



OFFICE OF THE GOVERNOR

June 30, 2021

The Honorable Xavier Becerra
Secretary of the U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

REQUEST FOR AMENDMENT AND FIVE-YEAR RENEWAL OF CALIFORNIA'S SECTION 1115 DEMONSTRATION

Dear Secretary Becerra:

I am pleased to submit the enclosed request for an amendment and five-year renewal of the Medi-Cal 2020 Section 1115 Demonstration, now entitled the CalAIM Section 1115 Demonstration, with a requested effective date of January 1, 2022. A 12-month extension approved by the Centers for Medicare & Medicaid Services (CMS) ends on December 31, 2021.

The Section 1115 Demonstration request is an essential component of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Much will change in California's Medicaid program through the CalAIM initiative, and the timing for approval is critical to ensure seamless transitions for beneficiaries and program partners.

The goal of CalAIM is to improve health outcomes and advance equity for Medi-Cal beneficiaries and other low-income people in the state. It is a multifaceted initiative, and seeks to take a population health, person-centered approach to providing services. It seeks to expand California's whole-person care approach – first authorized as whole person care (WPC) pilots by the Medi-Cal 2020 Demonstration – statewide through California's Medi-Cal delivery system.

We are submitting the CalAIM Section 1115 Demonstration renewal request along with a corresponding amendment and renewal request to expand the state's existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver. This request would transition nearly all Medi-Cal managed care delivery systems to a single authority, streamlining California's managed care programs and applying statewide lessons learned from previous Section 1115 Demonstrations, including WPC pilots, into standardized Medicaid authorities. Other authorities sought by California include

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various State Plan Amendments, enhanced care management, and in-lieu-of-services within Medi-Cal managed care, thus creating the opportunity to offer non-clinical interventions that target social determinants of health and reduce health disparities and inequities.

The attached CalAIM Section 1115 Demonstration renewal and amendment is a key component of the CalAIM transformation. It would continue successful elements of the current Section 1115 Demonstration, including the Global Payment Program, while also adding several new authorities to advance the state's goals. For example, the renewal request advances several key priorities of my Administration by more fully addressing the complex challenges facing California's most vulnerable residents. These include justice-involved populations who have significant clinical and social needs, providing limited pre-release services to help them successfully transition back into the community. The renewal also proposes initiatives, such as "PATH" (Providing Access and Transforming Health), that would strengthen the ability of health plans and community-based providers to ensure a seamless transition from the current pilots to a more ambitious statewide delivery system, and to support effective pre-release care for justice-involved populations.

The enclosed includes all information and content required for an amendment and renewal request under 42 CFR § 431.412, including evidence of lessons learned during the previous 1115 Demonstration period and a description of the public and Tribal stakeholder processes that the Department of Health Care Services has conducted over the last few months as we developed this request.

California's ambitious program, delivery system, and payment reforms complement the Biden Administration's priority to advance health equity, including through innovative strategies to address social determinants of health. We look forward to working with you to realize this vision for Medi-Cal beneficiaries, and to continue our efforts to build a healthy California.

Thank you for your consideration. If you have any questions, please contact Jacey Cooper, California's State Medicaid Director, at jacey.cooper@dhcs.ca.gov.

Sincerely,



Gavin Newsom
Governor of California

Enclosures

cc: See Next Page

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cc: Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Chiquita.Brooks-LaSure@cms.hhs.gov

Anne Marie Costello
Acting Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
AnneMarie.Costello@cms.hhs.gov

Susan Rice, Director
White House Domestic Policy Council

Mark Ghaly, MD, MPH, Secretary
California Health and Human Services Agency
Mark.Ghaly@chhs.ca.gov

Will Lightbourne
Director
California Department of Health Care Services
Will.Lightbourne@dhcs.ca.gov

Jacey Cooper
State Medicaid Director
Chief Deputy Director
Health Care Programs
California Department of Health Care Services
Jacey.Cooper@dhcs.ca.gov

Erika Sperbeck
Chief Deputy Director
Policy and Program Support
California Department of Health Care Services
Erika.Sperbeck@dhcs.ca.gov



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

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

June 30, 2021



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Commonly Used Acronyms

ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences
ADAP	AIDS Drug Assistance Program
AI/AN	American Indian and Alaska Native
AIR	All-Inclusive Rate
APM	Alternative Payment Methodology
ASAM	American Society of Addiction Medicine
BH-QIP	Behavioral Health Quality Incentive Program
BH-SAC	Behavioral Health Stakeholder Advisory Committee
BCCTP	Breast & Cervical Cancer Treatment Program
CalAIM	California Advancing & Innovating in Medi-Cal
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement Systems
CBAS	Community Based Adult Services
CBCME	Community-Based Care Management Entity
CBHDA	County Behavioral Health Directors Association of California
CBO	Community-Based Organizations
CCI	Coordinated Care Initiative
CCR	California Code of Regulations
CCS	California Children's Services
CDA	California Department of Aging
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CFR	Code of Federal Regulations



CHIP	Children's Health Insurance Program
CMC	Cal MediConnect
CMS	Centers for Medicare & Medicaid Services
COHS	County-Organized Health System
COMPAS	Correctional Offender Management Profiling for Alternative Sanctions
CPE	Certified Public Expenditure
CRIBB	California Rural Indian Health Board
CY	Calendar Year
Dental MC	Dental Managed Care
DDS	California Department of Developmental Services
DHCS	California Department of Health Care Services
DID	Difference-in-Differences
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMPH	District Municipal Hospital
DSH	Disproportionate Share Hospital
DSHP	Designated State Health Programs
D-SNP	Dual Eligible Special Needs Plan
DSRIP	Delivery System Reform Incentive Payment
DTI	Dental Transformation Initiative
DY	Demonstration Year
ECM	Enhanced Care Management
ED	Emergency Department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review



EQRO	External Quality Review Organization
FAQ	Frequently Asked Questions
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
GPP	Global Payment Program
HEDIS	Healthcare Effectiveness Data and Information Set
HHP	Health Homes Program
HIE	Health Information Exchange
IGT	Intergovernmental Transfer
IHCP	Indian Health Care Provider
IHS	Indian Health Services
IHSS	In Home Supportive Services
IHP	Indian Health Program
IHP-ODS	Indian Health Program Organized Delivery System
ILOS	In Lieu of Services
IMD	Institutions for Mental Disease
IP	Inpatient
IPC	Individualized Plan of Care
ISDEAA	Indian Self-Determination and Education Assistance Act
LIHP	Low-Income Health Program



LOC	Level of Care
LTSS	Long-Term Services and Services
MAA	Medi-Cal (or Medicaid) Administrative Activities
MAT	Medication for Addiction Treatment; Medication-Assisted Treatment
MCAG	Managed Care Advisory Group
MCMC	Medi-Cal Managed Care
MCO	Managed Care Organization
MCP	Managed Care Plan
MEGs	Medicaid Eligibility Groups
MHLAP	Mental Health Loan Assumption Program
MHP	Mental Health Plan (referred to as “County MHP”)
MIA-LTC	Medically Indigent Adult Long Term Care
MIS/DSS	Management Information System/Decision Support System
MLTSS	Managed Long-Term Services and Supports
MOA	Memorandum of Agreement
MSSP	Multipurpose Senior Services Program
NCQA	National Committee for Quality Assurance
OSHPD	California Office of Statewide Health Planning and Development
PACE	Program of All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PATH	Providing Access and Transforming Health
PCCM	Primary Care Case Management
PCTP	Prostate Cancer Treatment Program
PHM	Population Health Management
PHC	Partnership Health Plan of California
PHCS	Public Health Care System



PIHP	Prepaid Inpatient Health Plan
PMPM	Per Member Per Month
PPS	Prospective Payment System
PQI	Prevention Quality Indicator
PRIHD	California DHCS Primary, Rural, and Indian Health Division
PRIME	Public Hospital Redesign and Incentives in Medi-Cal
PSP	Population-Specific Health Plan
PSR	Preventive Services Report
PY	Program Year
QI	Quality Improvement
QIP	Quality Incentive Program
REAL	Race, Ethnicity, and Language
RFP	Request for Proposal
SAC	Stakeholder Advisory Committee
SAMHSA	Substance Abuse and Mental Health Services Administration
SBRIT	Screening Brief Intervention Referral to Treatment
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance (for children)
SHP	Specialty Health Plan
SMI	Serious Mental Illness (for adults)
SMHS	Specialty Mental Health Services
SNCP	Safety Net Care Pool
SOGI	Sexual Orientation and Gender Identity
SOP	Standards of Participation
SOR	State Opioid Response
SPA	State Plan Amendment



SPD	Seniors with Persons with Disabilities
STC	Special Terms and Conditions
STLRP	Steven M. Thompson Physician Corps Loan Repayment Program
STR	State Targeted Response
SUD	Substance Use Disorder
SUPPORT Act	Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act
TAS	Temporary Alternative Services
THP	Tribal Health Program
TPM	Two Plan Model
TUCWA	Tribal Uncompensated Care Waiver Amendment
UCC	Uncompensated Care
UCLA	University of California Los Angeles
UCSF	University of California San Francisco
UPL	Upper Payment Limit
WPC	Whole Person Care
WIC	California Welfare and Institutions Code
WOW	Without Waiver
WW	With Waiver



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 and reducing health disparities 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.

Through a separate submission, DHCS also is requesting a renewal and amendment to expand its Section 1915(b) waiver to authorize and 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 its other Medi-Cal managed care delivery systems from Section 1115 demonstration authority to 1915(b) waiver authority; these systems are Medi-Cal managed care (MCMC), Dental Managed Care (Dental MC), 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 better align 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, coupled with the introduction of Enhanced Care Management (ECM) statewide and a new menu of State-approved in lieu of services (ILOS) along with other 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 of focus” identified by DHCS, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income residents. CalAIM seeks 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 Section 1115 demonstration through December 31, 2021. The new CalAIM start date is January 1, 2022. Other elements of the CalAIM initiative do not require federal approval and will be implemented by the State as outlined in the State's overview of the CalAIM initiative overview, available [here](#).

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 (SDOH);
- 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 (FFS), 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 increase 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 Section 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 on the success of the Medi-Cal 2020 Whole Person Care (WPC) pilots and the State's Health Homes



Program (HHP) is the introduction of ECM statewide, as well as a new menu of State-approved 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 and ILOS, with support provided through the Providing Access and Transforming Health (PATH) component of this Section 1115 demonstration proposal. By addressing the clinical and nonclinical needs of the highest-needs beneficiaries, ECM and ILOS are key to achieving CalAIM's goal to provide a whole person approach to care—the State is positioned to translate the successes of the Medi-Cal 2020 Section 1115 demonstration into the new CalAIM program.

Stakeholder Engagement

Starting in fall 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 \(MLTSS\) 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 the impact of negative 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 conducted a 30-day comment period on this Section 1115 CalAIM demonstration proposal, as required by federal regulations. A summary of the comments received and changes made in response to those comments is included in Section 9 of this application; Appendix B includes a summary of all comments and the State's responses and all written public comments can be accessed [here](#).

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 90-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 pre-release Medi-Cal services include ECM or care coordination, as appropriate; and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed. In addition, services will include a 30-day supply of medication, including medication for addiction treatment (also known as medication-assisted treatment, or MAT) and durable medical equipment (DME) for use post-release into the community.
- Expenditure authority to support CalAIM implementation capacity at the community level, including payments for provider and community-based organizations (CBO) infrastructure and capacity building, as well as interventions



and services that will enable transition from Medi-Cal 2020 Section 1115 pilots to statewide CalAIM services that complement the array of benefits and services that will be authorized in the consolidated Section 1915(b) waiver delivery system and other authorities, and required or incentivized in managed care contracts. This PATH expenditure authority will underpin implementation of CalAIM population health management initiatives, including those focused on whole person care and addressing SDOH. Specifically, PATH will provide critical support for successful implementation of ECM and ILOS, as well as CalAIM initiatives for the justice-involved populations of focus. PATH will help drive transformation of service delivery networks at the community level to increase access to health care services, support better integration of physical and behavioral health and health-related services, and improve health outcomes. By targeting PATH resources to providers and CBOs in communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography or other factors, California will further its objectives related to advancing equity.

- A new component of the long-standing Global Payment Program (GPP)—which provides a pool of funding for value-based payments to participating designated public hospital systems providing care for California’s uninsured—to establish an Equity Sub-pool through which eligible designated public hospital systems earn points (and thereby receive payments) for services and activities specifically designed to address health inequities and SDOH, making the GPP a stronger tool for addressing health inequities.
- Additionally, to continue advancing the State’s progress in addressing the complex needs of beneficiaries with SUDs, and to do so in a way that relies on a culturally competent workforce, 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 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 Section 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 the authorities sought, or the federal approval vehicle for such authorities, as DHCS works with CMS to move the CalAIM initiative forward.



Table 1: Crosswalk of Medi-Cal 2020 Section 1115 Demonstration Initiatives and Requested Section 1115 CalAIM 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 <i>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.</i>	January 1, 2022–December 31, 2026
Low-Income Pregnant Women (109%–138% of the Federal Poverty Level (FPL)) ¹	January 1, 2022–December 31, 2026
Out-of-State Former Foster Care Youth	January 1, 2022–December 31, 2026 ²
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 ³

¹ Low-Income Pregnant Women: DHCS intends to transition the authority for this coverage initiative from Section 1115 to the Medi-Cal State Plan, and will prepare and submit the necessary State Plan Amendment(s) (SPAs) to make this change, if agreed to by CMS.

² 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.

³ 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
Tribal Uncompensated Care (UCC) for Chiropractic Services	January 1, 2022–December 31, 2026
Designated State Health Care Programs (DSHP)	January 1, 2022–December 31, 2026
<i>CalAIM Initiatives for Which DHCS Requests New Section 1115 Demonstration Authority</i>	
Peer Support Specialists (Drug Medi-Cal) <i>Waivers of statewideness and comparability for new Medi-Cal State Plan services in Drug Medi-Cal 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.</i>	January 1, 2022–December 31, 2026
Services for Justice-Involved Populations 90-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
<i>Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Seeks to Continue Under Alternate Authorities</i>	
Medi-Cal Managed Care ⁴ and Dental Managed Care	January 1, 2022–December 31, 2026

⁴ The consolidated Section 1915(b) waiver will authorize the Medi-Cal managed care delivery system.



Initiative	Duration of Authority Requested in Renewal/Alternate Authorities
<p>DMC-ODS</p> <p><i>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 demonstration 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).</i></p>	<p>January 1, 2022–December 31, 2026</p>
<p>Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Plans to / Has Sunset</p>	
<p>WPC Pilots and HHP</p> <p><i>DHCS seeks to continue the majority of WPC and HHP services under the managed care delivery system via ECM and ILOS.</i></p>	<p>N/A</p>
<p>Dental Transformation Initiative (DTI)</p> <p><i>DHCS is establishing a new, statewide dental benefit for children and certain adults and expanded pay-for-performance initiatives under the Medi-Cal State Plan.</i></p>	<p>N/A</p>
<p>Rady California Children’s Services (CCS) Pilot</p>	<p>N/A</p>
<p>Public Hospital Redesign and Incentives in Medi-Cal (PRIME)</p> <p><i>Applicable performance measures were transitioned to, and public hospitals may now qualify to receive managed care directed payments through, the Quality Incentive Program (QIP).</i></p>	<p>N/A</p>

Additional details about all these initiatives and authorities are described in this renewal request after the Background Section, 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 Section 1115 demonstration that have been or will be discontinued or will be transitioned to either the consolidated Section 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 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. The CCI 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 and LTSS carved into Medi-Cal managed care.⁵

- *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 (DMC-ODS). The DMC-ODS program provided California counties the opportunity to offer Medicaid beneficiaries that reside within the DMC-ODS county 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. As of June 2021, 37 of California's 58 counties have implemented the DMC-ODS program, providing access to 96 percent of the Medi-Cal population.
- *Tribal Uncompensated Care (UCC) Pool*: In April 2013 CMS approved an amendment to establish a UCC pool to reimburse Tribal health programs for the cost of providing services to American Indian and Alaska Native patients who had been eliminated from Medi-Cal coverage due to previous State budget shortfalls. The amendment was intended to maintain IHS and Tribal facilities' financial viability and provide services to eligible individuals. Notably, these services have since been restored in the Medi-Cal program, with the exception of chiropractic services.

Medi-Cal 2020 Section 1115 Demonstration (2015–2021)

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

⁵ 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 effective January 1, 2018, and the MSSP is proposed to be excluded from the carve-in beginning January 1, 2022.



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 that 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 Medi-Cal 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, nine 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 Section 1115 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 Section 1115 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 Section 1115 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 Section 1115 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.
- *Program for All-Inclusive Care for the Elderly (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 County-Organized Health System (COHS) including CalOptima PACE, and to be enrolled in a PACE organization not affiliated with CalOptima, if eligible.⁶

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 QIP.

CMS is still considering several amendment requests that were submitted as part of the temporary extension; in this CalAIM renewal proposal, 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 working with CMS to reestablish SNCP funding for that time period. Additionally, on April 2, 2021, CMS approved a modification of the Special Terms and Conditions (STCs) to allow DHCS, during a period of public health emergency, to adjust the GPP

⁶ In subsequent conversations with CMS, the agency confirmed that waiver authority for beneficiaries in selected COHS counties to enroll in a PACE independent of the COHS MCP is not necessary. Therefore, DHCS is not requesting separate authority here or in its CalAIM Section 1915(b) waiver renewal and amendment application to continue to allow enrollment in an alternative delivery system, such as PACE, when authorized in a COHS county.



thresholds without modifying the applicable total GPP payments, based on the estimated impact to usage rates.

- *DMC-ODS*: CMS gave verbal approval for amendments to make the following DMC-ODS programmatic changes in 2021 (written confirmation is pending at this time): (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 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 Section 1115 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 the Medi-Cal 2020 Section 1115 demonstration have improved 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 WPC pilots found 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; 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 6 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 progress in establishing 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 – CalAIM Demonstration 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 Section 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 goals of increasing population health and addressing health equity. The GPP provides a pool of funding for value-based payments to participating designated public hospital systems providing care for California's uninsured, who are disproportionately people of color, by combining federal Disproportionate Share Hospital (DSH) and diverted upper payment limit funding and incentivizing more appropriate and cost-effective care. These payments therefore both support designated public hospital systems' efforts to provide health care services for the uninsured and promote the delivery of higher-value care. This Section 1115 demonstration renewal is necessary to continue and expand GPP payments. DHCS seeks to make GPP an even stronger tool for addressing health inequities by expanding GPP 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 SDOH.
- *DMC-ODS*: As of June 2021, the DMC-ODS is available in 37 (out of 58) counties, providing access to 96 percent of the Medi-Cal population. DHCS aims to expand the program statewide and is actively providing technical assistance to several counties that have expressed interest in participating in the DMC-ODS in the future. In this 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. As applicable, waivers of statewideness and comparability associated with DMC-ODS benefits are requested in the CalAIM Section 1915(b) waiver application.
- *Low-Income Pregnant Women*: The State intends 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 to this policy as part of the Section 1115 demonstration renewal request; during the course of negotiations with CMS, however, DHCS will confirm whether it can amend the Medi-Cal State Plan to authorize full-scope benefits for this population in lieu of Section 1115 authorities.
- *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 to amend the demonstration to allow flexibility for the provision and reimbursement of remote services for CBAS-enrolled participants under specified emergency situations. California also 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.
- *Tribal Uncompensated Care*: DHCS made UCC payments for certain optional services previously eliminated from the Medi-Cal State Plan that are provided by Indian Health Service (IHS) facilities and Tribal health programs operating under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA) to eligible Medi-Cal beneficiaries. DHCS is requesting to reinstate the Tribal UCC payments and to modify the request to provide reimbursement for chiropractic services, which is the only optional benefit yet to be restored under the Medi-Cal State Plan.

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 Drug Medi-Cal services, and consistent with State legislation,⁷ peer support specialist services will be added to the Medi-Cal State Plan through a SPA, beginning no sooner than January 2022. As required by State legislation, peer support specialist services will be provided at a county's option, and the State is, therefore, seeking waivers of statewideness and comparability. (DHCS is seeking similar waiver authority in the Section 1915(b) waiver for SMHS and the DMC-ODS.) Peer support specialists will support California's effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions.

⁷ See California Welfare and Institutions Code (CA WIC) § 14045.14(a) and 14045.19, as amended by Senate Bill 803.



- *Services for Justice-Involved Populations 90-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 90-days pre-release. These pre-release Medi-Cal services include ECM; care coordination, as appropriate; and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed. In addition, services will include a 30-day supply of medication, including MAT, and DME for use post-release into the community. DHCS intends to use PATH funding, as described in further detail below, to support capacity building among providers, plans, counties, and justice agencies to ensure their readiness to support effective pre-release care for justice-involved populations, as well as to maintain and build on current WPC Pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved initiatives in 2023.
- *PATH Supports:* As California implements the CalAIM initiative statewide, the State is requesting expenditure authority to support CalAIM implementation capacity at the community level, including payments for provider and CBO infrastructure and capacity building, as well as interventions and services that will enable transition from Medi-Cal 2020 to CalAIM and complement the array of benefits and services that will be authorized in the consolidated Section 1915(b) waiver delivery system and other authorities, and required or incentivized in managed care contracts. This expenditure authority will bolster California’s efforts to integrate delivery systems, and to move from current waiver pilots to statewide services. PATH will enable California to further its objectives related to advancing equity and improving quality and coordination of care for all Medi-Cal beneficiaries. PATH funding will underpin implementation of CalAIM population health management initiatives, including those focused on whole person care and addressing SDOH. Specifically, PATH will provide critical support for successful implementation of ECM and ILOS, as well as CalAIM initiatives for the justice-involved populations of focus, all of which are key components of CalAIM. Importantly, PATH resources will help drive transformation of service delivery networks at the community level to increase access to health care services, support better integration of physical and behavioral health and health-related services, and improve health outcomes, with particular attention to providers and CBOs in communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors.
- *Federal Funding for DSHPs:* 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 DSHPs authorized in the initial five-year period of the Medi-Cal 2020 demonstration.

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 six 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 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 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, who are disproportionately people of color. 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 SDOH and, in so doing, advance health equity. 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, such as multidisciplinary outreach teams, day habilitation programs, and housing tenancy and sustaining services, among others.

Along with the new 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. Under the existing GPP structure as well as under prior SNCP programs, PHCSs have provided additional primary, specialty, and other



ambulatory care services to California's uninsured. Absent the flexibilities afforded through SNCP and GPP over the last 15 years, uninsured individuals, especially those with chronic diseases like diabetes who have been managed in the community by PHCSs, would not have experienced the same access to primary and preventive care, and likely would have relied more on emergency Medi-Cal services. A system that is heavily geared toward emergent care would require more state and federal Medicaid funding, as emergency treatments are significantly more costly than primary, specialty, and ambulatory care. The addition of CalAIM-aligned services under the GPP Equity Sub-pool will help to further promote the overall health of uninsured individuals and further reduce unnecessary emergency room visits and hospitalizations that would otherwise have to be paid for via Medi-Cal. The addition of these services, which has already begun in many counties led by PHCSs, has and will continue to naturally offset other more expensive emergency care. DHCS will evaluate the Equity Sub-pool to assess progress toward achieving these desired outcomes.

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 diverted Upper Payment Limit (UPL) dollars through the five-year renewal period (ending December 31, 2026), and to establish the Equity Sub-pool described above. The budget neutrality for GPP is 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 Drug Medi-Cal 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. As of June 2021, 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 will be bolstered by recent, significant investments in the State's behavioral health care continuum infrastructure and the behavioral health system for children and youth. These initiatives build on prior strategies that used 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 throughout the medical and behavioral health care and criminal justice systems, 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 all of 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. DHCS will continue to evaluate DMC-ODS to assess progress toward achieving desired outcomes through the DMC-ODS program improvements, including increasing the number of beneficiaries receiving SUD treatment services, improving treatment outcomes for beneficiaries in residential treatment, and increasing the percentage of people with an SUD who use MAT and/or recovery services. Other desired outcomes for DMC-ODS specific to American Indians and Alaska Natives beneficiaries include increasing the number of residential treatment admissions and beneficiaries receiving community-based SUD treatment.

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



Section 1115 demonstration, but it will transition the delivery system authority for the DMC-ODS to a consolidated Section 1915(b) waiver and the coverage authority for most DMC-ODS benefits to its State Plan. DHCS is requesting Section 1915(b)(3) authority for Contingency Management services, pending State budget authority.

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 more recent CMS policy regarding SUD demonstrations, described below.

As part of CalAIM's focus on advancing health equity, 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 SUD crisis continues to persist—with COVID-19 exacerbating a rise in overdoses—and shift as California experiences growing rates of addiction and 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 Section 1915(b) waiver; however, a targeted set of program modifications that DHCS seeks to continue require renewed 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, including for DMC-ODS services provided to short-term residents of IMDs, as authorized by the Section 1115 demonstration. These changes, which will go into effect no earlier than July 2022, 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 is not requesting any specific authority related to this transition, but until the changes are made, the existing CPE 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

As part of the Medi-Cal 2020 Section 1115 demonstration temporary extension approved in late 2020, CMS verbally approved program modifications to take effect as of January 2021; written confirmation is pending. 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 Section 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, Section 1915(b) waiver, and Section 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 Section 1915(b) waiver authority.

Table 2: DMC-ODS Benefits Under CalAIM⁸

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	<p>SBIRT by primary care providers is a service in fee-for-service (FFS) and managed care.</p> <p>SBIRT by DMC-ODS and Drug Medi-Cal providers represents components of assessment and treatment services in DMC-ODS and Drug Medi-Cal.</p> <p>Early intervention services include individual counseling, group counseling, and education services without the requirement of an SUD diagnosis, available in DMC-ODS and Drug Medi-Cal for beneficiaries under</p>	<p>FFS and managed care primary care providers</p> <p>Drug Medi-Cal and DMC-ODS providers</p>	Medicaid State Plan	Fee-for-service, 1915(b)

⁸ 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
		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 ⁹)	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 five 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)
3.3	Clinically Managed Population-Specific High-	24-hour care with trained counselors to stabilize multidimensional imminent danger.	DHCS-Licensed Residential Providers; Chemical	Medicaid State Plan (Contingent on SPA	1915(b)

⁹ As previously noted, DHCS is shifting the coverage authority for many existing DMC-ODS benefits that are authorized under the Section 1115 demonstration to the Medi-Cal State Plan.



ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
	Intensity Residential Services	Less intense milieu and group treatment for those with cognitive impairments.	Dependency Recovery Hospitals; Freestanding Acute Psychiatric Hospitals	approval)	
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 Hospitals	Medicaid State Plan	Fee-for-service, 1915(b)



ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
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 that are not manageable in an 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	Hospitals; 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 Hospitals; 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 Drug Medi-Cal 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,	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)	social, 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 provide MAT prescribing, administration, and monitoring on-site, or have a referral process in place to refer to MAT prescribers. All forms of MAT will be covered in alternative delivery sites outside of traditional pharmacies.	DHCS-Certified Providers	Medicaid State Plan (Contingent on SPA approval)	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 groups	Peer Support Specialists	Medicaid State Plan (Contingent on SPA approval)	Fee-for-service, 1115, 1915(b)
1-2.5	Contingency Management	Motivational incentives combined with	DHCS-Certified providers (the incentives may be	1915(b)(3)	1915(b)



ASAM LOC	Service	Service Definition	Provider Type	Coverage Authority	Delivery System Authority
	(provided as component of outpatient services, pending budget authority)	counseling	delivered through an independent third-party application, to be determined)		

Section 3.3 – Peer Support Specialist Services

Leveraging the Medi-Cal State Plan in combination with this Section 1115 demonstration renewal, 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, certified peer support specialists will be established as a distinct provider type in participating counties under Drug Medi-Cal, SMHS, and/or DMC-ODS programs. Under the pilot programs, certified peer support specialists will provide covered peer support services 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 specialists will support California’s effort to promote health equity by providing culturally competent services to promote recovery and enhanced access to care, across a diverse population, including race/ethnicity, gender identity, sexual orientation, generation, and geographic regions.

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*: Groups that 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 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 behavioral health peer support specialist pilot program is to improve recovery outcomes and prevent relapses and symptoms of behavioral health disorders and in so doing promote health equity and overall improved health outcomes. 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 a beneficiary who 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 Drug Medi-Cal 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 Section 1115 demonstration to provide full-scope benefits to pregnant women with incomes from 109 percent up to and including 138 percent of the FPL (including all benefits that would otherwise be covered for 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

California intends to extend this important coverage initiative to continue to provide necessary health benefits to low-income pregnant women. The State will work with CMS to pursue Medi-Cal State Plan authority to authorize full-scope benefits to this population, or a renewal of the current waiver and expenditure authorities, if necessary.

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 (ACEs). 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.¹⁰

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 includes an individual assessment; professional nursing services; physical, occupational, and speech therapies; mental health services; personal care; nutritional

¹⁰ [P.L. 115-271](#).



counseling; and transportation, among others. The CBAS demonstration amendment was renewed on November 28, 2014, and was included in the Medi-Cal 2020 Section 1115 demonstration. During the COVID-19 public health emergency, DHCS received time-limited authority to provide individuals already enrolled in CBAS with Temporary Alternative Services (TAS) in remote settings.

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 LTSS. The State requests that the authority granted for the CBAS program be extended in this renewal. In response to stakeholder comments received during the State's public comment period, and building on its experience during the COVID-19 public health emergency, DHCS is also requesting authority, in specified circumstances, to provide remote services to enrolled CBAS participants.

Such circumstances could include State or local disasters, such as wildfires or power outages resulting in a State or federal declaration of emergency, which make it unsafe or impossible for enrollees to receive on-site services. Remote services also could be authorized for CBAS enrollees experiencing personal emergencies, including time-limited illnesses or injuries, crises, or care transitions (e.g., hospital to home or skilled nursing facility to home) that temporarily restrict enrolled CBAS participants from receiving services at the center. These remote services are allowed for currently enrolled CBAS participants (approximately 80 percent of whom are dually eligible beneficiaries) with authorized days and an approved individualized plan of care (IPC) on file.

Under these specifically defined circumstances, approved CBAS providers would be authorized to deliver medically necessary services and supports and provide intensive care management/care coordination services to address the assessed and expressed needs of their complex, high-risk participants in the home, community and/or via telehealth. The CBAS multidisciplinary care and support model would remain primarily the same whether provided in the center, home and/or remotely via telehealth/telephone, including medical, therapeutic, and social service delivery. CBAS TAS would not duplicate other existing or new programs, including participation in the new enhanced care management benefit, but would instead address gaps in services and promote continuity of care.



This request – which furthers the goals of California’s Master Plan for Aging – is projected to be budget neutral; DHCS will limit remote services to existing CBAS enrollees and for time-limited periods as authorized by MCPs or DHCS, including reasonable caps on duration and billable units of remote services, in accordance with the participant’s existing authorization and IPC. If the emergency results in increased care needs, additional days of service are subject to appropriate authorization and utilization controls and the IPC should be updated accordingly.

DHCS also seeks to make technical amendments to the program, including to align portions of the STCs and Standards of Participation (SOP) with the existing CBAS components of the Medi-Cal Provider Manual and proposed Managed Care Contract language. The changes also align with updates to the SOP and guidance issued by the California Department of Aging (CDA).

DHCS also seeks to make technical amendments to the program, including to align portions of the STCs and SOP with the Medi-Cal Provider Manual, proposed MCP contract language, and guidance issued by the CDA.

Section 3.7 – Services for Justice-Involved Populations 90 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 90-day period prior to release for eligible justice-involved populations. These pre-release Medi-Cal services include ECM or care coordination, as appropriate, and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in person as needed. In addition, services will include a 30-day supply of medication, including MAT, and DME for use post-release into the community. Authority to cover these services is requested for persons incarcerated in State prisons, county jails, and youth correctional 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 composed disproportionately of 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 in California 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.¹¹ Over the course of a year,

¹¹ California’s Prison Population, Public Policy Institute of California, 2017. Available at <https://www.ppic.org/publication/californias-prison->



36,000¹² 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, with overdose death rates over 100-fold the rates of the general population.¹³ 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.¹⁴ Nearly 70 percent of individuals reoffend within three years after release from prison.¹⁵ While the factors contributing to recidivism are complex, effective treatment for mental health conditions and SUD can interrupt the cycle of reoffending.

In 2017, 66 percent¹⁶ 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

[population/#:~:text=African%20Americans%20remain%20overrepresented%20in,the%20state's%20adult%20male%20residents.](#)

¹² From Corrections to Community: Reentry Health Care, California Health Care Foundation, 2018. Available at <https://www.chcf.org/project/corrections-community-reentry-health-care/>.

¹³ 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.

¹⁴ Gates, A., Artiga, S., Rudowitz, R., “Health Coverage and Care for the Adult Criminal Justice-Involved 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/>.

¹⁵ National Institute of Justice Fact Sheet, “Recidivism Is a Core Criminal Justice Concern,” October 2008. Available at <https://nij.ojp.gov/topics/corrections/recidivism>.

¹⁶ Improving In-Prison Rehabilitation Programs, Legislative Analyst’s Office, 2017. Available at <https://lao.ca.gov/Publications/Report/3720>.



case.¹⁷ The California correctional health care system drug overdose death rate for individuals in the system is 12.6 per 100,000, more than three times the total rate in the United States, which is 3.7.¹⁸

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 individuals to the services they need when released into their communities.¹⁹ 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, community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in person as needed, a 30-day supply of medication, including MAT, and DME for use post-release into the community will contribute to improved health and longer-term treatment and medication adherence upon release from incarceration.

DHCS is seeking Medi-Cal services in the 90 days pre-release in order to build familiarity and trust with the community health system upon release into the community. In-reach ECM by community-based providers can improve engagement and aid in re-integration in the post-release period. The 90-day window builds in enough time pre-release to coordinate with correctional agency staff, establish trusted relationships with ECM providers, enable consultations via telehealth or, optionally, in-person as needed, from behavioral and physical health community-based providers, identify needed 30-day supply of medications and DME, and set up meaningful transition plans in order to support stabilization and continuity of services post-release. Further, appointments with community-based providers are usually not available on short timelines, so longer lead times are necessary to ensure a smooth release.

California expects that working to ensure justice-involved populations have a stable network of health care services and supports upon discharge will lead to a reduction in emergency department use, hospitalizations, and other medical expenses associated

¹⁷ 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, 2020. Available at https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

¹⁸ 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>.

¹⁹ “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>.



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. Seventeen of the WPC pilots authorized under the Medi-Cal 2020 Section 1115 demonstration²⁰ specifically target formerly incarcerated individuals. This includes the Los Angeles County WPC,²¹ 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 and PATH supports will help continue the best practices obtained as a result of the pilots.

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 720,²² 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 requirements of the federal SUPPORT Act and with recently released CMS guidance.²³ California has had long-standing suspension processes in place in its prison system. The Governor's proposed May Revision to the 2021 State Budget also includes critical funding to build capacity for effective pre-release services for justice-involved populations to enable coordination with justice agencies and Medi-Cal services.

²⁰ DHCS. "Whole Person Care Pilots." Available at <https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>.

²¹ Health Services – Los Angeles County. Whole Person Care – Los Angeles (WPC-LA). Available at <https://dhs.lacounty.gov/whole-person-care/>.

²² Assembly Bill No. 720. Available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB720.

²³ CMCS State Medicaid Director Letter #21-002 re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act). Available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>.



To further support continuity of care post-release, DHCS is mandating that all counties implement an inmate pre-release Medi-Cal application process by January 1, 2023, to ensure all eligible inmates in county jails and juvenile facilities, including those who are not in suspended status, receive timely access to Medi-Cal services upon release from incarceration.²⁴ The State has also made efforts to improve 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.²⁵

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 days pre-release. Section 5032 of the SUPPORT Act requires the U.S. 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, county jails, and youth correctional facilities (pretrial or post-conviction) during the 90-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

²⁴ Assembly Bill 720: Inmates: Health Care Enrollment. Available at http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201320140AB720&showAmends=false.

²⁵ Senate Bill 1469: Juvenile Justice: Benefit Coverage. Available at http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1451-1500/sb_1469_cfa_20060501_142757_sen_comm.html.



- Pregnancy
 - All youth who are inmates of a youth correctional facility

See Table 3 for more information on Medicaid eligibility groups affected by a 90-day pre-release demonstration.

Table 3: Medicaid Eligibility Groups Affected by 90-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

California projects that if CMS approves this demonstration proposal, approximately 200,000 individuals each year will potentially be targeted for Medi-Cal in-reach services during the 90 days pre-release. This estimate is based on data indicating that approximately 400,000 people are released from county jails and State prisons each year and assumes that approximately one-half of that group will qualify for Medi-Cal, have a complex health care need, SUD, or mental health diagnosis that would qualify them for coverage in the 90 days pre-release, and be identified for potential engagement pre-release.

Justice-Involved Initiative Benefits and Cost Sharing

In the 90 days period prior to release from a State prison, county jail, and/or youth correctional facility, eligible Medi-Cal enrollee inmates will receive ECM or care coordination, as appropriate, and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed. In addition, services will include a 30-day supply of medication, including MAT, and DME for use post-release 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 to secure and maintain stable housing, using housing-related ILOS as appropriate
- Developing a medication management plan, in consultation with clinical providers
- Linking individuals to ILOS 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 enrolled ECM providers with particular expertise working with justice-involved individuals. Delivery of services during the 90 days pre-release will require close coordination with the State prisons, county jails, and youth correctional facilities to identify and refer members and ensure connections to care once individuals are released from incarceration.

No cost sharing shall be applied during the 90 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 90 days pre-release by January 1, 2023, with the assumption that there will be a ramp up of individuals receiving services over the course of the demonstration.

Objective

This demonstration will address the health care needs of California's justice-involved population, advance the State's health equity priorities, 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 ECM and ILOS
- 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

DHCS will evaluate the justice-involved initiatives to assess progress toward achieving the above desired outcomes.

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, plans, counties, public hospital systems, justice agencies, and CBOs require tools and resources to work together, including the ability to exchange data, establish payment relationships, measure value and outcomes, and ensure that Medi-Cal enrollees are at the center of care. Although some plans, counties, public hospital systems, and CBOs already have such experience and established relationships, these collaborative initiatives must be restructured to align with a managed care structure where they exist, and cultivated where nascent. Accordingly, the State is seeking \$2.17 billion in federal support to maintain, build, and scale the capacity necessary to ensure successful implementation of CalAIM, including transition to ECM and ILOS and planning and operationalizing CalAIM initiatives for justice-involved populations. This transitional investment will scale down over the five-year demonstration renewal period.

The Medi-Cal 2020 Section 1115 demonstration includes expenditure authority to authorize expenditures for PATH; California is requesting this expenditure authority to take the State's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. As California implements CalAIM statewide, it requires expenditure authority to support implementation capacity at the community level, including payments for provider and CBO infrastructure and capacity building, as well as interventions and services 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 Section 1915(b) waiver.



Specifically, PATH would support the following:

- *ECM and ILOS Capacity Building:* PATH funding would support technical assistance for CBOs and other community-based providers to transition to ECM and ILOS, such as assistance with contracting and payment processes, workforce development, and staff training on issues such as how to provide enhanced care management to specific populations of focus. PATH funding would also be used to increase capacity of CBOs and other community-based providers across the State, including for ECM/ILOS provider capacity building (e.g., workforce needs, workflow development, operational requirements and oversight) and delivery system infrastructure investments (e.g., certified electronic health record (EHR) technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities). PATH funding also would provide resources to support collaborative planning across counties, managed care plans, providers, CBOs, and others, as well as resources to avoid the loss of existing WPC pilot and HHP capacity, including place-based and other specialized services that will transition to ECM and ILOS over time and are needed for successful implementation of ECM, ILOS, and other Medi-Cal initiatives.
- *Justice-Involved Capacity Building:* PATH funding would maintain and build on current WPC pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved initiatives in 2023. PATH funding also would provide resources to support collaboration and planning, and funding for correctional officials related to the design and launch of Medi-Cal application assistance and 90-days pre-release services, as well as to develop the IT services and infrastructure to support justice-involved Medi-Cal application process and 90-days pre-release services.
- *Population Health Management Services:* PATH funding would support DHCS in the development and procurement of a Population Health Management (PHM) service. The service will utilize DHCS administrative, clinical, dental, behavioral health, and social service data to provide standard risk assessment, risk stratification, and population health analytics for all Medi-Cal members. DHCS, managed care plans, counties, providers, and beneficiaries will have access to these services and analytics in order to effectively manage all beneficiaries by keeping them healthy via preventive and wellness services, assessing member risks to guide care management and care coordination, and addressing social determinants of health to reduce health disparities. The PHM service will also serve as the foundation by which ECM and ILOS populations can be identified and service interventions can be assessed to optimize clinical outcomes.



Objective

This expenditure authority will bolster California's efforts to integrate delivery systems, and to move from current waiver pilots to statewide services, and will enable California to further its objectives related to advancing equity and improving quality and coordination of care for all Medi-Cal beneficiaries. The expenditure authority will advance CalAIM population health management initiatives, including those focused on whole person care and addressing SDOH. The expenditure authority further promotes the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks at the community level to increase access to health care services, support better integration, and improve health outcomes, including across racial and ethnic groups. DHCS' evaluation of the demonstration will enable DHCS and CMS to assess improved health outcomes for the affected Medi-Cal populations.

Renewal Request

California is requesting expenditure authority totaling \$2.17 billion for PATH supports.

Section 3.9 – Designated State Health Programs (DSHP)

Historically, CMS has granted California authority to claim federal matching funds to support designed state health programs. Through this proposal, California is seeking \$1.15 billion over five years (total computable) to support the same state-funded programs that CMS has supported in the past, consistent with the goals and objectives of CalAIM.

Objective

California is requesting to reinstate the DSHPs authorized by the Medi-Cal 2020 Section 1115 demonstration as part of the State's overarching effort to stabilize and strengthen providers and provider networks available to serve Medicaid and low-income populations in the State.

Renewal Request

DHCS is requesting to reinstate DSHP expenditure authority during this five-year renewal period. This expenditure authority, which was previously provided under the Medi-Cal 2020 Section 1115 demonstration, but which is not in place under the one-year temporary extension, will support successful implementation of CalAIM. California is requesting to continue DSHP authority in light of gains in coverage that have been made over the course of the most recent demonstration period, which has resulted in an overall reduction in state spending on some of the programs described below.

California is requesting \$1.15 billion in DSHP funding for the following programs that are otherwise State funded and subject to the limitations and conditions applied in the Medi-



Cal 2020 Section 1115 demonstration: 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); and Steven M. Thompson Physician Corps Loan Repayment Program (STLRP). Supporting these programs with continued DSHP authority will enable the State to continue and strengthen key initiatives that have been supported by DSHP in the past as well as support new delivery system reforms aimed at providing whole person care, and addressing inequities in outcomes by race and ethnicity. California will work with CMS to update the approved STCs and DSHP funding and reimbursement protocols for the renewal period to reflect new demonstration goals and funding levels.

Section 3.10 – Tribal Uncompensated Care

Under the Medi-Cal 2020 Section 1115 demonstration, DHCS made uncompensated care payments for certain optional services previously eliminated from the Medi-Cal State Plan that are provided by IHS facilities and Tribal health programs operating under the authority of the ISDEAA to eligible Medi-Cal beneficiaries. Notably, these services have been restored in the Medi-Cal program with the exception of chiropractic services. Uncompensated care payments for these covered services are administered through a contract with the Tribal entities and the California Rural Indian Health Board, Inc. (CRIHB). CRIHB is a Tribal organization contracting under the ISDEAA that provides medical assistance as a facility of the IHS through a subcontracting process with 18 Tribal health programs. Additionally, CRIHB serves as the central administrator for the Tribal Medicaid Administrative Activities (MAA) program through contracts with 11 Tribal health programs and for 20 Tribal health programs participating in the Medi-Cal 2020 authorized Tribal Uncompensated Care Waiver Amendment (TUCWA).

CMS approved SPA 21-0044 which authorized the Tribal FQHC provider type in Medi-Cal on February 19, 2021. The Tribal FQHC provider type in Medi-Cal allows Tribal health programs electing this designation to provide FQHC services, including chiropractic services. Therefore, Tribal health clinics that enroll in the Medi-Cal program as a Tribal FQHC will be able to be reimbursed in full for chiropractic services provided to all patients with an effective date of January 1, 2021. DHCS understands, however, that not all Tribal health programs will seek to enroll as a Tribal FQHC, leaving a potential gap in payment and coverage.

Objective

Tribal uncompensated care payments promote the objectives of the Medicaid program by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the State and, in so doing,



by improving health outcomes for Medicaid beneficiaries. Renewing Tribal uncompensated care payments will also support the State's goal of promoting health equity and reducing health disparities.

Renewal Request

In response to stakeholder comments during the comment period on the draft Section 1115 demonstration, DHCS is requesting to reinstate Tribal Uncompensated Care payments to provide reimbursement for chiropractic services. This will assure that Tribal health programs that do not seek to enroll Tribal FQHCs can continue to be reimbursed for providing chiropractic services to their Medi-Cal populations.

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 Section 1915(b) waiver or the Medi-Cal State Plan, and some are no longer needed. In sunseting 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. The PATH request described above is essential to this transition process.

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 Section 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 Section 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 percent of the FPL 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 FFS. 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. The PATH request described above is essential to this transition process.

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,²⁶ will replace both models. The combination of ECM and ILOS within CalAIM represents an opportunity for MCPs to work with providers, counties, and CBOs 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, PATH expenditure authority described above will enable the State to ensure that providers, MCPs, justice agencies and the State, among other key implementation partners, have the resources necessary to transition WPC pilot and HHP capacity and services to CalAIM initiatives such as ECM/ILOS, and to maintain, build, and strengthen capacity for expanding whole person care and population health focused models of care statewide. For example, PATH expenditure authority will provide resources to retain and modify existing WPC pilot and HHP capacity that will be required in the future for successful implementation of ECM, ILOS and other Medi-Cal initiatives. This includes funding to maintain and build on current WPC pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved initiatives in 2023, as well as bridge funding to avoid the loss of existing WPC pilot and

²⁶ 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 SDOH.



HHP capacity that is needed for future initiatives or for situations in which MCPs, counties, and providers are moving forward with ECM and ILOS implementation but enrollees could be at risk of experiencing a gap in services while contracting arrangements and delivery approaches are implemented and brought to scale.

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 – 3 of the DTI. The State's approach aligns with the CMS Oral Health Initiative goals for Medicaid (increase by 10 percentage points the proportion of Medicaid and Children's Health Insurance Program (CHIP) 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
- 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 FFS delivery system into the managed care delivery system (i.e., enrolled them in Medi-Cal MCPs 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 Section 1915(b) waiver.



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 Supervisors, DHCS, and CMS approval, as approved in the Medi-Cal 2020 Section 1115 demonstration. DHCS currently has approval through the Section 1115 demonstration to allow Medi-Cal beneficiaries to enroll in PACE independent of the COHS MCP in two COHS counties: Humboldt and Orange. Because CMS has confirmed that specific authority is not necessary to allow Medi-Cal beneficiaries to enroll in PACE in selected COHS counties, DHCS is not requesting continued authority in either the Section 1115 demonstration or the Section 1915(b) waiver to continue this practice in COHS counties where PACE is authorized.

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 MLTSS.

DHCS is proposing to transition both components of the CCI into a statewide aligned enrollment structure. DHCS will continue to require individuals dually eligible for Medi-Cal and Medicare in CCI and COHS counties to enroll in MCMC for Medi-Cal benefits in 2022, and include institutional long-term care as a managed care benefit in CCI



counties. In 2023, DHCS will require dual eligibles to enroll in MCMC statewide. For dual eligible beneficiaries who opt to enroll in a Medicare Advantage plan, including a dual eligible special needs plan (D-SNP), DHCS will align these beneficiaries' Medi-Cal MCP enrollment with their Medicare Advantage plan enrollment whenever possible to allow for greater integration and coordination of care. DHCS plans to transition to aligned enrollment in select non-COHS counties in 2023, and will expand this approach statewide in future years.

DHCS seeks this managed care authority (now provided under the Section 1115 demonstration) via the consolidated Section 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 four 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 six percent increase in the number of uninsured patients served by the PHCSs, suggesting that the GPP is increasing access to care for the uninsured.
- **PHCSs report progress.** The PHCSs reported that their participation in the GPP has led to improvements in patient experience, care coordination, tailoring of patient care to the clinically appropriate setting, and wise allocation of resources. In addition, PHCS leaders were consistent in reporting a moderate to substantial association between strategy use and the third assessed outcome, “now being a part of your overall culture,” across six of the seven health strategy domains.

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

DMC-ODS Evaluation

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 applied to 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 (also known as medication-assisted 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. Prior to COVID-19, only 27 percent of DMC-ODS counties offered telehealth as an available method of service delivery. During the COVID-19 pandemic, the UCLA researchers found that nearly all DMC-ODS counties expanded their methods of service delivery to include telehealth; all counties expanded services by phone, and 96 percent of counties expanded services to include video and/or HIPAA-compliant apps to provide 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 four percent living in the 21 mostly small, rural counties that have not opted in to the DMC-ODS; DHCS currently is providing technical assistance to some of these counties that have expressed interest in



joining the DMC-ODS). 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
- Providing 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 of maintaining continuous health insurance coverage, improving and ensuring positive health outcomes, and improving 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); four percent used inpatient hospitalizations (up from three 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 were 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 FFS 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 Section 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 MCPs.
- **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 FFS, 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 FFS 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 Section 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 Section 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 (PY) 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 PY 2, with dental providers statewide having received incentive payments for emphasizing preventive care and noninvasive approaches for children (up to age six) identified as at 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 PY 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/provider as visited 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 CRIHB. 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 – 3 of the DTI.

The final DTI evaluation is expected to be submitted to CMS by December 30, 2022.

PRIME Evaluation

For the PRIME program, the UCLA Center for Health Policy Research conducted an [interim evaluation](#) (DHCS submitted to CMS in September 2019 and finalized in February 2020) and a [preliminary summative evaluation](#) (DHCS submitted to CMS in December 2020 and finalized in 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 California 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. (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. (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](#), Exhibit 183, page 356.
- **Goal 5: Transition public hospitals to value-based care through the adoption of alternate payment methodologies (APMs).** 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, page 70). Additionally, starting in 2018, all designated public hospital systems were required to establish 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 DYs of PRIME, from DY 11 to DY 15, will be included in the forthcoming final summative evaluation, which is expected to be submitted to CMS in draft form by August 31, 2021, and in final form by December 31, 2021.

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 of, continuous enrollment of, 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 seven 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 (five percent); and medical respite care (three 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 eight 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, an increase 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 had 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 SDOH, particularly for highly complex patients. Addressing these substantial challenges requires time, resources, and deliberate effort, the evaluators found. The final WPC evaluation to be submitted to CMS by December 30, 2022, 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 SDOH.

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 Section 1115 demonstration 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 2017.²⁷ 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 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 Section 1115 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.

²⁷ CMCS. State Medicaid Director Letter #17-003 re: Strategies to Address the Opioid Epidemic. Available <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf>.



Table 4: New Evaluation Hypotheses Under Consideration

New Hypotheses	Evaluation Approach	Data Sources
I. GPP: Equity Sub-pool		
<p>The demonstration will improve access to services that address the SDOH among the uninsured and contribute to reducing health disparities and promoting health equity.</p>	<p>Examine the utilization of SDOH-related services over time (from the first year of the equity pool), stratified by race/ethnicity.</p>	<ul style="list-style-type: none"> • GPP Equity Sub-pool services utilization data, stratified by race/ethnicity data
<p>Individuals who access GPP Equity Sub-pool services will experience reductions in emergency department (ED) utilization and inpatient hospitalizations.</p>	<p>Examine inpatient and ED utilization over time for individuals who receive GPP SDOH-related services via the GPP, stratified by race/ethnicity.</p>	<ul style="list-style-type: none"> • GPP Equity Sub-pool services utilization data, stratified by race/ethnicity data • Hospital and emergency utilization data, stratified by race/ethnicity data
<p>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.</p>	<p>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.</p>	<ul style="list-style-type: none"> • Surveys and/or interviews of GPP leads • Pre- and post-implementation surveys to track changes and progress over time



II. Justice-Involved Populations		
<p>The demonstration will improve physical and behavioral health outcomes of justice-involved populations post-release.</p>	<p>Examine the diagnoses and health outcomes for justice-involved populations.</p>	<ul style="list-style-type: none"> • Usage and diagnosis data • California Outcomes Measurement Systems (CalOMS) data • Quality measures (Healthcare Effectiveness Data and Information Set (HEDIS)) • Overdose morbidity and mortality records
<p>The demonstration will reduce ED visits, hospitalizations, and other avoidable services by connecting justice-involved populations to ongoing community-based physical and behavioral health services.</p>	<p>Examine the utilization of medical and behavioral health services and treatment.</p>	<ul style="list-style-type: none"> • Usage data • CalOMS data • Quality measures (HEDIS)
<p>The demonstration will promote continuity of medication treatment for individuals receiving medications.</p>	<p>Examine the number of medication claims and usage surveys and interviews to measure the usage and challenges associated with medication treatment post-release.</p>	<ul style="list-style-type: none"> • Pharmacy claims • CalOMS data • Surveys and interviews • Usage and diagnosis data



III. DMC-ODS Program Changes (<i>includes evaluations related to changes DHCS is currently negotiating with CMS and requested renewal changes</i>)		
(a) Increase access to SUD treatment for American Indians and Alaska Natives		
<p>The number of residential treatment admissions among American Indians and Alaska Natives beneficiaries will increase during the 12-month and five-year periods.</p>	<p>UCLA will examine residential treatment admissions among American Indians and Alaska Natives beneficiaries; UCLA will look for changes in metrics such as retention (time of treatment) and impact (e.g., treatment completion, satisfactory progress).</p>	<ul style="list-style-type: none"> • DMC-ODS claims • CalOMS discharge status data
<p>The number of American Indians and Alaska Natives beneficiaries receiving community-based SUD treatment will increase.</p>	<p>UCLA will examine usage of SUD treatment services among American Indians and Alaska Natives beneficiaries.</p>	<ul style="list-style-type: none"> • DMC-ODS claims
(b) Remove the limitations on residential treatment services that may be provided in a one-year period		
<p>Treatment outcomes for beneficiaries in residential treatment will improve.</p>	<p>Evaluator will review outcomes data.</p>	<ul style="list-style-type: none"> • CalOMS data • DMC-ODS claims
(c) 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		
<p>The number of beneficiaries served will increase.</p>	<p>UCLA will determine the usage of SUD treatment services by county and service type.</p>	<ul style="list-style-type: none"> • DMC-ODS claims • ASAM Level of Care usage data
(d) Expand access to MAT		



<p>The percentage of people with an SUD who use MAT will increase during the 12-month and five-year periods.</p>	<p>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.</p>	<ul style="list-style-type: none"> • DMC-ODS claims • County administrator surveys and interviews
<p><i>(e) Clarify the recovery services benefit</i></p>		
<p>The percentage of people with an SUD who use recovery services will increase during the 12-month and five-year periods.</p>	<p>UCLA examines the number of recovery services claims and uses surveys and interviews to measure the usage and challenges associated with recovery services.</p>	<ul style="list-style-type: none"> • DMC-ODS 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 is currently governed by a CPE protocol approved as attachment AA under California’s Medi-Cal 2020 Section 1115 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 DMC-ODS CPE protocol until at least July 2022. DHCS is working with counties and other stakeholders to both develop the policy and assure readiness, and will continually evaluate the implementation timeline as work continues throughout the coming year.

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 between Medi-Cal MCPs and County



mental health plans (MHPs), and reduce the administrative burden on State, county, and behavioral health providers 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 under the GPP 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 in the aggregate up to the sum of (1) the amount equal to the State's DSH allotment as set forth in § 1923(f) of the Social Security Act (the Act) and adjusted as described in subparagraphs (a) and (b) below (Adjusted DSH); (2) SNCP funding amounts established in the Medi-Cal 2020 demonstration (\$472 million annually); and (3) SNCP funding to establish the new GPP Equity Sub-pool (\$450 million annually) described below and in Section 3.

In order to align DSH amounts with each PY (which are shifting to calendar years), each PY will include 50 percent of the State's Adjusted DSH for each of the federal fiscal years (FY) in which it falls. For example, PY 6B (Calendar Year (CY) 2021) will include 50 percent of the Adjusted DSH for each of federal FYs 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, consistent with Attachment NN (DSH Coordination Methodology) in the Medi-Cal 2020 Section 1115 demonstration STCs.
- (b) In any year in which reductions to California's DSH allotment are required by § 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 annually in PYs 7-11, as shown below). This funding acknowledges the cost of providing services to uninsured individuals to address the social determinants of health; these services are not contemplated under the SNCP annual allocations of \$472 million for GPP PYs 1-5. Participating designated public hospital systems 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. CMS has approved the continuation of SNCP for PYs 6A and 6B, and expects to finalize Medi-Cal 2020 STC changes and amounts related to those time periods shortly. This renewal request relates to PYs 7–11.

- GPP PY 6A (July 1, 2020-December 31, 2020) – Adjusted DSH at 50 percent + \$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

* SNCP amounts pending finalization with CMS

DHCS will not make traditional DSH payments under the State Plan to designated public hospital systems participating in the GPP. The State will continue to follow the DSH Coordination Methodology as currently outlined in the Medi-Cal 2020 Section 1115 demonstration STCs, Attachment NN, and to be incorporated into the CalAIM STCs.

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 out-of-state former foster youth. In addition, as previously noted the State also intends to continue to provide full-scope Medi-Cal coverage to low-income pregnant women. The State will work with CMS to pursue Medi-Cal State Plan authority to authorize full-scope benefits to this population effective January 1, 2022, or a renewal of the current waiver and expenditure authorities, if necessary. Specific historical and projected estimates of the number of former foster youth and pregnant women gaining full-scope Medi-Cal coverage 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

Population	Historical Enrollment						
	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 percent of the 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 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
Low-Income Pregnant Women (109%–138% FPL) ²	15,127	15,127	15,127	15,127	15,127
Out-of-State Former Foster Care Youth ³	226	226	226	226	226

¹ Enrollment projections for DY 19 through DY 22 are held constant at DY 18 levels.

² Enrollment figures are estimated counts of unique beneficiaries based on an assumed percentage of Low-Income Pregnant Women (109-138 percent of the FPL) within the applicable aid code.

³ 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. As noted above, 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 this demonstration renewal request does not propose to otherwise expand eligibility, the CalAIM initiative (inclusive of the related Section 1915(b) waiver) is expected to improve care for all of the populations served by the Medi-Cal program. This is due to, for example, a greater focus on population health, availability of ECM and ILOS, and a comprehensive SUD system offering the full continuum of care needed for SUDs 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, 12.7 million



beneficiaries are expected to be enrolled in Medi-Cal during the first year of the renewed demonstration and 11.4 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. 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 Section 1915(b) waiver, a significantly smaller share of Medi-Cal enrollees will receive care via the Section 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	6,059
CHIP	954	940	926	917	907	883	904
Seniors and Persons with Disabilities	2,078	2,072	2,085	2,084	2,088	2,118	2,136
ACA Expansion	3,326	3,424	3,469	3,408	3,357	3,647	4,150
Other	44	47	48	50	50	53	56
Total	12,536	12,502	12,326	12,025	11,791	12,340	13,305

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 May 2021 Medi-Cal Estimate. Enrollment counts from the MIS/DSS warehouse are not final for CY 2020, and so are adjusted to account for expected future adjustments. Enrollment counts for periods following January 2021 are based on



projections in the May 2021 Medi-Cal Estimate. Population definitions and exclusions/inclusions reflect member groupings for budget purposes, and may not align with eligibility groupings used for waiver reporting.

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)	5,743	5,043	5,043	5,043	5,043
CHIP	905	905	905	905	905
Seniors and Persons with Disabilities	2,163	2,192	2,195	2,195	2,195
ACA Expansion	3,862	3,171	3,171	3,171	3,171
Other	56	54	54	54	54
Total	12,729	11,365	11,368	11,368	11,368

¹ The enrollment projections presented above are based on the May 2021 Medi-Cal Estimate. Individuals that receive only restricted scope services are excluded from the counts. Population definitions and exclusions/inclusions reflect member groupings for budget purposes, and may not align with eligibility groupings used for waiver reporting.

Budget Neutrality Calculation

The renewal request represents a dramatic streamlining of the Section 1115 demonstration, particularly due to the transition of MCMC, Dental MC, and much of DMC-ODS to a consolidated Section 1915(b) waiver that already authorizes the SMHS program. Thus, total demonstration expenditures during the renewal period will be significantly below Medi-Cal 2020 expenditure levels. Further, most of the authorities requested in the demonstration renewal do not represent new spending but instead represent spending that would otherwise be expected under the Medi-Cal State Plan. For example, the inclusion of selected services for justice-involved individuals prior to



release is expected to keep total spend at or below current levels by averting the need for significant expenditures on inpatient, emergency department, and other acute services post-release. California also proposes to continue the treatment of spending on out-of-state former foster youth and CBAS as hypothetical populations. Expenditures for full-scope benefits for certain low-income pregnant women are captured in the cost-effectiveness calculations in the consolidated Section 1915(b) waiver request, and as such, are not included in the budget neutrality projections for the CalAIM 1115 demonstration below. PATH spending will be a combination of demonstration savings and hypothetical expenditures; California anticipates discussion with CMS on budget neutrality for PATH. Some GPP spending will also be paid for through demonstration savings.

As it developed the budget neutrality calculation for the five-year renewal period, DHCS endeavored to simplify CMS' review and enhance alignment of reporting across the Section 1115 demonstration and consolidated 1915(b) waiver. As such, DHCS will, as much as possible, align Medicaid eligibility groups (MEGs) used for the Section 1115 demonstration budget neutrality and 1915(b) waiver 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 many of the innovations and initiatives authorized under the preceding demonstration into the Medi-Cal State Plan and a consolidated Section 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 \$44.5 billion in annual expenditures on average, while the projected annual expenditures under the renewal are approximately \$7.6 billion on average, which is 17 percent of the prior demonstration.

DHCS developed the budget neutrality models for both the current demonstration period (2016-2021) and the renewal period (2022-2026). For the portions of the current demonstration period for which actual expenditures were not final at the time of analysis, DHCS utilized projections informed by programmatic expectations and historical trends. For the renewal period, DHCS developed projections informed by State historical expenditures where available and anticipated cost and utilization trends and levels.

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 updating the reporting for the initial five-year period of Medi-Cal 2020 Section 1115 demonstration based on feedback from CMS. DHCS is working with CMS to account for the period of the temporary extension, and will subsequently report for this period as well.



The Medi-Cal 2020 Section 1115 demonstration STCs define the limits under which demonstration enrollment and expenditures will be monitored to demonstrate budget neutrality. Limit A is calculated for each MEG and four hypothetical populations or services, Limit B is calculated based on the total computable unspent public hospital amounts, and Limit C is calculated based on annual DSH allotments for California. The following per member per months (PMPMs) and trend rates, Limit B, and Limit C are defined in the STCs for the Medi-Cal 2020 MEGs and hypothetical populations or services to develop the without waiver (WOW) budget ceiling.

Table 9: Medi-Cal 2020 Budget Neutrality Expenditure Limits Under Limit A

MEGs	Trend Rate	DY 11 PMPM	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM ¹	DY 17 PMPM ¹
State Plan Groups								
Urban—Family TPM/GMC	4.00%	\$196.82	\$204.69	\$212.88	\$221.40	\$230.26	\$230.26	\$230.26
Rural Family—TPM/GMC	4.00%	\$172.17	\$179.06	\$186.22	\$193.67	\$201.42	\$201.42	\$201.42
SPD—TPM/GMC	4.00%	\$899.54	\$935.52	\$972.94	\$1,011.86	\$1,052.33	\$1,052.33	\$1,052.33
Duals—TPM/GMC	3.28%	\$121.84	\$125.84	\$129.97	\$134.23	\$138.63	\$138.63	\$138.63
Urban Family—COHS	4.00%	\$224.03	\$232.99	\$242.31	\$252.00	\$262.08	\$262.08	\$262.08
Rural Family—COHS	4.00%	\$183.36	\$190.69	\$198.32	\$206.25	\$214.50	\$214.50	\$214.50
SPD—COHS	4.00%	\$1,719.62	\$1,788.40	\$1,859.94	\$1,934.34	\$2,011.71	\$2,011.71	\$2,011.71
Duals—COHS	2.47%	\$450.10	\$461.22	\$472.61	\$484.28	\$496.24	\$496.24	\$496.24
MLTSS Family—TPM/GMC	4.00%	\$195.32	\$203.13	\$211.26	\$219.71	\$228.50	\$228.50	\$228.50
MLTSS SPDs—TPM/GMC	4.00%	\$1,093.06	\$1,136.78	\$1,182.25	\$1,229.54	\$1,278.72	\$1,278.72	\$1,278.72
MLTSS Duals—TPM/GMC	3.40%	\$774.83	\$801.17	\$828.41	\$856.58	\$885.70	\$885.70	\$885.70
Cal Medi-Connect—TPM/GMC	3.40%	\$774.83	\$801.17	\$828.41	\$856.58	\$885.70	\$885.70	\$885.70



MEGs	Trend Rate	DY 11 PMPM	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM ¹	DY 17 PMPM ¹
MLTSS Family—COHS	4.00%	\$222.30	\$231.19	\$240.44	\$250.06	\$260.06	\$260.06	\$260.06
MLTSS SPDs—COHS	4.00%	\$2,114.13	\$2,198.70	\$2,286.65	\$2,378.12	\$2,473.24	\$2,473.24	\$2,473.24
MLTSS Duals—COHS	1.61%	\$663.28	\$673.96	\$684.81	\$695.84	\$707.04	\$707.04	\$707.04
Cal Medi-Connect—COHS	1.61%	\$663.28	\$673.96	\$684.81	\$695.84	\$707.04	\$707.04	\$707.04
Hypothetical Services²								
CBAS	3.16%	\$1,166.69	\$1,203.56	\$1,241.59	\$1,280.82	\$1,321.30	\$1,321.30	\$1,321.30
New Adult—COHS	3.20%	\$664.73	\$686.00	\$707.95	\$730.61	\$753.99	\$753.99	\$753.99
New Adult—TPM/GMC	3.20%	\$521.37	\$538.05	\$555.27	\$573.04	\$591.38	\$591.38	\$591.38
DMC-ODS	n/a	n/a	\$2,942.29	\$3,418.10	\$2,913.42	\$2,912.74	\$2,912.74	\$2,912.74
Out-of-State Former Foster Care Youth	5.20%	n/a	n/a	\$204.33	\$214.96	\$226.14	\$226.14	\$226.14
HHP	n/a	n/a	n/a	\$65.00	\$65.00	\$65.00	\$65.00	\$65.00

Key: TMP = Two Plan Model counties; GMC=Geographic Managed Care counties

¹ DY 16 and DY 17 PMPMs are held constant at DY 15 levels.

² These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical expenditures on the overall expenditure limit. The actual expenditures for these hypothetical populations are included in the budget neutrality limit.

The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limits A, B, and C. Limit B is the amount of the designated public hospital spending as determined in the chart below, and Limit C is Annual DSH allotments for California, as determined under § 1923(f) of the Act and 42 CFR Part 447, Subpart E.



Table 10: Medi-Cal 2020 Budget Neutrality Expenditure Limits Under Limits B and C

Expenditure (in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Limit B							
Total Computable IP Unspent Public Hospital Amounts	\$863.1	\$863.1	\$863.1	\$863.1	\$863.1	\$431.55	\$863.1
Limit C							
Annual DSH Allotments	\$2,385.1	\$2,406.6	\$2,457.1	\$2,516.1	\$2,530.5	\$1156.5	\$2,313.0

The Medi-Cal 2020 Section 1115 demonstration STCs also establish the following savings phase-out. The reduced variance, calculated as a percentage of the total variance, is used in place of the total variance to determine budget neutrality for the Medi-Cal 2020 Section 1115 demonstration.

Table 11: Medi-Cal 2020 Budget Neutrality Savings Phase-Out

	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Urban Family—TPM/GMC	23%	23%	23%	23%	23%	0%	0%
Rural Family—TPM/GMC	100%	100%	100%	90%	80%	0%	0%
SPD—TPM/GMC	100%	90%	80%	70%	60%	0%	0%



	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Duals— TPM/GMC	23%	23%	23%	23%	23%	0%	0%
Urban Family— COHS	23%	23%	23%	23%	23%	0%	0%
Rural Family— COHS	100%	100%	100%	90%	80%	0%	0%
SPD— COHS	23%	23%	23%	23%	23%	0%	0%
Duals— COHS	23%	23%	23%	23%	23%	0%	0%
MLTSS Family— TPM/GMC	23%	23%	23%	23%	23%	0%	0%
MLTSS SPDs— TPM/GMC	100%	100%	100%	90%	80%	0%	0%
MLTSS Duals— TPM/GMC	100%	100%	100%	100%	90%	0%	0%
Cal Medi- Connect— TPM/GMC	100%	100%	100%	100%	90%	0%	0%
MLTSS Family— COHS	23%	23%	23%	23%	23%	0%	0%
MLTSS SPDs— COHS	100%	100%	100%	90%	80%	0%	0%



	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
MLTSS Duals— COHS	100%	100%	100%	100%	90%	0%	0%
Cal Medi- Connect— COHS	100%	100%	100%	100%	90%	0%	0%

The Medi-Cal 2020 Section 1115 demonstration STCs establish a separate annual budget limit for the new adult group, which is calculated as the product of the trended monthly per person cost, listed in the following table, multiplied by the actual number of member months.

Table 12: New Adult Group Spending

MEGs	Trend Rate	DY 11 PMPM	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM	DY 15 PMPM	DY 16 PMPM ¹	DY 17 PMPM ¹
New Adult—COHS	3.20%	\$664.73	\$686.00	\$707.95	\$730.61	\$753.99	\$753.99	\$753.99
New Adult—TPM/GMC	3.20%	\$521.37	\$538.05	\$555.27	\$573.04	\$591.38	\$591.38	\$591.38

¹ DY 16 and DY 17 PMPMs are held constant at DY 15 levels.

Budget Neutrality—Medi-Cal 2020

The following table shows the WOW expenditures, as established in the Medi-Cal 2020 STCs, the actual with waiver (WW) expenditures under the Medi-Cal 2020 Section 1115 demonstration, and the savings phase-down, used to calculate budget neutrality under the Medi-Cal 2020 demonstration.

California has experienced and is working to resolve system/technical challenges in order to refine and improve the mapping of expenditures from DHCS' capitation payment system to the appropriate waiver MEGs and applicable hypothetical services



or populations. As the system updates are still in process, DHCS applied refined mapping logic to appropriately categorize expenditures across the waiver categories. The manual adjustments primarily shift expenditures between waiver categories but also produce some changes in total expenditures that better represent actual expenditures under the demonstration.

Adjustments include, but are not limited to: 1) adjustments to address previously mentioned system mapping challenges by shifting expenditures to the appropriate State Plan groups; 2) reallocation of expenditures from State Plan groups to the CBAS, Out-of-State Former Foster Care Youth, HHP, and New Adult Group hypothetical services or populations; and 3) application of pharmacy rebates allocated in proportion to the actual expenditures by waiver category.

In addition, DHCS developed and included projections for anticipated increases or decreases in expenditures that had not yet occurred at the time of analysis. In the managed care delivery system, it is not uncommon for expenditures to change retroactively due to the time and data runout required for various payment arrangements, risk corridors and other retrospective financial calculations.

To determine the appropriate amounts to project, DHCS utilized information from the November 2020 Local Assistance Estimate and other, internal fiscal estimates. The estimates were reviewed and applicable expenditures under the waiver were included for each DY and waiver category. Estimated amounts that were developed in aggregate across the managed care delivery system were allocated to waiver categories using the best available information for each projection. Anticipated expenditure changes for which an amount was not reasonably estimable are not included, such as certain retrospective risk corridor, reconciliation, and withhold calculations for which results are not known.

As described in more detail in the following table, total cumulative expenditures under the Medi-Cal 2020 Section 1115 demonstration were \$265.4 billion. This total includes actual expenditures as well as projections (both positive and negative) that are intended to reflect anticipated final expenditure levels for the budget neutrality reporting period. These amounts will be updated in future budget neutrality reporting to CMS as actuals become available and can replace existing projections.



Table 13: Medi-Cal 2020 WOW and WW Historical Expenditures

(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
State Plan Groups							
Urban— Family TPM/GMC							
<i>Without Waiver</i>	\$3,088.8	\$3,250.2	\$3,301.8	\$3,306.4	\$3,345.2	\$1,672.6	\$1,672.6
<i>With Waiver</i>	\$2,405.4	\$2,652.2	\$2,748.9	\$2,794.8	\$2,831.2	\$1,415.6	\$1,415.6
Rural Family— TPM/GMC							
<i>Without Waiver</i>	\$386.4	\$399.8	\$408.1	\$411.2	\$416.3	\$208.2	\$208.2
<i>With Waiver</i>	\$374.2	\$384.0	\$406.3	\$424.8	\$387.9	\$194.0	\$194.0
SPD— TPM/GMC							
<i>Without Waiver</i>	\$2,546.3	\$2,643.6	\$2,742.8	\$2,832.9	\$2,949.6	\$1,474.8	\$1,474.8
<i>With Waiver</i>	\$2,434.9	\$2,422.6	\$2,547.5	\$2,693.3	\$2,803.3	\$1,401.7	\$1,401.7
Duals— TPM/GMC							
<i>Without Waiver</i>	\$129.3	\$153.6	\$175.2	\$194.7	\$213.0	\$106.5	\$106.5
<i>With Waiver</i>	\$137.4	\$177.4	\$210.3	\$236.8	\$236.2	\$118.1	\$118.1
Urban Family— COHS							



(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
<i>Without Waiver</i>	\$1,334.0	\$1,403.7	\$1,422.1	\$1,424.4	\$1,443.4	\$721.7	\$721.7
<i>With Waiver</i>	\$1,013.7	\$1,095.9	\$1,162.2	\$1,305.6	\$1,401.7	\$700.9	\$700.9
Rural Family—COHS							
<i>Without Waiver</i>	\$168.7	\$176.3	\$180.6	\$184.4	\$189.6	\$94.8	\$94.8
<i>With Waiver</i>	\$164.3	\$173.0	\$188.6	\$223.9	\$236.7	\$118.4	\$118.4
SPD—COHS							
<i>Without Waiver</i>	\$1,661.8	\$1,697.8	\$1,743.2	\$1,788.4	\$1,854.4	\$927.2	\$927.2
<i>With Waiver</i>	\$992.8	\$977.4	\$1,016.4	\$1,116.9	\$1,199.1	\$599.6	\$599.6
Duals—COHS							
<i>Without Waiver</i>	\$724.4	\$754.2	\$779.5	\$800.0	\$823.2	\$411.6	\$411.6
<i>With Waiver</i>	\$745.4	\$742.9	\$769.5	\$842.1	\$860.4	\$430.2	\$430.2
MLTSS Family—TPM/GMC							
<i>Without Waiver</i>	\$5,413.3	\$5,945.3	\$6,046.4	\$6,038.7	\$6,051.6	\$3,025.8	\$3,025.8
<i>With Waiver</i>	\$3,773.9	\$4,219.4	\$4,398.6	\$4,410.3	\$4,649.6	\$2,324.8	\$2,324.8



(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
MLTSS SPDs— TPM/GMC							
<i>Without Waiver</i>	\$5,022.9	\$5,508.6	\$5,790.4	\$5,885.7	\$5,979.7	\$2,989.9	\$2,989.9
<i>With Waiver</i>	\$4,797.2	\$5,171.8	\$5,012.0	\$4,628.1	\$4,931.3	\$2,465.7	\$2,465.7
MLTSS Duals— TPM/GMC							
<i>Without Waiver</i>	\$4,057.5	\$4,446.6	\$5,005.5	\$5,227.5	\$5,368.9	\$2,684.5	\$2,684.5
<i>With Waiver</i>	\$4,029.8	\$4,404.1	\$3,729.2	\$2,641.8	\$2,792.7	\$1,396.4	\$1,396.4
Cal Medi- Connect— TPM/GMC							
<i>Without Waiver</i>	\$924.1	\$849.9	\$887.3	\$891.8	\$903.7	\$451.9	\$451.9
<i>With Waiver</i>	\$609.0	\$514.2	\$379.3	\$245.7	\$252.5	\$126.3	\$126.3
MLTSS Family— COHS							
<i>Without Waiver</i>	\$982.0	\$1,006.9	\$998.6	\$982.1	\$971.3	\$485.7	\$485.7
<i>With Waiver</i>	\$729.3	\$779.3	\$723.8	\$750.9	\$885.5	\$442.8	\$442.8
MLTSS SPDs— COHS							



(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
<i>Without Waiver</i>	\$1,318.2	\$1,345.3	\$1,359.5	\$1,399.3	\$1,458.3	\$729.2	\$729.2
<i>With Waiver</i>	\$673.2	\$713.9	\$682.6	\$667.6	\$744.9	\$372.5	\$372.5
MLTSS Duals— COHS							
<i>Without Waiver</i>	\$678.9	\$658.9	\$693.1	\$718.3	\$738.2	\$369.1	\$369.1
<i>With Waiver</i>	\$613.8	\$604.0	\$530.0	\$482.4	\$507.5	\$253.8	\$253.8
Cal Medi- Connect— COHS							
<i>Without Waiver</i>	\$154.1	\$209.4	\$196.2	\$191.7	\$191.7	\$95.9	\$95.9
<i>With Waiver</i>	\$133.9	\$158.4	\$123.8	\$91.9	\$96.7	\$48.4	\$48.4
Hypothetical Services							
CBAS							
<i>With Waiver</i>	\$457.3	\$476.8	\$472.1	\$460.6	\$471.2	\$235.6	\$235.6
New Adult Group							
<i>Without Waiver</i>	\$18,161.4	\$20,578.5	\$21,847.4	\$22,225.3	\$22,512.9	\$11,256.5	\$11,256.5
<i>With Waiver</i>	\$13,791.5	\$13,404.2	\$14,935.8	\$14,823.7	\$14,633.6	\$7,316.8	\$7,316.8
DMC-ODS							
<i>With Waiver</i>	n/a	\$14.0	\$184.3	\$338.5	\$469.0	\$469.0	\$234.5



(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
Out-of-State Former Foster Care Youth							
<i>With Waiver</i>	n/a	n/a	\$0.3	\$0.5	\$0.5	\$0.3	\$0.5
HHP							
<i>With Waiver</i>	n/a	n/a	n/a	\$11.0	\$102.4	\$51.2	\$102.4
Other Expenditures							
DSH							
<i>Without Waiver</i>	\$2,385.1	\$2,406.6	\$2,457.1	\$2,516.1	\$2,530.5	\$2,313.0	\$2,313.0
<i>With Waiver</i>	\$645.8	\$599.8	\$594.3	\$581.9	\$564.5	\$282.3	\$564.5
IP UPL PH							
<i>Without Waiver</i>	\$863.1	\$863.1	\$863.1	\$863.1	\$863.1	431.55	\$863.1
GPP							
<i>With Waiver</i>	\$2,211.3	\$2,220.8	\$2,334.9	\$2,406.2	\$2,261.4	\$1,130.7	\$2,261.4
DTI							
<i>With Waiver</i>	\$0	\$30.1	\$116.1	\$151.0	\$243.1	\$243.1	\$121.6
PRIME							
<i>With Waiver</i>	\$1,597.6	\$1,582.6	\$1,577.2	\$1,440.0	\$1,224.0	n/a	n/a
WPC Pilots							
<i>With Waiver</i>	\$358.5	\$498.7	\$542.1	\$755.2	\$446.9	\$446.9	\$223.5
DSHP							



(in millions)	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16 ^{1,2}	DY 17 ^{1,3}
<i>With Waiver</i>	\$162.7	\$150.0	\$37.4	\$100.1	\$269.5	\$134.8	n/a
Tribal UCC							
<i>With Waiver</i>	\$2.4	\$2.2	\$1.2	\$0.7	\$0.9	\$0.5	\$0.9

¹ Projected expenditures for DY 16 and DY 17 are derived from DY 15 expenditures and equivalent to either 6 or 12 months of expenditures as described in footnotes 2 and 3.

² With limited exceptions, such as DTI, WPC, and DMC-ODS, DY 16 reporting represents expenditures attributable to the period of July 1, 2020, through December 31, 2020.

³ To maintain alignment between the 6-year duration of the demonstration and the duration of the budget neutrality expenditure reporting, DHCS has proposed to CMS to report DY 17 expenditures as follows:

- Through June 30, 2021, for all State Plan groups and hypothetical services (i.e., CBAS) for which Medi-Cal 2020 budget neutrality expenditure reporting begins on July 1, 2015.
- Through December 31, 2021, for the DMC-ODS, Out-of-State Former Foster Care Youth, and HHP hypothetical services/populations, and for other expenditures in effect during this time period.

Trend Rates and Member Months – CalAIM Renewal

The trend rates used to develop the PMPM rates were developed from State historical expenditures. Enrollment projections were based on historical enrollment trends, consideration of anticipated population changes (for example, an influx of new enrollees under the demonstration following the statewide mandatory transition of beneficiaries dually eligible for Medi-Cal and Medicare into the managed care delivery system in 2023 [DY 19]), and other factors as appropriate for individual services or populations. See Table 14, below, for CalAIM renewal trend rates and member months.



Table 14: CalAIM Renewal Trend Rates and Member Months

Initiative	Trend Rate ¹	Member Months ²				
		DY 18	DY 19	DY 20	DY 21	DY 22
Hypothetical Services						
CBAS ³	4.95%	70,000,000	73,865,000	73,865,000	73,865,000	73,865,000
Out of State Former Foster Care Youth	4.95%	984	984	984	984	984
DMC-ODS: IMD	5.5%	153,990,930	137,498,501	137,526,001	137,526,001	137,526,001
DMC-ODS: AI/AN	5.5%	153,990,930	137,498,501	137,526,001	137,526,001	137,526,001
Justice-Involved ⁴	4.95%	0	163,265	244,898	293,878	326,531

¹ The 4.95% trend rate used here is consistent with the trend rate used in California’s Section 1915(b) waiver for SMHS. California’s actuaries reviewed the Medi-Cal managed care program experience trend with a focus on the major rate categories over a four-year period (CY 2016 to CY 2019) and the national per capita trend for the four major Medicaid categories of aid as projected by CMS through CY 2026 in its most recent [2018 actuarial report](#). The trend rate is not specific to the hypothetical services in this waiver but is, nonetheless, viewed to be a reasonable aggregate trend assumption for this purpose (except for CBAS for DY 19, as described below).

² Except for CBAS, enrollment projections for DY 19 through DY 22 are held constant at DY 18 levels.

³ Enrollment projections reflect high-level estimates of the populations that meet the age threshold for CBAS. For DY 19 and beyond, the projections reflect the mandatory enrollment, with certain exceptions, of dually eligible beneficiaries into the Medi-Cal managed care delivery system on a statewide basis. Relative to the average member, the incoming population disproportionately utilizes CBAS; therefore, the trend rate from DY 18 to DY 19, inclusive of both cost growth and utilization growth, is 31.88%.

⁴ Enrollment projections represent estimated average utilizer months during the eligibility period up to 90 days pre-release, assuming ramp-up from DY 19 through DY 22.



Budget Neutrality—CalAIM Renewal Period

The limit on expenditures in the current Medi-Cal 2020 Section 1115 demonstration is based on a combination of per-capita and aggregate spending amounts. California proposes to continue this model for the CalAIM renewal. However, under CalAIM, the renewal request represents a dramatic streamlining of the Section 1115 demonstration, particularly due to the transitioning of MCMC, Dental MC, and much of DMC-ODS to a consolidated Section 1915(b) waiver that also includes SMHS. As a result, the expenditures included under Limit A are much more streamlined.

The CalAIM budget neutrality model also proposes to retain the existing waiver diversion of hospital Upper Payment Limit, “Limit B,” and California’s Medicaid DSH allotment, “Limit C.”

Budget neutrality for the CalAIM demonstration also includes new proposals to provide certain Medi-Cal services to justice-involved populations pre-release, establish PATH supports, and create a GPP Equity Sub-pool.

Cost projections for the per-capita expenditures, historical hospital UPL funding, and DSH expenditures will establish the WOW budget ceiling. Actual waiver expenditures for CalAIM initiatives will be applied against the WOW budget limit.

Table 15: Projected CalAIM WOW and WW Expenditures

Projected WOW Expenditures for DYs 18-22 (in thousands)					
Waiver Year PMPM Limits	DY 18	DY 19	DY 20	DY 21	DY 22
Hypothetical Services					
CBAS ¹	\$611,408	\$850,830	\$892,946	\$937,147	\$983,536
Out of State Former Foster Care Youth	\$376	\$395	\$415	\$435	\$457
DMC-ODS: IMD	\$209,982	\$217,153	\$223,211	\$229,818	\$236,437
DMC-ODS: AI/AN Healers/Helpers	\$4,059	\$4,164	\$4,280	\$4,407	\$4,534
Justice-Involved	n/a	\$84,086	\$132,372	\$166,710	\$194,402



Other Expenditures					
DSH ²	\$2,052,818	\$2,094,655	\$2,137,329	\$2,180,857	\$2,225,255
IP UPL PH	\$3,504,933	\$3,504,933	\$3,504,933	\$3,504,933	\$3,504,933
Medi-Cal 2020 Budget neutrality savings needed					\$3,614,730
Projected WW Expenditures for DYs 18-22 (in thousands)					
	DY 18	DY 19	DY 20	DY 21	DY 22
Hypothetical Services					
CBAS ¹	\$611,408	\$850,830	\$892,946	\$937,147	\$983,536
Out of State Former Foster Care Youth	\$376	\$395	\$415	\$435	\$457
DMC-ODS: IMD	\$209,982	\$217,153	\$223,211	\$229,818	\$236,437
DMC-ODS: AI/AN Healers/Helpers	\$4,059	\$4,164	\$4,280	\$4,407	\$4,534
Justice-Involved	n/a	\$84,086	\$132,372	\$166,710	\$194,402
Other Expenditures					
PATH Supports ³	\$713,000	\$584,500	\$405,500	\$231,000	\$231,000
IP UPL PH	\$2,641,879	\$2,641,879	\$2,641,879	\$2,641,879	\$2,641,879
GPP					
<i>DSH²</i>	\$2,052,818	\$2,094,655	\$2,137,329	\$2,180,857	\$2,225,255
<i>SNCP</i>	\$472,000	\$472,000	\$472,000	\$472,000	\$472,000



<i>Equity Sub-pool</i>	\$450,000	\$450,000	\$450,000	\$450,000	\$450,000
Tribal UCC	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
DSHP	\$230,000	\$230,000	\$230,000	\$230,000	\$230,000

¹ As described above, relative to the average member, the incoming population DY 19 disproportionately utilizes CBAS; therefore, the trend rate from DY 18 to DY 19, inclusive of both cost growth and utilization growth, is 31.88%.

² Amounts are estimated; final amounts will be based on actual DSH allocations.

³ PATH spending will be paid for through a combination of demonstration savings and hypothetical expenditures; California anticipates discussion with CMS on budget neutrality for PATH.

Table 16: Projected CalAIM Monthly Per Capita Expenditures

Projected Monthly Per Capita Expenditures for DYs 18-22					
	DY 18	DY 19	DY 20	DY 21	DY 22
Hypothetical Services					
CBAS ¹	\$8.73	\$11.52	\$12.09	\$12.69	\$13.32
Out of State Former Foster Care Youth ²	\$382.45	\$401.38	\$421.25	\$442.10	\$463.99
DMC-ODS: IMD	\$1.36	\$1.58	\$1.62	\$1.67	\$1.72
DMC-ODS: AI/AN Healers/Helpers	\$0.03	\$0.03	\$0.03	\$0.03	\$0.03
Justice-Involved ³	n/a	\$515.03	\$540.52	\$567.28	\$595.36

¹ The denominator is Medi-Cal managed care member months for members age 18 and older.



²The denominator is estimated Medi-Cal managed care member months based on an assumed percentage of Out-of-State Former Foster Care Youth within the applicable aid code.

³The denominator is Medi-Cal managed care utilizer months during the eligibility period up to 90 days pre-release.

Section 8 – Proposed Waiver and Expenditure Authorities

DHCS intends to maintain in the new CalAIM Section 1115 demonstration the relevant waiver and expenditure authorities that were approved under the Medi-Cal 2020 Section 1115 demonstration and is requesting limited new authorities, as described below, while proposing to transition certain authorities currently authorized in the Medi-Cal 2020 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 Section 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 MC, and the DMC-ODS), DHCS is requesting to waive Freedom of Choice (§ 1902(a)(23)(A)) under the consolidated Section 1915(b) waiver and therefore is not requesting to continue those authorities during the Section 1115 demonstration renewal period.



Table 17: Waiver Requests

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
<p>§ 1902(a)(13)(A) (insofar as it incorporates Section 1923) DSH Requirements</p>	<p>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.</p>	<p>Yes</p>
<p>§ 1902(a)(1) Statewideness</p>	<p>To enable the State to operate the demonstration on a county-by-county basis.</p> <p>To enable the State to provide short-term residential treatment services in DMC-ODS to individuals on a geographically limited basis.</p> <p>To enable the State to provide peer support specialist services within Drug Medi-Cal State Plan counties to individuals on a geographically limited basis. (Peer support specialist services will be available in Drug Medi-Cal counties that opt in.)</p>	<p>Yes, with modifications to reflect a new request related to peer support specialists in Drug Medi-Cal</p>



Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
<p>§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability</p>	<p>To enable the State to provide different benefits for low-income pregnant women from 109 percent up to and including 138 percent of the FPL, as compared to other pregnant women in the same eligibility group.²⁸</p> <p>To enable the State to provide short-term residential treatment services to eligible individuals with SUDs under the DMC-ODS program that are not otherwise available to all beneficiaries in the same eligibility group.</p> <p>To the extent necessary, to enable the State to provide peer support specialist services within Drug Medi-Cal State Plan counties that are not otherwise available to all beneficiaries in the same eligibility group.</p>	<p>Yes, with modifications to reflect the modification and sunset of Medi-Cal 2020 Section 1115 programmatic features, new requests for peer support specialists in Drug Medi-Cal</p>

²⁸ As noted above, DHCS intends to transition this authority from Section 1115 to the Medi-Cal State Plan and will prepare and submit the necessary State Plan Amendment(s) to make this change, if agreed to by CMS. It will not be necessary to continue this waiver authority if the State Plan Amendment is approved.



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 § 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:

1. Expenditure authorities 1, 6, 7, 9 and 10 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.
2. 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.
3. Expenditure authorities 2, 3, 4, 5, 6, 7, 8, and 10 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the State.

Table 18: 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 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



Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
3. Expenditures Related to Low-Income Pregnant Women²⁹	Expenditures to provide benefits for pregnant women with incomes from 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, 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
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 and 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

²⁹ As noted above, DHCS intends to transition this authority from Section 1115 to the Medi-Cal State Plan and will prepare and submit the necessary State Plan Amendment(s) to make this change, if agreed to by CMS. It will not be necessary to continue this expenditure authority if the State Plan Amendment is approved.



Expenditure Authority	Use for Expenditure Authority	Currently Approved Expenditure Authority?
6. Expenditures Related to PATH Supports	Expenditure authority to support CalAIM implementation capacity at the community level, including payments to qualified entities as described in the STCs for infrastructure and capacity building, as well as for interventions and services that will enable transition from Medi-Cal 2020 to CalAIM and complement the array of benefits and services authorized in the consolidated CalAIM Section 1915(b) waiver delivery system and other related authorities.	No
7. Expenditures Related to the DMC-ODS: Traditional Healers and Natural Helpers	Expenditure authority as necessary to receive federal reimbursement for traditional healers and natural helper services provided to DMC-ODS beneficiaries by facilities and clinics operated by IHCPs.	No
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 90 days prior to their release, including ECM or care coordination, as appropriate; and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed. In addition, services will include a 30-day supply of medication, including MAT, and DME for use post-release into the community. ³⁰	No

³⁰ 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 that are otherwise state-funded, subject to the terms and limitations set forth in the STCs for the following programs: <ul style="list-style-type: none"> • AIDS Drug Assistance Program (ADAP) • Breast & Cervical Cancer Treatment Program (BCCTP) • California Children’s 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
10. Expenditures for Uncompensated Care for Indian Health Service (IHS) and Tribal Facilities	Expenditures for supplemental payments to support participating IHS and Tribal facilities that incur uncompensated care costs associated with chiropractic services for which Medi-Cal coverage was eliminated by SPA 09-001 that are furnished by these providers to individuals enrolled in the Medi-Cal program.	Yes, with modifications to limit to chiropractic services only

Section 9 – Stakeholder Engagement and Public Notice

The CalAIM Section 1115 demonstration renewal is the product of many years of stakeholder engagement. Key to DHCS’ public engagement efforts has been the Stakeholder Advisory Committee (SAC), which provides DHCS with valuable input from the stakeholder community on ongoing implementation efforts for the State’s Section 1115 demonstration, as well as other relevant Medi-Cal and health care policy issues



being addressed by DHCS. Specifically, SAC members are recognized stakeholders and/or experts in their fields, including, but not limited to, beneficiary advocacy organizations and representatives of various Medi-Cal provider groups. DHCS also engages regularly with the Behavioral Health SAC (BH-SAC), which follows the model of the SAC, to advise DHCS on the behavioral health components of the Medi-Cal program and on behavioral health policy issues more broadly. BH-SAC membership includes providers, association leaders, advocates, health systems and hospitals, and County MHP representatives. DHCS also actively engages with the County Behavioral Health Directors Association of California (CBHDA), and other key stakeholders on behavioral policy issues and changes, including those that do not require waiver authority.

In addition, DHCS actively engages with the dozens of MCPs active in the State through quarterly meetings with the Managed Care Advisory Group (MCAG), inclusive of MCP representatives and other stakeholders and advocates to inform on issues that impact managed care beneficiaries. Present to engage with these stakeholders and the public are key DHCS leaders including decision makers and those who are subject matter experts in their respective programs and involved in the implementation of the Section 1115 demonstration.

From these stakeholder meetings, DHCS considered all feedback received from stakeholders and the public. In addition, the CalAIM proposal has been disseminated publicly since it was announced in fall of 2019, first in draft form and later as revised based on stakeholder feedback. DHCS' internal consultations and analyses thereafter helped to inform the important steps of developing the State's application for an extension or renewal of parts of the Section 1115 demonstration. SAC meetings are conducted in accordance with the California Bagley-Keene Open Meeting Act and other applicable requirements, and public comment occurs at the end of each meeting. Meeting information, materials, and minutes are available on the DHCS webpage [DHCS Stakeholder Advisory Committee](#). This section – Section 9 – describes the public outreach and stakeholder engagement that DHCS conducted in spring of 2021, in accordance with federal regulations at 42 CFR § 431.408.

Public Notice Process

California has undertaken a robust public notice process in compliance with State and federal requirements, and made clarifying edits to the application to reflect feedback received throughout the public comment process.

Public Website and Materials

On April 6, 2021, the State notified the public of its intent to submit the CalAIM Section 1115 demonstration amendment and renewal request, publishing the application and public notice on the [DHCS homepage](#) and the [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#) webpage. Because the 1915(b) waiver, as well as initiatives under other



authorities, such as ILOS, all contribute to the CalAIM initiative and the Section 1115 demonstration renewal request, and also because, over the course of negotiations with CMS, the sources of authority for some components of the CalAIM initiative might evolve, the public notice included information about these complementary initiatives. DHCS will negotiate both waivers with CMS simultaneously to ensure that California secures the authorities needed to implement CalAIM. The actual authority (e.g., Section 1115 demonstration, 1915(b) waiver, Medi-Cal State Plan) for any particular initiative may change over the course of the public comment process and engagement with CMS.

At the start of the public comment period, the CalAIM 1115 Demonstration & 1915(b) Waiver webpage included the State's public comment materials (see links below), a summary of the public comment period's dates and purpose, details about upcoming public hearings (i.e., dates, access information, accessibility details), and information about how stakeholders could submit public comment submissions via email, by U.S. mail, and in public hearings. Posted materials included:

- [Proposed CalAIM Section 1115 application](#)
- [Proposed CalAIM Section 1915\(b\) overview](#)
- [Public notice](#)
- [Section 1115 abbreviated notice](#)

The [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#) webpage, and the materials themselves, also linked to the CalAIM initiative homepage to give stakeholders a comprehensive view of the State's proposed approach. Screenshots of the DHCS webpage updates are available in Appendix E. The public notice is available in Appendix C.

Publication of Section 1115 Abbreviated Notice in the California State Register

On April 9, 2021, the State published the [Section 1115 abbreviated notice](#) in the [California State Register](#). The notice included a summary description of the CalAIM Section 1115 demonstration request; dates, times, and login details for the public hearings; instructions about how to submit public comments; and information regarding how to access copies of the demonstration amendment and renewal application available for public review and comment. The California State Register notice is available on the [California State Register \(2021, Volume Number 15-Z\)](#) and in Appendix E.

Stakeholder Publications

On April 7, 2021, the State emailed interested parties via the DHCS public stakeholder listserv to inform them of the posting of the application, the public comment period,



public hearings, and the process for public comment submission. These emails announced dates and details about how to participate in two public hearings (April 26, 2021, and May 3, 2021) and the Tribal public hearing (April 30, 2021), all held virtually to prevent and mitigate the spread of COVID-19. Copies of the stakeholder emails, DHCS webpage updates, and social media postings are available in Appendix E. Throughout the comment period, DHCS disseminated regular reminders (via its stakeholder listserv and social media accounts) about the public hearings and public comment deadlines, available in Appendix E.

Public Hearings

The State certifies that it held two public hearings to present the details of the demonstration amendment and extension application and to take public comment. Both public hearings were held electronically via Zoom to promote social distancing and mitigate the spread of COVID-19. The first hearing was held on April 26, 2021, from 1–2:30 pm Pacific Time, with approximately 335 attendees. The second hearing was held on May 3, 2021, from 2–3:30 pm Pacific Time, with approximately 339 attendees. The State made online video streaming and telephonic conference capabilities available, as well as closed captioning, to ensure statewide accessibility. At both hearings, DHCS presented an overview of the proposed CalAIM Section 1115 demonstration renewal application and then accepted public comments from webinar and telephonic participants. The PowerPoint presentation used during the public hearings was posted on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#) page and is accessible [here](#).

In addition to the two public hearings, DHCS leadership provided an overview of the amendment and extension request at meetings of the SAC (April 29, 2021) and BH-SAC (April 29, 2021). There were opportunities for public comments at both meetings.

Public Comment Period

The required 30-day public comment period ran from April 6, 2021, through May 6, 2021.

The State received approximately 271 public comments during the public comment period, including 169 comments submitted via email (CalAIMWaiver@dhcs.ca.gov) and/or U.S. mail as well as approximately 102 comments provided orally or via the Zoom Q&A box functionality during public hearings and other meetings. The written comments are available [DHCS webpage CalAIM 1115 Demonstration & 1915\(b\) Waiver](#) and a synthesis of the comments and responses is available in Appendix B. Because DHCS conducted a joint public comment period on the CalAIM Section 1115 application and the proposed CalAIM 1915(b) waiver renewal, commenters commented on both proposals; the majority of comments concerned policies related to the Section 1915(b) waiver delivery system and various aspects of the CalAIM initiative.



The State appreciates the public’s robust review of the CalAIM Section 1115 demonstration amendment and renewal application. The State reviewed and considered all public comments. Overall, the State received strong support for the CalAIM waivers and associated policies and their importance in advancing DHCS’ CalAIM initiatives and vision. Commenters expressed support for CalAIM proposals to continue GPP and develop the GPP Equity Sub-pool; to provide PATH supports; and to permit traditional healers and natural helpers to provide DMC-ODS services to advance culturally appropriate services for American Indians and Alaska Natives populations. Commenters provided a number of policy recommendations and considerations on the development of these programs.

In addition, commenters were generally positive about the following topics, while flagging important questions and potential issues related to DHCS’ proposed justice-involved population initiatives related to providing select Medi-Cal services pre-release; transitioning select DTI Domains from a pilot program to a statewide benefit; and transitioning WPC/HHP to ECM/ILOS. Commenters also raised important issues for DHCS to consider, including the care coordination between dental and physical health, and proposed changes to CCI and D-SNP aligned enrollment. Commenters proposed new policy items and changes for CBAS for DHCS’ consideration as well. Changes made in response to these comments are described below.

Though not related to this immediate demonstration application, commenters provided feedback on a number of topics under DHCS’ purview, including the transition of pharmacy benefits from Medi-Cal managed care to FFS; expansion of postpartum coverage from 60 days to 12 months; application for an SMI/SED demonstration to authorize federal reimbursement for IMDs; integration of SMHS and DMC-ODS into a single health plan in 2027; development of the Population Health Management Strategy; and oversight and accountability parameters for MCPs.

A summary of the comments and the State’s responses are available in Appendix B. All of the written public comment letters are available on the [DHCS webpage CalAIM 1115 Demonstration & 1915\(b\) Waiver](#).

Tribal Consultation and Public Comment

California is home to 109 federally recognized Tribal governments. In accordance with the California [SPA 12-002](#), California [Tribal Consultation Policy SPA Synopsis](#), and federal regulations at 42 CFR § 431.408(b), the State conducted Tribal consultation for the CalAIM Section 1115 demonstration amendment and renewal application through a written notice, as well as a public hearing held virtually to promote social distancing and mitigate the spread of COVID-19. The State’s required 30-day Tribal public comment period ran from April 7, 2021, through May 7, 2021. The Tribal public notice is available on the [Notices of Proposed Changes to Medi-Cal Program webpage](#) and in Appendix D.



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

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

During the meeting, participants raised concerns about the conclusion of the Tribal UCC program and impacts to Tribal health programs that do not elect to become Tribal FQHCs. Additionally, commenters were concerned that Tribal FQHC policies were not yet published. Participants also noted support for the proposed Indian Health Program Organized Delivery System (IHP-ODS), including access to traditional healers and natural helpers in the DMC-ODS program as a way to provide culturally appropriate SUD services and supports. The State thanked the Tribes for the operational questions and support and responded that additional details on the Tribal FQHCs' implementation would be available later in May 2021. DHCS published additional [Tribal FQHC guidance](#) on May 14, 2021, including details for providers on [billing services rendered by Tribal FQHCs](#) and [billing codes](#), and reviewed the new policy with IHP providers and Tribal organizations on June 11, 2021. As described above, in response to comments, DHCS is seeking authority to reinstate the Tribal UCC supplemental payments for chiropractic services, which are not accessible for Tribal health programs that do not elect to enroll as a Tribal FQHC.

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

In addition to the April 30 webinar, DHCS also discussed the Section 1115 demonstration application during the regularly scheduled Tribal Quarterly Meetings (March 5, 2021 and May 28, 2021). During the May 28 webinar, DHCS received three comments regarding payment rates for peer support specialists, natural helpers, and traditional healers, as well as a request to continue the Tribal UCC program and a



request for responses to public comments submitted during the CalAIM waiver public comment period on the waiver proposals. DHCS thanked the Tribes for their questions and noted all public comments will be posted on the [DHCS webpage CalAIM 1115 Demonstration & 1915\(b\) Waiver](#), with responses addressed in the CalAIM Section 1115 demonstration application.

Summary of Changes to Demonstration Amendment and Renewal Application

In response to comments received, the State modified the CalAIM Section 1115 demonstration application to modify its requests and/or to request additional authority in several areas.

The State received a number of comments supporting the justice-involved initiatives and with helpful recommendations. In response to comments received, DHCS has modified the CalAIM Section 1115 demonstration application to add an evaluation measure to assess changes in deaths related to fatal overdoses related to the proposed pre-release initiative for justice-involved populations. DHCS will also revise the timeframe of pre-release services from the proposed 30 days to 90 days, given the many public comments received on the importance of building in enough time pre-release to coordinate with correctional agency staff, establish trusted relationships with ECM providers, enable consultations via telehealth or, optionally, in-person as needed, from behavioral and physical health community-based providers, identify needed 30-day supply of medications or DME, and set up meaningful transition plans in order to support stabilization and continuity of services post-release.

In response to both stakeholder input and further refinement of our analysis, the State also adjusted our PATH request to \$2.17 billion and provided additional details about how PATH will support CalAIM implementation capacity at the community level and advance California's objectives related to advancing equity and improving quality and coordination of care for all Medi-Cal beneficiaries.

In addition, in response to stakeholder feedback, the State also added requests to:

- Authorize remote delivery of CBAS to current CBAS enrollees in specified circumstances.
- Reinstate the Tribal UCC pool to provide reimbursement for chiropractic services delivered outside of new Tribal FQHC providers and continue the Tribal UCC expenditure authority from the prior waiver.

The revised application also includes other technical changes to improve clarity as well as several updates to evaluation and EQRO reports to reflect later-posted information. Since publishing its draft Section 1115 demonstration application for public comment, the State also refined its budget neutrality estimates and included a more detailed



accounting of demonstration spending in this revised application, including an updated DSHP request.

Finally, the State received many public comments regarding the proposed behavioral health policy changes included in the attachments of the CalAIM Section 1915(b) waiver overview. The State continues to review these public comments and engage with stakeholders to address changes that do not require waiver authority but will be addressed in State statute, MCP procurement request for proposals (RFPs), SPAs, County MHP contracts, and/or additional informational notices and guidance issued by DHCS.

Compliance With Post-Award Public Input Process

In accordance with 42 CFR §§ 431.408, 431.412(c)(2)(vii), and 431.420(c), following CMS approval of the Medi-Cal 2020 Section 1115 demonstration renewal in 2015, DHCS convened the initial post-award forum on January 25, 2016. At this forum, through a webinar format, DHCS gave a walkthrough of the Medi-Cal 2020 Section 1115 demonstration's components and requirements and allotted time for public comment and questions.

Thereafter, DHCS continued its public notice processes by conducting additional post-award forums for the Medi-Cal 2020 Section 1115 demonstration. DHCS did so through the DHCS SAC meetings, announcing all meeting dates and materials in advance on the DHCS website and using a stakeholder distribution list. Through these SAC meetings (see above), DHCS continued to provide updates and solicit public comments regarding the State's Section 1115 demonstration. These quarterly meetings served as the annual post-award forums.

Going forward, DHCS will conduct the post-award forum for the CalAIM Section 1115 demonstration approximately 30 days after CMS approves the demonstration renewal and waiver approvals and thereafter will continue to present updates and solicit public comments on a quarterly basis through ongoing SAC meetings.



Appendix A: EQRO and Quality Reports

2019–20 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review Organization (EQRO) Report

Executive Summary ([Full Report Available Here](#))

This external quality review (EQR) report summarizes county programs providing SUD treatment services as part of the Medicaid SUD 1115 waiver demonstration in California: the DMC-ODS. The report was published on November 16, 2020, and covers FY 2019–20.

As of July 2020, 30 counties and one regional group of seven counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) were contracted to provide DMC-ODS. During FY 2019–20, 26 active counties had been operational for at least 12 months, allowing for an EQR evaluation. For 12 counties, FY 2019–20 was their first year of DMC-ODS services; for purposes of the report, these counties are referred to as Year One counties. Eleven counties (Contra Costa, Imperial, Los Angeles, Monterey, Napa, Nevada, Santa Clara, Santa Cruz, San Diego, San Francisco, and San Luis Obispo) were completing their second year of services when they were reviewed, and three counties (Marin, Riverside, and San Mateo) were completing their third year of services; collectively, these 14 counties are referred to as “pioneer” counties. The 12 Year One counties are Alameda, Fresno, Kern, Merced, Orange, Placer, Santa Barbara, San Bernardino, San Joaquin, Stanislaus, Ventura, and Yolo.

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 pioneer counties that began in the years before. 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 from DHCS. The report provides recommendations for DHCS to build on the progress of DMC-ODS, including adapting the DMC-ODS model for smaller counties, including developing regional approaches such as the regional model DHCS approved with the Partnership Healthplan of California’s seven-county coalition; incorporating best practices in access, timeliness, and quality of care into the Section 1915(b) waiver related to DMC-ODS; continuing State and local infrastructure investments to improve SUD treatment and access; and supporting stigma reduction and affordable housing initiatives to support clients and communities.



The report includes highlights and best practices emerging from each area that the CalEQRO evaluated in the county reviews. These included performance measures 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 to enhance areas related to clinical or administrative services, information system capacity assessments and their use for quality and administrative requirements, highlights from key stakeholder focus groups, and key findings and recommendations.

2019–20 Medi-Cal Managed Care External Quality Review Technical Report

Executive Summary ([Full Report Available Here](#))

As required by CFR 42 § 438.364 and 457.1250,³¹ DHCS contracts with Health Services Advisory Group, Inc. (HSAG), an 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 CHIP populations, including:

- A description of the manner in which the data from all activities conducted in accordance with CFR § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity
- For each EQR-related activity conducted in accordance with 42 CFR § 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 42 CFR § 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

³¹ U. S. Department of Health and Human Services, CMS. *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.



- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, and PAHP, including how the State can target goals and objectives in the quality strategy, under 42 CFR § 438.340, to better support improvement in the quality and timeliness of and access to health care services furnished to Medicaid beneficiaries
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities consistent with guidance included in the EQR protocols issued in accordance with 42 CFR § 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 42 CFR § 438.364(a)(6)

The review period for this *2019–20 Medi-Cal Managed Care External Quality Review Technical Report* is July 1, 2019, through June 30, 2020. HSAG will report on activities that take place beyond this report's review period in the *2020–21 Medi-Cal Managed Care External Quality Review Technical Report*.

42 CFR § 438.2 defines an MCO, in part, as “an entity that has or is seeking to qualify for a comprehensive risk contract.” CMS designates DHCS-contracted managed care plans (MCPs) as MCOs and Dental MC plans as PAHPs. DHCS designates two of its MCOs as population-specific health plans (PSPs). DHCS' 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 MC 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 2020)³² in California through a combination of contracted MCPs, SHPs, PSPs, and Dental MC plans. During the review period, DHCS contracted with 25 MCPs,³³ three PSPs, and one SHP to provide health care services in all of California's 58 counties. Additionally, DHCS contracted with three Dental MC plans that each operate in Los Angeles and Sacramento counties.

³² “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 15, 2020.

³³ 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).



Note that beginning in March 2020, to comply with the California shelter in place mandates and to allow MCMC plans as well as their contracted providers to focus on COVID-19 pandemic response efforts, DHCS allowed MCMC plans flexibility related to some activities that required in-person interaction. This operational flexibility was given to two focus studies, the Timely Access and Encounter Data Validation studies, neither of which are federally mandated EQR activities. DHCS also allowed flexibility to MCMC plans related to quality reporting of annual measures, which require an in-person chart review in order to complete a hybrid reporting methodology; all allowances made by DHCS were within either National Committee for Quality Assurance (NCQA) or CMS allowable parameters. Impact of COVID-19 to specific activities is described in detail in the 2019-20 Technical Report.

2018 Medi-Cal Managed Care Quality Strategy Report

Summary ([Full Report Available Here](#)):

The Medi-Cal Managed Care Quality Strategy Report submitted to CMS in July 2018 describes California's Medicaid quality strategy and how it meets the requirements of the Medicaid Managed Care and CHIP Managed Care Final Rule (Final Rule) at 42 CFR § 438.340. The final report includes quality strategies across all of California's Medicaid managed care delivery systems, including: (i) MCPs; (ii) County MHPs; (iii) DMC-ODS plans; and (iv) Dental MC plans.

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 department-wide priorities. In addition, DHCS' ten-year vision for Medi-Cal is to implement a whole-system, person-centered, population health approach to equitable health and social care. This will be an integrated "wellness" system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health. Services and support will deliver high-quality care that is accessible and useable to achieve more equal health outcomes across the entire continuum of care, for all. As part of this effort, DHCS is in the process of updating its Comprehensive Quality Strategy to encompass not just MCPs but also the FFS and other programs to achieve quality and health equity goals across the full spectrum of care DHCS provides.

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 LTSS. 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 Centers for Medicare & Medicaid Services (CMS) Form 416 EPSDT/CHIP Report

The 2019 Form 416 EPSDT/CHIP report (file name: 2019EPSDT_StateRpt20201112.pdf; pages 13–15) is available at <https://www.medicaid.gov/medicaid/benefits/downloads/fy-2019-data.zip>.

In accordance with § 1902(a)(43)(D) of Act, the State submits the annual Form CMS-416 to report on the provision of the EPSDT benefit, specifically providing the (1) number of children provided child health screening services; (2) number of children referred for corrective treatment; (3) number of children receiving dental services; and (4) the State's results in attaining the goals described in § 1905(r) of the Act.

The basic information provided in Form CMS-416 provides a baseline to measure the quality of and access to care provided by DHCS through the Medi-Cal program generally and under the demonstration specifically. Compared to FY 2018, the 2019 Form CMS-416 showed modest increases in the total screens received. The screening ratio increased across all age groups, as well compared to FY 2018. California experienced modest increases in total eligible children referred for corrective treatment in FY 2019 compared to the year prior, with the largest gains in age ranges six to 20. Similarly, California had an increase in total eligible children receiving preventive dental services, with the State's youngest children (under age two) reporting more services compared to older children enrolled in Medi-Cal.

Through regular review of the data collected each year, DHCS seeks to identify trends that may illustrate barriers to access or areas that could be improved; if concerns are identified, DHCS takes necessary actions to address such issues. For example, because the majority of children receive Medi-Cal services through MCPs, DHCS has issued a number of All Plan Letters to clearly outline and delineate MCPs' obligations to ensure children are able to access and receive all EPSDT services (see, e.g., [All Plan Letter 19-010](#)). In addition to statewide guidance and clarification, DHCS regular reviews the MCP's Evidence of Coverage and contract language to ensure the description of the EPSDT benefit includes the latest guidance issued by the American Academy of Pediatrics/Bright Futures' Recommendations for Preventive Pediatric Health Care Periodicity Schedule.

In addition, DHCS uses the annual Children's Preventive Services Report (PSR) as a tool to identify and monitor appropriate utilization of preventive services for children in Medi-Cal managed care. DHCS worked with its independent EQRO to develop the PSR to assess the provision of preventive services across MCPs and regions according to



State regulatory requirements as well as the national Healthcare Effectiveness Data and Information Set (HEDIS) measures. Efforts were made to expand measures that were used for monitoring MCPs to address pediatric preventive care services. Due to the disruptions caused by COVID-19, the 2020 PSR was released in two phases: Phase 1 was released in December 2020 and contained statewide and regional reporting while Phase 2 was released in February 2021 and reflected MCP-specific performance as well as included Blood Lead Screening rates in accordance with State requirements. The 2020 PSR Part 1 can be found [here](#) and Part 2 (Addendum) can be found [here](#).

It is important to note that special efforts were made to ensure children were receiving preventive care services during the COVID-19 pandemic. Over the last year, DHCS required MCPs to conduct outbound call campaigns to encourage families to ensure children are receiving immunizations and blood lead level screenings. DHCS has also made supplemental payments to pediatric primary care providers to screen for EPSDT services including, ACEs screenings and developmental screenings. DHCS also established family therapy as a covered Medi-Cal benefit and clarified EPSDT protections for mental health, SUD, and early intervention services.

DHCS will continue to monitor EPSDT services carefully as the Medi-Cal delivery system transitions from the Section 1115 demonstration to Section 1915(b) delivery system authority. As outlined in the CalAIM Section 1915(b) waiver, DHCS attests that contracting MCPs comply with EPSDT requirements.



Appendix B: Responses to Public Comments

Overview

DHCS received approximately 271 comments during the comment period for the [proposed CalAIM Section 1115 Demonstration Application](#) and [proposed CalAIM Section 1915\(b\) Overview](#), which describes the 1915(b) waiver and related policy changes that California will be pursuing in tandem with this Section 1115 demonstration renewal. The total number of public comments includes comments received during three public webinars and 169 letters and emails; all written public comments are de-identified for personal information and posted on the [DHCS webpage CalAIM 1115 Demonstration & 1915\(b\) Waiver](#).

The following summary of comments and DHCS responses primarily reflects input on the proposed CalAIM Section 1115 Demonstration Application (as required by 42 CFR §§ 431.408 and 431.412) as well as topics that are relevant to the integrated CalAIM federal waiver requests. DHCS also includes below a brief summary of comments related to the proposed CalAIM 1915(b) waiver. In addition to comments related to the State's demonstration and waiver requests to CMS, various commenters provided input about other CalAIM and Medi-Cal topics, including ECM/ILOS. The State appreciates those comments and will consider them as it continues to work to strengthen Medi-Cal and implement the CalAIM initiative.

Section 1115 Demonstration

Overarching CalAIM Waiver Comments

Comment: Many commenters supported the approach of the CalAIM waivers, including the focus on improving the Medi-Cal delivery system and adopting a whole person model. Multiple commenters also supported the three overarching goals of the [CalAIM Proposal](#):

1. Identify and manage member health risk and health needs via SDOH and whole person care approaches.
2. Facilitate Medi-Cal to be more consistent and seamless by increasing alignment across delivery systems, reducing complexity, and increasing flexibility.
3. Improve quality outcomes, reduce health inequities, and foster delivery system transformation and innovation via value-based initiatives, system modernization, and payment reform.

Response: The State appreciates the commenters' support for the CalAIM waivers and initiatives. DHCS is committed to improving the Medi-Cal delivery system for all Medi-Cal beneficiaries through a whole person care and service model.



Comment: One commenter opposed the integrated CalAIM 1115 and 1915(b) waivers, expressing concerns that elements of the CalAIM proposal could disrupt access to behavioral health care services for children

Response: The State appreciates the commenter’s concerns and is committed to ensuring that the transition from 1115 to 1915(b) delivery system authority preserves access to behavioral health care for children, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The CalAIM 1915(b) waiver will bring each of the managed care delivery systems under one federal authority, standardizing federal requirements to the extent possible. The State’s behavioral health proposals are in part aimed at strengthening access to appropriate care, including clarifying the current division of responsibilities between MCPs and County MHPs to improve beneficiaries’ access to medically necessary services. These proposals were developed following extensive consultation with stakeholders and incorporation of their feedback. The State is conducting ongoing consultations to continue refining its proposals and, as changes are implemented, will oversee and monitor changes to further ensure that access for children with behavioral health care needs is not disrupted.

Health Equity

Comment: Commenters encouraged DHCS to maximize the federal waiver opportunity to address health equity goals detailed in the CalAIM proposal for Medi-Cal and Medi-Cal MCPs, and to engage stakeholders in innovative solutions to address health disparities. Another commenter recommended that DHCS establish a consumer advisory committee to ascertain the extent to which CalAIM initiatives are addressing equity concerns.

Response: The State appreciates these comments and continues to strive to incorporate equitable principles and policies in all of DHCS’ work, including the CalAIM proposal. Equity has been, and continues to be, a key focus of the Administration and DHCS to advance diversity, equity, and inclusion both within DHCS and on behalf of the Californians we serve. For example, the CalAIM Section 1115 demonstration includes the proposed establishment of a new, separate GPP Equity Sub-pool to address social needs and respond to the impacts of systemic racism and inequities on the uninsured populations served by public hospital systems. If approved by CMS, the GPP Equity Sub-pool 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. In addition, the department’s request for PATH supports resources will help support the transformation of service delivery networks at the community level to increase access to health care services, support better integration of physical and behavioral health and health-related services, and improve health outcomes, with particular attention to providers and community-based organizations in communities that have been historically under-resourced because of economic or social



marginalization due to race, ethnicity, rural geography, or other factors. Furthermore, DHCS will continue to focus on health equity and addressing health disparities with stakeholders in SAC and BH-SAC meetings.

American Indians and Alaska Natives Tribal SUD Services

Comment: Many commenters supported the request for DMC-ODS to include culturally appropriate services and practices delivered by traditional healers and natural helpers, and one commenter requested an allowance for specific cultural health care practices for Tribal 638 clinics, noting that having culturally appropriate practices reimbursed is important for Tribal providers, regardless of who the administrative entity is providing the service. One commenter requested DHCS ensure IHPs, including residential treatment facilities, receive 100 percent Federal Medical Assistance Percentage (FMAP) for services provided by traditional healers and natural helpers.

Response: The State appreciates the comments and looks forward to working with CMS to secure the requested authority to reimburse culturally appropriate services and practices delivered by traditional healers and natural helpers.

Comment: A commenter urged DHCS to work directly with American Indians and Alaska Natives communities to ensure that the spirit and integrity of the services provided by these providers are not altered to fit within the Western medical model framework. Commenters urged DHCS' continued consultation with IHPs in identifying the appropriate "evidence based practices."

Response: The State appreciates these comments and will continue to consult with our Tribal partners as we negotiate with CMS for approval of this request to ensure culturally appropriate services for American Indians and Alaska Natives communities. Consultations with Tribal partners will continue through the demonstration's implementation.

Comment: Commenters recommended that DHCS define "culture" for culturally appropriate traditional healers and natural helpers beyond race and ethnicity to include other cultural communities, including gender identity, sexual orientation, generation, and geographic region.

Response: The State appreciates the commenters' perspective. In addition to the demonstration request to authorize traditional healers and natural helpers, the State is also pursuing a SPA to authorize peer support services in DMC-ODS, SMHS, and Drug Medi-Cal to enable access to peer support specialists across human diversity factors, including gender identity, sexual orientation, generation, and geographic region. Peers will be able to provide culturally competent services across all communities to promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of



natural supports, and identification of strengths. In combination, authorization of traditional healers and natural helpers along with peer support specialists will help advance the goal of providing Medi-Cal enrollees with enhanced access to care from all of the cultural communities represented in California.

Comment: One commenter noted that traditional healers and natural helpers are already able to deliver mental health services as “Other Qualified Providers” but are not routinely used by either the MCP or County MHP. The commenter requested that DHCS issue guidance to encourage MCPs and MHPs to leverage traditional healers and natural helpers to provide mental health services as an “Other Qualified Provider.”

Response: The State appreciates the commenter’s input and will consider opportunities to encourage MCPs and County MHPs to utilize traditional healers and natural helpers, pending the outcome of negotiations with CMS.

Community-Based Adult Services (CBAS)

Comment: One commenter requested clarification on the proposed technical changes to CBAS that are described in the draft CalAIM Section 1115 demonstration application. One commenter requested additional details regarding the proposed MCP contract changes related to CBAS.

Response: The technical changes related to the CBAS program are focused on aligning the STCs with the existing CBAS components of the Medi-Cal Provider Manual and the proposed MCP contract changes. The changes also align with updates to the Standards of Participation and guidance issued by the California Department of Aging (CDA).

Comment: Many commenters expressed support for the continuation and modernization of the CBAS model by incorporating lessons learned during the COVID-19 public health emergency and aligning those lessons with the goals of the Master Plan for Aging to improve access to home and community-based services throughout the State. Many commenters encouraged DHCS to update the CBAS model to permit additional flexibilities, including adopting the Temporary Alternative Services (TAS) model as an ongoing CBAS feature, implementing telehealth to deliver CBAS, and adopting a Home Health type of service within the CBAS model.

Response: The State appreciates the commenters’ helpful feedback. Although CBAS will remain a largely center-based model of care, in recognition of stakeholder feedback to continue the TAS flexibilities implemented in response to the COVID-19 public health emergency, DHCS amended the Section 1115 application to allow a modified version of the flexibilities to continue in specified circumstances where an existing CBAS participant experiences a personal or public health emergency. If approved, DHCS and



the CDA will work collaboratively with CMS to develop additional standards for CBAS delivery to allow for an immediate response and continuity of care for CBAS participants when they are restricted/prevented from receiving services at the center. As with flexibility provisions implemented during the COVID-19 public health emergency, under specifically defined circumstances, approved CBAS providers would be authorized to deliver medically necessary services and supports and provide intensive care management/care coordination services to address the assessed and expressed needs of their complex, high-risk participants in the home, in the community, and/or via telehealth. The CBAS multidisciplinary care and support model would remain primarily the same whether provided in the center, in the home, and/or remotely via telehealth/telephone, including medical, therapeutic, and social service delivery.

Comment: Many commenters recommended that DHCS include additional revisions to CBAS, including adding a research component for CBAS, encouraging MCPs to contract with CBAS providers for ECM as a feature of CBAS and “CBAS Plus”, and encouraging partnerships between adult day health centers and MCPs.

Response: Through the implementation of CalAIM, DHCS will seek to address the intent of these comments with regard to continuing to define how CBAS interacts and partner with MCPs, both generally and in relation to ECM and ILOS.

Comment: Commenters requested DHCS consider defining presumptive eligibility for CBAS for individuals who are within 60 days of a nursing home or hospital stay and who meet medical necessity criteria, transitioning CBAS to a Medi-Cal State Plan benefit, creating a DHCS, CDA, CBAS leadership workgroup to modernize the STCs and SOPs for CBAS, and requiring access standards for CBAS beneficiaries.

Response: The State acknowledges the importance of these comments and points to its planned HCBS/MLTSS Gap Analysis and Multi-Year Roadmap as the appropriate vehicle to further examine these recommendations. Specifically, the gap analysis plans to address the following objectives: reduce inequities in access and services, meet client needs, increase program integration and coordination, improve quality, and streamline access.

Comment: One commenter requested that DHCS consider modifying CBAS to include mental health and SUD provisions, including providing information to beneficiaries to improve their ability to be their own advocate and/or partner with peer support staff, ensuring CBAS abides by Substance Abuse Mental Health Services Administration (SAMHSA) recovery principles, and permitting consumers to receive mental health and SUD services at the same location, date, and time.



Response: The commenter’s comments appear focused on community-based adult services generally, rather than on CBAS specifically. The CBAS benefit includes assessment processes to identify if a referral to a CBAS mental health consultant is appropriate, recommended, and/or requested. An appointment with a CBAS mental health consultant is scheduled to occur at a CBAS center during a beneficiary’s scheduled day of attendance.

Comment: One commenter requested DHCS provide updated guidance and regulations pertaining to county Medi-Cal eligibility functions for CBAS, supporting a robust technical assistance framework and a continuous improvement process in lieu of any penalties.

Response: The State appreciates this comment, but does not believe the county eligibility functions raised by the commenter are applicable to the proposed changes to the CBAS program.

Comment: One commenter noted that projected expenditures for Demonstration Year (DY 18 through DY 22 for CBAS do not align with projections over the past eight years. The commenter raised concerns regarding the projections for mandatory enrollment of dual eligible beneficiaries statewide as of January 2023, noting concerns about capacity for MCPs to serve the expanded population, and recommended connecting CBAS to ECM for assistance.

Response: The State appreciates the comment and reviewed the DY 18 through DY 22 projections for CBAS when finalizing budget neutrality estimates. The projections for DY 18 through DY 22 broadly consider the impact of cost trends and higher Medi-Cal managed care enrollment relative to historical levels, including, but not limited to, the mandatory enrollment of dual eligible beneficiaries statewide as of January 2023.

Dental Benefits and Dental Transformation Initiative (DTI)

Comment: Commenters noted in prior conversations with DHCS that DTI would likely conclude in June 2021 and urged the State to consider additional funds in the Governor’s May Revision. A commenter asked if the new dental benefits proposed in CalAIM will be (1) included in the State Plan and (2) available to FQHC providers, and (3) if reimbursement is available to FQHC providers outside of Prospective Payment System (PPS).

Response: Based on the [Governor’s May Revision budget](#) released May 14, 2021, DTI will continue to provide dental preventive services, dental continuity of care, caries risk assessment, and silver diamine fluoride through the one-year temporary extension period, with the initiative concluding on December 31, 2021. Although the temporary Medi-Cal 2020 Section 1115 demonstration extension did not continue DSHP funding—



which had been used as the nonfederal share for these DTI initiatives—the State is using State general funds to continue the services through the end of this year.

Beginning in 2022, the proposed dental benefits will be included in the Medi-Cal State Plan, and FQHCs, Tribal FQHCs, and Tribal IHS Memorandum of Agreement (MOA) clinics would similarly bill as they do today for all covered dental benefits, based on the eligible populations and medical necessity for the covered benefit. Covered benefits would be at the applicable PPS rate or the All-Inclusive Rate (AIR), when billed by billable providers. DHCS will also be seeking federal approval to pay the applicable incentive payment for the provision of preventive services or maintaining continuity of care in a separate payment that is separate and apart from the applicable PPS or AIR rate.

Comment: Commenters recommended DHCS continue DTI Domain 4, permitting local DTI pilot projects with local dental providers, First 5 Commissions, schools, and other community stakeholders.

Response: DHCS appreciates the commenters' perspective but has decided to discontinue DTI Domain 4. The Local Dental Pilot Projects fell short of their goals, which were self-selected measurements by which to gauge their success, including their requested shifts in strategies, during the progression of the pilot program. While some local efforts have been more successful than others, DHCS was unable to obtain enough data to determine or influence any additional components for statewide policy, outside of what is already being put forward for Domains 1–3, nor do we have any indication that a one-year extension would move this outcome in a substantive way.

Commenter: Commenters supported the pilot project at the Health Plan of San Mateo to carve in historically carved-out dental benefits and urged DHCS to require robust outcome metrics and evaluations for the pilot's successes and challenges.

Response: The State appreciates the commenters' support of the Health Plan of San Mateo dental integration program. DHCS will seek the authority in the consolidated CalAIM 1915(b) waiver with an anticipated implementation date of January 1, 2022. DHCS intends to require outcome metrics and the evaluation that is required by the state law that authorized the Health Plan of San Mateo dental integration program. The evaluation and outcome metrics are being developed in collaboration with the Health Plan of San Mateo.

Comment: Commenters requested DHCS implement greater oversight of the FFS dental program by integrating with the physical health side of Medi-Cal via MCMC MCPs. Commenters also expressed support for DHCS establishing a new statewide benefit building on the success of DTI for children and select adults to encourage oral health preventive services, as well as incentives for providers'



delivery of preventive oral health care. Commenters requested DHCS consider recommendations to the proposed provider incentives, including expanding incentives to be eligible for additional preventive treatments; expanding silver diamine fluoride to all populations regardless of age or medical complexities; adding flexibility to encourage dental services based on medical necessity; and clarifying the monitor and evaluation measures to be leveraged with the provider incentive program. Other commenters encouraged DHCS to support the use of teledentistry services and promote the utilization of dental services for beneficiaries with special health care needs.

Response: The State appreciates the commenters' support and will continue to focus on improving preventive oral health and consider the recommendations to strengthen the provider incentive payments and dental benefits as DTI is transitioned out of the Section 1115 demonstration.

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

Comment: Commenters supported DHCS' proposal to continue the DMC-ODS program and its transition to the Section 1915(b) waiver. Other commenters encouraged DHCS to consider expanding DMC-ODS statewide, noting that any counties that have not yet opted in to DMC-ODS are rural counties with a high level of need to be addressed.

Response: The State appreciates the commenters' support for DMC-ODS as DHCS provides a robust continuum of care for SUD treatment services. DMC-ODS is a voluntary delivery system, permitting counties to opt in, which 37 of California's 58 counties have, providing access to 96 percent of the total Medi-Cal population statewide. DHCS continues to encourage statewide adoption of DMC-ODS and is actively working to streamline entry into DMC-ODS on a voluntary basis.

Comment: Commenters expressed the importance of ensuring access to SUD treatment for Tribal members and ensuring that Tribal health programs can be reimbursed for providing SUD services. Commenters asked for clarification on how Indian Health Service (IHS) clinics and Tribal FQHCs can participate in DMC-ODS. One commenter recommended that DHCS consider including technical assistance and support for community partners in Tribal health programs that are applying to be DMC-ODS providers. Commenters also encouraged DHCS to include the Indian Health Program Organized Delivery System (IHP-ODS) as an option in the CalAIM waivers.

Response: The State agrees with the commenters' desire to improve access to SUD services and is committed to working with Tribal leaders to ensure that Tribal health programs can participate in DMC-ODS. The State is eager to partner with IHS clinics to provide DMC-ODS services. IHS clinics are not required to have a separate contract



with a DMC-ODS county in order to provide DMC-ODS services. Tribal FQHC providers are required to carve out Drug Medi-Cal services and instead apply to be Drug Medi-Cal providers; DHCS is currently in discussions with CMS to develop a methodology to carve out DMC-ODS services from their APM rate. Please see [Behavioral Health Information Notice 20-065](#) for additional information.

Dual Eligibles/Coordinated Care Initiative (CCI)

Comment: Commenters requested clarification on DHCS’ vision, strategy, and work plan for moving toward an aligned D-SNP and MLTSS structure for dual eligible beneficiaries, starting in 2023 in counties that participate in the CCI. In particular, commenters requested clarification on the implications these reforms will have on dual eligible beneficiaries’ care quality and outcomes, provider networks and provider participation, and the Medi-Cal and Medicare health plan markets. In addition, some commenters supported and some opposed the CalAIM initiative proposal to align with federal changes to end D-SNP lookalikes, which are Medicare Advantage plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population.

Response: The State appreciates these comments and is committed to improving integration and coordination of care for dual eligible beneficiaries, as well as working with stakeholders to achieve these goals. DHCS will continue to solicit input on these important topics with its ongoing stakeholder workgroup on MLTSS and integrated care for dual eligible beneficiaries, as well as other stakeholders, as it develops and implements its aligned D-SNP and MLTSS approaches.

Global Payment Program (GPP) and Equity Sub-pool

Comment: Many commenters expressed strong support for the continuation of GPP, emphasizing that the program plays a critical role in increasing engagement with populations who are either uninsured or underinsured and incentivizing cost-effective, preventive, and outpatient care. Multiple commenters highlighted the importance of continuing the Safety Net Care Pool (SNCP) funding; one commenter specifically indicated that public health care systems cannot afford to maintain their existing levels of service for the uninsured without ongoing SNCP funding as part of the GPP, and multiple commenters noted that the COVID-19 pandemic has only increased the importance of the GPP. Some commenters posed clarifying questions about the program, asking whether GPP will include the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and Quality Incentive Program (QIP) and which entity determines, facilitates, and monitors GPP payments.



Response: The State agrees that continuing GPP is a crucial component of the CalAIM demonstration, including the SNCP funding. The GPP does not include PRIME; the applicable performance measures of PRIME were transitioned to, and public hospitals may now qualify to receive, managed care directed payments through QIP, which is distinct from GPP. DHCS facilitates and monitors GPP payments and the program's evaluation was conducted by an independent evaluator, the RAND corporation.

Comment: Many commenters supported the addition of the Equity Sub-pool in GPP, noting its importance to providing equitable care and addressing the specific needs of the remaining uninsured. Multiple commenters requested that DHCS provide additional information about the Equity Sub-pool and proposed activities. One commenter urged DHCS to provide flexibility in developing the Equity Sub-pool parameters, while other commenters requested that the Equity Sub-pool include specific activities and design components. These include requests for funding for tobacco cessation supports, medical-legal services, partnerships to measure disparities and implement community-wide disparity reduction plans, and funding for the convening and coordinating of necessary work to connect the health care sector to other sectors and community resources.

Response: The State agrees that the addition of the Equity Sub-pool is critical to CalAIM's comprehensive, cross-delivery-system approach to providing equitable, person-centered care to low-income Californians. DHCS is committed to implementing the Equity Sub-pool in a manner that best addresses the needs of California's uninsured and underinsured populations, to improve equitable outcomes. Doing so requires DHCS to incentivize the delivery of services that address not only the physical and behavioral aspects but also the social drivers of health.

Institutions for Mental Diseases (IMDs) Exemption for SUD Services

Comment: Commenters supported the continuation of the IMD exemption for SUD services as part of DMC-ODS. Many commenters supported DHCS' proposals to remove the limitation on the number of residential treatment episodes that can be reimbursed in one year. One commenter is opposed to DHCS' proposal to remove the limitation on the number of residential treatment episodes. Other commenters provided additional feedback, including requesting that medical necessity determine the length of stay, and not the State's 30-day average, for residential treatment stays. Another commenter recommended improving the current data collection practices, which reportedly have failed to capture the need for residential services (e.g., requirements to report "no waitlist"), and supporting additional investment to ensure true network adequacy. One commenter recommended that the State apply the same pre-diagnosis criteria in residential and inpatient levels of care as it does in outpatient levels of care.



Response: The State appreciates the commenters' support for the continuation of the expenditure authority that allows reimbursement for costs not otherwise reimbursable due to the IMD exclusion for short-term residential services as part of DMC-ODS. DHCS is committed to ensuring that Medi-Cal beneficiaries with an SUD are placed at the level of care with a length of stay that appropriately meets their individualized needs, which is why SUD treatment providers across all levels of care are required to use the ASAM multi-dimensional assessment for patient placement. DHCS also recognizes that individuals with an SUD can move in and out of treatment and recovery in a non-linear fashion and that some individuals may require multiple residential stays throughout a single year. DHCS' proposed removal of the limitation on the number of residential treatment episodes that can be reimbursed per year will enable beneficiaries with an SUD to obtain residential treatment SUD services in accordance with their needs. As a condition of continuing the IMD-related expenditure authority, DHCS will be federally required to strive toward a statewide average length of stay of 30 days for stays in an IMD across residential and inpatient treatment and withdrawal management levels of care, similar to all other states with an approved demonstration. This requirement will not impact an individual's ability to obtain residential treatment for as long as it is medically required. DHCS will work with stakeholders to better capture the need for residential treatment services and ensure that sufficient providers exist to meet the need.

Justice-Involved Populations

***Comment:* All commenters expressed support for the proposal to provide pre-release services to eligible justice-involved populations prior to release. Commenters encouraged DHCS to engage stakeholders while designing and implementing the program to ensure a whole person approach and to mitigate operational challenges.**

Response: The State appreciates the commenters' overwhelming support for this policy initiative. DHCS believes providing Medi-Cal services to prison and jail inmates prior to release will help ensure continuity of health coverage and care for justice-involved populations that experience disproportionately higher rates of physical and behavioral health diagnoses. In response to public comment on the logistics of effectuating and operationalizing this initiative and the importance of building in enough time pre-release to coordinate with correctional agency staff, establish trusted relationships with ECM providers, enable consultations via telehealth or, optionally, in-person as needed, from behavioral and physical health community-based providers, identify needed 30-day supply of medications, including MAT, and DME, and set up meaningful transition plans in order to support stabilization and continuity of services post-release, the State will provide the pre-release services proposed in the CalAIM initiative 90 days prior to release, extending the time frame from the proposed 30 days. DHCS recognizes that robust stakeholder engagement is critical to understanding the operational complexity



involved with implementing this initiative in State prisons, county jails, and youth correctional facilities and is committed to engaging stakeholders in the State's design and implementation planning.

Comment: Many commenters requested clarification on the delivery system for the pre-release period and whether the services would be provided by MCPs or through FFS. If the pre-release services are to be delivered via managed care, commenters requested clarification on the timeline for MCP selection and advised that to effectuate this process, the Medi-Cal enrollment and MCP selection period would need to occur well in advance of the pre-release period. Some commenters encouraged DHCS to consider auto-assignment into an MCP during the pre-release period to expedite the connection to ECM services. One commenter requested that DHCS authorize county correctional health systems to deliver services and receive Medi-Cal payment in the pre-release period.

Response: The State is currently evaluating the options and considerations with respect to delivering the pre-release services either through managed care, FFS, or a hybrid approach. DHCS is considering multiple factors related to delivery systems including, but not limited to, timeliness of MCP enrollment, provider network, reimbursement processes, operational complexity, and facilitating continuity of ECM services pre- and post-release, to the maximum extent possible. DHCS will engage stakeholders as it further develops and implements its proposed approach for delivering pre-release services.

Comment: Many commenters encouraged DHCS to engage with stakeholders across delivery systems and counties to ensure successful program implementation. Multiple commenters encouraged the development of a process for facilitating referrals and linkages with stakeholders including county correctional institutions, Medi-Cal MCPs, County MHPs, DMC-ODS plans, and Drug Medi-Cal plans. One commenter encouraged county collaboration in order to ensure pre-release services are integrated with other county-based re-entry services. One commenter requested that County Sheriff and Chief Probation Officers retain authority to approve entities entering the jail facility. This commenter also requested that the County Board of Supervisors have the authority to design the pre-release program for each county.

Response: The State recognizes that the success of this demonstration initiative rests on close collaboration with multiple stakeholders across delivery systems, State prisons, and county corrections agencies. Services provided pre-release will need to be closely coordinated with the services provided to justice-involved populations upon re-entry into the community. DHCS is committed to working with stakeholders on all aspects of design and implementation planning including, but not limited to, establishing clear roles



and responsibilities, ensuring continuity of service provision, and making warm handoffs to community-based providers and resources upon release.

Comment: A few commenters expressed concern with operationalizing the delivery of pre-release services in jails at the same time jails will be required to implement standardized pre-release Medi-Cal application processes on January 1, 2023. To ease the administrative burden of conducting pre-release Medi-Cal applications, commenters encouraged DHCS to consider extending the timeline of suspension processes beyond one year.

Response: California State statute currently limits suspension processes to one year for adults. The State agrees with the commenters on the importance of long-term suspension processes in order to promote continuity of Medi-Cal services upon release into the community and to ease the administrative burden of conducting pre-release Medi-Cal applications. DHCS will continue to monitor State legislative efforts that seek to extend suspension periods beyond one year.

Comment: Many commenters provided input on the eligibility criteria for receiving services in the pre-release period. One commenter noted that the broad definition of individuals eligible for services in the pre-release period exceeds the enrollment thresholds that have been communicated to Medi-Cal MCPs. One commenter requested that DHCS expand the eligibility definition to include all Medi-Cal-eligible justice-involved populations. One commenter requested clarification on the definition of “chronic mental illness” for youth. One commenter requested clarification on eligibility criteria related to traumatic brain injury.

Response: The State thanks the commenters for their input on the eligibility criteria for receiving services prior to release. DHCS intends to further refine the definitions for the eligibility criteria as it engages with stakeholders, negotiates the STCs with CMS, and develops an operational plan. DHCS clarifies that it is proposing that all youth in youth correctional facilities be eligible for pre-release services. If an individual is in a youth correctional facility, then that youth would be eligible for 90-day pre-release services and would not be required to meet any physical or behavioral health eligibility criteria.

Comment: A few commenters requested that DHCS expand eligible facilities to include other secure facilities, such as private jails used in transition facilities, out-of-state facilities, and federal prisons.

Response: The State appreciates the commenters’ suggestions regarding eligible facilities. For the current CalAIM Section 1115 demonstration, DHCS intends to continue to focus its initial design and implementation efforts on State prisons, county jails, and youth correctional facilities.



Comment: Some commenters encouraged DHCS to consider expanding the list of covered services that will be provided in the pre-release period. Two commenters proposed expanding covered services to include behavioral health and chronic health condition treatment, prescription administration for chronic diseases, stabilizing drugs, and release planning activities. One commenter requested the provision of child and family team supports to youth prior to release. One commenter requested coverage of naloxone upon release into the community.

Response: The State thanks the commenters for their input on services that could be covered in the pre-release period and agrees with the commenters regarding the importance of providing intensive care coordination and care management supports both pre- and post-release. Based on comments received, DHCS has revised the pre-release Medi-Cal services to include ECM or care coordination, as appropriate, and community-based physical and behavioral health clinical consultation services provided via telehealth or, optionally, in-person as needed. In addition, services will include a 30-day supply of medication, including MAT, and DME for use post-release into the community. California has allowed pharmacists to furnish naloxone without a physician's prescription since January 2016. Naloxone is currently immediately available to Medi-Cal beneficiaries through the covered outpatient drug benefit when ordered by an authorized prescriber or a trained pharmacist. Naloxone is available upon patient request or pharmacist suggestion.

Comment: Many commenters requested funding to support the implementation of Medi-Cal coverage in the pre-release period. Two commenters recommended funding be available to counties, county jails, and youth correctional facilities to effectively support the implementation of this program. One commenter requested county SMHS receive funding to help with implementation pursuant to Proposition 30/the California Constitution. One commenter requested workforce investments, including supports for forensic behavioral health specialists, to expand assistance for the justice-involved populations.

Response: The State thanks the commenters for their input on where investments should be made to support the implementation of this initiative. In response to comments received, DHCS intends to use PATH funding to support capacity building among providers, plans, counties, and justice agencies to ensure their readiness to support effective pre-release care for justice-involved populations, as well as to maintain and build on current WPC Pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved initiatives in 2023.

Comment: One commenter sought clarification on how the pre-release services will intersect with the Medi-Cal Inmate Program.



Response: The Medi-Cal Inmate Program occurs at both the State and county levels and allows for the claiming of Medi-Cal allowable inpatient hospital services, including inpatient psychiatric services and physician services provided during the inpatient hospital stays of inmates off the grounds of correctional facilities who are determined eligible for Medi-Cal. DHCS is seeking to expand upon the services that are Medi-Cal reimbursable during the 90 days prior to an inmate's release.

***Comment:* One commenter encouraged DHCS to invest in data and communications solutions to implement the pre-release services.**

Response: The State recognizes the importance of information exchange that will enable a transfer of relevant pre-release services data in order to ensure a smooth ECM transition post-release. DHCS is evaluating options for investing in data sharing infrastructure to support justice-involved CalAIM initiatives. To support pre- and post-release planning, DHCS is seeking PATH funding to support IT services.

***Comment:* Some commenters provided feedback on the proposed CalAIM Section 1115 demonstration's evaluation measures related to the pre-release period. One commenter recommended DHCS assess changes in deaths related to fatal opioid overdose post-release in the evaluation measure. Another commenter requested additional details on the evaluation parameters for the justice-involved population, specifically related to the pre-release period.**

Response: DHCS thanks commenters for their input on evaluation measures. DHCS has revised the CalAIM Section 1115 demonstration evaluation measures to include an assessment of changes in deaths related to fatal overdoses. DHCS expects the demonstration evaluation measures will continue to be refined through its engagement with stakeholders and negotiations with CMS.

***Comment:* One commenter recommended DHCS provide a one-year implementation delay for counties to coordinate local processes. Another commenter requested that the State approach this policy with a longer time horizon.**

Response: DHCS thanks the commenter for this input.

***Comment:* Commenters provided recommendations on DHCS' mandate that all county jails conduct pre-release Medi-Cal applications by January 1, 2023. One commenter sought clarification on the intersection of the pre-release Medi-Cal application process and the provision of services pre-release under the demonstration request. One commenter requested that DHCS extend the pre-release Medi-Cal application processes to State and federal prisons and juvenile detention facilities.**



Response: The State understands that before services are offered in the pre-release period, clear timelines and standardized pre-release operational processes must be put into place to effectuate Medi-Cal enrollment if the individual is uninsured. Standardized pre-release Medi-Cal application processes are already in place in State prisons. DHCS will work closely with stakeholders including State prisons, county jails, and youth correctional facilities to assess readiness for Medi-Cal pre-release application, benefit reinstatement processes, and 90-day Medi-Cal service provision.

Medi-Cal Rx

Comment: Commenters urged DHCS to continue to delay the transition of pharmacy benefits from MCMC to FFS (Medi-Cal Rx) or reverse the transition.

Response: The State appreciates the commenters' concern about carving the Medi-Cal Rx benefit out of managed care and into fee-for-service and is committed to ensuring access to prescriptions for Medi-Cal beneficiaries. In January 2021, Centene Corporation announced that it plans to acquire Magellan Health; Magellan Health is the State's contracted vendor to transition the pharmacy benefit from MCMC to FFS pursuant to [Executive Order N-01-19](#). Given the unexpected acquisition and additional time required to ensure acceptable conflict avoidance protocols are in place to address adjudication of pharmacy prior authorization requests and pharmacy claims of all Medi-Cal beneficiaries, the Medi-Cal Rx transition has been delayed. A revised timeline for the pharmacy benefit transition has not yet been determined as of this writing, and the [Governor's May Revision budget](#) assumes a transition will take place January 1, 2022. The State is continuing with its plans to transition Medi-Cal Rx and will update the public as plans are solidified.

Out-of-State Former Foster Care Youth

Comment: Commenters expressed support for the continued Medi-Cal eligibility for out-of-state former foster care youth. One commenter recommended that DHCS engage former foster youth and the California Department of Social Services (CDSS) Foster Care Ombudsperson to develop communication strategies and materials to increase knowledge about the benefit. Another commenter requested that DHCS provide updated guidance and regulations pertaining to county Medi-Cal eligibility functions for out-of-state former foster care youth, supporting a robust technical assistance framework and a continuous improvement process in lieu of any penalties.

Response: The State appreciates the commenters' support for its proposal to continue authority to cover this important population, as well as the input about how to improve awareness of the eligibility option.

Providing Access and Transforming Health (PATH) Supports



Comment: Numerous commenters supported the inclusion of PATH supports in the Section 1115 demonstration as an important mechanism to ensure a smooth transition from Medi-Cal 2020 Section 1115 to the CalAIM waivers. Many commenters recommended that community providers, including health centers, FQHCs, and UIHPs, be eligible for PATH supports. Two commenters requested that the State expand PATH funding in order to stabilize and support public health care systems, with one urging that DHCS increase the statewide funds available to public health care systems through PATH by \$500 million and make those funds available for activities and work conducted by the hospitals and clinics within public health care systems. Other commenters recommended that, regardless of federal approval of the PATH funding request, DHCS consider State funding to build provider networks and support the transition to ECM/ILOS, with specific funding set aside for homeless service providers with the cultural competency to provide evidence-based housing support services as a way to build adequate capacity for a future housing support services benefit.

Response: The State appreciates the commenters' recognition of the fundamental role that PATH funding will play in supporting California's efforts to transition from WPC pilots and HHP to CalAIM initiatives that focus on identifying and managing member risk and need through whole person care approaches and addressing social determinants of health and health equity statewide through MCMC. To successfully implement ECM/ILOS and the justice-involved initiatives envisioned under CalAIM, MCPs, counties, public hospital systems, community-based organizations, and justice agencies will be required to work together in new ways, including exchanging data, establishing payment relationships, measuring value and outcomes, and ensuring that Medi-Cal enrollees are at the center of care. Although some of these stakeholders have experience and established relationships, DHCS is seeking federal support to maintain, broaden, and scale such arrangements to ensure statewide availability of comprehensive, statewide, community-based, and whole person-centered care management and related services. DHCS understands the critical importance of these funds to a wide range of providers and community-based organizations and has re-evaluated required PATH resources in the context of capacity-building needs, as well as the [Governor's May Revision budget](#), released May 14, 2021, which includes State general funds for a range of capacity- and infrastructure-building investments, including for effective Medi-Cal enrollment and transitional care for justice-involved populations and population health IT infrastructure. Based on this reassessment, DHCS has increased its request for federal support for PATH to \$2.17 billion.

Finally, the State recognizes the importance of cultural competency across the network of ECM and ILOS providers, including homeless service providers, and will be requiring MCPs to ensure ECM and ILOS providers have the capacity to provide culturally appropriate services (see the [MCP ECM/ILOS Contract Template Provisions](#)).



Comment: Several commenters requested additional details on PATH supports provisions, including how much funding will be available and for which programs and uses, as well as how providers can access funding. Some commenters recommended that funds flow directly to CBOs to build the staffing and infrastructure needed to bill, report, and contract with MCPs. Commenters expressed support for using PATH supports to build capacity, infrastructure, and IT systems for community-based ECM/ILOS providers and to advance CalAIM justice-involved initiatives. Commenters also requested that DHCS consider additional uses of PATH supports, including funding to conduct outreach and engagement services for hard-to-reach populations; convene and coordinate necessary work to connect the health care sector to other sectors and community resources to improve health equity and health outcomes; support partnerships to better measure disparities and implement community-wide disparity reduction plans; develop preventive care and basic care coordination infrastructure, particularly for children; convene MCP and County MHPs to engage in joint population health planning, including to advance coordination and reliable plan-to-plan data exchange; and provide workforce development and training for providers and case managers on whole person care approaches and cross-sector work and data exchange across organizational silos, as well as specialized training to ensure required competency and capacity to meet the complex needs of justice-involved individuals.

Response: The State appreciates the commenters' questions and suggestions. Many of the PATH programmatic details, including total funding amounts and the distribution of funding, will be determined during negotiations with CMS, through development of a PATH implementation plan, and as DHCS conducts additional analysis and assesses stakeholder input. DHCS anticipates that PATH may be used for:

- *ECM and ILOS Capacity Building:* PATH funding would support technical assistance for CBOs and other community-based providers to transition to ECM and ILOS, such as assistance with contracting and payment processes, workforce development, and staff training on issues such as how to provide enhanced care management to specific populations of focus. PATH funding would also be used to increase capacity of CBOs and other community-based providers across the State, *including* for ECM/ILOS provider capacity building (e.g., workforce needs, workflow development, operational requirements and oversight) and delivery system infrastructure investments (e.g., certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities). PATH funding also would provide resources to support collaborative, cross-entity planning across counties, managed care plans, providers, CBOs, and others, as well as resources to avoid the loss of existing WPC pilot and HHP capacity, including place-based and other



specialized services that will transition to ECM and ILOS over time and are needed for successful implementation of ECM, ILOS, and other Medi-Cal initiatives.

- *Justice-Involved Capacity Building.* PATH funding would maintain and build on current WPC pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved initiatives in 2023. PATH funding also would provide resources to support collaboration and planning, as well as funding for correctional officials related to the design and launch of Medi-Cal application assistance and 90-day pre-release services, as well as to develop the IT services and infrastructure to support the justice-involved Medi-Cal application process and 90-day pre-release services.
- *Population Health Management Services:* PATH funding would support DHCS in the development and procurement of a Population Health Management (PHM) service. The service will utilize DHCS administrative, clinical, dental, behavioral health, and social service data to provide standard risk assessment, risk stratification, and population health analytics for all Medi-Cal members. DHCS, managed care plans, counties, providers, and beneficiaries will have access to these services and analytics in order to effectively manage all beneficiaries by keeping them healthy via preventive and wellness services, assessing member risks to guide care management and care coordination, and addressing social determinants of health to reduce health disparities. The PHM service will also serve as the foundation by which ECM and ILOS populations can be identified and service interventions can be assessed to optimize clinical outcomes.

DHCS shares the commenters' support for using PATH funding to advance health equity and address disparities, and anticipates that PATH resources will help support the transformation of service delivery networks at the community level to increase access to health care services, support better integration of physical and behavioral health and health-related services, and improve health outcomes, with particular attention to providers and community-based organizations in communities that have been historically under-resourced because of economic or social marginalization due to race, ethnicity, rural geography, or other factors.

Additional details on potential uses of PATH supports and interactions with other funding streams can be found [here](#) in a publicly available PATH frequently asked questions (FAQ).

Comment: Commenters requested that PATH funding adequately support WPC pilot lead entities and providers as they transition to providing ECM/ILOS through the managed care delivery system, noting the importance of investment in



capacity building, infrastructure, and IT to ensure providers and partner agencies can meet managed care administration requirements, including related to contracting, data collection, and billing, and to allow for better integration and exchange of electronic health record data with data from other agencies or social service sectors. Other commenters noted that as programmatic elements of ECM/ILOS will impact provider operations and infrastructure (e.g., new processes for referral, claims submission, patient assignment), technical assistance and support will be imperative for program success, including for Tribal health program partners.

Response: The State agrees that PATH can provide critical support in the transition from WPC pilots to ECM/ILOS. As noted above, support for ECM/ILOS provider capacity building and delivery system infrastructure investments, including for IT system enhancements and data exchange capabilities necessary to meet programmatic and administrative requirements under ECM/ILOS, is among the priorities for PATH spending, pending CMS approval. PATH is intended as an important source of additional funding to ensure continuity of care for Medi-Cal enrollees as services transition from the Medi-Cal 2020 Section 1115 demonstration to ECM and ILOS through Medi-Cal MCPs, and PATH will also support the development of necessary infrastructure to ensure continuity of health care coverage and care for individuals leaving prisons and county jails and re-entering the community.

Comment: Commenters asked DHCS for clarification regarding whether PATH supports will be an MCP incentive structure or exist as a separate and additional pool of funds, as well as clarification regarding any overlap or intersections between these potential approaches. Another commenter requested that DHCS include the DMC-ODS delivery system as eligible for PATH supports, noting the delivery system had a shorter runway for managed care implementation.

Response: PATH spending will complement, not duplicate, other investments in capacity building and infrastructure developed for successful implementation of CalAIM. PATH will be a separate, additional source of funding for infrastructure, interventions, and services that will help ensure access to ECM, ILOS, and justice-involved initiative-related services. For example, performance incentive funding, supported by the [Governor's May Revision budget](#), also is expected to support ECM and ILOS capacity development and would be complementary to and non-duplicative of PATH funding.

Payment Reform (Certified Public Expenditure (CPE)/Intergovernmental Transfers (IGT) Transition)

Comment: Many commenters noted their strong support for the payment reform proposals to transition from CPEs to IGTs and for reforming the current rate setting methodology. Commenters supported the goal of eventually implementing



a capitation-based system to allow County MHPs to better serve more beneficiaries and make investments in the local system. One commenter raised concerns that the IGT structure will open the service delivery system to payment lags, eligibility lapses, service denials, and other unknown factors, and another commenter encouraged DHCS to offer timely and accurate IGT payments to County MHPs to mitigate risk to counties. Other commenters expressed concerns that the change in methodology could increase federal revenue for counties and open up the possibility of claiming against nonfederal dollars already being spent in other systems that serve children.

Response: The State appreciates the commenters' support for its plans to move from a CPE, or cost-based methodology, to a fee schedule with rate-based financing and payment methodologies for county expenditures. DHCS is committed to working with counties and providers to ensure a smooth transition to the new payment system when the State and stakeholders are ready to transition to the new rate setting methodology. DHCS is also committed to working with counties to assure that payments are made in a timely manner and that funds used for IGTs do not displace funding that has been dedicated to supporting other critical needs for children and other Medi-Cal populations.

***Comment:* Commenters asked for additional detail and clarification about the CalAIM payment reform timeline and expressed interest in engaging with DHCS in developing the rate setting policy. One commenter requested that DHCS adjust the implementation timeline from 2022 to establish the IGT process, shift EHR claiming codes, and execute new contracts. Another commenter did not provide a recommended shift in timeline but did request flexibility to ensure county readiness. Commenters also requested that DHCS share regular updates on payment reform policy and implementation decisions with counties, behavioral health providers, and other stakeholders.**

Response: The State appreciates the commenters' input. As noted in the [proposed CalAIM Section 1115 renewal and amendment application](#), the State expects to transition financing to a fee schedule structure to better align payment methodologies across the Medi-Cal delivery system no sooner than July 2022. DHCS is working with counties and other stakeholders to both develop the policy and assure readiness, and will continually evaluate the implementation timeline as work continues throughout the coming year. The timeline for the transition may change based on consultation with counties, providers, and other stakeholders. Therefore, this CalAIM Section 1115 demonstration application requests authority to extend the current CPE protocol until at least July 2022 to provide potential flexibility. DHCS is committed to sharing regular updates with counties, behavioral health providers, and other stakeholders throughout this process.



Comment: Many commenters requested that DHCS provide additional details about how the rate setting process will work prior to implementation, including any CMS approvals that may be required. Commenters also requested that DHCS share details with stakeholders about the process for rate setting, share a crosswalk of the coding changes for engagement with stakeholders, and incorporate provider feedback into the new rate setting methodology. Several commenters requested that DHCS establish cost-plus FFS reimbursement rates that fully cover the costs of services for counties and enable system reinvestment; one commenter noted concerns that transitioning to FFS could result in high-cost counties not being reimbursed at a level that fully covers the cost of providing services. Other commenters requested that DHCS consider the atypical size of large counties when developing a rate methodology. Another commenter requested that DHCS create a mechanism to review rates and adjust if needed, as well as offer timely and accurate IGT payments to County MHPs to mitigate risk to counties.

Response: The State appreciates the commenters' input and will consider these issues as it develops the rate setting and peer grouping methodology. As noted, the State is committed to ongoing stakeholder engagement and communication as it implements this important payment reform and will continue its current CPE methodologies in the interim.

Comment: Commenters provided DHCS with a number of recommendations to consider when implementing the CPE-to-IGT transition, including permitting flexible service delivery, streamlined reporting, and a reduction in overall administrative requirements. Other commenters urged DHCS to leverage the IGT transition as an incremental step to adopting capitated rates and eventually enabling value-based payments for behavioral health services. Other commenters focused on the need for technical assistance to County MHPs, including with respect to rate setting for community-based organizations, and requested that DHCS provide clarity on new reporting, reconciliation, and/or auditing requirements.

Response: The State appreciates the comments and is committed to working with stakeholders to ensure a smooth transition from CPEs to IGTs, which will include technical assistance to counties and County MHPs as the changes are implemented in the future.

Comment: One commenter requested that DHCS share additional information related to the cost reports, including whether DHCS has conducted a comparison of the CPT schedule to county cost reports. The commenter also asked how the separate FFP programs will be handled in the shift for the four FFP programs in the State cost report—administrative, utilization review/quality assurance, mental



health Medi-Cal administrative activities (MAA), and direct services. Another commenter requested that DHCS ensure that the proposed mixture of HCPCS Level II codes and CPT codes for SMHS and DMC-ODS allow for flexible service delivery, “apples to apples” reporting, and a reduction in overall administrative requirements.

Response: The State appreciates the comments and understands the commenters’ requests for reductions in the administrative requirements of each delivery system. The transition to a fee schedule from a cost-based payment structure, along with other initiatives such as documentation reform, will reduce much of the administrative burden counties and providers currently deliver services under. The State plans to transition all financial components of SMHS, Drug Medi-Cal, and DMC-ODS to fee schedule and will retain certain specific HCPCS Level II codes where appropriate to ensure appropriate claiming.

Comment: One commenter—who wrote to support the proposal to move from a cost-based reimbursement system to a more nimble and flexible intergovernmental transfer structure—requested transition funding and supports for counties to shift between payment structures.

Response: The State appreciates the requests and is continuously working with counties to identify and mitigate financial gaps when transitioning between the two payment systems. The State acknowledges the significant changes associated with payment reform and created the Behavioral Health Quality Incentive Program (BH QIP) to support counties. BH QIP is designed to provide targeted incentives and technical assistance over two years for counties to build the key infrastructure components needed to operationalize CalAIM initiatives, including these changes.

Peer Support Specialists

Comment: Many commenters expressed appreciation for the peer support specialists implementation as critical to consumers and requested clarification on the peer support specialists’ certification, timeline, county requirements, and delivery system. Multiple commenters recommended that DHCS expand peer support specialists to be a statewide benefit. Another commenter urged DHCS to expand peer support specialists from only SMHS, DMC-ODS, and Drug Medi-Cal to all health and social services systems.

Response: The State appreciates the commenters’ questions, feedback, and support. DHCS will authorize the peer support specialists program through California’s Medicaid State Plan. The program will be available in Drug Medi-Cal, SMHS, and DMC-ODS delivery systems starting January 1, 2022. To enable voluntary county participation—as required in [Senate Bill 803](#), signed into law September 2020—DHCS is seeking the Section 1115 waiver to waive statewideness and comparability for Drug Medi-Cal; a



similar request in the 1915(b) waiver will ensure voluntary county participation for SMHS and DMC-ODS as well. Recognizing the value of peer support specialists, the State is committed to engaging and supporting counties to offer peer support specialists across the State. [Senate Bill 803](#) authorizes peer support specialists to support the ongoing provision of services for individuals experiencing mental health care needs, SUD needs, or both; at this time DHCS is limiting peer support specialist services to the Medi-Cal delivery systems that focus on those needs.

Comment: Commenters also encouraged DHCS to continue engaging with stakeholders, counties, and existing peer support specialists as the peer support specialists' training and certification are developed by DHCS.

Response: DHCS is working with stakeholders to determine the statewide requirements for certification that participating counties will use and anticipates releasing program guidance in July 2021.

Comment: One commenter requested that DHCS recognize and clearly state that EPSDT require peer supports be provided to children under age 21.

Response: The State will ensure that Medi-Cal beneficiaries under age 21 have access to all applicable Medicaid services that are required under the EPSDT requirements and are medically necessary to correct or ameliorate a physical or mental health condition.

Postpartum Coverage Extension

Comment: Commenters encouraged DHCS to extend Medi-Cal eligibility coverage for pregnant women from 60 days to 12 months postpartum, noting the impact this will have in addressing health disparities in maternal mortality.

Response: The State appreciates the commenters' support and agrees that postpartum Medi-Cal coverage is a critical necessity to support families and children. The American Rescue Plan Act of 2021 signed by President Biden on March 11, 2021, permits states to submit SPAs to receive federal match to extend Medicaid eligibility from 60 days to 12 months for postpartum women eligible for Medicaid. The American Rescue Plan State option is effective from April 1, 2022, to April 1, 2027. The [Governor's May Revision budget](#) released in May 2021 proposes State general funds to support the State option to extend postpartum coverage for five years for Medi-Cal eligibility for postpartum women, up to 12 months.

Pregnant Women Eligibility

Comment: Commenters expressed support for California's request to renew its authority to provide full-scope Medi-Cal coverage to pregnant women with incomes at 109–138 percent of the FPL.



Response: The State appreciates commenters' support for its proposal 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). As noted in the application, the State intends to pursue Medi-Cal State Plan authority to authorize full-scope coverage for pregnant women with incomes between 109 and 138 percent FPL but has retained its request to continue its existing Section 1115 authorities pending negotiations with CMS.

Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Institutions for Mental Diseases (IMD) Waiver

Comment: Many commenters expressed displeasure that the proposed CalAIM Section 1115 demonstration application does not include a request for waiver authority to waive the federal Medicaid IMD exclusion that prevents Medi-Cal payment for inpatient admissions in IMDs of over 16 beds for adults with SMI and children with SED. Commenters underscored the urgency of submitting the SMI/SED IMD waiver, urged DHCS to submit the waiver request immediately, and asked DHCS how advocates could help accelerate the process. Some commenters disagreed with the recommendation for DHCS to request a Section 1115 demonstration SMI/SED IMD waiver, advocating that DHCS should avoid unnecessary institutionalization and stating that individuals should have access to the full range of services in communities.

Response: The State appreciates the commenters' interest and advocacy. As described in the CalAIM proposal, DHCS is committed to developing an SMI/SED IMD waiver request no sooner than July 1, 2022, and understands its importance to beneficiaries and families. Given federal requirements for waiver submission, DHCS is unable to submit the request to CMS in the current CalAIM Section 1115 demonstration application but is moving ahead with planning, recognizing this critical area of need.

Tribal Uncompensated Care (UCC)

Comment: Many commenters expressed displeasure at the conclusion of the Tribal UCC. Commenters requested the Tribal UCC payments be extended for certain optional services previously eliminated from the Medi-Cal State Plan that are provided by Tribal health programs (THPs) operating under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA) to IHS-eligible Medi-Cal beneficiaries, such as acupuncture, chiropractic, dental, optometry, podiatry, psychological, and speech therapy services.

Response: The State appreciates the commenters' concern. The Medi-Cal 2020 Section 1115 demonstration included a provision for an uncompensated care pool to reimburse Tribal health programs for services provided to American Indians and Alaska



Natives patients that had been eliminated from Medi-Cal coverage due to previous State budget shortfalls. Notably, these services have been restored in the Medi-Cal program, with the exception of chiropractic services. Although CMS approved SPA 21-0044, which authorized the Tribal FQHC provider type in Medi-Cal on February 19, 2021, DHCS understands that not all Tribal health programs will seek to enroll as a Tribal FQHC. Therefore, in response to public comments, DHCS is amending the demonstration request to request that CMS reinstate the Tribal UCC pool to provide reimbursement for chiropractic services.

Tribal health clinics that enroll in the Medi-Cal program as a Tribal FQHC will be able to be reimbursed in full for chiropractic services provided to all patients with an effective date of January 1, 2021. DHCS published additional [Tribal FQHC guidance](#) on May 14, 2021, including details for providers on [billing services rendered by Tribal FQHCs](#) and [billing codes](#), and reviewed the new policy with IHP providers and Tribal organizations on June 11, 2021.

Whole Person Care Pilots (WPC)/Home Health Programs (HHP) Conclusion and Implementation of Enhanced Care Management (ECM) and In Lieu of Services (ILOS)

Comment: A number of commenters expressed support for transitioning WPC/HHP to ECM/ILOS as a way to integrate related services into the MCMC delivery system and broaden and scale services across the State, as well as for ECM/ILOS more generally. Numerous commenters emphasized the importance of ensuring that these programs build on the design and successes of the WPC pilots and HHP, leveraging those programs' significant investments, relationships, expertise, and infrastructure (e.g., community-based and patient-centered outreach and enrollment processes, invoicing and billing templates), and that individuals currently receiving these services seamlessly transition to ECM/ILOS. Several commenters suggested that the State require that MCPs contract with counties for the provision of ECM services and ILOS, particularly those counties with WPC pilot experience and infrastructure; require that MCPs contract with public behavioral health systems; and fund and/or require ongoing joint population health and program planning between MCPs, County MHPs, and community partners. Two commenters advocated that DHCS exercise firm oversight of MCPs to ensure robust take-up and implementation of ECM/ILOS and ensure access for Medi-Cal beneficiaries.

Response: The State agrees that as the WPC pilots and HHP are phased out, careful planning and handoffs will be of critical importance to ensure continuity of coverage and a seamless transition to ECM/ILOS and that successful program implementation necessitates ongoing collaboration across multiple stakeholders, including among MCPs, counties, providers, public hospital systems, and community-based



organizations. The State has developed implementation documents following extensive consultation with stakeholders and incorporation of their feedback, including through a separate public comment process conducted February–March 2021 that solicited input on ECM/ILOS program design and related requirements. Finalized implementation documents—including the DHCS-MCP ECM and ILOS Contract Template, Standard Provider Terms and Conditions, Model of Care Template, and Coding Guidance—were released in early June 2021. ECM/ILOS resources, including fact sheets and FAQs, are available on the DHCS [ECM/ILOS webpage](#). The State is committed to continued engagement with stakeholders as program planning and implementation move forward and will oversee and monitor changes to ensure Medi-Cal beneficiaries’ access to these critical services.

***Comment:* Many commenters reiterated the importance of ensuring the availability of technical assistance to providers and community-based organizations to meet managed care administration and other program requirements as WPC pilots transition into the MCMC delivery system via the launch of ECM/ILOS.**

Response: The State recognizes the need to offer technical assistance to providers and community-based organizations to ensure they are well-positioned to offer ECM/ILOS services and is committed to offering technical assistance and other forms of support to providers and community-based organizations as they transition to the new ECM/ILOS structure, including through the use of PATH funding.

***Comment:* Numerous commenters emphasized the need to provide sufficient funding supports to providers and community-based organizations to ensure a successful transition from the WPC pilots to ECM/ILOS, including to support capacity building, programmatic infrastructure, staff hiring, workforce training, IT investments, and data exchange.**

Response: The State agrees that to move beyond WPC pilots and address social determinants of health and health equity statewide through MCMC, MCPs, counties, providers, public hospital systems, and community-based organizations require resources that will enable them to collaborate in new ways, including to exchange data, establish payment relationships, measure value and outcomes, and ensure that Medi-Cal enrollees are at the center of care. To ensure that stakeholders have the resources necessary to successfully implement ECM/ILOS, the State intends to make robust investments in community-based providers’ capacity to deliver these services, including through PATH funding. PATH expenditure authority will provide resources to retain and modify existing WPC pilot and HHP capacity that will be required in the future for successful implementation of ECM, ILOS, and other Medi-Cal initiatives. This includes funding to maintain and build on current WPC pilot pre-release and post-release services as a bridge to implementation of the full suite of CalAIM justice-involved



initiatives in 2023, as well as bridge funding to avoid the loss of existing WPC pilot and HHP capacity that is needed for future initiatives or for situations in which MCPs, counties, and providers are moving forward with ECM and ILOS implementation but enrollees could be at risk of experiencing a gap in services while contracting arrangements and delivery approaches are implemented and brought to scale.

Comment: One commenter expressed concern that with the conclusion of HHP and related implementation of ECM and ILOS in January 2022, FQHCs and community-based care management entities (CBCMEs) would not have enough time to contract with all MCPs.

Response: The State appreciates the commenter's input. DHCS encourages MCPs and providers to begin working on contracting as soon as possible, if they have not already. MCPs were provided with draft rates at the end of May. Providers will continue to be able to contract with whom they choose.

Section 1915(b) Waiver

As noted, the State public comment period on the [proposed CalAIM Section 1115 demonstration renewal and amendment application](#) also provided the public with an opportunity to comment on upcoming changes to California's 1915(b) waiver. The following provides a brief synopsis of comments that the State received on the [proposed CalAIM Section 1915\(b\) Waiver Overview](#), organized by delivery system (MCMC, Dental MC, SMHS, DMC-ODS). The comments will inform the State's final CalAIM 1915(b) waiver submission and implementation plans. DHCS will continue to engage with stakeholders as it implements the CalAIM initiative, including through the rulemaking process.

Medi-Cal Managed Care (MCMC)

Summary of Comments Received: Commenters shared feedback, recommendations, and suggestions on CalAIM proposals related to MCMC, which is proposed to be transitioned from Section 1115 to Section 1915(b) authority effective January 1, 2022, in an effort to integrate DHCS' Medi-Cal delivery systems into a single, consolidated waiver. Many commenters asked clarifying questions or noted potential concerns related to the upcoming MCMC reprocurement, including DHCS' proposal to expand a number of Medi-Cal aid categories into mandatory managed care, as well as DHCS' quality and monitoring mechanisms for MCPs. Other comments and questions related to providers' reimbursement rates; MCPs' use of risk stratification algorithms, data, and information sharing policies; pediatric preventive care; and community health workers as a Medi-Cal benefit. DHCS also received comments regarding specific MCMC programs, including Program of All-Inclusive Care for the Elderly (PACE) in COHS counties, In Home Supportive Services (IHSS), and Coordinated Care Initiative (CCI).



DHCS also received comments on the proposed CalAIM initiative of “full integration” of Medi-Cal MCPs—MCMC, SMHS, DMC-ODS, Drug Medi-Cal—into one contracted entity in 2027, which is not included in the CalAIM Section 1915(b) waiver.

Specialty Mental Health Services (SMHS)

Summary of Comments Received: Commenters shared feedback, recommendations, and suggestions on CalAIM proposals and related behavioral health modifications for SMHS, which is proposed to continue in the renewed Section 1915(b) SMHS waiver, which will be consolidated with other managed care delivery systems under the 1915(b) authority. Many commenters supported DHCS’ CalAIM initiatives to strengthen or streamline SMHS and asked DHCS to provide additional details and/or consider proposed modifications to the “no wrong door” approach, diagnosis requirements for SMHS, standardized assessment tools, co-occurring disorders guidance, documentation requirements, provider reimbursement rates, data sharing policies, and County MHP contracting and partnership opportunities. Many commenters also provided public comment on the proposed eligibility criteria to align EPSDT parameters with SMHS for children under age 21 and how ACEs screenings can be used effectively; additional clarification is to be provided in external documents regarding “eligibility criteria” versus “medical necessity” for this population. Commenters urged DHCS to improve the care coordination between the MCMC behavioral health “mild-to-moderate” benefit and County MHPs, as well as strengthen performance metrics and quality standards for County MHPs. Some commenters opposed the carve-in of SMHS in Solano and Sacramento counties.

DHCS also received comments on SMHS related initiatives that are not included in the CalAIM 1915(b) waiver: the proposed SMHS/SUD administrative integration by 2027 and the Foster Model of Care Workgroup’s findings (expected summer 2021).

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

Summary of Comments Received: Commenters shared feedback, recommendations, and suggestions on CalAIM proposals and related SUD modifications for DMC-ODS, which is proposed to be transitioned from Section 1115 to Section 1915(b) authority effective January 1, 2022, in an effort to integrate DHCS’ Medi-Cal delivery systems into a single, consolidated waiver. As described above, many commenters supported DHCS continuing DMC-ODS through Section 1915(b) authority, with commenters urging DHCS to consider expanding DMC-ODS statewide, noting that counties that have not yet opted in to DMC-ODS are rural counties with a high level of unaddressed need. Therefore, some of these commenters opposed the waiver of statewideness in the 1915(b) waiver for DMC-ODS.

Many commenters supported DHCS’ proposed CalAIM initiatives to strengthen or clarify DMC-ODS and asked DHCS to provide additional details and/or consider proposed



modifications to the additional MAT definition, MAT referral requirements for providers, the Contingency Management benefit, standardized assessments, documentation requirements, the recovery services definition, and EPSDT requirements for children under age 21 to receive DMC-ODS services. Commenters also supported DHCS' proposal to include American Society of Addiction Medicine (ASAM) criteria for screening and brief intervention and ASAM 0.5 Early Intervention. Other commenters encouraged DHCS to expand eligible providers in DMC-ODS and include additional services. One commenter requested clarification for IHPs' billing for DMC-ODS services if not contracted with a DMC-ODS plan.

DHCS also received comments on the proposed SMHS/SUD administrative integration by 2027, the Drug Medi-Cal delivery system to improve coordination between MCPs and Drug Medi-Cal plans, and how the DMC-ODS proposed program changes would impact Drug Medi-Cal, if at all.

Dental Managed Care (Dental MC)

Summary of Comments Received: Commenters shared concerns that Dental MC would be discontinued and not included in the CalAIM 1915(b) waiver and encouraged DHCS to continue Dental MC in the single, consolidated waiver for Los Angeles and Sacramento counties. One commenter requested that DHCS periodically evaluate the clinical outcomes of Dental MC to assist MCPs in evaluating care coordination efforts to identify gaps in care.



Appendix C: Public Notice

DEPARTMENT OF HEALTH CARE SERVICES NOTICE OF GENERAL PUBLIC INTEREST

RELEASE DATE: APRIL 6, 2021

PROPOSED CALAIM SECTION 1115 DEMONSTRATION AND SECTION 1915(B) WAIVER AMENDMENT AND RENEWAL APPLICATIONS

The California Department of Health Care Services (DHCS) is providing public notice of its intent to (1) submit to the federal Centers for Medicare & Medicaid Services (CMS) an amendment and five-year renewal of California's Section 1115 demonstration and a corresponding amendment and renewal expanding the existing Section 1915(b) waiver and (2) hold public hearings to receive public comments on these requests.

DHCS is seeking these approvals to implement key provisions of its California Advancing & Innovating Medi-Cal (CalAIM) initiative. CalAIM recognizes the opportunity to move California's whole person care approach—first authorized by the Medi-Cal 2020 Section 1115 demonstration—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM allow California to take a population health, person-centered approach to providing services, with the goal of improving health outcomes for Medi-Cal and other low-income populations in the State.

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, currently in effect through December 31, 2021. The 1915(b) waiver will be an amendment and renewal expanding the existing Specialty Mental Health Services (SMHS) program 1915(b) waiver and will consolidate Medi-Cal managed care, dental managed care, SMHS, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single authority. While the Section 1115 demonstration and 1915(b) waiver authorities are distinct, the policies reflected in the Section 1115 demonstration and the 1915(b) waiver are complementary; for that reason and because negotiations with CMS might lead to changes in how the proposed policies are authorized, this notice informs the public of both initiatives. DHCS is soliciting public input on the Section 1115 demonstration amendment and renewal application, as well as the planned delivery system that will be part of the 1915(b) waiver and that are described in the Section 1915(b) overview. A full draft of the proposed CalAIM Section 1115 demonstration and a detailed overview of the proposed consolidated CalAIM Section 1915(b) waiver are available on the DHCS CalAIM waiver website: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>



I. Overview of Proposed Changes

The CalAIM framework encompasses broad delivery system, program, and payment reforms 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:

1. Identify and manage member risk and need through whole person care approaches and addressing social determinants of health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity, and increasing flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

To accomplish this transition, DHCS is requesting two federal waivers: (1) a five year renewal, with amendment, of some initiatives in the State's existing Medi-Cal 2020 Section 1115 demonstration (to be renamed the CalAIM demonstration), to continue to advance the State's objective of improving health outcomes for Medi-Cal and other low-income populations in the State, and (2) a five year renewal, with amendment, to expand the State's existing SMHS 1915(b) waiver to authorize nearly all of California's Medi-Cal managed care programs, enabling the State to take advantage of flexibilities to implement an integrated, patient-centered, whole person-focused delivery system and support additional benefits for Medi-Cal beneficiaries. Because each of these waiver authorities addresses related aspects of the Medi-Cal program and the CalAIM initiative, this notice provides information with respect to both authorities: the proposed CalAIM Section 1115 demonstration and the consolidated CalAIM Section 1915(b) waiver.

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). 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 Section 1115 demonstration initiatives, is an important step forward along this path.

A key feature of CalAIM that builds off the success of Medi-Cal 2020 Whole Person Care (WPC) pilots and the State’s Health Homes Program (HHP) is the introduction of Enhanced Care Management (ECM), to be implemented statewide along with a menu of new 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 non-clinical needs of Medi-Cal beneficiaries—translating the successes of the Medi-Cal 2020 Section 1115 demonstration into the new CalAIM program. Collectively, the Section 1115 CalAIM demonstration and Section 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 needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the state.

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 CalAIM 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 <i>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.</i>	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
CalAIM Initiatives for Which DHCS Requests New Section 1115 Demonstration Authority	

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
Peer Support Specialists (Drug Medi-Cal) <i>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.</i>	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 <i>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 Section 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).</i>	January 1, 2022– December 31, 2026
Medi-Cal 2020 Section 1115 Demonstration Initiatives DHCS Plans to/Has Sunset	

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
Tribal Uncompensated Care (UCC) <i>DHCS implemented Tribal Federally Qualified Health Centers (FQHCs), obviating the need for these UCC payments.</i>	N/A
WPC Pilots and HHP <i>DHCS seeks to continue the majority of WPC and HHP services under the managed care delivery system via ECM and ILOS.</i>	N/A
	N/A
Dental Transformation Initiative (DTI) <i>DHCS is establishing a new, statewide dental benefit for children and certain adults and expanded pay-for-performance initiatives under the State Plan.</i>	N/A
Rady California Children’s Services (CCS) Pilot	N/A
PRIME <i>Applicable performance measures were transitioned to, and public hospitals may now qualify to receive managed care directed payments through, the Quality Incentive Program (QIP).</i>	N/A

CalAIM implementation was originally scheduled to begin in January 2021 but was delayed due to the impact of the COVID-19 public health emergency. CMS granted the State’s request for a temporary extension of the Medi-Cal 2020 Section 1115 demonstration, extending most components of the demonstration through December 31, 2021. DHCS is proposing a new CalAIM start date of January 1, 2022, for the renewed and amended Section 1115 demonstration and consolidated 1915(b) waiver. 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>.

II. Background on Section 1115 Demonstrations and Section 1915(b) Waivers

Section 1115 of the Social Security Act gives the United States Secretary of Health & Human Services (HHS) authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children’s Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.



To learn more about Section 1115 demonstrations, visit the CMS website at: <https://www.medicaid.gov/medicaid/section-1115-demo/index.html>.

Section 1915(b) of the Social Security Act gives the Secretary of HHS authority to waive statutory requirements for comparability, statewideness, and freedom of choice so that states can modify their delivery systems. States may use 1915(b) waivers to authorize managed care delivery systems. California currently operates its SMHS program under a 1915(b) waiver and now is proposing to use Section 1915(b) to authorize managed care for other populations. This change will allow the State to streamline, align, and simplify federal authorities; maintain flexibilities to further integrate the Medi-Cal delivery systems; and fund additional services for Medi-Cal beneficiaries through savings generated by the use of Medi-Cal managed care (known as “1915(b)(3) services”).

DHCS will negotiate both waivers with CMS simultaneously to ensure that California secures the authorities needed to implement CalAIM. The actual authority (e.g., Section 1115 demonstration, Section 1915(b) waiver, Medi-Cal State Plan) for any particular initiative may change over the course of the public comment process and engagement with CMS.

III. Summary of Current Demonstration Features to Be Continued Under the Section 1115 Demonstration Renewal

A. Description

DHCS is requesting a five-year renewal of the Section 1115 demonstration waiver and expenditure authorities to continue operating a discrete set of program elements that generally cannot be covered under the Medi-Cal State Plan or 1915(b) waiver authorities. Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that are proposed to continue under the five-year renewal, with modifications as noted:

- **Global Payment Program (GPP)** – 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 uncompensated care (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 funds for the relevant time period and enhanced Safety Net Care Pool (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.

- **Drug Medi-Cal Organized Delivery System (DMC-ODS)** – 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 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 the 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 Federal Poverty Level (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 Section 1115 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.
- **Community-Based Adult Services (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 to 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.

B. Eligibility Requirements

The Section 1115 demonstration does not affect Medi-Cal eligibility under the Medi-Cal State Plan, with the exception of out-of-state former foster care youth. Additionally, low-income pregnant women (109 percent to 138 percent of the FPL) receive access to full-



scope benefits through the Section 1115 demonstration. These provisions are not changing under the Section 1115 demonstration renewal. Because of the delivery system changes described here, during the renewal period, fewer Medi-Cal beneficiaries will be directly impacted by the Section 1115 demonstration as the authority for many of the components of the demonstration will be through the consolidated 1915(b) waiver, SPAs, and the MCP contract requirements.

C. Cost Sharing

There are no cost-sharing requirements in the current Medi-Cal 2020 Section 1115 demonstration nor the proposed CalAIM Section 1115 demonstration.

IV. Summary of New Medi-Cal Program Features to Be Included in the CalAIM Section 1115 Demonstration

- **Peer Support Specialists** – To enhance DMC services, and consistent with State legislation,⁴ peer support specialist services will be added to the Medi-Cal State Plan through a SPA, 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 to allow peer support in the 1915(b) waiver for SMHS and 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 from county jails, state and federal prisons, and youth facilities. 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

⁴ See Sections 14045.14(a) and 14045.19 of the California Welfare & Institution Code, as amended by Senate Bill 803.



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

V. Summary of Current Medi-Cal 2020 Section 1115 Demonstration Initiatives Being Discontinued or Transitioned to Other Authority

A. Description

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 sunseting 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 Medi-Cal 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 the Coordinated Care Initiative (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 percent – 213 percent of the FPL who are citizens or lawfully present)—will be required to enroll in Medi-Cal managed care in all counties starting in 2020. Some American Indians or Alaska Natives residing in non-County Organized Health System (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 mandatory 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.
- **Managed Care for Seniors With Disabilities (SPDs)** – To streamline managed care authority, the authority to enroll the SPDs population in Two-Plan and



Geographic Managed Care plan model counties into managed care will transition out of the Section 1115 demonstration and into the consolidated 1915(b) waiver.

- **Coordinated Care Initiative (CCI)** – The State will transition both components of the CCI—(1) Cal MediConnect (CMC), a Section 1115A demonstration project under the federal Financial Alignment Initiative; 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)—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. 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.
- **Rady Children’s Hospital of San Diego California Children’s Services (CCS) Pilot** – The State will sunset the CCS pilot.
- **Program of All-Inclusive Care for the Elderly (PACE)** – The State will shift authority to the consolidated 1915(b) waiver to continue to allow Medi-Cal beneficiaries to enroll in PACE independent of the COHS MCP in select Medi-Cal COHS counties (currently Humboldt and Orange).
- **Oral Health Services** – Building upon the success of the Dental Transformation Initiative (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. DHCS also will offer new dental benefits statewide for children and certain adult enrollees including: the Caries Risk Assessment Bundle for young children; Silver Diamine Fluoride for young children (ages 0-6) and adults in specified high-risk and institutional populations; and pay-for-performance initiatives that will offer payments to service office locations that render preventive services. These services and payment initiatives will be included in forthcoming amendments to the Medi-Cal State Plan.
- **Tribal Uncompensated Care** – DHCS implemented Tribal federally qualified health centers (FQHCs), obviating the need for these uncompensated care payments.



- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** – The State transitioned PRIME to the Quality Incentive Program (QIP) managed care directed payment program as of July 1, 2020.
- **WPC & HHP** – California is not requesting the renewal of authorities related to the WPC pilots and HHP during this renewal period. Instead, the State intends to build on the success of WPC pilots and the HHP by implementing ECM and targeted ILOS, which will be delivered through Medi-Cal managed care and community providers. A key feature of CalAIM is the introduction ECM statewide, as well as ILOS, which, at the option of a MCP can be offered to members as a cost-effective alternative benefit. MCPs will be responsible for administering both ECM and ILOS, with a phased implementation for both ECM and State approved ILOS beginning in 2022. 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.

B. Health Care Delivery Systems and Benefits

As noted above, California is proposing to transition the key Medi-Cal managed care delivery systems from Section 1115 demonstration authority to 1915(b) waiver authority; these systems are (1) Medi-Cal managed care; (2) dental managed care; (3) DMC-ODS; and (4) SMHS. This transition will streamline California’s managed care programs into a consolidated 1915(b) waiver, while continuing key Section 1115 demonstration programs, in order to meet the behavioral, developmental, physical, and oral health needs of all Medi-Cal members in an integrated, patient-centered, whole person fashion.

With respect to DMC-ODS, the State is proposing to transition the federal authorization for some DMC-ODS benefits to the Medi-Cal State Plan and Section 1915(b) waiver (which will continue to authorize waivers of statewideness and comparability in order for DMC-ODS to remain available only in counties that opt in) and to add new Contingency Management services for recipients of DMC-ODS. These changes will not result in a change to the benefits currently available to DMC-ODS beneficiaries or to the voluntary participation of counties in DMC-ODS; instead, they are being made to align the benefits and delivery systems as described in this notice.

VI. Goals and Objectives of the Section 1115 Demonstration

Through this proposed CalAIM Section 1115 demonstration, California seeks to continue advancing the State’s goal of improving health outcomes for Medi-Cal beneficiaries or other low-income populations in the State. With respect to particular



initiatives included in the demonstration, California seeks to accomplish the following goals and objectives:

- **GPP*** – Promote the objectives of Title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medi-Cal and low-income populations while increasing efficiency, equity, and quality of care; move away from payments restricted to hospital setting; 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 Medi-Cal, but that substitute for or complement services that are reimbursable.
- **DMC-ODS*** – Improve access, quality, and coordination of care for SUD services in participating counties.
- **Peer Support Specialist Services** – Improve recovery outcomes and prevent relapses and symptoms of behavioral disorders; and provide further integration between local mental health and SUD delivery systems and support administrative efficiencies.
- **Low-Income Pregnant Women*** – Improve health outcomes for Medi-Cal enrollees who are pregnant or have recently given birth.
- **Out-of-State Former Foster Care Youth*** – Improve health outcomes by extending Medi-Cal coverage to former foster care youth who may not otherwise be eligible for coverage.
- **CBAS*** – 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 Medi-Cal beneficiaries.
- **Services for Justice-Involved Populations 30-Days Pre-Release** – Improve physical and behavioral health outcomes of justice-involved populations post-release; reduce the number of justice-involved populations being released into homelessness by, prior to their release, connecting them to ECM and ILOS; 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; and reduce health care costs by ensuring continuity of care and services upon release into the community.
- **PATH Supports** – Advance the coordination and delivery of quality care for Medi-Cal beneficiaries and will help improve health outcomes for Medi-Cal and



other low-income populations in the State; and 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 including across racial and ethnic groups.

** Indicates original policy objectives of the Medi-Cal 2020 Section 1115 demonstration.*

VII. Enrollment Projections and Annual Expenditures

A. Enrollment Projections

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 care 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 care youth and pregnant women gaining full Medi-Cal under the demonstration are provided in Tables 2 and 3.



Table 2. Historical Enrollment for Out-of-State Former Foster Care Youth and Low-Income Pregnant Women

Population	Historical Enrollment						
	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
	1/1/16– 6/30/16	7/1/16– 6/30/17	7/1/17– 6/30/18	7/1/18– 6/30/19	7/1/19– 6/30/20	7/1/20– 12/31/20	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 3. 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, ECM, 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 4 provides information on the number of beneficiaries enrolled in each of the major eligibility categories on an historical basis; Table 5 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 4. Historical Enrollment by Category of Aid

Category of Aid	Historical Enrollment (in thousands) ¹						
	DY 11	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
	1/1/16–6/30/16	7/1/16–6/30/17	7/1/17–6/30/18	7/1/18–6/30/19	7/1/19–6/30/20	7/1/20–12/31/20	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 5. Projected Enrollment by Category of Aid

Category of Aid	Projected Enrollment (in thousands) ¹				
	DY 18	DY 19	DY 20	DY 21	DY 22
	1/1/22– 12/31/22	1/1/23– 12/31/23	1/1/24– 12/31/24	1/1/25– 12/31/25	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.

B. Expenditure Projections

California’s total demonstration expenditures are expected to decrease from approximately \$45 billion in DY 15 (the last full, concluded year of the current demonstration period) to approximately \$5 billion per year over the course of the renewal period (see Tables 6 and 7 for a detailed breakdown of historical and projected expenditures). 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 expenditures under the renewal are \$4.9 billion on average, which is 11 percent of the prior demonstration.

Based on the programmatic details described above, California has estimated projected spending for the renewal period. For the purposes of public notice and comment, the State has summarized in the table 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 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 6. 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 7. Projected Expenditures, CalAIM Demonstration

Expenditure Authorities	Projected Expenditures (in thousands of dollars)				
	DY 18	DY 19	DY 20	DY 21	DY 22
	1/1/22–12/31/22	1/1/23–12/31/23	1/1/24–12/31/24	1/1/25–12/31/25	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



Projected Expenditures (in thousands of dollars)					
Expenditure Authorities	DY 18	DY 19	DY 20	DY 21	DY 22
	1/1/22–12/31/22	1/1/23–12/31/23	1/1/24–12/31/24	1/1/25–12/31/25	1/1/26–12/31/26
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
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).

VIII. Section 1115 Demonstration Waiver and Expenditure Authorities

DHCS intends to maintain the relevant waiver and expenditure authorities approved under the Medi-Cal 2020 Section 1115 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.

Table 8. Section 1115 Waiver Authority Requests

The State is seeking to continue §1115(a)(1) waiver authority for various programmatic features and for new features, as described below. For purposes of transitioning Medi-Cal managed care delivery systems from Section 1115 demonstration authority to Section 1915(b) waiver authority (for Medi-Cal managed care, dental managed care, and DMC-ODS), DHCS will request 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 renewal period.

Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
<p>§ 1902(a)(13)(A) (insofar as it incorporates Section 1923) DSH Requirements</p>	<p>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.</p>	<p>Yes</p>



Waiver Authority	Use for Waiver	Currently Approved Waiver Request?
<p>§ 1902(a)(1) Statewide</p>	<p>To enable the State to operate the demonstration on a county-by-county basis.</p> <p>To enable the state to provide DMC-ODS services to individuals on a geographically limited basis.</p> <p>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.)</p>	<p>Yes, with modifications to reflect a new request related to peer support specialists in DMC</p>
<p>§ 1902(a)(10)(B) Amount, Duration, and Scope and Comparability</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>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</p>

Table 9. Section 1115 Expenditure Authority Requests

The State is seeking to continue §1115(a)(2) expenditure authority for various programmatic features and for new features, as described below.



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 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. ⁵	No

⁵ 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: <ul style="list-style-type: none"> • 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 original Medi-Cal 2020 demonstration

IX. Section 1115 Demonstration Hypotheses and Evaluation Approach

The State intends to contract with independent third parties to evaluate: (1) the objectives and hypotheses under the current Medi-Cal 2020 Section 1115 demonstration that the State is seeking to continue in the amended and renewed CalAIM Section 1115 demonstration; and (2) the objectives and hypotheses for the new authorities requested for the CalAIM Section 1115 demonstration.



The hypotheses under consideration for the new authorities requested for the CalAIM Section 1115 demonstration application period are below.

Table 10. 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • GPP Equity Sub-pool services utilization data, stratified by race/ethnicity data • Hospital and emergency utilization data, stratified by race/ethnicity data



<p>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.</p>	<p>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.</p>	<ul style="list-style-type: none"> • Surveys and/or interviews of GPP leads • Pre- and post-implementation surveys to track changes and progress over time
<p>II. Justice-Involved Populations</p>		
<p>The demonstration will improve physical and behavioral health outcomes of justice-involved populations post-release.</p>	<p>Examine the diagnoses and health outcomes for justice-involved populations.</p>	<ul style="list-style-type: none"> • Usage and diagnosis data • California Outcomes Measurement Systems (CalOMS) data • Quality measures (Healthcare Effectiveness Data and Information Set (HEDIS))
<p>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.</p>	<p>Examine the utilization of medical and behavioral health services and treatment.</p>	<ul style="list-style-type: none"> • Usage data • CalOMS data • Quality measures (HEDIS)



<p>The demonstration will promote continuity of medication treatment for individuals receiving medications.</p>	<p>Examine the number of medication claims and usage surveys and interviews to measure the usage and challenges associated with medication treatment post-release.</p>	<ul style="list-style-type: none"> • Pharmacy claims • CalOMS data • Surveys and interviews • Usage and diagnosis data
<p>III. DMC-ODS Program Changes <i>(includes evaluations related to changes DHCS is currently negotiating with CMS and requested renewal changes)</i></p>		
<p>(a) Increase access to SUD treatment for American Indians and Alaska Natives</p>		
<p>The number of residential treatment admissions among American Indian/Alaska Native beneficiaries will increase during the 12-month and five-year periods.</p>	<p>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).</p>	<ul style="list-style-type: none"> • DMC claims • CalOMS discharge status data
<p>The total per-person time in residential treatment each year will increase during the 12-month and five-year periods.</p>		
<p>The number of American Indian/Alaska Native beneficiaries receiving community-based SUD treatment will increase.</p>	<p>UCLA will examine usage of SUD treatment services among American Indian/Alaska Native beneficiaries.</p>	<ul style="list-style-type: none"> • Medi-Cal claims
<p>(b) Expand evidence-based practice options to include Contingency Management</p>		
<p>The number of deaths among people with stimulant use disorder will be lower if using Contingency Management.</p>	<p>UCLA will examine the number of deaths among beneficiaries with stimulant disorder who have utilized Contingency Management services and those that have not.</p>	<ul style="list-style-type: none"> • DMC-ODS claims • Death data from the California Department of Public Health



<p>SUD treatment retention rates will increase among individuals with stimulant use disorder who receive Contingency Management incentives.</p>	<p>UCLA will examine usage of SUD treatment services among individuals using Contingency Management. It also will gather information by asking specific questions in surveys.</p>	<ul style="list-style-type: none"> • DMC-ODS claims • Patient-reported outcomes survey
<p>The percentage of people with stimulant use disorder who participate in Contingency Management will increase during the five-year period.</p>	<p>UCLA will examine the usage of Contingency Management for people with stimulant use disorder, pending implementation of a benefit and establishment of billing codes.</p>	<ul style="list-style-type: none"> • DMC-ODS claims
<p>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.</p>	<p>UCLA will examine rates of positive and negative drug screens among individuals with stimulant use disorder using Contingency Management.</p>	<ul style="list-style-type: none"> • Data from Contingency Management app
<p>(c) Remove the limitations on residential treatment services that may be provided in a one-year period</p>		
<p>Treatment outcomes for beneficiaries in residential treatment will improve.</p>	<p>Evaluator will review outcomes data.</p>	<ul style="list-style-type: none"> • CalOMS data • DMC-ODS claims
<p>(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</p>		
<p>The number of beneficiaries served will increase.</p>	<p>UCLA will determine the usage of SUD treatment services by county and service type.</p>	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Drug Medi-Cal claims • Surveys and interviews

X. Public Review and Comment Process

The 30-day public comment period for the CalAIM Section 1115 demonstration application and DHCS’ plans for the consolidated 1915(b) waiver as described in the 1915(b) waiver overview is from Tuesday, April 6, 2021 until Thursday, May 6, 2021. All comments must be received no later than 11:59 PM (Pacific Time) on **Thursday, May 6, 2021**.

All information regarding the CalAIM Section 1115 demonstration application and the 1915(b) overview can be found on the DHCS website (<https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>). DHCS will update this website throughout the public comment and application process.

DHCS will host the following public hearings to solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Monday, April 26, 2021 – First Public Hearing
 - 1:00 – 2:30 PM PT



- Register for Zoom conference link:
https://manatt.zoom.us/webinar/register/WN_csWzNuSFQiiY46ZinTufLg
 - Please register in advance to receive your unique login details and link to add to calendar
- Call-in information (669) 900-6833 or (888) 788-0099 (Toll Free)
 - Webinar ID: 944 4865 1547
 - Passcode: 042621
 - Callers do not need an email address to use the phone option and do not need to register in advance
- Monday, May 3, 2021 – Second Public Hearing
 - 2:00 – 3:30 PM PT
 - Register for Zoom conference:
https://manatt.zoom.us/webinar/register/WN_dj9UAypdQ76aOtcXafuhSA
 - Please register in advance to receive your unique login details and link to add to calendar
 - Call-in information (669) 900-6833 or (888) 788-0099 (Toll Free)
 - Webinar ID: 994 3157 8945
 - Passcode: 050321
 - Callers do not need an email address to use the phone option and do not need to register in advance

The complete version of the draft of the CalAIM Section 1115 demonstration application and the 1915(b) waiver overview are available for public review at <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

You may request a copy of the proposed CalAIM Section 1115 demonstration application; CalAIM Section 1915(b) waiver overview; and/or a copy of submitted public comments related to the CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview by sending a written request to the mailing or email address listed below.

Written comments may be sent to the following address; please indicate “CalAIM Section 1115 & 1915(b) Waiver” in the written message:

Department of Health Care Services
Director’s Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413



Comments may also be emailed to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & and 1915(b) Waivers" in the subject line of the email message.

To be assured consideration prior to submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 PM PT (Pacific Time) on **Thursday, May 6, 2021**. Please note that comments will continue to be accepted after May 6, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.

Upon submission to CMS, a copy of the proposed CalAIM Section 1115 demonstration and Section 1915(b) waiver will be published at the following internet address:
<https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

After DHCS reviews comments submitted during this State public comment period, the CalAIM Section 1115 demonstration and 1915(b) waiver will be submitted to CMS. Interested parties will also have the opportunity to officially comment on the CalAIM Section 1115 demonstration during the federal public comment period; the submitted application will be available for comment on the CMS website at:
<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>. There is no federal public comment period for the 1915(b) waiver.



Appendix D: Tribal Public Notice

April 7, 2021

To: Tribal Chairpersons, Designees of Indian Health Programs, and Urban Indian Organizations

Subject: Notice of Intent to Submit Amendments and Renewals of Section 1115 Demonstration and Section 1915(b) Waiver

The purpose of this letter is to provide information regarding a proposed change to the Department of Health Care Services' (DHCS) Medi-Cal program that will be submitted to the Centers for Medicare & Medicaid Services (CMS). DHCS is forwarding this information for your review and comment.

DHCS is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on Medi-Cal matters having a direct effect on American Indians, Indian Health Programs or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009 (ARRA). DHCS must solicit the advice of designees prior to submission to CMS of any State Plan Amendments (SPAs), waiver requests or amendments, or proposals for demonstration projects in the Medi-Cal program.

Please see the enclosed summary for a detailed description of this DHCS proposal.

QUESTIONS AND COMMENTS

Tribes and Indian Health Programs may also submit written comments or questions concerning this proposal within 30 days from receipt of notice. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) on Friday, May 7, 2021. Please note that comments will continue to be accepted after Friday, May 7, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver applications to CMS. Comments may be sent by email to CalAIMWaiver@dhcs.ca.gov or by mail to the address below:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413



Please also note that DHCS will host a CalAIM hearing for Tribes and Designees of Indian Health Programs on Friday, April 30, 2021 at 2:00 – 3:30 PM PT. Registration and call-in information are listed at the end of this document.

Sincerely,

Original Signed By

Sandra “Sam” Willburn, Chief
Primary, Rural, and Indian Health Division
Department of Health Care Services

Enclosure



Department of Health Care Services Tribal and Designees of Indian Health Programs Notice

PURPOSE

The California Department of Health Care Services (DHCS) is providing notice of its intent to (1) submit to the federal Centers for Medicare & Medicaid Services (CMS) an amendment and five-year renewal of California's Section 1115 demonstration and a corresponding amendment and renewal expanding the existing Section 1915(b) waiver and (2) hold a hearing to receive comments on these requests. The purpose of this notice is to request written feedback on the Section 1115 demonstration and Section 1915(b) waiver proposals described in this notice.

BACKGROUND

CalAIM Overview

DHCS is seeking these approvals to implement key provisions of its [California Advancing & Innovating Medi-Cal \(CalAIM\) initiative](#). CalAIM recognizes the opportunity to move California's whole person care approach—first authorized by the Medi-Cal 2020 Section 1115 demonstration—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM allow California to take a population health, person-centered approach to providing services with the goal of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the State.

CalAIM Section 1115 Demonstration and CalAIM Section 1915(b) Waiver

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, currently in effect through December 31, 2021. Today, the Medi-Cal 2020 demonstration authorizes Medi-Cal managed care programs, with the exception of California's 1915(b) waiver, which authorizes the Specialty Mental Health Services (SMHS) program. Going forward, the CalAIM 1915(b) waiver will authorize nearly all of California's Medi-Cal managed care programs: Medi-Cal managed care, dental managed care, SMHS, and Drug Medi-Cal Organized Delivery System (DMC-ODS). This will enable the State to streamline, align, and simplify federal authorities; to implement a more seamless, integrated, patient-centered, and whole person-focused delivery system; and to support additional benefits for Medi-Cal beneficiaries.

CalAIM implementation was originally scheduled to begin in January 2021 but was delayed due to the impact of the COVID-19 public health emergency. CMS granted California's request for an extension of the Medi-Cal 2020 Section 1115 demonstration,



extending most components of the demonstration through December 31, 2021. DHCS is proposing a new CalAIM start date of January 1, 2022, for the renewed and amended Section 1115 demonstration and the expanded 1915(b) waiver.

DHCS is soliciting input on the CalAIM Section 1115 demonstration amendment and renewal application as well as the planned delivery system changes in the CalAIM Section 1915(b) waiver that are described in the 1915(b) waiver overview. Both documents are available on the [DHCS website](#).

SUMMARY OF PROPOSED CHANGES

CalAIM Section 1115 Demonstration

Note that the full CalAIM proposal is posted on the [DHCS website](#). Additionally, a copy of the proposed CalAIM Section 1115 demonstration and detailed overview of the CalAIM Section 1915(b) waiver is available on the [DHCS website](#).

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that are proposed to continue under the CalAIM Section 1115 demonstration:

- Global Payment Program (GPP)
- Expenditure Authority for Residential Treatment for Substance Use Disorder (SUD) in Institutions for Mental Diseases (IMDs) in DMC-ODS Counties
- Low-Income Pregnant Women (109 percent–138 percent of the federal poverty level (FPL))
- Out-of-State Former Foster Care Youth
- Community-Based Adult Services (CBAS)
- DMC-ODS Certified Public Expenditure (CPE) Protocols
- Designated State Health Programs (DSHP)

Following are the elements of the CalAIM initiative that are proposed for inclusion under the CalAIM Section 1115 demonstration:

- Waiver of Statewideness and Comparability for Peer Support Specialist Services in Drug Medi-Cal Counties That Opt In
- Services for Justice-Involved Populations 30 Days Pre-Release
- Providing Access and Transforming Health Supports
- DMC-ODS Traditional Healers and Natural Helpers

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that will or have sunset, and are not included for renewal under the CalAIM Section 1115 demonstration:

- Dental Transformation Initiative (DTI)
- Health Homes Program (HHP)



- Tribal Uncompensated Care (UCC)
- Rady California Children's Services (CCS) Pilot
- Whole Person Care (WPC) Pilots
- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

CalAIM Section 1915(b) Waiver and Medi-Cal State Plan

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that DHCS proposes to authorize via a consolidated 1915(b) waiver and/or via amendments to the Medi-Cal State Plan. Key elements of the above programs will be incorporated into either the Medi-Cal State Plan or the consolidated 1915(b) waiver that DHCS is seeking. Additional information is available on the [DHCS CalAIM webpage](#).

:

- Medi-Cal Managed Care, including the Coordinated Care Initiative (CCI), Program of All-Inclusive Care for the Elderly (PACE) as an Alternative Delivery System in select County Organized Health Systems (COHS), and managed care for Seniors with Disabilities (SPDs) in Two-Plan and GMC counties.
 - Additional aid code groups – under which some American Indian and Alaska Native beneficiaries may derive their eligibility – will be required to enroll in Medi-Cal managed care plans starting January 2022. American Indian and Alaska Native beneficiaries in non-COHS counties will continue to have the ability to opt out of Medi-Cal managed care for fee-for-service.
- Dental Managed Care
- DMC-ODS (except the services that will remain in the 1115 demonstration)

IMPACT TO TRIBAL HEALTH PROGRAMS

To the extent that a Tribal health program provides, or plans to provide, these services, the following waiver proposals may have an impact:

CalAIM Section 1115 Demonstration

- Eliminate Tribal Uncompensated Care (UCC) Payments.
IMPACT. DHCS implemented Tribal Federally Qualified Health Centers (FQHCs) via State Plan Authority on January 1, 2021 (see [SPA CA 20-0044](#)). This change eliminated the need for these UCC payments. In the past, UCC payments were made under the Section 1115 demonstration for certain optional services previously eliminated from the Medi-Cal State Plan that were 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.



- Increase Access to Substance Use Disorder (SUD) Treatment for American Indians and Alaska Natives.
IMPACT. DHCS seeks to improve access to SUD treatment for American Indians and Alaska Natives through Indian Health Care Providers and promote access to culturally appropriate and evidence-based SUD treatment for American Indians and Alaska Natives starting on January 1, 2022. To achieve these objectives, DHCS seeks federal reimbursement for DMC-ODS services provided by traditional healers and natural helpers using culturally specific, evidence-based practices. DHCS also plans to require Indian Health Care Providers to use at least two evidence-based practices as defined in DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

CalAIM Section 1915(b) Waiver

- Continue to Provide DMC-ODS Coverage in Participating Counties
IMPACT. American Indians and Alaska Natives who are eligible for Medi-Cal and reside in counties that have opted in to DMC-ODS can receive DMC-ODS services through Indian Health Care Providers. Indian Health Care Providers must also have Drug Medi-Cal certification in order to provide services under the DMC-ODS waiver program. As required by 42 CFR § 438.14, DMC-ODS counties must demonstrate that there are sufficient Indian Health Care Providers participating in the provider network to ensure timely access to DMC-ODS services. DMC-ODS counties must adhere to all 42 CFR § 438.14 requirements.
- Delivery System Benefit Changes
IMPACT. Under CalAIM, DHCS is proposing to further standardize benefits offered under the managed care plans to mitigate Medi-Cal managed care enrollee confusion and streamline DHCS administrative rate-setting processes. Effective in 2022, DHCS intends to carve out the Multipurpose Senior Services Program (MSSP, only available in CCI counties) to FFS and carve out specialty mental health services from the MCMC benefit package for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties. DHCS intends to carve into the Medi-Cal managed care benefit package statewide major organ transplants by 2022 and institutional long-term care services by 2023. Beneficiaries requiring specialty mental health and SUD services will continue to access those services through the SMHS and DMC-ODS or Drug Medi-Cal programs. Subject to ongoing deliberations with the State's contracted vendor for Medi-Cal Rx, DHCS intends to carve pharmacy benefits out of the Medi-Cal managed care benefit package, at an effective date to be subsequently announced (see [All Plan Letter 20-020](#) for more information; on February 17, 2021, DHCS announced a delay to the planned April 1, 2021 effective date for Medi-Cal Rx and the carve-out of pharmacy benefits from MCMC contracts; DHCS anticipates providing further information, including with respect to a



revised effective date for the carve-out, in May 2021). For a detailed breakdown of managed care benefit changes, please see [Appendix E of the CalAIM proposal](#).

- Behavioral Health Payment Reform

IMPACT. DHCS intends to transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This proposal has no direct impact on Tribal health programs.

IMPACT TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

To the extent that a Urban Indian health organization is enrolled in Medi-Cal as a FQHC and provides, or plans to provide, the waiver services described above (e.g., DMC-ODS), there could be an impact.

CalAIM Section 1115 Demonstration. Except as noted above, there is no direct impact to FQHCs since DHCS is not proposing changes to FQHC services, rates, eligibility, or any other related requirement authorized by this demonstration authority or the Medi-Cal State Plan.

CalAIM Section 1915(b) Waiver. There is no direct impact to FQHCs since DHCS is not proposing changes to FQHC services, rates, eligibility, or any other related requirement authorized by this waiver authority or the Medi-Cal State Plan.

IMPACT TO INDIAN MEDI-CAL BENEFICIARIES

CalAIM Section 1115 Demonstration. In general, the changes that DHCS is requesting will alter the Medi-Cal delivery system but will not change eligibility for Medi-Cal or reduce benefits. DHCS intends to seek expenditure authority to provide certain benefits and services through the Section 1115 demonstration that are intended to maintain and improve coverage and access for American Indian and Alaska Native populations.

- Eliminate Tribal Uncompensated Care (UCC) Payments.

IMPACT. DHCS implemented Tribal FQHCs via State Plan Authority on January 1, 2021 (see [SPA CA 20-0044](#)). This change eliminated the need for these UCC payments. In the past, UCC payments were made under the Section 1115 demonstration for certain optional services previously eliminated from the Medi-Cal State Plan that were provided by IHS Tribal health programs operating under



the authority of the ISDEAA to IHS-eligible Medi-Cal beneficiaries. This change may impact American Indian and Alaskan Native beneficiaries to the extent a clinic chooses not to participate as a Tribal FQHC.

- Increase Access to SUD Treatment for American Indians and Alaska Natives
IMPACT. DHCS seeks to improve access to SUD treatment for American Indians and Alaska Natives through Indian Health Care Providers and promote access to culturally appropriate and evidence-based SUD treatment for American Indians and Alaska Natives starting on January 1, 2022. To achieve these objectives, DHCS seeks federal reimbursement for DMC-ODS services provided by traditional healers and natural helpers using culturally specific evidence-based practices. DHCS also plans to require Indian Health Care Providers to use at least two evidence-based practices as defined in DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.
- Continue to Provide Coverage for Out-of-State Former Foster Care Youth
IMPACT. There is no change to Indian Medi-Cal beneficiaries. DHCS will continue to provide Medi-Cal State Plan coverage for 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 the time.
- Authorize Services for Justice-Involved Populations 30 Days Pre-Release
IMPACT. To ensure continuity of health coverage and care for justice-involved populations—who experience disproportionately higher rates of physical and behavioral health diagnoses—DHCS is requesting authority to provide targeted Medi-Cal services to eligible justice-involved populations 30 days pre-release. These Medi-Cal services include Enhanced Care Management (ECM) and limited community-based clinical consultation services provided via telehealth or e-consultation and a 30-day supply of medication for pre-release into the community. This change will benefit justice-involved Medi-Cal beneficiaries.
- Oral Health Changes
IMPACT. Building upon the success of the DTI aimed at improving children’s oral health, the State will be concluding DTI and transitioning the elements of Domains 1 through 3 statewide. The Caries Risk Assessment Bundle and Silver Diamine Fluoride will be added as dental benefits for children (ages 0-6) and certain adult enrollees and will be available statewide, along with expanded pay-for-performance initiatives that will offer payments to service office locations that render preventive dental services. DHCS will separately develop and seek comment on amendments to the Medi-Cal State Plan to add the referenced oral health benefits and pay-for-performance payments to the Medi-Cal State Plan. DTI payments to participating Indian Health Programs participating in the dental



initiative will no longer be available; however, comparable pay-for-performance payments and benefits are proposed to be included in the Medi-Cal State Plan.

- New Benefit: Peer Support Specialist Services

IMPACT. Consistent with recent State legislation, DHCS will be establishing peer support specialist services to expand the use of certified peer support specialists. Peer support specialist services are culturally competent services provided by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. DHCS will propose changes to the Medi-Cal state plan to include peer support specialist services as a distinct service type and will require peers to obtain a peer support specialist certification. As part of the Section 1115 demonstration, the State will request authority to make peer support specialist services available at the option of each county under Drug Medi-Cal. This new benefit will be available to American Indians and Alaska Natives through Drug Medi-Cal in counties that opt in. Indian Health Programs in participating counties may be able to provide peer support specialist services. (As noted below, DHCS is submitting a similar 1915(b) waiver request for SMHS and DMC-ODS.)

CalAIM Section 1915(b) Waiver. DHCS is making delivery system and benefit changes that impact American Indians and Alaska Natives through this waiver.

- Medi-Cal Managed Care for American Indians and Alaska Natives

IMPACT. Currently, most Medi-Cal children, pregnant women, parents/caretaker relatives, and adults without disabilities must enroll in Medi-Cal managed care. DHCS will require Medi-Cal beneficiaries in additional aid code groups to enroll in Medi-Cal managed care starting on January 1, 2022. Some American Indians and Alaska Natives may be eligible for Medi-Cal coverage in these additional aid code groups that will be subject to mandatory Medi-Cal managed care enrollment. As is consistent with current policy, all American Indians and Alaska Natives residing in non-COHS counties will continue to have the ability to opt out of Medi-Cal managed care and receive their benefits in the fee-for-service delivery system.

- Delivery System Benefit Changes

IMPACT. Under CalAIM, DHCS is proposing to further standardize benefits offered by the managed care plans to mitigate Medi-Cal managed care enrollee confusion and streamline DHCS administrative rate-setting processes. Effective in 2022, DHCS intends to carve out the Multipurpose Senior Services Program (MSSP, only available in CCI counties) to FFS and carve out specialty mental health services from the MCMC benefit package for Medi-Cal members enrolled



in Kaiser in Solano and Sacramento counties. DHCS intends to carve into the Medi-Cal managed care benefit package statewide major organ transplants by 2022 and institutional long-term care services by 2023. Beneficiaries requiring specialty mental health and SUD services will continue to access those services through the SMHS and DMC-ODS or Drug Medi-Cal programs. Subject to ongoing deliberations with the State's contracted vendor for Medi-Cal Rx, DHCS intends to carve pharmacy benefits out of the Medi-Cal managed care benefit package, at an effective date to be subsequently announced (see [All Plan Letter 20-020](#) for more information; as noted above, on February 17, 2021, DHCS announced a delay to the planned April 1, 2021 effective date for Medi-Cal Rx and the carve-out of pharmacy benefits from MCMC contracts; DHCS anticipates providing further information, including with respect to a revised effective date for the carve-out, in May 2021). For a detailed breakdown of managed care benefit changes, please see [Appendix E of the CalAIM proposal](#).

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
IMPACT. California is not requesting the renewal of authorities related to the WPC pilots and HHP during this renewal period. Instead, the State intends to build on the success of the WPC pilots and HHP by implementing ECM and targeted ILOS, which will be delivered through Medi-Cal managed care plans and community providers. A key feature of CalAIM is the introduction of ECM statewide, as well as ILOS, which, at the option of a Medi-Cal managed care plan, can be offered to members as a cost-effective alternative benefit. Medi-Cal managed care plans will be responsible for administering both ECM and ILOS, with a phased implementation for both ECM and State-approved ILOS beginning January 1, 2022. These changes will make new services available to American Indians and Alaska Natives who are enrolled in Medi-Cal managed care. Indian Health Programs may be able to contract with Medi-Cal managed care plans to provide these services.
- New Benefit: Peer Support Specialist Services
IMPACT. Consistent with recent State legislation, DHCS will be establishing peer support specialist services to expand the use of certified peer support specialists. Peer support specialist services are culturally competent services provided by certified peer support specialists that promote recovery, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. DHCS will propose changes to the Medi-Cal State Plan to include peer support specialist services as a distinct service type and will require peers to obtain a peer support specialist certification. As part of the 1915(b) waiver, the State will request authority to make peer support specialist services available at the option of each county under SMHS and DMC-ODS. This new benefit will be available to American Indians and Alaska Natives who are enrolled in Medi-Cal managed care and receive services through SMHS and



DMC-ODS in counties that opt in. Indian Health Programs in participating counties may be able to provide peer support specialist services. (As noted above, DHCS is submitting a similar Section 1115 demonstration request for Drug Medi-Cal.)

- **New Benefit: Contingency Management in DMC-ODS**
IMPACT. DHCS is requesting authority to add Contingency Management as a new component of existing DMC-ODS services with authority under Section 1915(b)(3). Contingency management is an evidence-based, cost-effective treatment practice for SUDs that combines motivational incentives with behavioral health treatments, and it is the only currently effective treatment for stimulant use disorders, for which there is no approved medication. This new benefit will be available to American Indians and Alaska Natives who receive services through DMC-ODS. Indian Health Programs that participate in DMC-ODS may be able to provide these services.

RESPONSE DATE

Tribes and Indian Health Programs may also submit written comments or questions concerning this proposal within 30 days from the receipt of notice. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) on Friday, May 7, 2021. Please note that comments will continue to be accepted after May 7, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver applications to CMS.

Comments may be sent by email to CalAIMWaiver@dhcs.ca.gov or by mail to the address below.

DHCS will host the following hearing to solicit Tribal and Indian Health Program stakeholder comments. The public hearing will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meeting will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Friday, April 30, 2021 – Tribal and Designees of Indian Health Programs Webinar for CalAIM Waivers
 - 2:00 – 3:30 PM PT
 - Register for conference: https://manatt.zoom.us/webinar/register/WN_-karjUOkQmKZaLd1DghbJQ
 - Please register in advance to receive your unique login details and link to add to calendar
 - Call-in information (669) 900-6833 or (888) 788-0099 (Toll Free)
 - Webinar ID: 942 9300 6698
 - Passcode: 043021



- Callers do not need an email address to use the phone option and do not need to register in advance

CONTACT INFORMATION

Written comments on the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waiver may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waiver" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413



Appendix E: Documentation of Compliance with Public Notice Process



California Register Notice

Friday, April 9, 2021

Link: <https://oal.ca.gov/wp-content/uploads/sites/166/2021/04/2021-Notice-Register-Number-15-Z-April-9-2021.pdf>

CALIFORNIA REGULATORY NOTICE REGISTER 2021, VOLUME NUMBER 15-Z

- 2) The Applicant shall not initiate any Project construction activities that may impact SONCC coho salmon until the Applicant has a mutually approved contract with the Tribe. The approved contract shall include a budget that funds at least 20% of the construction implementation specific to the remediation of fish passage barriers associated with the Rowdy Creek Restoration Project. The Applicant shall submit written evidence of the approved contract and the secured funding with the Tribe as evidence of financial assurances to CDFW prior to the initiation of any construction activities that may impact SONCC coho salmon associated with the Project.

Pursuant to Fish and Game Code section 2080.1, take authorization under CESA is not required for the Project for incidental take of SONCC coho salmon provided the Applicant implements the Project as described in the ITS and associated BO, including adherence to all measures contained therein, and complies with the mitigation measures and other conditions described in the ITS, BO, and the Addendum and Amendment Letters. If there are any substantive changes to the Project, including changes to the mitigation measures, or if the Service amends or replaces the ITS, BO, or the Addendum and Amendment Letters, the Applicant shall be required to obtain a new consistency determination or a CESA incidental take permit for the Project from CDFW. (See generally Fish & Game Code, §§ 2080.1, 2081, subdivisions (b) and (c)).

CDFW's determination that the Service BO and ITS are consistent with CESA is limited to SONCC coho salmon.

DEPARTMENT OF HEALTH CARE SERVICES

ABBREVIATED NOTICE OF GENERAL PUBLIC INTEREST PROPOSED SECTION 1115 DEMONSTRATION AMENDMENT AND RENEWAL APPLICATION

This abbreviated public notice provides information of public interest regarding a proposed amendment and renewal request to the federal Centers for Medicare & Medicaid Services (CMS) for the Medi-Cal 2020 Section 1115 demonstration by the

California Department of Health Care Services (DHCS), to be renamed the California Advancing & Innovating Medi-Cal (CalAIM) Section 1115 demonstration. DHCS is seeking this demonstration approval to implement key provisions of its CalAIM initiative. DHCS will also concurrently seek from CMS an amendment and renewal of the existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver to consolidate Medi-Cal managed care, dental managed care, SMHS, and Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single authority.

The CalAIM Section 1115 demonstration will amend and renew the Medi-Cal 2020 demonstration, currently in effect through December 31, 2021. The effective term of the proposed amendment and renewal for the CalAIM Section 1115 demonstration is January 1, 2022, to December 31, 2026. All proposed requests are subject to approval by CMS.

A copy of the proposed CalAIM Section 1115 demonstration and initial notice of public interest, both posted on April 6, 2021, is available on the DHCS website at <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>.

The CalAIM proposal is posted on the DHCS website at <https://www.dhcs.ca.gov/calaim>.

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that are proposed to continue under the CalAIM Section 1115 demonstration:

- Global Payment Program (GPP)
- Expenditure Authority for Residential Treatment for Substance Use Disorder (SUD) in Institutions for Mental Diseases (IMDs)
- Low-Income Pregnant Women (109 percent-138 percent of the federal poverty level (FPL))
- Out-of-State Former Foster Care Youth
- Community-Based Adult Services (CBAS)
- DMC-ODS Certified Public Expenditure (CPE) Protocols
- Designated State Health Care Programs (DSHP)

Following are the elements of the CalAIM initiative that are proposed for inclusion under the CalAIM Section 1115 demonstration:

- Waiver of Statewideness and Comparability for Peer Support Specialist Services in Drug Medi-Cal Counties That Opt In



Friday, April 9, 2021 (Cont'd)

Link: <https://oal.ca.gov/wp-content/uploads/sites/166/2021/04/2021-Notice-Register-Number-15-Z-April-9-2021.pdf>

CALIFORNIA REGULATORY NOTICE REGISTER 2021, VOLUME NUMBER 15-Z

- Services for Justice-Involved Populations 30 Days Pre-Release
- Providing Access and Transforming Health (PATH) Supports
- DMC-ODS Traditional Healers and Natural Helpers

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that DHCS proposes to authorize via an alternate authority:

- Medi-Cal Managed Care, including the Coordinated Care Initiative (CCI), Program of All-Inclusive Care for the Elderly (PACE) as an Alternative Delivery System in Select County-Organized Health Systems (COHS), and managed care for Seniors with Disabilities (SPDs). Medi-Cal Managed Care as transitioned to the 1915(b) waiver includes other proposed changes which are described in greater detail in the 1915(b) overview.
- Dental Managed Care
- DMC-ODS (except the services that will remain in the 1115 demonstration)

Following are the elements of the Medi-Cal 2020 Section 1115 demonstration that will or have sunset and are not included for renewal under the CalAIM Section 1115 demonstration. Key elements of these programs will be incorporated into either the Medi-Cal State Plan or the consolidated 1915(b) waiver that DHCS is seeking.

- Dental Transformation Initiative (DTI)
- Health Homes Program (HHP)
- Tribal Uncompensated Care (UCC)
- Rady California Children's Services (CCS) Pilot
- Whole Person Care (WPC) Pilots
- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

PUBLIC REVIEW AND COMMENTS

DHCS will host the following public hearings to solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Monday, April 26, 2021 — First Public Hearing
 - 1:00–2:30 p.m. PT
 - Register for Zoom conference link: https://manatt.zoom.us/webinar/register/WN_csWzNuSFQiiY46ZinTufLg
 - Please register in advance to receive your unique login details and link to add to calendar

- Call-in information (669) 900–6833 or (888) 788–0099 (Toll Free)

■ Webinar ID: 944 4865 1547

■ Passcode: 042621

■ Callers do not need an email address to use the phone option and do not need to register in advance

- Monday, May 3, 2021 — Second Public Hearing

- 2:00–3:30 p.m. PT

- Register for Zoom conference: https://manatt.zoom.us/webinar/register/WN_dj9UAypdQ76aOtCXafuhSA

■ Please register in advance to receive your unique login details and link to add to calendar

- Call-in information (669) 900–6833 or (888) 788–0099 (Toll Free)

■ Webinar ID: 994 3157 8945

■ Passcode: 050321

■ Callers do not need an email address to use the phone option and do not need to register in advance

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waiver" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899–7413

Comments may also be emailed to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & 1915(b) Waiver" in the subject line of the email message.

To be assured consideration prior to submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 p.m. (Pacific Time) on Thursday, May 6, 2021. Please note that comments will continue to be accepted after May 6, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.



Initial Stakeholder Emails

DHCS Stakeholder Update Email Listserv (Tuesday, April 6, 2021)

From: DHCS Communications <DHCSCommunications@DHCS.CA.GOV>

Sent: Tuesday, April 06, 2021 1:40 PM

Subject: CalAIM waivers: Start of 30-day public comment



California Advancing and Innovating Medi-Cal (CalAIM) Demonstration 30-Day Public Comment and Public Hearings

The Department of Health Care Services (DHCS) has begun a 30-day public comment period for the CalAIM Section 1115 demonstration (or waiver), starting on April 6 and ending on May 6. This email provides background information, links to public comment materials, and information on how to provide feedback during the public comment period.

Background

DHCS is seeking federal approval to implement key provisions of the [CalAIM initiative](#). CalAIM will move California's whole person care approach—first authorized by the [Medi-Cal 2020 Section 1115 demonstration](#)—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM will allow California to take a population health, person-centered approach to providing services, with the goal of improving health outcomes for Medi-Cal and other low-income populations in the state.

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) in December 2015 and ending on December 31, 2021. DHCS also plans to seek an amendment and renewal to expand the



DHCS Stakeholder Update Email Listserv (Cont'd) (Tuesday, April 6, 2021)

existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver and consolidate Medi-Cal managed care, dental managed care, SMHS, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single 1915(b) waiver. Federal regulations require California to seek public comments on the Section 1115 demonstration prior to CMS submission.

Public Comment Materials

All public comment materials can be found on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#); DHCS will update this page throughout the public comment period and application process. The following materials are posted on the webpage:

- [Public Notice](#)
- [Abbreviated Public Notice](#)
- [Proposed CalAIM Section 1115 Demonstration Amendment and Renewal Application](#)
- [Proposed CalAIM Section 1915\(b\) Waiver Overview](#)

Opportunities to Comment

Stakeholders may submit public comments via mail, electronic mail, and/or during two upcoming public hearing webinars (scheduled for April 26 and May 3).

Written Comments

Comments will be accepted via U.S. mail or electronic mail.

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Email comments may be submitted to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the subject line of the email message.

To be assured consideration prior to our submission of the CalAIM Section 1115 demonstration application



DHCS Stakeholder Update Email Listserv (Cont'd) (Tuesday, April 6, 2021)

and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 p.m. PT (Pacific Time) **Thursday, May 6, 2021**. Please note that comments will continue to be accepted after May 6, 2021, but DHCS may not be able to consider those comments prior to our submission of CalAIM waiver applications to CMS.

Public Hearings

DHCS will host the following public hearings to encourage and solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

Monday, April 26 – First Public Hearing

- 1 – 2:30 p.m. PT
- Register for Zoom conference link:
https://manatt.zoom.us/webinar/register/WN_csWzNuSFQiiY46ZinTufLg
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
- Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 944 4865 1547
 - Passcode: 042621
 - Callers do not need an email address to use the phone option and do not need to register in advance

Monday, May 3 – Second Public Hearing

- 2 – 3:30 p.m. PT
- Register for Zoom conference:
https://manatt.zoom.us/webinar/register/WN_dj9UAypdQ76aOtCXafuhSA
 - Please register in advance to receive your unique login details and link to add to calendar
- Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 994 3157 8945
 - Passcode: 050321
 - Callers do not need an email address to use the phone option and do not need to register in advance

For individuals with disabilities, DHCS will provide assistive devices, including sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into Braille, large print, audiocassette, or computer disk. To request these services or copies in an alternate format, please call or write:

Department of Health Care Services
Director's Office
P. O. Box 997413, MS 0000, Sacramento, CA 95899-7413
(916) 440-7400
Email: CalAIMWaiver@dhcs.ca.gov

Please note that the range of assistive services available may be limited if requests are received less than ten working days prior to the meeting or event.



Legislative & Governmental Affairs Email (Tuesday, April 6, 2021)

From: Rolland, Melissa@DHCS <Melissa.Rolland@dhcs.ca.gov>

Sent: Tuesday, April 6, 2021 11:11 AM

Subject: DHCS: CalAIM Demonstration 30-Day Public Comment and Public Hearings

The Department of Health Care Services (DHCS) has begun a 30-day public comment period for the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration (or waiver), starting on April 6 and ending on May 6. This email provides background information, links to public comment materials, and information on how to provide feedback during the public comment period.

Background

DHCS is seeking federal approval to implement key provisions of the [CalAIM initiative](#). CalAIM will move California's whole person care approach—first authorized by the [Medi-Cal 2020 Section 1115 demonstration](#)—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM will allow California to take a population health, person-centered approach to providing services, with the goal of improving health outcomes for Medi-Cal and other low-income populations in the state.

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) in December 2015 and ending on December 31, 2021. DHCS also plans to seek an amendment and renewal to expand the existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver and consolidate Medi-Cal managed care, dental managed care, SMHS, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single 1915(b) waiver. Federal regulations require California to seek public comments on the Section 1115 demonstration prior to CMS submission.

Public Comment Materials

All public comment materials can be found on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#); DHCS will update this page throughout the public comment period and application process. The following materials are posted on the webpage:

- [Public Notice](#)
- [Abbreviated Public Notice](#)
- [Proposed CalAIM Section 1115 Demonstration Amendment and Renewal Application](#)
- [Proposed CalAIM Section 1915\(b\) Waiver Overview](#)

Opportunities to Comment

Stakeholders may submit public comments via mail, electronic mail, and/or during two upcoming public hearing webinars (scheduled for April 26 and May 3).

Written Comments

Comments will be accepted via U.S. mail or electronic mail.

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Email comments may be submitted to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the subject line of the email message.

To be assured consideration prior to our submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 p.m. PT (Pacific Time) **Thursday, May 6, 2021**. Please note that comments will continue to be accepted after May 6, 2021, but DHCS may not be able to consider those comments prior to our submission of CalAIM waiver applications to CMS.



Legislative & Governmental Affairs Email (Cont'd) (Tuesday, April 6, 2021)

Public Hearings

DHCS will host the following public hearings to encourage and solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Monday, April 26 – First Public Hearing
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 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 944 4865 1547
 - Passcode: 042621
 - Callers do not need an email address to use the phone option and do not need to register in advance

- Monday, May 3 – Second Public Hearing
 - 2 – 3:30 p.m. PT
 - Register for Zoom conference: https://manatt.zoom.us/webinar/register/WN_dj9UAypdQ76aOtCXafuhSA
 - Please register in advance to receive your unique login details and link to add to calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
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 - Callers do not need an email address to use the phone option and do not need to register in advance

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Department of Health Care Services
Director's Office
P. O. Box 997413, MS 0000, Sacramento, CA 95899-7413
(916) 440-7400
Email: CalAIMWaiver@dhcs.ca.gov

Please note that the range of assistive services available may be limited if requests are received less than ten working days prior to the meeting or event.

Thank you,

Melissa Rolland

Assistant Deputy Director
Office of Legislative and Governmental Affairs
Department of Health Care Services
(916) 440-7500



Tribal & Indian Health Program Email (Wednesday, April 7, 2021)

From: Zubiante, Andrea@DHCS <Andrea.Zubiante@dhcs.ca.gov>
Sent: Wednesday, April 07, 2021 3:53 PM
Subject: Notice of Proposed Change to the Medi-Cal Program

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration 30-Day Tribal and Indian Health Program Public Comment & Public Hearings

The Department of Health Care Services (DHCS) has begun a 30-day Tribal and Indian Health Programs public comment period of the CalAIM Section 1115 demonstration (or waiver) and Section 1915(b) waiver, starting on April 7 and ending on May 7. This email provides background information, links to public comment materials, and information on how to provide feedback during the public comment period.

Background

DHCS is seeking the federal approval to implement key provisions of the [CalAIM initiative](#). CalAIM will move California's whole person care approach—first authorized by the [Medi-Cal 2020 Section 1115 demonstration](#)—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM will allow California to take a population health, person-centered approach to providing services with the goal of improving health outcomes for Medi-Cal and other low-income populations in the state.

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) in December 2015 and ending on December 31, 2021. DHCS also plans to seek an amendment and renewal to expand the existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver and consolidate Medi-Cal managed care, dental managed care, SMHS, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single 1915(b) waiver.

DHCS is required to seek advice from Tribes and designees of Indian Health Programs on Medi-Cal matters having a direct effect on American Indians, Indian Health Programs or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009. DHCS must solicit the advice of designees prior to submission to CMS of any State Plan Amendments (SPAs), waiver requests or amendments, or proposals for demonstration projects in the Medi-Cal program.

Public Comment Materials

All public comment materials can be found on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#) and [Indian Health Program webpage](#); DHCS will update these pages throughout the public comment period and application process. The following materials are posted on the websites:

- [Tribal and Designees of Indian Health Programs Public Notice](#)
- [Public Notice](#)
- [Abbreviated Public Notice](#)
- [Proposed CalAIM Section 1115 Demonstration Amendment and Renewal Application](#)
- [Proposed CalAIM Section 1915\(b\) Waiver Overview](#)



Tribal & Indian Health Program Email (Cont'd) (Wednesday, April 7, 2021)

Opportunities to Comment

Tribes, Indian Health Programs, and other stakeholders may submit public comments via mail, electronic mail, and/or during an upcoming public hearing webinar (scheduled for April 30).

Written Comments

Comments will be accepted via U.S. mail or electronic mail.

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Email comments may be submitted to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the subject line of the email message.

To be assured consideration prior to our submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 PM PT (Pacific Time) **Friday, May 7, 2021**. Please note that comments will continue to be accepted after May 7, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.

Public Hearings

DHCS will host a public hearing to encourage and solicit comments from Tribes and Indian Health Programs. The public hearing will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meeting will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Friday, April 30, 2021 – Tribal and Designees of Indian Health Programs Webinar for CalAIM Waivers
 - 2:00 – 3:30 PM PT
 - Register for Zoom conference link: https://manatt.zoom.us/webinar/register/WN_-karjUOkQmKZaLd1DghbJQ
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 942 9300 6698
 - Passcode: 043021
 - Callers do not need an email address to use the phone option and do not need to register in advance

For individuals with disabilities, DHCS will provide assistive devices such as sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into Braille, large print, audiocassette, or computer disk. To request such services or copies in an alternate format, please call or write:

Department of Health Care Services
Director's Office
P. O. Box 997413, MS 0000, Sacramento, CA 95899-7413
(916) 440-7400
Email: CalAIMWaiver@dhcs.ca.gov

Please note, the range of assistive services available may be limited if requests are received less than ten working days prior to the meeting or event.

In addition, two public hearings for the general public will be held on: Monday, April 26, 2021 and Monday, May 3, 2021. Additional information about these hearings is available on the [DHCS CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#).

Tribal and Indian Health Programs Quarterly Webinar

In addition to the webinar listed above, DHCS will also review the Section 1115 demonstration and Section 1915(b) waiver proposals during the DHCS Tribal and Designees of Indian Health Programs Quarterly Webinar.

- Friday, May 28, 2021
 - 2:00 – 3:00 PM PT
 - Register for conference: <https://dhcs.webex.com/dhcs/j.php?MTID=m67280e5c5d99e0a4cd76d08cc7c245cb>
 - Please register in advance to receive your unique login details and link to add the webinar to your calendar
 - Call-in information: 1-415-655-0001
 - Webinar ID: 145 248 1251
 - Passcode: PRIHD



Stakeholder Reminder Emails

DHCS Stakeholder Update Email Listserv (Friday, April 16, 2021)

From: DHCS Communications <DHCSCommunications@DHCS.CA.GOV>

Sent: Friday, April 16, 2021 6:19 PM

Subject: Significant Updates of Interest to DHCS Stakeholders



Dear Stakeholders,

The Department of Health Care Services (DHCS) is providing this update of significant developments regarding DHCS programs, including guidance related to the COVID-19 public health emergency (PHE).

Increased Access to Student Behavioral Health Services

DHCS is providing the attached fact sheet related to the increased access to student behavioral health services [proposal](#) included in the 2021 Governor's Budget. The fact sheet describes the \$400 million proposal for incentive payments paid through Medi-Cal managed care plans (MCPs) to better integrate behavioral health services in schools by building infrastructure, partnerships, and capacity statewide. DHCS will work with MCPs, county behavioral health departments, and schools to further refine this proposal.

MCP Procurement Update

On April 13, DHCS [released a memorandum](#) to counties and MCPs participating in the upcoming procurement



DHCS Stakeholder Update Email Listserv (Cont'd) (Friday, April 16, 2021)

of commercial Medi-Cal MCPs. The memo provides details on an optional county letter of support for potential MCPs to include as part of their Request for Proposal (RFP) submission. The optional letter, which must be included with the final RFP to be part of the evaluation and scoring process, demonstrates the county's support for the MCP.

The memo identifies and takes into account the counties that submitted a preliminary letter of interest or a full letter of intent on or before March 31 for potentially changing the MCP model type operating in the county. Counties that only submitted a preliminary letter of interest must submit a full letter of intent by April 30, but a county letter of support can still be submitted for these counties.

DHCS will evaluate an RFP submission without a county letter of support. A letter is only applicable for counties where DHCS is procuring more than one commercial plan. Therefore, a county letter of support is not applicable for County Organized Health Systems (COHS) or Two-Plan model counties.

DHCS intends to release the final RFP in late 2021. Contract awards are anticipated in mid-2022, and MCP operational readiness activities will begin shortly thereafter. If MCPs successfully demonstrate operational readiness, implementation is scheduled to begin on January 1, 2024.

California Advancing and Innovating Medi-Cal (CalAIM) Waiver Public Comments/Hearings

DHCS is currently conducting a 30-day public comment period for the proposed CalAIM Section 1115 demonstration. Stakeholders have the opportunity to submit comments via email and written correspondence, as well as during two public webinars scheduled for April 26 and May 3. DHCS will host a separate hearing for Tribal public comments on April 30. Additional information, including the proposed CalAIM Section 1115 demonstration renewal application and Section 1915(b) overview, how to submit public comments, and how to participate in a public hearing, is available on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#). The public comment period concludes on May 6 at 11:59 p.m. Pacific Time.



DHCS Stakeholder Update Email Listserv (Cont'd) (Friday, April 16, 2021)

COVID-19 Vaccination Information and Access

In response to access barriers faced by certain populations and individuals who are inappropriately being charged for COVID-19 vaccine fees, the Health Resources and Services Administration has developed COVID-19 patient and provider [fact sheets](#) available in English and Spanish. The fact sheets serve as a reminder that vaccines, testing, and treatment for COVID-19 are free to all individuals living in the United States, regardless of immigration status. Please share the [materials](#) widely with those who may find this information helpful.

Additional Published COVID-19 PHE Guidance

- [SPA 21-0027: Disaster Relief for the Golden State Supplement and Grant - April 9, 2021](#)

Additional updates will be posted to the [DHCS COVID-19 Response page](#).

Thank you,

Department of Health Care Services

www.dhcs.ca.gov





Tribal & Indian Health Program Email (Wednesday, April 21, 2021)

From: Zubiante, Andrea@DHCS <Andrea.Zubiante@dhcs.ca.gov>
Sent: Wednesday, April 21, 2021 2:58 PM
Subject: Reminder: Notice of Proposed Change to the Medi-Cal Program

California Advancing and Innovating Medi-Cal (CalAIM) Demonstration 30-Day Tribal and Indian Health Program Public Comment & Public Hearings

The Department of Health Care Services (DHCS) began a 30-day Tribal and Indian Health Programs public comment period of the CalAIM Section 1115 demonstration (or waiver) and Section 1915(b) waiver, starting on April 7 and ending on May 7. This email provides background information, links to public comment materials, and information on how to provide feedback during the public comment period.

Background

DHCS is seeking the federal approval to implement key provisions of the [CalAIM initiative](#). CalAIM will move California's whole person care approach—first authorized by the [Medi-Cal 2020 Section 1115 demonstration](#)—to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. The broader multiyear system, program, and payment reforms included in CalAIM will allow California to take a population health, person-centered approach to providing services with the goal of improving health outcomes for Medi-Cal and other low-income populations in the state.

The CalAIM Section 1115 demonstration proposal seeks to amend and renew the Medi-Cal 2020 Section 1115 demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) in December 2015 and ending on December 31, 2021. DHCS also plans to seek an amendment and renewal to expand the existing Specialty Mental Health Services (SMHS) Section 1915(b) waiver and consolidate Medi-Cal managed care, dental managed care, SMHS, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) under a single 1915(b) waiver.

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Public Comment Materials

All public comment materials can be found on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#) and [Indian Health Program webpage](#); DHCS will update these pages throughout the public comment period and application process. The following materials are posted on the websites:

- [Tribal and Designees of Indian Health Programs Public Notice](#)
- [Public Notice](#)
- [Abbreviated Public Notice](#)
- [Proposed CalAIM Section 1115 Demonstration Amendment and Renewal Application](#)
- [Proposed CalAIM Section 1915\(b\) Waiver Overview](#)

Opportunities to Comment

Tribes, Indian Health Programs, and other stakeholders may submit public comments via mail, electronic mail, and/or during an upcoming public hearing webinar (scheduled for April 30).

Written Comments

Comments will be accepted via U.S. mail or electronic mail.

Written comments may be sent to the following address; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

Email comments may be submitted to CalAIMWaiver@dhcs.ca.gov. Please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the subject line of the email message.

To be assured consideration prior to our submission of the CalAIM Section 1115 demonstration application and Section 1915(b) waiver application to CMS, comments must be received no later than 11:59 PM PT (Pacific Time) **Friday, May 7, 2021**. Please note that comments will continue to be accepted after May 7, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.

Public Hearings

DHCS will host a public hearing to encourage and solicit comments from Tribes and Indian Health Programs. The public hearing will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meeting will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

- Friday, April 30, 2021 – Tribal and Designees of Indian Health Programs Webinar for CalAIM Waivers
 - 2:00 – 3:30 PM PT
 - Register for Zoom conference link: https://manatt.zoom.us/webinar/register/WN_-kariUOkQmKZaLd1DqhbJQ
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 942 9300 6698
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Tribal & Indian Health Program Email (Cont'd) (Wednesday, April 21, 2021)

For individuals with disabilities, DHCS will provide assistive devices such as sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into Braille, large print, audiocassette, or computer disk. To request such services or copies in an alternate format, please call or write:

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In addition, two public hearings for the general public will be held on: Monday, April 26, 2021 and Monday, May 3, 2021. Additional information about these hearings is available on the [DHCS CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#).

Tribal and Indian Health Programs Quarterly Webinar

In addition to the webinar listed above, DHCS will also review the Section 1115 demonstration and Section 1915(b) waiver proposals during the DHCS Tribal and Designees of Indian Health Programs Quarterly Webinar.

- Friday, May 28, 2021
 - 2:00 – 3:00 PM PT
 - Register for conference: <https://dhcs.webex.com/webappng/sites/dhcs/meeting/info/f1d495fb50d34ac68e0d25e5c81a827e?isPopupRegisterView=true>. Please register in advance to receive your unique login details and link to add the webinar to your calendar
 - Call-in information: 1-415-655-0001
 - Webinar ID: 145 248 1251
 - Passcode: PRIHD



DHCS Stakeholder Update Email Listserv (Friday, April 23, 2021)

From: DHCS Communications <DHCSCommunications@DHCS.CA.GOV>

Sent: Friday, April 23, 2021 6:18 PM

Subject: Significant Updates of Interest to DHCS Stakeholders



Dear Stakeholders,

The Department of Health Care Services (DHCS) is providing this update of significant developments regarding DHCS programs, including guidance related to the COVID-19 public health emergency (PHE).

California Advancing and Innovating Medi-Cal (CalAIM) Waiver Public Comments/Hearings

As a reminder, DHCS is conducting a 30-day public comment period for the proposed CalAIM Section 1115 demonstration. CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of Californians by implementing broad delivery system, program, and payment reform across Medi-Cal.

Stakeholders have the opportunity to submit comments via email and written correspondence, as well as during two public webinars scheduled for April 26 and May 3. DHCS will host a separate hearing for Tribal public comments on April 30.

Additional information, including the proposed CalAIM Section 1115 demonstration renewal application and Section 1915(b) overview, how to submit public comments, and how to participate in a public hearing, is available on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#). The public comment period concludes on May 6 at 11:59 p.m. Pacific Time.



DHCS Stakeholder Update Email Listserv (Cont'd) (Friday, April 23, 2021)

Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Resources

DHCS recently released resources that provide information about the ECM and ILOS components of the CalAIM initiative. They include individual facts sheets on [ECM](#) and [ILOS](#) and [Frequently Asked Questions \(FAQ\)](#) that provide answers to some of the most common questions about ECM & ILOS. The FAQ document will be updated throughout the year with new information as it becomes available.

CalAIM MLTSS and Duals Integration May Workgroup Meeting

On May 6 at 12:30 p.m., DHCS will hold its third meeting of the [CalAIM Managed Long-Term Services and Supports \(MLTSS\) and Duals Integration Workgroup](#). The goal of the workgroup is to collaborate with stakeholders on the transition of Cal MediConnect (CMC) to a statewide MLTSS and Dual Eligible Special Needs Plan (D-SNP) aligned enrollment structure.

Stakeholders will have the opportunity to comment on policy, operations, and strategy related to the Department's transition plan for dual eligible individuals within the CalAIM initiative. The workgroup is open to the public. Expected meeting topics include presentations on care coordination and models of care to support dual eligible beneficiaries with dementia, and a discussion on how to support this population under aligned enrollment. The meeting will also include a discussion on the six-month enrollment moratorium for CMC plans ahead of the end of the demonstration and transition to aligned D-SNPs and MLTSS.

You can [register](#) now for the May 6 meeting. Background materials, transcripts, and video recordings of the February and March workgroup meetings, along with additional information about the workgroup, are posted on the CalAIM MLTSS and Duals Integration Workgroup [webpage](#).

U.S. Department of Health and Human Services (HHS) Renews PHE

On April 21, HHS renewed the COVID-19 PHE for a full 90-day extension through July 20, 2021. The formal PHE declaration was posted on the HHS [website](#).

Thank you,

Department of Health Care Services
www.dhcs.ca.gov





DHCS Stakeholder Update Email Listserv (Friday, April 30, 2021)

From: DHCS Communications <DHCSCommunications@DHCS.CA.GOV>

Sent: Friday, April 30, 2021 7:06 PM

Subject: Significant Updates of Interest to DHCS Stakeholders



Dear Stakeholders,

The Department of Health Care Services (DHCS) is providing this update of significant developments regarding DHCS programs, including guidance related to the COVID-19 public health emergency (PHE).

Request for Proposal (RFP): Dental Fiscal Intermediary

On May 7, DHCS will release a RFP for a new Dental Fiscal Intermediary-Dental Business Operations (FI-DBO) contractor (currently known as the Administrative Services Organization). The Dental FI-DBO contractor performs business service functions for dental services provided through the Medi-Cal fee-for-service delivery system. The FI-DBO adjudicates claims and treatment authorization requests, enrolls providers, and oversees provider and member services, including the telephone service center.

The draft RFP will be posted on the DHCS [website](#) to solicit input from interested parties, including prospective bidders, providers, advocates, counties, and other stakeholders. The feedback received will be considered during the development of the final RFP. Comments on the draft RFP are due by **5 p.m. on May 28**.



DHCS Stakeholder Update Email Listserv (Cont'd) (Friday, April 30, 2021)

California Advancing and Innovating Medi-Cal (CalAIM) Waiver Public Comments/Hearings

As a reminder, DHCS is conducting a 30-day public comment period for the proposed CalAIM Section 1115 demonstration. CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of Californians by implementing broad delivery system, program, and payment reform across Medi-Cal.

Stakeholders have the opportunity to submit comments via email and written correspondence, as well as during public webinars. The final public hearing is scheduled for May 3.

Additional information, including the proposed CalAIM Section 1115 demonstration renewal application and Section 1915(b) overview, how to submit public comments, and how to participate in the final public hearing, is available on the [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#). The public comment period concludes on May 6 at 11:59 p.m. Pacific Time.

Grant Funding Opportunity for Health Center Program Look-Alikes

The Health Resources & Services Administration (HRSA) recently announced \$145 million in one-time grant funding available to eligible Health Center Program look-alikes (LALs). Made available under the American Rescue Plan, the funding will support designated LALs in responding to and mitigating the spread of COVID-19, strengthening vaccination efforts, and enhancing health care services and infrastructure in communities across the country. LALs are community-based health care providers that provide essential primary care services to underserved communities and vulnerable populations, but are not Health Center Program grantees. More information is available on the HRSA [website](#).

Additional Published COVID-19 PHE Guidance

- [APL 20-022 \(Revised\): COVID-19 Vaccine Administration](#)

Additional updates will be posted to the [DHCS COVID-19 Response page](#).

Thank you,

Department of Health Care Services

www.dhcs.ca.gov





DHCS Website Updates

DHCS Homepage (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/>

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DEPARTMENT OF HEALTH CARE SERVICES

Important Change to Federal Public Charge Rule

Immigrants and their loved ones across California can seek and accept medical care, food assistance and public housing without fear or confusion about public charge consequences, thanks to changes in federal policy. The [U.S. Department of Homeland Security has stated](#) that it will return to using policies in place before the 2019 Public Charge Final Rule. Check the [U.S. Citizenship and Immigration Services webpage on Public Charge](#) for updates.

[LEARN MORE](#)

California Advancing and Innovating Medi-Cal

CalAIM is a DHCS initiative to reform the Medi-Cal program and, in turn, improve the quality of life and health outcomes of Medi-Cal members. We will implement broad delivery system, program and payment reform across the Medi-Cal system, building upon the successful outcomes of various pilots.

▶ [CalAIM Section 1115 Demonstration Public Comment](#)

[LEARN MORE](#)

COVID-19 Latest Updates

- ▶ [DHCS COVID-19 Vaccine Administration FAQs for Beneficiaries](#)
- ▶ [DHCS COVID-19 Vaccine Administration FAQs for Providers](#)
- ▶ [SPA 21-0016 CMS-Approved State Plan Amendment](#)
- ▶ [SPA 20-0040 - CMS-Approved State Plan Amendment](#)
- ▶ [CMS Fourth Approval of Additional 1135 Waivers](#)

[MORE UPDATES](#)



DHCS Homepage (Cont'd) (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/>

Updates

- ▶ [CalAIM Section 1115 Demonstration Public Comment](#)
- ▶ [Stakeholder Communication Update – April 2021](#)
- ▶ [DHCS 12-Month Extension of Medi-Cal 2020 Waiver](#)
- ▶ [California Awards Grants to Help Medi-Cal Providers Learn About Adverse Childhood Experiences](#)
- ▶ [Notice Regarding State Nondiscrimination Requirements](#) - Updated June 13, 2020

Laws & Policies

- ▶ Updated: CHHS Agency Public Charge Guide (English) (Spanish)
- ▶ [Medicaid Managed Care Final Rule](#)
- ▶ [Medi-Cal 2020 Waiver](#)
- ▶ [Proposed State Plan Amendments](#)
- ▶ [DHCS Strategic Plan \(PDF\)](#)

Popular Searches

- ▶ [Other Health Coverage \(OHC\)](#)
- ▶ [Form 1095-B](#)
- ▶ [Health Insurance Premium Payment \(HIPP; form 9061\)](#)
- ▶ [Protected Health Information \(forms 6247 and 6236\)](#)
- ▶ [California Children's Services Program \(CCS\)](#)

Resources

- ▶ [Emergency Resources](#)
- ▶ [Calendar of Events](#)
- ▶ [DHCS A-Z index](#)
- ▶ [Medi-Cal Waivers](#)
- ▶ [Privacy & HIPAA](#)
- ▶ [Stakeholder Engagement](#)

Affiliated Sites

- ▶ [Health Care Options \(Managed Care\)](#)
- ▶ [Medi-Cal Dental](#)
- ▶ [Medi-Cal Providers](#)
- ▶ [Family PACT](#)
- ▶ [Open Data Portal](#)
- ▶ [Public Records Act](#)

<p>California Governor</p> <p>Gavin Newsom</p> <p>Governor's Website</p>	
<p>CHHS Secretary</p> <p>Mark Ghaly</p> <p>Secretary's Website</p>	
<p>DHCS Director</p> <p>Will Lightbourne</p> <p>Director's Website</p>	



CalAIM 1115 Demonstration & 1915(b) Waiver Webpage (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

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[Return to CalAIM Homepage](#)

CalAIM 1115 Demonstration & 1915(b) Waiver

California is requesting federal authority necessary to implement California Advancing & Innovating Medi-Cal (CalAIM), a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program. CalAIM recognizes the opportunity to move California's whole-person care approach – first authorized by the Medi-Cal 2020 Section 1115 demonstration – to a statewide level, with a clear focus on improving health and reducing health disparities and inequities. Collectively, the Section 1115 CalAIM demonstration and Section 1915(b) waiver, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high needs, hard-to-reach populations, with the objective of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the state.

Since 2018, DHCS has been working closely with stakeholders to design a transformation of key aspects of the Medi-Cal delivery system in order to accomplish three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing social determinants of health;
2. Move Medi-Cal to a more consistent and seamless system by increasing alignment across delivery systems, reducing complexity and increase flexibility; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

In 2019 and early 2020, DHCS conducted extensive stakeholder engagement for proposed CalAIM initiatives. CalAIM implementation was originally scheduled to begin in January 2021 but was delayed due the impact of the COVID-19 public health emergency. In light of this delay, on December 29, 2020 DHCS received approval from the Centers for Medicare & Medicaid Services (CMS) for a 12-month extension (through December 31, 2021) of the existing Medi-Cal 2020 Section 1115 demonstration. DHCS is currently preparing a request for a five-year renewal, with amendment, of the Medi-Cal 2020 Section 1115 demonstration, along with a comprehensive Section 1915(b) managed care waiver request that would also be for a five-year period. This webpage will be updated regularly as California seeks comments on and submits its CalAIM demonstration and waiver for federal approval. Pending negotiations with CMS, the CalAIM initiative is scheduled to begin implementation on January 1, 2022.



CalAIM 1115 Demonstration & 1915(b) Waiver Webpage (Cont'd) (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

The screenshot shows the DHCS website header with the CA.GOV logo, social media icons, and navigation links. The main content area is titled "State Public Comment Opportunities" and contains the following text:

The draft CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview are available for public review during the upcoming State public comment period starting April 6.

- [Proposed CalAIM Section 1115 demonstration amendment and renewal application](#)
- [Proposed Section 1915\(b\) waiver overview](#)
- [Public notice](#)
- [Abbreviated public notice](#)

The 30-day public comment period for the CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview will take place from Tuesday, April 6, 2021 through Thursday, May 6, 2021. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) **Thursday, May 6, 2021**. Please note that comments will continue to be accepted after May 6, 2021, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS.

DHCS is inviting comments from stakeholders during two upcoming public hearing webinars, email, and/or mail.

- **Public Hearing.** DHCS will host the following public hearings to solicit stakeholder comments. The public hearings will be held electronically to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.
- Monday, April 26, 2021 – First Public Hearing
 - 1:00 – 2:30 PM PT
 - Register for Zoom conference link: https://manatt.zoom.us/webinar/register/WN_csWzNuSFQiiY46ZinTuflg
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 944 4865 1547
 - Passcode: 042621
 - Callers do not need an email address to use the phone option and do not need to register in advance



CalAIM 1115 Demonstration & 1915(b) Waiver Webpage (Cont'd) (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

- Monday, May 3, 2021 – Second Public Hearing
 - 2:00 – 3:30 PM PT
 - Register for Zoom conference: https://manatt.zoom.us/webinar/register/WN_dj9UAypdQ76aOtcXafuhSA
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
 - Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 994 3157 8945
 - Passcode: 050321
 - Callers do not need an email address to use the phone option and do not need to register in advance
- Email.** You may send comments to CalAIMWaiver@dhcs.ca.gov; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the subject line of the email message.
- Mail-in.** You may send written comments to the following address below; please indicate "CalAIM Section 1115 & 1915(b) Waivers" in the written message:

Department of Health Care Services
Director's Office
Attn: Angeli Lee and Amanda Font
P.O. Box 997413, MS 0000
Sacramento, California 95899-7413

You may request a copy of the proposed CalAIM Section 1115 demonstration application; CalAIM Section 1915(b) waiver overview; and/or a copy of submitted public comments related to the CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview by sending a written request to the mailing or email address listed above.

For individuals with disabilities, DHCS will provide assistive devices such as sign-language interpretation, real-time captioning, note takers, reading or writing assistance, and conversion of training or meeting materials into Braille, large print, audiocassette, or computer disk. To request such services or copies in an alternate format, please call or write:

Director's Office
P. O. Box 997413, MS 0000, Sacramento, CA 95899-7413
(916) 440-7400
Email: CalAIMWaiver@dhcs.ca.gov

Please note, the range of assistive services available may be limited if requests are received less than ten working days prior to the meeting or event.



CalAIM 1115 Demonstration & 1915(b) Waiver Webpage (Cont'd) (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx>

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After DHCS reviews comments submitted during this State public comment period, the CalAIM Section 1115 demonstration and Section 1915(b) waiver will be submitted to CMS. Upon submission to CMS, a copy of the proposed CalAIM Section 1115 demonstration and Section 1915(b) waiver will be published on this webpage. Interested parties will also have the opportunity to officially comment on the CalAIM Section 1115 demonstration during the federal public comment period; the submitted application will be available for comment on the CMS website (<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81046>). There is no federal public comment period for the 1915(b) waiver.

General Resources

- [CalAIM homepage](#)
- [Current Medi-Cal 2020 Section 1115 Demonstration on Medicaid.gov](#) (external link to CMS' website)
- [Medi-Cal 2020 Section 1115 demonstration 12-month extension webpage](#)
- [Medi-Cal 2020 Section 1115 demonstration webpage](#)
- [SMHS Section 1915\(b\) waiver webpage](#)
- [DHCS Indian Health Program webpage](#)

Stakeholder Engagement

DHCS values your input and will update this page shortly with information about CalAIM demonstration public comment opportunities. For more information about the CalAIM initiative and stakeholder engagement process, please visit the [CalAIM homepage](#) or contact CalAIMWaiver@dhcs.ca.gov.

[Subscribe](#) if you wish to be added to the DHCS stakeholder email service.

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CalAIM Webpage (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx>

CalAIM Waiver Public Comment

The draft CalAIM Section 1115 demonstration application and Section 1915(b) waiver overview are available for public review starting April 6:

- [Proposed CalAIM Section 1115 demonstration amendment and renewal application](#)
- [Proposed Section 1915\(b\) waiver overview](#)
- [Public notice](#)

The 30-day public comment period for the CalAIM Section 1115 demonstration application is from Tuesday, April 6, 2021 through Thursday, May 6, 2021. To be assured consideration prior to submission to CMS, comments must be received no later than 11:59 PM (Pacific Time) Thursday, **May 6, 2021**. Please note that comments will continue to be accepted after **May 6, 2021**, but DHCS may not be able to consider those comments prior to the initial submission of the CalAIM waiver applications to CMS. For more details on how to submit public comments, visit [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#).

Resources

- [CalAIM 1115 and 1915\(b\) Waiver Renewals](#)
- [Medi-Cal Waivers Homepage](#)
- [1115 Waiver Medi-Cal 2020 Demonstration Homepage](#)
- [1915\(b\) Medi-Cal Specialty Mental Health Services Waiver Homepage](#)

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Medi-Cal Waivers Webpage (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx>

Pending Waivers

- [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#): (Note: DHCS is currently accepting public comments and plans to submit materials to CMS for review later this year)

Additional Resources

- [CalAIM Homepage](#)
- [California Medicaid Waivers Factsheet \(External Link\)](#)
- [HCBS Programs \(External Link to DDS\)](#)
- [Health Care Coverage Initiative](#)
- [Section 1115 Waiver Resources](#)



Section 1115 Medicaid Waiver Resources Webpage (Tuesday, April 6, 2021)

Link: <https://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

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[Back to Medi-Cal Waivers](#)

Section 1115 Medicaid Waiver Resources

California is requesting an amendment and renewal of the state's current Section 1115 demonstration, entitled Medi-Cal 2020, which was approved by the Centers for Medicare & Medicaid Services (CMS) on December 30, 2015, and is effective from January 1, 2016, through December 31, 2021.

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Resources

- [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#)
- [Medi-Cal 2020 Waiver](#)
- [Bridge to Reform Waiver Resources](#)



Medi-Cal Specialty Mental Health Services Webpage (Wednesday, April 7, 2021)

Link: https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx

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"carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver Program which provides SMHS to Medi-Cal beneficiaries through County Mental Health Plans (MHPs). The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals.

DHCS is planning to pursue a renewal and amendment to the SMHS Section 1915(b) waiver – to be called the CalAIM Section 1915(b) waiver – that will include the SMHS program, as well as streamlined authorization for Medi-Cal managed care, dental managed care, and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The CalAIM Section 1915(b) waiver application will be negotiated with CMS and is expected to be implemented on January 1, 2022.

1915(b) SMHS Waiver ▶

- Waiver and Attachments
- Approval Letters
- Special Terms and Conditions

Mental Health Plan Information ▶

- MHP Quality Improvement Plans
- Mental Health Plan Plans of Correction
- Mental Health Plan Performance Improvement Project Information
- Beneficiary Problem Resolution Processes
- MHP Medicaid Managed Care and Parity Information

CalAIM 1915(b) Waiver ▶

- Waiver Overview

Performance Dashboards ▶

- Mental Health Plan Data
- Children and Youth Performance Outcome System

Contracts and State Plan ▶

- Mental Health Plan Contract
- Performance Contract
- Medicaid State Plan

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1915(b) Medi-Cal Specialty Mental Health Services Waiver Webpage (Wednesday, April 7, 2021)

Link: [https://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medi-Cal_Specialty_Mental_Health_Waiver.aspx](https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-Cal_Specialty_Mental_Health_Waiver.aspx)

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1915(b) Medi-Cal Specialty Mental Health Services Waiver

California's 1915(b) SMHS Waiver renewal was approved for a five-year term, July 1, 2015, through June 30, 2020, and includes Special Terms and Conditions (STCs). The STCs are included in the Centers for Medicare & Medicaid Services' (CMS) approval letter below and are geared toward improving program integrity, monitoring, and compliance. Among other requirements, the STCs specifically require the posting of MHP performance data (dashboards), Plans of Correction, and Quality Improvement Plans on the DHCS website.

On March 23, 2021 CMS [approved](#) DHCS' request for a temporary extension of the Medi-Cal Specialty Mental Health Services (SMHS) 1915(b) waiver program through December 31, 2021. This nine-month extension allows DHCS time to develop and obtain approval for specific California Advancing and Innovating Medi-Cal (CalAIM) initiatives, and to align with the proposed one-year extension of the Section 1115 demonstration (Medi-Cal 2020). CalAIM is a multi-year Department of Health Care Services (DHCS) initiative to implement overarching policy changes across all Medi-Cal delivery systems. Throughout 2019 and 2020, DHCS conducted extensive stakeholder engagement for both CalAIM and the Medicaid Section 1115 demonstration renewal. The goal is to transition all existing managed care authorities into one consolidated Section 1915(b) California managed care waiver, with a proposed effective date of January 1, 2022. For more information about the CalAIM initiatives and stakeholder engagement process, please visit the [CalAIM homepage](#) and [CalAIM 1115 Demonstration & 1915\(b\) Waiver webpage](#).

Medi-Cal Specialty Mental Health Services Waiver

- [4-6-2021 - Notice of General Public Interest re: Section 1115 Demonstration and Section 1915\(b\) Waiver Amendment and Renewal Application](#)
- [4-6-2021 - Proposed Section 1915\(b\) waiver overview](#)
- [3-23-2021 - CMS Approval of California's Section 1915\(b\) Specialty Mental Health Services Waiver Extension](#)
- [12-16-2020 - Response from CMS for Extension of California's Section 1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)
- [7-31-2020 - Notice of General Public Interest re: Request Letter for 12-month Extension of California's Section 1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)
- [6-1-2020 - Response from CMS for Extension of California's Section 1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)
- [5-8-2020 - Request Letter for Extension of California's Section 1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)
- [1915\(b\) Medi-Cal Specialty Mental Health Services Waiver](#)
 - [Appendices D1-D7](#)
 - [Attachments 1-16](#)

Waiver Resources

- [June 24, 2015 CMS Approval Letter and STCs](#)
- [October 5, 2016 CMS Supplemental Approval Letter and Certified Public Expenditure Protocols](#)
- [Behavioral Health Stakeholder Advisory Committee \(BH-SAC\)](#)
- [1915\(b\) Waiver Standard Funding Questions](#)
- [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#)
- [CalAIM Homepage](#)

[Back to Medi-Cal Specialty Mental Health Services Page](#)

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Indian Health Program Homepage (Wednesday, April 7, 2021)

Link: <https://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx>

Indian Health Program

The mission of the Indian Health Program (IHP) is to improve the health status of American Indians living in urban, rural, and reservation or rancheria communities throughout California. Health services for American Indians are based on a special historical legal responsibility identified in treaties with the U.S. government. California voluntarily accepted this responsibility by adopting Public Law (P.L.) 83-280 in 1954, which allowed for State jurisdiction of Indian affairs. The legislative authority for the program is Health and Safety (H&S) Code, Sections 124575 – 124595 and Title XVII Chapter 3.1, Section 1500-1541.



Upcoming Events

- [CalAIM Section 1115 Demonstration & 1915\(b\) Tribal 30-Day Public Comment \(April 7 – May 7, 2021\)](#)
- [Tribal Webinar for CalAIM Waivers \(April 30, 2021\)](#)
- [Tribal public notice \(April 7, 2021\)](#)

IHP Authority and Activities

- [Indian Health Program Regulations](#)

IHP Contact Information

- [DHCS IHP Program Staff](#)

Special Programs

- [American Indian Maternal Support Services Program](#)
- [Emergency Preparedness](#)

Tribal and Indian Health Program Designee Medi-Cal Advisory Process

- [Tribal and Indian Health Program Designee Medi-Cal Advisory Process](#)
- [Notices of Proposed Changes to Medi-Cal Program](#)
- [Meetings, Webinars, and Presentations](#)

Related External Links

- [Centers for Medicaid and Medicare Services \(Not DHCS\)](#)
- [Federal Indian Health Service](#)

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Indian Health Program: Notices or Proposed Changes to Medi-Cal Program Webpage (Wednesday, April 7, 2021)

Link: https://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx

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Quarter Ending June 30, 2021

Tribal/Designee Notifications	Title	Release Date
Demonstration Amendment and Renewal Under Section 1115 of the Social Security Act; Waiver Overview Under Section 1915(b) of the Social Security Act	Notice of Intent to Submit Section 1115 Demonstration Amendment and Renewal and Section 1915(b) Waiver Related to Medi-Cal authorization	04/07/2021

Indian Health Program: Meetings, Webinars, and Presentations Webpage (Wednesday, April 7, 2021)

Link: <https://www.dhcs.ca.gov/services/rural/Pages/MeetingandWebinars.aspx>

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Meetings, Webinars, and Presentations

The following meetings, webinars and presentations contain information related to Department of Health Care Services (DHCS) proposed budget proposals, American Indian Medi-Cal Utilization data, and/or proposed changes to the Medi-Cal Program. The presentations, meeting materials, and webinar recordings are from various DHCS sponsored meetings or webinars, Centers for Medicare & Medicaid Services Outreach & Education Meetings, and Federal Indian Health Services Program Directors' meetings.

Meeting materials, webinars, and presentations are available below:

2021 Meetings/Webinars

Title: Tribal Webinar for CalAIM Waivers

Date: April 30, 2021

- Time: 2:00 – 3:30 PM PT
- Register for conference: https://manatt.zoom.us/webinar/register/WN_-karjUOkOmKZaLd1DghbJO
 - Please register in advance to receive your unique login details and link to add the hearing to your calendar
- Call-in information (669) 900-6833 or (888) 788 0099 (Toll Free)
 - Webinar ID: 942 9300 6698
 - Passcode: 043021
 - Callers do not need an email address to use the phone option and do not need to register in advance

Presentation Materials and Additional Information:

- [Tribal public notice](#) (April 7, 2021)
- [Proposed CalAIM Section 1115 demonstration amendment and renewal application](#) (April 6, 2021)
- [Proposed Section 1915\(b\) waiver overview](#) (April 6, 2021)
- [Public notice](#) (April 6, 2021)



Social Media Posts

In addition to stakeholder emails, DHCS posted on Twitter ([@DHCS_CA](#)) and Facebook ([@DHCS.CA](#)) throughout the public comment period to encourage stakeholders to participate in the CalAIM waiver public hearings and public comment period. DHCS posted reminders about the public hearings and about the upcoming conclusion of the public comment period.

Twitter posts were shared on the following dates and links; an illustrative post and screenshot is included below:

- Wednesday, April 14, 2021:
https://twitter.com/DHCS_CA/status/1382481916713123840?s=20
- Monday, April 19, 2021:
https://twitter.com/DHCS_CA/status/1384176300630233095?s=20
- Thursday, April 22, 2021:
https://twitter.com/DHCS_CA/status/1385282283221958664?s=20
- Monday, April 26, 2021:
https://twitter.com/DHCS_CA/status/1386712993686335490?s=20
- Wednesday, April 28, 2021:
https://twitter.com/DHCS_CA/status/1387437783803904004?s=20
- Friday, April 30, 2021:
https://twitter.com/DHCS_CA/status/1388162321994952707?s=20
- Monday, May 3, 2021:
https://twitter.com/DHCS_CA/status/1389249009961816073?s=20
- Tuesday, May 4, 2021:
https://twitter.com/DHCS_CA/status/1389611395738656768?s=20

Facebook posts were shared on the following dates and links; an illustrative post and screenshot is included below:

- Wednesday, April 14, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal
- Monday, April 19, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal
- Monday, April 26, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal
- Wednesday, April 28, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal
- Friday, April 30, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal



- Monday, May 3, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal
- Tuesday, May 4, 2021:
https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal

Twitter: Wednesday, April 14, 2021

Link: https://twitter.com/DHCS_CA/status/1382481916713123840?s=20



Facebook: Wednesday, April 14, 2021

Link: https://www.facebook.com/pg/DHCS.CA/posts/?ref=page_internal

