



## California Advancing and Innovating Medi-Cal (CalAIM) Executive Summary and Summary of Changes

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California’s most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on individuals’ health and quality of life, and through iterative system transformation, will ultimately reduce per-capita costs over time. DHCS intends to work with the Administration, Legislature and other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals. The “Summary of Changes” table at the end of this document summarizes major changes to the CalAIM proposal since its original release in October 2019.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

### Background and Overview

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

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate Medi-Cal our delivery systems and align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.

Together these CalAIM proposals offer solutions designed to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as the Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and public hospital system delivery transformation, that advance the coordination and delivery of high-quality care for all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It 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.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care, and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

## Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles of the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities 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.

## Key Goals

To achieve such principles, CalAIM has three primary goals:

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

## **Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health**

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

To achieve such goals, DHCS proposes the following whole system, person centered approach

that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Development of a statewide **population health management strategy** and require plans to submit local population health management plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g., housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness (SMI) /Serious Emotional Disturbance (SED) demonstration opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

### Population Health Management

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

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

### Enhanced Care Management

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

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental and oral health needs (e.g., California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

#### In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services

- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

#### [SMI/SED Demonstration Opportunity](#)

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institutional for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily “opt-in” to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

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

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

#### [Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities](#)

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation and overall integration back into the community are met. Studies have shown these types of coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2023. Additionally, DHCS proposes mandating that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

#### [Full Integration Plans](#)

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected plans would not go live no sooner than 2027.

#### [Develop a Long-Term Plan for Foster Care](#)

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.



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

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

To achieve such goals, DHCS proposes the following recommendations.

### **Managed Care**

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

### **Behavioral Health**

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

### **Dental**

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 11 children preventive services codes and continuity of care through a Dental Home

### **County-Based Services**

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



## Managed Care

### *Managed Care Enrollment*

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and requiring all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

### *Standardize Managed Care Benefit*

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

### *Transition to Statewide Managed Long-Term Services and Supports*

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

**January 2022:** The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

**January 2023:** Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

**January 2025:** Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and

are not statewide.

### *NCQA Accreditation of Medi-Cal Managed Care Plans*

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

### *Regional Rates*

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

### Behavioral Health

#### *Behavioral Health Payment Reform*

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our 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 shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

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

### *Revisions to Behavioral Health Medical Necessity*

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and SUD services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

### *Administrative Behavioral Health Integration*

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

### *Behavioral Health Regional Contracting*

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

### *DMC-ODS Program Renewal and Policy Improvements*

DHCS proposes to update the DMC-ODS program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

### Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for

eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

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

## County Partners

### *Enhancing County Oversight and Monitoring: Eligibility*

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

### *Enhancing County Oversight and Monitoring: CCS and CHDP*

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

### *Improving Beneficiary Contact and Demographic Information*

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

## Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care, and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care into the future of the program. CalAIM will also

support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

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

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

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

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

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

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

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

**Aging Population:** In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of California's Master Plan for Aging.

## **From Medi-Cal 2020 to CalAIM**

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system authorities in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care delivery system.



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

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g., counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

## **CalAIM Stakeholder Engagement**

DHCS' released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM

proposal incorporates the broad range of feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

## Conclusion

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

### CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and SUD services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically -linked housing continuum via in lieu of services for California's homeless population, including housing transitions navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

## Summary of Changes from Original Release in October 2019

Proposal	Key Changes
<b>Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health</b>	
<b>2.1</b> Population Health Management	<ul style="list-style-type: none"> <li>• Implementation delayed until 1/1/23</li> <li>• Adds requirements and clarifications:               <ul style="list-style-type: none"> <li>○ Managed care plans must partner with community-based providers to address members' needs.</li> <li>○ Clarification that population health management strategies should be developed in coordination with both county behavioral health and public health departments.</li> </ul> </li> <li>• Assessment of Risk and Need               <ul style="list-style-type: none"> <li>○ This section underwent substantial edits based on stakeholder feedback. Detail was added on data collection expectations, risk stratification and segmentation, risk tiering, and development of the IRA tool. Predictive algorithms will incorporate the population needs assessment and the NCQA requirements to identify rising risks and communities.</li> </ul> </li> <li>• Adds planned learning collaborative topics and continuing areas of policy development.</li> <li>• Review main document for additional changes, including an update to population health management strategy requirements based on workgroup feedback.</li> </ul>
<b>2.2</b> Enhanced Care Management	<ul style="list-style-type: none"> <li>• Enhanced care management will be implemented using a phased-in approach.               <ul style="list-style-type: none"> <li>○ 1/1/22: Medi-Cal managed care plans in counties with Whole Person Care pilots and/or and Health Homes Programs (HHP) will transition aligning target populations on 1/1/22;</li> <li>○ 7/1/22:                   <ul style="list-style-type: none"> <li>▪ Medi-Cal managed care plans in counties with WPC and/or HHP will implement additional mandatory target populations</li> <li>▪ Medi-Cal managed care plans in counties without WPC or</li> </ul> </li> </ul> </li> </ul>

	Proposal	Key Changes
		<p>HHP will begin implementation of mandatory target populations</p> <ul style="list-style-type: none"> <li>○ 1/1/23: Full implementation of all target populations in all counties.</li> <li>● Appendix I, describing the enhanced care management benefit, its core concepts, and each target population in detail was developed and finalized based on workgroup feedback and added to the document. The descriptions include the target population descriptions and the services included in the benefit specific to each population.</li> <li>● Clarifies that Local Government Agency Targeted Case Management (TCM) will continue (pending CMS approval). It will be the responsibility of managed care plans to ensure services are not being duplicated.</li> <li>● Clarifies that managed care plans will be required to contract with Health Homes community-based care management entities and Whole Person Care providers.</li> <li>● Changes name of Transition Plan to "Transition and Coordination Plan" and added details around timeline and requirements for the plan and the required Model of Care.</li> </ul>
2.3	In Lieu of Services	<ul style="list-style-type: none"> <li>● Implementation delayed until January 1, 2022.</li> <li>● The ILOS menu was revised extensively based on workgroup feedback. Most notably, a 14<sup>th</sup> service, Asthma Remediation, was added. The menu is Appendix J of the CalAIM proposal and includes the following for each service: 1) description, 2) eligibility, 3) restrictions and limitations, 4) allowable providers, and 5) state plan services to be avoided.</li> </ul>
2.4	Shared Risks, Savings and Incentive Payments	<ul style="list-style-type: none"> <li>● Updated timeline: <ul style="list-style-type: none"> <li>○ 2021: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.</li> <li>○ 1/1/22: Begin implementation of managed care plan incentives.</li> <li>○ No sooner than 1/1/23: Begin implementation of a seniors and persons with disabilities/long-term care blended rate.</li> </ul> </li> <li>● Clarifies that the tiered model would be available for three calendar years -- 2023, 2024 and 2025.</li> <li>● Clarifies that a prospective model of shared savings/risk incorporated</li> </ul>

	Proposal	Key Changes
		via capitation rate development would be implemented beginning in calendar year 2026 once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.
2.5	SMI/SED Demonstration Opportunity	<ul style="list-style-type: none"> <li>• Clarifies the implementation timeline and confirms that DHCS will pursue this demonstration opportunity. The waiver proposal would be developed no sooner than 7/1/22, and if approved by CMS, DHCS would work with counties for an expected launch in 2023.</li> <li>• Updates the list of states that have submitted or have an approved 1115 waiver application to CMS.</li> <li>• Updates to the summary of key requirements for the Section 1115 demonstration opportunity.</li> </ul>
2.5	Mandatory Medi-Cal Application Process Upon Release from Jail	<ul style="list-style-type: none"> <li>• Implementation date change to 1/1/23.</li> </ul>
2.6	Full Integration Pilots	<ul style="list-style-type: none"> <li>• Implementation delayed to no sooner than January 2027 to allow sufficient time for planning &amp; preparation, in partnership with counties, plans, and other key stakeholders.</li> </ul>
2.7	Develop a Long-term Plan for Foster Care	<ul style="list-style-type: none"> <li>• Adds details on the workgroup, which launched in June 2020 &amp; will continue to meet until June 2021. DHCS &amp; CDSS will then develop a comprehensive set of recommendations and plan of action based on input from the workgroup.</li> <li>• More information on the workgroup can be found here: <a href="https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx">https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx</a></li> </ul>
<b>Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility</b>		
3.1	Managed Care Benefit Standardization	<ul style="list-style-type: none"> <li>• Clarifies and revises timeline for carved-out and carved-in benefits <ul style="list-style-type: none"> <li>○ Benefits to be carved out: <ul style="list-style-type: none"> <li>▪ 4/1/21: Pharmacy benefits or services by a pharmacy billed on a pharmacy claim</li> <li>▪ 1/1/22: <ul style="list-style-type: none"> <li>• Specialty mental health services for Kaiser Medi-Cal members in Solano and Sacramento</li> </ul> </li> </ul> </li> </ul> </li> </ul>

	Proposal	Key Changes
		<ul style="list-style-type: none"> <li>Counties <ul style="list-style-type: none"> <li>• Multipurpose Senior Services Program (MSSP) in the seven Coordinated Care Initiative (CCI) counties</li> </ul> </li> <li>○ Benefits to be carved-in <ul style="list-style-type: none"> <li>▪ 1/1/22: All major organ transplants</li> <li>▪ 1/1/23: Institutional long-term care services</li> </ul> </li> <li>○ 1/1/23 <ul style="list-style-type: none"> <li>▪ All Medi-Cal managed care plans provide the same benefit package.</li> </ul> </li> <li>• See Appendix F for more details</li> </ul>
3.2	Mandatory Managed Care Enrollment	<ul style="list-style-type: none"> <li>• Implementation date moved to 1/1/22. <ul style="list-style-type: none"> <li>○ Transition to mandatory enrollment of all non-dual eligible beneficiaries that are not currently required to enroll in managed care.</li> </ul> </li> <li>• 1/1/23: Transition to mandatory enrollment of dual eligibles into managed care</li> </ul>
3.3	Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans	<ul style="list-style-type: none"> <li>• Implementation moved to 1/1/27 to align with demonstration renewal periods.</li> <li>• Clarifies the definition of a non-dual, partial dual, and full-dual eligible population.</li> <li>• Clarifies that all dual and non-dual eligible individuals eligible for long-term care services, including long-term care share of cost populations, will transition to Medi-Cal managed care in 2023 (except those already in managed care in COHS and CCI counties).</li> <li>• Per new federal regulations, updated section around limiting Medicare Advantage D-SNP "look-alikes." CMS will not enter into new contracts with look-alikes starting in 2022 and will not renew contracts with look-alikes starting in 2023. DHCS will allow plans in CCI counties with MCP contracts, existing D-SNPs, and existing Medicare Advantage D-SNP look-alikes to transition their dual population enrolled in the look-alike into an existing D-SNP in 2022, prior to the end of CCI.</li> <li>• Clarifies that DHCS will require D-SNPs to use a model of care that supports coordinated care, high-quality care transitions, and information sharing.</li> </ul>

	Proposal	Key Changes
3.4	NCQA Accreditation of Medi-Cal Managed Care Plans	<ul style="list-style-type: none"> <li>• Adds information on LTC carve-in and intersection with mandatory managed care for dual populations with LTC.</li> <li>• Accreditation will be required by 2026.</li> <li>• Clarifies that DHCS will not accept accreditation from agencies besides NCQA.</li> <li>• DHCS will require a Long Term Services and Supports (LTSS) Distinction Survey by 2027 <ul style="list-style-type: none"> <li>○ The survey will only be required after all MCPs have achieved routine health plan accreditation.</li> </ul> </li> <li>• DHCS will not yet require the Medicaid Module but may in the future.</li> <li>• DHCS will not require managed care plans to ensure their non-health plan sub-contractors are NCQA accredited, but may in the future.</li> <li>• Accreditation elements that are selected for potential deeming will be vetted with stakeholders before any final decisions are made.</li> </ul>
3.5	Regional Managed Care Capitation Rates	<ul style="list-style-type: none"> <li>• All implementation timelines moved back a year beginning on 1/1/22. See proposal for more details.</li> </ul>
3.6	Behavioral Health Payment Reform	<ul style="list-style-type: none"> <li>• Earliest start date moved to July 1, 2022.</li> <li>• Adds a proposal to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.</li> <li>• Clarifies transition from HCPCS Level II coding to CPT coding for specialty mental health services and SUD services.</li> <li>• Clarifies the rate setting methodology establishing reimbursement rates based on peer grouping. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component.</li> <li>• Added a bullet to rational "Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value"</li> </ul>
3.7	Medical Necessity Criteria	<ul style="list-style-type: none"> <li>• Implementation moved to 1/1/22.</li> <li>• Based on extensive stakeholder feedback, this proposal required a full</li> </ul>



	Proposal	Key Changes
		<p>re-write.</p> <ul style="list-style-type: none"> <li>• Proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.</li> <li>• Proposes to clarify EPSDT protections for beneficiaries under age 21 and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.</li> <li>• Proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed care or fee for service system.</li> <li>• Proposes to develop a standardized transition tool, for when a beneficiary’s condition changes, and they would be better served in the other delivery system.</li> <li>• Proposes to implement a “no wrong door” policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care.</li> <li>• Proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.</li> <li>• Proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations.</li> </ul>
3.8	Administrative Integration of Specialty Mental Health and SUD Services	<ul style="list-style-type: none"> <li>• DHCS’s goal is to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver, effective 2027.</li> <li>• Clarifies the distinction between behavioral health administrative integration and the Full Integration Plan.</li> <li>• Revises “cultural competence plan” to “culturally responsive care”.</li> </ul>
3.9	Behavioral Health Regional Contracting	<ul style="list-style-type: none"> <li>• No substantial changes.</li> </ul>

	Proposal	Key Changes
3.10	Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements	<ul style="list-style-type: none"> <li>• Clarifies the timeline, delineating components included in the 12-month extension request (tentative effective date of 1/1/21, if approved) vs. remaining proposals that would go into effect 1/1/22. If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.</li> <li>• Terminology changed from “Substance Use Disorder Managed Care” back to “DMC-ODS” throughout the document to reflect the reversion to the original program name.</li> <li>• Minor update to the background, noting that there are now 37 counties participating in the DMC-ODS.</li> <li>• Announces that DHCS intends to provide non-DMC-ODS counties another opportunity to opt-in.</li> <li>• Notes that the request to remove the number of residential treatment episodes that can be reimbursed in a one-year period was submitted with the 12-month extension request.</li> <li>• Notes that proposed clarifications to recovery services, additional MAT, and tribal services were submitted with the 12-month extension request.</li> <li>• Changes "physician consultation services" to "clinician consultation services" and proposes clarifications related to billing.</li> <li>• Proposes new clarifications related to medical necessity for NTPs</li> <li>• Proposes adding ASAM 0.5 for beneficiaries under 21.</li> </ul>
3.11	New Dental Benefits and Pay for Performance	<ul style="list-style-type: none"> <li>• Implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.</li> <li>• Clarifies that expanded initiatives would be available statewide for children and adult enrollees.</li> <li>• Adds preventative services codes for children and adults</li> <li>• Specifies coverage of Silver Diamine Fluoride for children ages 0-6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/Intermediate Care Facility.</li> <li>• Adds maximum of four treatments per tooth.</li> </ul>

	Proposal	Key Changes
		<ul style="list-style-type: none"> <li>Proposes providing an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.</li> <li>Adds Appendix G: Dental in Proposition 56 vs. CalAIM</li> </ul>
3.12	Enhancing County Eligibility Oversight and Monitoring	<ul style="list-style-type: none"> <li>Revised implementation timeline with initial work beginning 6/1/21</li> <li>Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected in this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.</li> </ul>
3.13	Enhancing County Oversight and Monitoring: CCS and CHDP	<ul style="list-style-type: none"> <li>Minor changes to the implementation timeline. Phase I began in August 2020.</li> </ul>
3.14	Improving Beneficiary Contact and Demographic Information	<ul style="list-style-type: none"> <li>DHCS will engage with partners in 2022-2023.</li> </ul>