managed Care Plans, based on a set of quality improvement measures. DHCS is not requesting authority to renew PRIME as part of this renewal request and will continue QIP as a managed care directed payment program.

WPC Evaluation

California's WPC pilots implemented under the Medi-Cal 2020 Section 1115 demonstration are designed to coordinate medical, behavioral, and social services in order to improve the health and well-being of Medi-Cal beneficiaries with complex needs. The State engaged the UCLA Center for Health Policy to conduct an evaluation

of the WPC program. In an interim evaluation, published in September 2019, the researchers found that in the three years since the program's inception in January 2017, the WPC pilots successfully implemented many essential care coordination processes, but they continued to further develop needed infrastructure. The researchers concluded that these findings highlight the opportunities and challenges in implementing a cross-sector care coordination program for patients with complex health and social needs.

The interim evaluation found that the WPC pilots had already made progress in improving data sharing infrastructure, including implementing tools to coordinate care in real time and maintain a shared care plan, accessible to multiple service providers. UCLA's findings include the following:

- **Strong motivation for WPC participation.** The WPC pilots reported their highest objectives for participating in WPC were: (1) reducing silos in care; (2) improving the value of care; and (3) increasing access to patient-centered care. WPC lead entities reported their highest motivators as getting necessary services to enrollees, improving integration of care for enrollees with multiple needs, and improving quality of care.
- **Improvements in health information technology and data sharing infrastructure.** The WPC pilots reported that data improvements through the WPC pilots allowed them to identify eligible Medi-Cal beneficiaries and target populations, as well as track performance and providers. Health Information Exchanges (HIEs) were a common platform for pilots, with 13 out of 27 participating in an HIE.
- **Improved identification, continuous enrollment, and engagement with beneficiaries.** The pilots saw significant growth in WPC enrollment, with limited churn and high levels of retention among enrollees, with the WPC pilots collectively enrolling 108,667 unique individuals between 2017 and 2018, and nearly half (49 percent) of enrollees staying continuously enrolled; only 7 percent of enrollees enrolled and disenrolled multiple times.
- **Targeted pilot services offered and delivered.** All the WPC pilots provided care coordination and housing services, with UCLA finding that the services delivered by the pilots were frequently aligned with the needs of the target population. Other services used frequently by WPC enrollees included peer supports (46 percent); benefit supports for Medi-Cal, CalFresh, or transportation to appointments (69 percent); employment assistance (45 percent); sobering center care (5 percent); and medical respite care (3 percent).
- **Improved care coordination.** To deliver care coordination, the WPC pilots formed care coordination teams, implemented data sharing across sectors, 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. Overall, 20 of the 26 pilots included peers with similar

lived experiences to their target populations in providing care coordination, and all 26 pilots required the care coordinators to contact enrollees more than once a month.

- **Improved care for pilot enrollees.** The WPC pilots successfully provided better care to WPC enrollees, including an increase in follow-up rates after hospitalization for mental illness at seven days (an increase from 55 percent baseline to 59 percent) and at 30 days (an increase from 74 percent baseline to 82 percent), as well as an increase of initiation and engagement of alcohol- and other drug-dependent treatment rates (an increase from 41 percent baseline to 53 percent), an increase in suicide risk assessments conducted for enrollees with a diagnosis of major depressive disorder (an increase from 10 percent baseline to 21 percent), and an increase in the number of enrollees receiving a comprehensive care plan within 30 days of enrollment (from 12 percent baseline to 27 percent).
- **Improved health for pilot enrollees.** WPC pilot enrollees reported a decrease in emergency department visits (from 214 to 181 in the second year of pilot enrollment). In addition, WPC pilot enrollees who were incarcerated reported improved health while participating in the pilots, including an increase from 8 percent to 22 percent having reported being in excellent/very good overall health and an increase from 15 percent to 22 percent having reported being in excellent/very good emotional health. Justice-involved individuals enrolled in the pilot were found to have increased control of their blood pressure, from 36 percent to 65 percent, as well as an increase from 52 percent to 58 percent with controlled HbA1c among enrollees with diabetes.

Overall, the results indicated significant progress in the establishment of needed infrastructure and processes to support effective care coordination, including the development of health information technology and the establishment of partnerships for managing care and better care outcomes. The interim evaluation provided extensive evidence that the WPC pilots developed infrastructure and followed deliberate processes to implement the program and deliver services in order to promote better care and better health and to reduce costs. While the evidence of success for specific infrastructure and process elements was variable, independent analyses of Medi-Cal data showed success in better care and potential improvements in health to be further assessed at the conclusion of the WPC program. The interim evaluation confirmed the program's success in enrolling high-risk, high-use Medi-Cal beneficiaries, many of whom had ongoing medical and psychosocial conditions and were medically complex prior to enrollment. These enrollees required intensive care coordination and service needs.

The interim evaluation notes that the progress of the WPC pilots reflected the challenges of historical gaps in the management of these patients and difficulties in addressing underlying social determinants of health, particularly for highly complex

patients. Addressing these substantial challenges requires time, resources, and deliberate effort, the evaluators found. The final WPC evaluation will include an assessment of each target population by pilot and compare the differences in the "package of interventions" of each pilot to potentially identify services that improve outcomes. Further, the final WPC evaluation report will include an assessment of all five years of the WPC program, as well as analyses of lower costs and the likelihood of sustainable elements of WPC.

The WPC pilots will inform California's implementation of its CalAIM initiatives, which are designed to identify and manage beneficiary risk and need through WPC approaches and addressing social determinants of health.

CCS Evaluation

Consistent with the STCs of the Medi-Cal 2020 Section 1115 demonstration, DHCS engaged the University of California San Francisco (UCSF) Philip R. Lee Institute for Health Policy Studies to assess the CCS demonstration pilot in accordance with the CMS-approved evaluation plan. The CCS pilot program focused on pediatric populations enrolled in CCS pilots in order to increase access to care, increase patient and family satisfaction, increase provider satisfaction with the delivery and reimbursement of services, increase high-quality care, decrease inpatient and emergency room care (thus increasing care coordination), and decrease the total cost of care. The interim evaluation concluded in August 2020 and public results are expected to be finalized by December 2021. DHCS is not requesting authority to continue the CCS pilot as part of this renewal request.

Section 6 – Demonstration Renewal Evaluation

During the five-year renewal period, for elements of the demonstration that are continuing unchanged in the Section 1115 five-year extension, DHCS will continue to contract with independent third parties to evaluate the demonstration consistent with sanctioned evaluation and monitoring protocols approved in the Medi-Cal 2020 STCs, collaborating with CMS where necessary to update evaluation and monitoring plans as required by subsequent federal guidance. For new programmatic elements, CalAIM also will test the hypotheses included in Table 4 below. With respect to the DMC-ODS, in addition to assessing the new programmatic elements described below, DHCS will work with CMS to establish modified monitoring and evaluation protocols that are consistent with CMS guidance issued in November 2017.[25] As described above, DHCS has conducted thorough evaluations of the DMC-ODS; however, CMS has, since California became the first state in the country to receive a Section 1115 SUD demonstration, established specific milestones, performance measures, and evaluation report requirements for all states. Although DHCS is requesting authority for the DMC-ODS

[25] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

using both Section 1115 demonstration and 1915(b) waiver authorities (along with corresponding SPAs for certain DMC-ODS benefits), DHCS anticipates establishing comprehensive, program-wide evaluation and monitoring protocols in the CalAIM Section 1115 demonstration STCs.

For elements of the Medi-Cal 2020 demonstration that are continuing during this renewal period (the CalAIM demonstration), the State will include the January 1, 2021–December 31, 2021 temporary extension period in the final CalAIM demonstration evaluations for those programs.

Consistent with past practice, the demonstration design and evaluation plan will support generalized findings, and the evaluation reports will carefully explore and explain the limitations of the demonstration design, as well as the integrity and appropriateness of the data and the analytic methods used to support the study. The evaluation plan will include use of comparison groups wherever possible, establish or identify baseline data, measure the programs, and explore the meanings of the findings in a lessons-learned format. The evaluation will aim to ensure sufficient causal factors and population effects.

Table 4. New Evaluation Hypotheses Under Consideration

New Hypotheses	Evaluation Approach	Data Sources
I. GPP: Equity Sub-pool		
The demonstration will improve access to services that address the social determinants of health among the uninsured and contribute to reducing health disparities and promoting health equity.	Examine the utilization of SDOH-related services over time (from the first year of the equity pool), stratified by race/ethnicity.	• GPP Equity Sub-pool services utilization data, stratified by race/ethnicity data
Individuals who access GPP Equity Sub-pool services will experience reductions in ED utilization and inpatient hospitalizations.	Examine inpatient and emergency utilization over time for individuals who receive GPP SDOH-related services via the GPP, stratified by race/ethnicity	• GPP Equity Sub-pool services utilization data, stratified by race/ethnicity data • Hospital and emergency utilization data, stratified by race/ethnicity data

By providing funding for services to address SDOH, the demonstration will improve participating public health care systems' capacity to provide SDOH services to the uninsured.	Examine progress in developing capacity to serve the uninsured with SDOH-related services, including: improved data sharing and collaboration between public health care systems and social service/community-based organizations, improved ability to collect and analyze REAL data for the uninsured, and system improvements in screening uninsured populations to assess need for SDOH supports.	• Surveys and/or interviews of GPP leads • Pre- and post-implementation surveys to track changes and progress over time
II. Justice-Involved Populations		
The demonstration will improve physical and behavioral health outcomes of justice-involved populations post-release.	Examine the diagnoses and health outcomes for justice-involved populations	• Usage and diagnosis data • California Outcomes Measurement Systems (CalOMS) data • Quality measures (Healthcare Effectiveness Data and Information Set (HEDIS))
The demonstration will reduce emergency department visits, hospitalizations, and other avoidable services by connecting justice-involved populations to ongoing community-based physical and behavioral health services.	Examine the utilization of medical and behavioral health services and treatment	• Usage data • CalOMS data • Quality measures (HEDIS)

The demonstration will promote continuity of medication treatment for individuals receiving medications.	Examine the number of medication claims and usage surveys and interviews to measure the usage and challenges associated with medication treatment post-release	• Pharmacy claims • CalOMS data • Surveys and interviews • Usage and diagnosis data
III. DMC-ODS Program Changes *(includes evaluations related to changes DHCS is currently negotiating with CMS and requested renewal changes)*		
(a) *Increase access to SUD treatment for American Indians and Alaska Natives*		
The number of residential treatment admissions among American Indian/Alaska Native beneficiaries will increase during the 12-month and five-year periods.	UCLA will examine residential treatment admissions among American Indian/Alaska Native beneficiaries; UCLA will look for changes in metrics such as retention (time of treatment) and impact (e.g., treatment completion, satisfactory progress).	• DMC claims • CalOMS discharge status data
The total per-person time in residential treatment each year will increase during the 12-month and five-year periods.		
The number of American Indian/Alaska Native beneficiaries receiving community-based SUD treatment will increase.	UCLA will examine usage of SUD treatment services among American Indian/Alaska Native beneficiaries.	• Medi-Cal claims

(b) *Expand evidence-based practice options to include Contingency Management*		
The number of deaths among people with stimulant use disorder will be lower if using Contingency Management.	UCLA will examine the number of deaths among beneficiaries with stimulant disorder who have utilized Contingency Management services and those that have not.	• DMC-ODS claims • Death data from the California Department of Public Health
SUD treatment retention rates will increase among individuals with stimulant use disorder who receive Contingency Management incentives.	UCLA will examine usage of SUD treatment services among individuals using Contingency Management. It also will gather information by asking specific questions in surveys.	• DMC-ODS claims • Patient-reported outcomes survey
The percentage of people with stimulant use disorder who participate in Contingency Management will increase during the five-year period.	UCLA will examine the usage of Contingency Management for people with stimulant use disorder, pending implementation of a benefit and establishment of billing codes.	• DMC-ODS claims
The rate of negative drug screens (stimulant-free biological tests) will be higher among individuals with stimulant use disorder who participate in Contingency Management than among individuals with stimulant use disorder who do not participate in Contingency Management.	UCLA will examine rates of positive and negative drug screens among individuals with stimulant use disorder using Contingency Management.	• Data from Contingency Management app

(c) *Remove the limitations on residential treatment services that may be provided in a one-year period*		
Treatment outcomes for beneficiaries in residential treatment will improve.	Evaluator will review outcomes data.	• CalOMS data • DMC-ODS claims
(d) *Clarify that reimbursement is available for SUD assessment and appropriate treatment in nonresidential settings for up to 30 days (or 60 days if experiencing homelessness) prior to a diagnosis*		
The number of beneficiaries served will increase.	UCLA will determine the usage of SUD treatment services by county and service type.	• Drug Medi-Cal claims • ASAM Level of Care usage data
(e) *Expand access to MAT*		
The percentage of people with an SUD who use MAT will increase during the 12-month and five-year periods.	UCLA will determine the use of MAT among people receiving treatment from DMC-ODS providers. It also includes questions about MAT use and the use of effective referrals using county administrator surveys and interviews.	• Drug Medi-Cal claims • County administrator surveys and interviews
(f) *Clarify the recovery services benefit*		
The percentage of people with an SUD who use recovery services will increase during the 12-month and five-year periods.	UCLA examines the number of recovery services claims and uses surveys and interviews to measure the usage and challenges associated with recovery services.	• Drug Medi-Cal claims • Surveys and interviews

Section 7 – Demonstration Financing and Budget Neutrality

This section describes the demonstration initiatives for which DHCS anticipates financing changes and provides budget neutrality calculations for all demonstration initiatives.

DMC-ODS Financing

Financing for the DMC-ODS Program is currently governed by a certified public expenditure (CPE) protocol approved as attachment AA under California's Medi-Cal 2020 demonstration STCs. As part of this renewal application, DHCS seeks approval to transition DMC-ODS financing to a fee schedule structure to better align payment methodologies across the Medi-Cal delivery system, no sooner than July 2022. Accordingly, DHCS seeks to extend the current CPE protocol until at least July 2022, to be replaced by an intergovernmental transfer (IGT) protocol thereafter.

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to IGT-based methodologies will allow California to establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services, provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value, create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal Managed Care Plans and counties, and reduce State and county administrative burden by eliminating the cost-reconciliation process.

In conjunction with these financing changes, DHCS plans to transition from HCPCS Level II coding to CPT coding (where a suitable code exists). This will allow counties to receive payment for each service rendered under the rate established for each code. It also will allow counties and DHCS to better report performance outcomes and measures, and in turn will provide more useful information to inform policy decisions.

GPP Funding and Annual Limits

Continuation of GPP including DSH and SNCP Funding

The majority of the State's existing DSH allotment is allocated to make payments to participating designated public hospital systems that incur costs for services to the remaining uninsured. During each GPP PY, federal financial participation (FFP) will be available for such GPP expenditures up to the sum of (1) the amount equal to the State's DSH allotment as set forth in Section 1923(f) of the Social Security Act (the Act) and adjusted as described in subparagraphs (a) and (b) below (Adjusted DSH); (2) Safety Net Care Pool (SNCP) funding amounts established in the Medi-Cal 2020 demonstration ($472 million); and (3) SNCP funding to establish the new GPP Equity Sub-pool ($450 million) described below and in Section 3.

In order to align DSH amounts with each PY (which are shifting calendar years), each PY will include 50 percent of the State's Adjusted DSH for each of the federal fiscal years in which it falls. For example, PY 6B (Calendar Year (CY) 2021) will include 50 percent of the Adjusted DSH for each of federal fiscal years 2021 and 2022.

(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 amount set aside will be identified in the CalAIM STCs, currently Attachment NN (DSH Coordination Methodology) of the Medi-Cal 2020 demonstration.

(b) In any year in which reductions to California's DSH allotment are required by Section 1923(f)(7) of the Act, the amount of the DSH allotment attributable to GPP in a given GPP PY shall be reduced consistent with CMS guidelines.

Establishment of the GPP Equity Sub-Pool

Under the proposed GPP Equity Sub-pool, DHCS seeks to establish an additional $450 million in annual SNCP funding (bringing total SNCP funding to $922 million in PYs 7-11, as shown below). This funding acknowledges the cost of providing to uninsured individuals services to address the social determinants of health; these services are not contemplated under the SNCP allocations calculated to be $472 million for GPP PYs 1-5. Designated public hospitals would earn payments from the GPP Equity Sub-Pool by completing services and activities to promote holistic, whole-person care.

DHCS seeks to begin the GPP Equity Sub-pool payments in CY 2022. The total computable annual limits for the GPP Equity Sub-pool will not exceed $450 million in each of PYs 7 through 11 (CY 2022 through CY 2026).

GPP Annual Limits

The total computable annual limits for GPP PYs 6A–11 payments will not exceed the limits set forth below. DHCS is currently negotiating with CMS the approach to PYs 6A and 6B, and expects to finalize STCs related to those time periods in 2021. This renewal request relates to PYs 7–11.

- GPP PY 6A (July 1, 2020-December 31, 2020) – Adjusted DSH at 50% + $236 million = approximately $1.3 billion
- GPP PY 6B (CY 2021) – Adjusted DSH + $472 million = approximately $2.5 billion
- GPP PY 7 (CY 2022) – Adjusted DSH + $922 million = approximately $3.1 billion
- GPP PY 8 (CY 2023) – Adjusted DSH + $922 million = approximately $3.1 billion
- GPP PY 9 (CY 2024) – Adjusted DSH + $922 million = approximately $3.2 billion
- GPP PY 10 (CY 2025) – Adjusted DSH + $922 million = approximately $3.2 billion
- GPP PY 11 (CY 2026) – Adjusted DSH + $922 million = approximately

$3.2 billion

DHCS will not make DSH payments to designated public hospitals authorized to participate in the GPP. The State will continue to follow the DSH Coordination Methodology as currently outlined in Attachment NN.

Expected Enrollment Impact

The State is not proposing any changes to Medi-Cal eligibility requirements in the Section 1115 demonstration renewal request. As such, the demonstration is not expected to affect enrollment trends, which will continue to be determined largely by demographic changes, economic conditions and, if applicable, continued coverage requirements during the COVID-19 public health emergency. The amended and renewed Section 1115 demonstration will continue to authorize full-scope Medi-Cal benefits for 1) out-of-state former foster youth, and 2) low-income pregnant women, who would not otherwise be eligible for such benefits under the Medi-Cal State Plan. Specific historical and projected estimates of the number of former foster youth and pregnant women gaining full Medi-Cal under the demonstration are provided in Tables 5 and 6 below.

Table 5. Historical Enrollment for Out-of-State Former Foster Care Youth and Low-Income Pregnant Women

	Historical Enrollment						
Population	**DY 11** *1/1/16–6/30/16*	**DY 12** *7/1/16–6/30/17*	**DY 13** *7/1/17–6/30/18*	**DY 14** *7/1/18–6/30/19*	**DY 15** *7/1/19–6/30/20*	**DY 16** *7/1/20–12/31/20*	**DY 17** *1/1/21–12/31/21*
Low-Income Pregnant Women (109%–138% FPL)[1]	9,717	13,208	11,643	11,286	11,364	6,860	14,407
Out-of-State Former Foster Care Youth[2]	-	-	176	193	200	177	215

[1] Enrollment figures are estimated counts of unique beneficiaries based on an assumed percentage of Low-Income Pregnant Women (109%-138% FPL) within the applicable aid code.
[2] Enrollment figures are estimated counts of unique beneficiaries based on an assumed percentage, derived using information from Medi-Cal 2020 Annual Progress Reports, of Out-of-State Former Foster Care Youth within the applicable aid code.

Table 6. Projected Enrollment for Out-of-State Former Foster Care Youth and Low-Income Pregnant Women

Population	Projected Enrollment				
	DY 18 *1/1/22–12/31/22*	DY 19 *1/1/23–12/31/23*	DY 20 *1/1/24–12/31/24*	DY 21 *1/1/25–12/31/25*	DY 22 *1/1/26–12/31/26*
Low-Income Pregnant Women (109%–138% FPL)[1]	15,127	15,883	16,677	17,511	18,387
Out-of-State Former Foster Care Youth[2]	226	237	249	262	275

[1] Enrollment figures are estimated counts of unique beneficiaries based on an assumed percentage of Low-Income Pregnant Women (109%-138% FPL) within the applicable aid code.
[2] Enrollment figures are estimated counts of unique beneficiaries based on an assumed percentage, derived using information from Medi-Cal 2020 Annual Progress Reports, of Out-of-State Former Foster Care Youth within the applicable aid codes. As noted above, DHCS California seeks authority to extend coverage of this population through the Section 1115 demonstration until states are able to provide Medicaid eligibility for out-of-state former foster care youth through the Medicaid State Plan, as outlined in the SUPPORT Act.

Even though the renewed demonstration does not propose to otherwise expand eligibility, the CalAIM initiative (inclusive of the related 1915(b) waiver) is expected to improve care for all of the populations served by Medi-Cal. This is due to a greater focus on population health, Enhanced Care Management, ILOS, and a strong SUD system facilitated by coverage of the full continuum of care needed for substance use disorders in DMC-ODS counties.

Table 7 provides information on the number of beneficiaries enrolled in each of the major eligibility categories on an historical basis; Table 8 provides information about projected enrollment under California's current projections. Overall, 13.7 million beneficiaries are expected to be enrolled in Medi-Cal during the first year of the renewed demonstration and 11.8 million by Year 5. As noted, California is not making changes to Medi-Cal eligibility standards or procedures through this renewal. Rather, actual and projected enrollment displayed in these tables reflect a longstanding declining enrollment, followed by a sharp increase in enrollment due to the COVID-19 pandemic (primarily due to federal requirements limiting the number of discontinuances

while the federal public health emergency is in place), followed by the phase-out of pandemic-related impacts over a few years. Since a major goal of CalAIM is to move a number of the innovations and initiatives authorized under the preceding demonstration into the Medi-Cal State Plan and a consolidated 1915(b) waiver, a significantly smaller share of Medi-Cal enrollees will receive care via the 1115 demonstration than in the past.

Table 7. Historical Enrollment by Category of Aid

Category of Aid	Historical Enrollment (in thousands)[1]						
	DY 11 *1/1/16–6/30/16*	DY 12 *7/1/16–6/30/17*	DY 13 *7/1/17–6/30/18*	DY 14 *7/1/18–6/30/19*	DY 15 *7/1/19–6/30/20*	DY 16 *7/1/20–12/31/20*	DY 17 *1/1/21–12/31/21*
Families and Children (not CHIP)	6,134	6,018	5,798	5,566	5,389	5,639	6,447
CHIP	954	940	926	917	907	883	1,011
Seniors and Persons with Disabilities	2,078	2,072	2,085	2,084	2,088	2,118	2,332
ACA Expansion	3,326	3,424	3,469	3,408	3,357	3,647	4,246
Other	44	47	48	50	50	53	56
Total	12,536	12,502	12,326	12,025	11,791	12,340	14,093

[1] The enrollment counts presented above are drawn from eligibility data extracted from the Management Information System/Decision Support System (MIS/DSS) data warehouse. Individuals that receive only restricted scope services are excluded from the counts. The enrollment counts are grouped according to major categories of aid presented in the November 2020 Medi-Cal Estimate. Enrollment counts from the MIS/DSS warehouse are not final for calendar year 2020, and so are adjusted to account for expected future adjustments. Enrollment counts for periods following January 2021 are based on projections in the November 2020 Medi-Cal Estimate.

Table 8. Projected Enrollment by Category of Aid

Category of Aid	Projected Enrollment (in thousands)[1]				
	DY 18 *1/1/22–12/31/22*	DY 19 *1/1/23–12/31/23*	DY 20 *1/1/24–12/31/24*	DY 21 *1/1/25–12/31/25*	DY 22 *1/1/26–12/31/26*
Families and Children (not CHIP)	6,278	5,448	5,366	5,326	5,326
CHIP	1,007	928	914	907	907
Seniors and Persons with Disabilities	2,313	2,177	2,180	2,179	2,179
ACA Expansion	4,082	3,402	3,344	3,318	3,318
Other	56	54	54	54	54
Total	13,735	12,009	11,858	11,783	11,783

[1] The enrollment projections presented above are based on the November 2020 Medi-Cal Estimate. Individuals that receive only restricted scope services are excluded from the counts.

Budget Neutrality Calculation

DHCS is working to finalize the financial data associated with the State's historical expenditures under the Medi-Cal 2020 demonstration, including the temporary extension period through December 31, 2021, to demonstrate performance against budget neutrality caps. Currently, DHCS' efforts are concentrated on reporting for the initial 5-year period of Medi-Cal 2020. DHCS is working with CMS to account for the period of the temporary extension, and will subsequently report for this period as well.

The renewal request represents a dramatic streamlining of the 1115 demonstration, particularly due to the transitioning of Medi-Cal Managed Care, Dental Managed Care, and much of DMC-ODS to a consolidated 1915(b) waiver that also includes SMHS. Thus, total demonstration expenditures during the renewal period will be significantly below Medi-Cal 2020 expenditure levels. Further, the authorities requested in the demonstration renewal do not represent new spending but instead represent spending that would otherwise be allowable under the State Plan. For example, the inclusion of the justice-involved population is expected to simply shift costs from one time period (post-release) to another (30 days pre-release) while keeping total spend at or below current levels by allowing for a more person-centered care management approach pre-

release that could help to replace or avoid more acute service needs post-release. California also proposes to continue the treatment of spending on out of state former foster youth; low-income pregnant women, who would not otherwise be eligible for full scope benefits under the State Plan; and CBAS as hypothetical populations.

Currently, DHCS is developing the budget neutrality calculation for the five-year renewal period. In an effort to simplify CMS' review and enhance alignment of reporting across the 1115 demonstration and consolidated 1915(b) waiver, DHCS will, as much as possible, align Medicaid Eligibility Groupings used for the 1115 budget neutrality and 1915(b) cost-effectiveness calculations.

Based on the programmatic details described above, California has estimated projected spending for the renewal period. Since a major goal of CalAIM is to move a number of the innovations and initiatives authorized under the preceding demonstration into the Medi-Cal State Plan and a consolidated 1915(b) waiver, a significantly smaller share of Medi-Cal expenditures will be authorized via the 1115 demonstration than in the past. Historically, the demonstration represented approximately $44.30 billion in annual expenditures on average, while the projected annual expenditures under the renewal are approximately $4.9 billion on average, which is 11 percent of the prior demonstration.

For the purposes of public notice and comment, the State has summarized in the tables below the projected expenditures for the renewal, including spending on newly requested expenditure authorities. The State will include final projections in the Demonstration renewal request submitted to CMS; final numbers may differ as California continues to finalize financial data demonstrating the State's historical expenditures under the Medi-Cal 2020 demonstration and to determine the impact that the COVID-19 public health emergency has had on the enrollment and expenditure trends. As in the current demonstration, California will establish budget neutrality for these items by building estimates into detailed budget neutrality tables.

Table 9. Historical Expenditures, Medi-Cal 2020 Demonstration

Expenditure Authorities	Historical Expenditures (in thousands of dollars)[1,2]					
	DY 11 *1/1/16–6/30/16*	DY 12 *7/1/16–6/30/17*	DY 13 *7/1/17–6/30/18*	DY 14 *7/1/18–6/30/19*	DY 15 *7/1/19–6/30/20*	DY 16 *7/1/20–12/31/20*
GPP[3]	2,211,335	2,220,803	2,334,853	2,406,232	2,261,438	916,644
PRIME[4]	798,814	1,582,643	1,577,230	1,415,732	1,223,690	-
DTI	-	38,799	102,886	147,100	249,333	128,342
Whole Person Care	179,246	498,726	542,092	755,193	763,214	339,782
IHS Uncompensated Care	534	2,159	1,243	720	893	214
DSHP	75,000	150,000	37,437	100,063	269,493	12,010
Medi-Cal Managed Care[5,6]	18,709,907	38,594,788	39,564,778	38,376,446	39,411,772	19,705,886
CBAS[5]	228,669	476,797	472,084	460,632	471,174	235,587
Health Homes Program[5]	-	-	-	10,978	102,395	51,197
Out-of-State Former Foster Care Youth[5,7]	-	-	172	283	295	159
DMC-ODS	-	14,045	184,330	338,550	469,039	287,082
Total Expenditures	**22,203,505**	**43,578,760**	**44,817,105**	**44,011,929**	**45,222,736**	**21,676,903**

[1] Expenditure amounts are the sum of actual expenditures as of November 2020 plus estimates of future expenditures applicable to DYs 11-16. DY 16 amounts are based on estimated expenditures for DY 15 or for 7/1/20-6/30/21.
[2] CMS approved a temporary extension of the demonstration through DY 17 (1/1/21-12/31/21). Expenditures for this period are not included at this time.
[3] DY 11 includes GPP expenditures for 7/1/15-6/30/16.

[4] As of 7/1/20, the PRIME program transitioned to a Medi-Cal Managed Care quality incentive program.
[5] DY 11 expenditures, if applicable, are estimated for 1/1/16-6/30/16 based on annual expenditures for 7/1/15-6/30/16. DY 16 expenditures are estimated based on DY 15 expenditures.
[6] Amounts include expenditures for the New Adult Group and Low-Income Pregnant Women, but exclude expenditures for CBAS and HHP.
[7] Expenditures are approximations based on the estimated percentage of Out-of-State Former Foster Care Youth for member months within the applicable aid code.

Table 10. Projected Expenditures, CalAIM Demonstration

Expenditure Authorities	Projected Expenditures (in thousands of dollars)				
	DY 18 *1/1/22–12/31/22*	DY 19 *1/1/23–12/31/23*	DY 20 *1/1/24–12/31/24*	DY 21 *1/1/25–12/31/25*	DY 22 *1/1/26–12/31/26*
GPP[1]	3,050,000	3,050,000	3,150,000	3,150,000	3,150,000
PATH Supports	450,000	300,000	250,000	125,000	125,000
DSHP	90,000	90,000	75,000	30,000	30,000
CBAS[2]	609,220	957,508	1,005,384	1,055,653	1,108,436
Low-Income Pregnant Women[3]	130,768	144,172	158,949	175,242	193,204
Out-of-state Former Foster Care Youth[4]	377	415	458	505	557
DMC-ODS: IMD Exclusion[5]	209,982	217,153	223,211	229,818	236,437
DMC-ODS: AI/AN Traditional Healers and Natural Helpers[6]	4,059	4,164	4,280	4,407	4,534
Justice-Involved Populations[7]	-	186,841	190,932	195,117	199,399

Expenditure Authorities	Projected Expenditures (in thousands of dollars)				
	DY 18 *1/1/22–12/31/22*	DY 19 *1/1/23–12/31/23*	DY 20 *1/1/24–12/31/24*	DY 21 *1/1/25–12/31/25*	DY 22 *1/1/26–12/31/26*
Total Expenditures	**4,544,406**	**4,950,253**	**5,058,214**	**4,965,742**	**5,047,567**

[1] Projections assume DSH Allotments will increase by 2% each year. Projections assume the GPP/UC split will remain at 21.896% and new funding for Equity Sub-pool.
[2] Projections assume mandatory enrollment of dually eligible beneficiaries statewide as of 1/1/23.
[3] Projections are based on estimated counts of unique beneficiaries with an assumed percentage of Low-Income Pregnant Women (109%-138% FPL) within the applicable aid code, and include the projected cost of monthly capitation as well as a delivery event for approximately 90% of beneficiaries.
[4] Projections are approximate based on the estimated percentage of Out-of-State Former Foster Care Youth for member months within the applicable aid code, and further assume 5% annual expenditure growth per member.
[5] DHCS used SFY 2019 – 2020 actual (DMC-ODS counties) and estimated (DMC Regional Model) claims for Substance Use Disorder services rendered in an IMD coupled with the Home Health Agency Market Basket Index to project future expenditures. Additional adjustments were made to account for 6 additional counties have notified DHCS that they intend to participate in DMC-ODS beginning July 1, 2022. This estimate does not assume significant increase in utilization during any of the demonstration years.
[6] Projections reflect DMC-ODS services provided by AI/AN traditional healers and natural helpers that otherwise would be provided by other DMC-ODS providers.
[7] Projections assume approximately 250,000 utilizers of services 30 days pre-release annually. Services reflected in the projections for the 30-day period include ECM, clinical consultation (assuming 1.2 visits on average), and a 30-day supply of outpatient medications dispensed upon release (assuming the average managed care pharmacy cost for an SPD beneficiary, plus an assumed amount for costs of medications that are currently not covered under MCP contracts).

Section 8 – Proposed Waiver and Expenditure Authorities

DHCS intends to maintain the relevant waiver and expenditure authorities approved under the Medi-Cal 2020 demonstration in the new CalAIM Section 1115 demonstration and is requesting limited new authorities, as described below, while proposing to transition certain authorities currently authorized in the Section 1115 demonstration to the consolidated 1915(b) waiver or to the Medi-Cal State Plan.

These requests are being made in tandem with requests that the State will submit as part of its coordinated request for a 1915(b) waiver. To the extent that CMS advises the State that additional authorities are necessary to implement the programmatic vision and operational details described above, the State is requesting such waiver or

expenditure authority, as applicable. California's negotiations with the federal government, as well as state legislative/budget changes, could lead to refinements in these lists as we work with CMS to move the CalAIM initiative forward.

Waiver Authorities

Under the authority of Section 1115(a)(1) of the Act, the following waivers shall enable California to implement the CalAIM Section 1115 demonstration through December 31, 2026. For the purposes of transitioning Medi-Cal managed care delivery systems from Section 1115 demonstration authority to 1915(b) waiver authority (for Medi-Cal managed care, dental managed care, and the DMC-ODS), DHCS is requesting to waive Freedom of Choice (§ 1902(a)(23)(A)) under the consolidated 1915(b) waiver and therefore is not requesting to continue those authorities during the Section 1115 demonstration renewal period.

Table 11. Waiver Requests

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
§ 1902(a)(13)(A) (insofar as it incorporates Section 1923) DSH Requirements	To exempt the State from making DSH payments, in accordance with Section 1923, to a hospital that qualifies as a DSH during any year for which the participating designated public hospital system with which the DSH is affiliated receives payment pursuant to the GPP.	Yes
§ 1902(a)(1) Statewideness	To enable the State to operate the demonstration on a county-by-county basis. To enable the state to provide DMC-ODS services to individuals on a geographically limited basis. To enable the State to provide peer support specialist services within DMC State Plan counties to individuals on a geographically limited basis. (Peer support specialist services will be available in DMC counties that opt in.)	Yes, with modifications to reflect a new request related to peer support specialists in DMC

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability	To enable the State to provide different benefits for low-income pregnant women between 109 percent up to and including 138 percent of the FPL, as compared to other pregnant women in the same eligibility group. To enable the State to provide certain services, supports, and other interventions to eligible individuals with SUDs under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group. To the extent necessary, to enable the State to provide peer support specialist services within DMC State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group.	Yes, with modifications to reflect the modification and sunset of Medi-Cal 2020 Section 1115 programmatic features, and a new request for peer support specialists in DMC

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, California is requesting the renewal of approved expenditure authorities and new expenditure authorities so that the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, through December 31, 2026, be regarded as expenditures under the State's title XIX plan.

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

- Expenditure authorities 1, 6, 7, and 9 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 6 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 2, 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.

Table 12. Expenditure Authority Requests

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
1. Expenditures Related to the GPP for Participating Designated Public Hospital Systems	Expenditures for payments to eligible designated public hospital systems, subject to the annual expenditure limits set forth in the Special Terms and Conditions (STCs), to support participating designated public hospital systems that incur costs for uninsured care under the value-based global budget structure set forth in the STCs.	Yes, with technical modification
2. Expenditures Related to CBAS	Expenditures for CBAS furnished to individuals who meet the level of care and other qualifying criteria.	Yes
3. Expenditures Related to Low-Income Pregnant Women	Expenditures to provide benefits for pregnant women with incomes between 109 percent up to and including 138 percent of the FPL, which includes all benefits that would otherwise be covered for pregnant women with incomes below 109 percent of the FPL.	Yes, with technical modification
4. 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 and 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.	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
5. Expenditures Related to the 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 IMD. 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.	Yes
6. Expenditures Related to Providing Access and Transforming Health (PATH) Supports	Expenditure authority to support services and capacity building, including payments for services, supports, infrastructure and interventions, to strengthen the delivery and efficacy of care otherwise available in the Medi-Cal program as California implements the CalAIM initiative statewide.	No
7. Expenditures Related to the DMC-ODS: Traditional Healers and Natural Helpers	Expenditure authority as necessary to receive federal reimbursement for traditional healing and natural helper services provided to DMC-ODS beneficiaries by facilities and clinics operated by IHCPs.	No

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
8. Expenditures Related to Justice-Involved Populations	Expenditure authority as necessary under the pre-release demonstration to receive federal reimbursement for costs not otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release, including ECM and limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for use post-release into the community.[26]	No

[26] As this demonstration request is a novel one, the specific additional waivers or expenditure authorities, if any, will be identified in collaboration with CMS.

Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
9. Expenditures for Designated State Health Care Programs	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)	Yes, as approved in the original Medi-Cal 2020 demonstration

Section 9 – Stakeholder Engagement and Public Notice

DHCS will update this section following completion of the public comment period.

Appendix A: EQRO and Quality Reports

2018–19 DMC-ODS EQRO Report

Executive Summary (Full Report Available Here)

This external quality review (EQR) report summarizes the second year of county programs providing substance use disorder (SUD) treatment services as part of the Medicaid SUD 1115 Waiver Demonstration in California: the Drug Medi-Cal Organized Delivery System (DMC-ODS). The report was published on October 20, 2019, and covers Fiscal Year (FY) 2018–19.

As of August 2019, 30 counties had begun implementation of the DMC-ODS. During FY 2018–19, 14 active counties had been operational for at least 12 months, allowing for an EQR evaluation. For 11 counties, FY 2018–19 was their first year of DMC-ODS services; for purposes of the report, these counties are referred to as Year One counties. Three counties were completing their second year of services when they were reviewed and are referred to as Year Two counties. The Year One counties are San Luis Obispo, San Francisco, Los Angeles, Santa Clara, Santa Cruz, Monterey, San Diego, Imperial, Nevada, Napa, and Contra Costa. The Year Two counties are Marin, Riverside, and San Mateo.

In this year of quality reviews, the California external quality review organization (CalEQRO) reviewed a diverse range of county SUD models, ranging from Los Angeles County (which serves approximately one-third of the state population in both urban and rural environments) to Nevada County, which is a small rural county in the Sierra foothills. Many of the Year One counties benefited from lessons learned and best practices of the three counties that began the year before: Marin, Riverside, and San Mateo. Most reached out to request advice and support from these early adopters of the waiver. Also, all counties continued to benefit from ongoing training and extensive technical assistance (TA) from DHCS. TA was offered both directly and through numerous contracts to keep building new clinical skills and capacity as well as refining some of the more complex issues arising with computer systems and new billing and cost reporting requirements.

The report includes highlights and best practices emerging from each area that CalEQRO evaluated in the county DMC reviews. These included performance measures (PMs) related to access, continuity of care, and quality. Also reviewed were key components linked to optimal care and quality, observations of major shifts in the delivery systems, the performance improvement projects (PIPs) to enhance areas related to clinical or administrative services, information system capacity assessments (ISCAs) and their use for quality and administrative requirements, highlights from key stakeholder focus groups, and key findings and recommendations.

2018–19 Medi-Cal Managed Care External Quality Review Technical Report

Executive Summary (Full Report Available Here)

As required by the Code of Federal Regulations (CFR) at Title 42, Sections 438.364 and 457.1250,[27] the California Department of Health Care Services (DHCS) contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care for the Medicaid and Children's Health Insurance Program (CHIP) populations, including:

- A description of the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity
- For each external quality review (EQR)-related activity conducted in accordance with § 438.358:
    - Objectives
    - Technical methods of data collection and analysis
    - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with § 438.358(b)(1)(i) and (ii)
    - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, and PCCM entity's strengths and weaknesses for the quality and timeliness of and access to health care services furnished to Medicaid beneficiaries
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality and timeliness of and access to health care services furnished to Medicaid beneficiaries

[27] Department of Health & Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and CHIP Programs; Medicaid Managed Care, CHIP Delivered in Managed Care and Revisions Related to Third-Party Liability; Final Rule. Available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on December 2, 2019.

- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e)
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR in accordance with § 438.364(a)(6)

The review period for this *2018–19 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2018, through June 30, 2019. HSAG will report on activities that take place beyond this report's review period in the *2019–20 Medi-Cal Managed Care External Quality Review Technical Report*.

Title 42 CFR § 438.2 defines an MCO, in part, as "an entity that has or is seeking to qualify for a comprehensive risk contract." The Centers for Medicare & Medicaid Services (CMS) designates DHCS-contracted Managed Care Plans (MCPs) as MCOs and dental managed care plans as PAHPs. DHCS designates two of its MCOs as population-specific health plans (PSPs). DHCS' Medi-Cal Managed Care (MCMC) program has one contracted MCO and one PIHP with specialized populations, which are designated as specialty health plans (SHPs). Unless citing Title 42 CFR, this report refers to DHCS' MCOs as MCPs or PSPs (as applicable), DHCS' PAHPs as dental managed care plans, and the MCO and PIHP with specialized populations as SHPs. This report will sometimes collectively refer to these Medi-Cal MCPs as "MCMC plans."

MCMC plans provide managed health care services to more than 11 million beneficiaries (as of June 2019)[28] in California through a combination of contracted MCPs, SHPs, PSPs, and dental managed care plans. During the review period, DHCS contracted with 25 MCPs,[29] two PSPs, and two SHPs to provide health care services in all 58 counties of California. Additionally, DHCS contracted with three dental managed care plans that each operate in Los Angeles and Sacramento counties. A summary of HSAG's assessment of performance and notable results for the July 1, 2018, through June 30, 2019, review period follows.

2018 Medi-Cal Managed Care Quality Strategy Report

Summary (Full Report Available Here):

[28] "Medi-Cal Managed Care Enrollment Report." Available at https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report. Enrollment information is based on the report downloaded on July 26, 2019.

[29] Note: HSAG refers to Kaiser NorCal and Kaiser SoCal as two separate MCPs in this report; however, DHCS holds just one contract with Kaiser (KP Cal, LLC).

The Medi-Cal Managed Care Quality Strategy Report describes California's Medicaid quality strategy and how it meets the requirements of the Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule) at 42 Code of Federal Regulations (CFR) § 438.340. The final report includes quality strategies across all of California's Medicaid managed care delivery systems, including: i) Medi-Cal Managed Care Plans (MCPs); county mental health plans (MHPs); iii) the Drug Medi-Cal Organized Delivery System (DMC-ODS); and iv) dental managed care plans.

The California Department of Health Care Services (DHCS) is the single State agency responsible for the administration of California's Medicaid program, called Medi-Cal. Each of the four Medi-Cal managed care delivery systems has developed goals, objectives, metrics, and performance improvement projects aligned to the Triple Aim and seven departmentwide priorities. Some of the Medi-Cal managed care delivery systems already publish these and additional quality improvement measures in other documents, and the current report includes links to these other documents where appropriate. This report also describes California's arrangements for external quality reviews, descriptions of transition of care policies, plans to reduce health disparities, use of intermediate sanctions, and identification of persons who need long-term services and supports. The DHCS emphasizes learning and sharing of best practices among our managed care delivery systems, as DHCS has previously implemented many of the quality strategy reporting requirements for MCPs.

California CMS Form 416 EPSDT/CHIP Report

The 2018 Form 416 EPSDT/CHIP report (file name: 2018EPSDT_StateRprt20191113.pdf; pages 13–15) is available at https://www.medicaid.gov/sites/default/files/2019-12/fy-2018-data.zip.